



# Hospital side hustles: Funding conundrums and perverse incentives in Tanzania's publicly-funded health sector

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## ABSTRACT

Following three decades of international financial institutions implementing austerity measures in sub-Saharan Africa, many health systems remain chronically underfinanced. During this period, countries like Tanzania have moved from a post-independence vision of a strong social sector providing free care for citizens, to a model of increased privatization of public health facilities, shifting the burden of self-financing to individual health facilities and the constituents they serve. Drawing on longitudinal ethnographic research and document analysis undertaken between 2008 and 2017 within three publicly-funded hospitals in north-central Tanzania, this article examines the actions and perspectives of administrators to explore how novel shifts towards semi-privatization of public facilities are perceived as taken-for-granted solutions to funding shortfalls. Specifically, hospital administrators used “side hustle” strategies of projectification and market-based income generating activities to narrow the gap between inadequate state financing and necessary recurrent expenditures. Examples from publicly-funded hospitals in Tanzania demonstrate that employing side hustles to address funding conundrums derives from perverse incentives: while these strategies are supposed to generate revenues to sustain or bolster services to poor clients, in practice these market-based approaches erode the ability of publicly-funded hospitals to meet their obligations to the poorest. These cases show that neoliberal ideas promoting health financing through public-private initiatives offer little opportunity in practice for strengthening health systems in low income countries, undermining those health systems' ability to achieve the goal of universal health care.

## 1. Introduction

Health systems strengthening in low income countries (LICs) has long been recognized as essential for achieving universal health coverage, first through the Millennium Development Goals (MDGs), and now the Sustainable Development Goals (SDGs) (Marchal et al., 2009; Singh, 2006; United Nations, 2015; World Health Organization, 2007). Subsequent to imposed austerity measures and efforts to privatize and decentralize public services since the 1980s, scholars highlight how many global health initiatives to strengthen health systems in LICs (for example, Sector Wide Approaches, cost-sharing, insurance, and Public Private Partnerships) paradoxically eroded them, and continue to do so despite development policy frameworks suggesting otherwise (Pfeiffer et al., 2008, 2017; Storeng and Béhague, 2016; Turshen, 1999). Austerity measures, modeled on neoliberal reforms promoting market fundamentalism, aimed to reduce public expenditures in order to balance state budgets while increasing the private sector's role in generating economic growth in poor countries (Keshavjee, 2014; Pfeiffer

and Chapman, 2010; Stan and Toma, 2019). In practice, austerity reduced public spending on health systems in LICs, exacerbating underfunding, understaffing, under-resourcing, and donor dependency. Despite calls to strengthen health systems, these conditions often undermined public health sectors' ability to provide effective and equitable health care to their poorest constituents (Pfeiffer et al., 2017).

In health sectors, development policymakers and LIC governments focus on achieving an aspirational future framed around Sustainable Development Goal 3, which in part seeks to “Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all” (United Nations, 2015). However, after decades of austerity and widespread semi-privatization of public health care in LICs (Foley, 2010; Turshen, 1999), inadequate government funding combined with narrow vertical donor initiatives (targeting HIV/AIDS, reproductive health, malaria, etc.) challenge health facilities' ability to finance recurrent operating costs. In response, hospital administrators face few options for addressing

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persistent resource shortages: orient services towards donor priorities (Pfeiffer, 2003); or further privatize, thereby eroding health care accessibility for the poor (Geissler, 2014). In principle, these options suggest marketing to private or donor interests might help facilities finance and expand care for impoverished citizens. In practice, market-based or donor-prioritizing solutions to budgetary shortfalls can impair facilities' ability to provide care.

Drawing on longitudinal research within north-central Tanzanian health facilities over the past decade, this article explores how administrators at three publicly-funded hospitals creatively envisioned income-generating “side hustles” in hopes of keeping facilities running or subsidizing care for the poor. The term side hustle emerged in the United States in the 1950s, referring either to making money through swindling or fraud, or to legitimate income-generating endeavors apart from one's primary job (see Merriam-Webster.com, n.d.). Tanzanians have long engaged in money-making activities outside the formal economy, often skirting government regulation or control (see Tripp, 1997). Further, there is a long history of Tanzanian health workers engaging in (il)legal income-generating activities beyond their formal jobs to supplement inadequate pay, both through informal payments or “bribes” (Iliffe, 2002; Mæstad and Mwisongo, 2011), and through legal activities like selling products or owning private businesses (see for instance Sullivan, 2012). The term “side hustle” thus conveys some of the ambiguities of common economic activities beyond the formal sector in Tanzania.

Below we apply the term side hustle to hospitals' income-generating activities, highlighting that initiatives undertaken—while not illegal—were decidedly outside the facilities' formal mandate to provide quality care to the poor. Hospital side hustles aimed to bolster revenues to address their inadequate incomes so they could keep running. We divide hospital administrators' efforts at economic problem-solving into two general categories of side hustles: “projectification” side hustles to appeal to private donors; and market-based side hustles to attract wealthy consumers. Projectification side hustles create time-delimited projects beyond facilities' main responsibilities in hopes of enticing donors to fund them. Market-based side hustles are money-making activities undertaken on the side, targeting wealthier prospective consumers.

Both side hustle types are tied to prominent neoliberal ideas, incentivizing facilities and providers to stimulate markets for hospital commodities (here, health services or products), in hopes of generating income to finance the wider health system. Ideally, profits earned through market-based approaches would bolster services to the poor through a “trickle down” effect, where funds generated through wealthier markets could finance health care for the poor. However, in practice these side hustles reveal a perverse incentive—in principle a seemingly beneficial incentive that in practice leads to unintended adverse consequences. In this case, applying market-based approaches to public health systems in LICs caters to the interests of the wealthy in order to generate income, which, we show below, is perverse in that doing so inadvertently erodes the very accessibility, quantity, and quality of the services hospital personnel aim to strengthen.

## 2. Health policies and trends amid austerity

During the late 1970s–80s, some of the most progressive transnational health policies emerged in conjunction with the implementation of austerity measures in LICs. In 1977 the World Health Assembly highlighted governments' and the World Health Organization's (WHO) critical role in working towards robust primary health care with the goal of “Health for All by 2000”, and in 1978 the World Health Assembly signed the Alma Ata Declaration declaring health a human right for the first time.

Yet these progressive initiatives were adopted just as International Monetary Fund (IMF) and World Bank policies impeded many LICs' ability to achieve them (Pfeiffer et al., 2017; Stubbs et al., 2017). A

global economic recession from the late 1970s to early 1980s drained LICs' finances. In response, the IMF and the World Bank provided conditional loans to LIC governments as part of “structural adjustment programs” (SAPs), prescribing deep changes to state financing and governance structures aiming to stimulate economic growth through austerity. In 1987 the World Bank published a privatization agenda for LICs, in which market-based solutions became taken-for-granted financial strategies to fund health systems (Keshavjee, 2014; World Bank, 1988). The agenda promoted measures like user fees, private insurance schemes, government decentralization, and NGO and private health services expansion, intending to augment LIC health system financing in part by converting patients into “consumers”, thereby shifting responsibility from the state to individuals (Keshavjee, 2014; Pfeiffer and Chapman, 2010).

Considerably weakened by austerity, since the 1990s, many LIC governments struggled to collaborate efficiently on development initiatives (Pfeiffer et al., 2017). In response, several foreign donors began funneling health resources through NGOs, faith-based organizations and the private sector, which seemed better positioned to execute donors' initiatives (Buse and Walt, 1997; Keshavjee, 2014; Lange, 2008; Pfeiffer et al., 2017)—a trend that continues to present. Many donors prefer funding “vertical” projects targeting specific ailments or populations (e.g. HIV, malaria, reproductive and child health), which international NGOs often implement within existing public health facilities (Brown, 2015; Prince and Marsland, 2014). The proliferation of time-delimited, NGO-administered projects are central to what Meinert and Whyte call the projectification of care, as (often overlapping) vertical projects erode a system once delivered through a centralized state (2014). The siloing of health interventions through projectification created numerous problems, including the establishment of parallel and often duplicative systems (Kutzin et al., 2018), and increased patients' dependence on short-term programs with limited “packages” of services (Meinert and Whyte, 2014), as is well illustrated in the Tanzanian health sector.

## 3. Funding conundrums and market-based “solutions” to health financing in Tanzania

Tanzania's health sector has never been adequately financed. Tanganyika Territory gained independence in 1961, and in 1964 merged with Zanzibar to form the United Republic of Tanzania. Echoing conditions under the colonial period, the country faced critical human resource shortages (Iliffe, 2002; Nsekela and Nhonoli, 1976). However, insufficient state revenues stymied early efforts to address the shortfall and improve health services. By the 1970s, foreign donors, particularly from Scandinavia, financed over 70% of Tanzania's health budget (Bagachwa et al., 1997), primarily through vertical projects like constructing rural health facilities (Havnevik et al., 1988). Acknowledging gratitude for foreign assistance, in 1977 Tanzania's Minister of Health, Dr. Leader Stirling, nonetheless expressed reservations:

The trouble is that every piece of development, be it a new building, a new apparatus, a new technique or a new intake of students, automatically involves an increase in running costs, and the hard fact is that almost no donors are willing to commit themselves to recurrent expenditure, except on a very temporary basis. (1977:137–38)

Stirling's critique of aid earmarking was prescient. Donors' reticence to fund recurrent expenses hampered government efforts to strengthen the health sector from the early postcolonial years through subsequent decades.

War with Uganda from 1978–79, coupled with the 1979 oil crisis and the break-up of the East African Community precipitated a financial crisis. By 1982 Tanzania's economic situation was dire. The government initially avoided taking loans through self-imposed austerity. These efforts ultimately failed, culminating in an SAP agreement with the IMF

and World Bank in 1986 (Biermann and Wagao, 1986). From 1987 to 1999, as the Tanzanian government planned and gradually rolled out SAP-compliant reforms, salaries were reduced, new hires capped, and public health funding slashed, further eroding the health sector (Bech et al., 2013; Lugalla, 1995). A nurse administrator who worked in a public hospital in the 1990s described conditions during this period in a 2008 interview with Sullivan, stating:

It was really difficult, and then there was a big shortage of staff .... Even medicine, firstly there was none .... But as an administrator of course it was to try to encourage people [staff], “my goodness, let us fulfill our responsibilities ... we must help patients!” But how could we help them? You had no medicine, no equipment. So it was really difficult”. (Interview, 16 July 2008; see also Bech et al., 2013).

Decentralization occurred after the reintroduction of multiparty rule in 1992, transferring power from the central government to local governmental entities in order to expand their capacity to improve public services (Lange, 2008). Local authorities became responsible for making decisions, allocating funds, and managing services for their own communities, with expectations of community financial contributions (Frumence et al., 2013). Local authorities also became responsible for submitting budgets for each district's health needs to the central government. Decentralization aligned with neoliberal ideology, emphasizing self-sufficiency and individual or community responsibility for well-being in lieu of state support.

Tanzania's current health financing system emerged beginning in the late 1990s. In 1999/2000, the country adopted a Sector Wide Approach (SWAp) to health financing (see Pfeiffer et al., 2017), in which donor funds were pooled together to finance the sector based on government-donor agreements on funding allocations.

In addition, the central government began implementing other sector revenue initiatives: offering a series of insurance schemes, imposing user fees, and improving tax collection. Health insurance schemes were introduced in 1999/2000 to increase citizens' contributions to health care through pre-paid employer-based and voluntary health insurance, which have continued to be promoted with mixed results. 76% of Tanzania's non-agricultural employment is in the informal sector (Vanek et al., 2014), where employer-based insurance is unavailable. By 2014 only 6.7% of Tanzanians possessed voluntary health insurance, a fraction of the 30% national target. As of March 2018, only 34% of the population carried some form of health insurance, whether employer-based or voluntary individual insurance—far short of the government's 45% goal (Mamdani et al., 2018).

In 2000, out-of-pocket spending by Tanzanian “consumers” through newly-introduced user fees made up an estimated 47% of overall health sector spending (United Republic of Tanzania, UNICEF, 2018). However, donors' expanded funding through the SWAp in the early 2000s had a buffering effect: in 2004/05, donor financing through SWAps made up 44% of total government health expenditures (Development Partners Group Tanzania, n.d.); by 2008 individuals' out-of-pocket payments for health services made up only 18% of total country health expenditure (Mamdani et al., 2018).

However, the 2008 global economic crisis had concerning implications for health sector financing. Donor SWAp contributions dropped significantly, from 44% of total health expenditures in 2004/05 to 14% by 2014/15 (Development Partners Group Tanzania, n.d.). Most overseas aid from 2013/14–2017/18 was earmarked for vertical projects targeting HIV/AIDS, malaria, and reproductive and child health, raising from 56% of total health expenditures in 2013/2014, to 70% for 2017/2018. During this period, donor funding for the sector's recurrent expenses through the SWAp went down from 44% to 30% (United Republic of Tanzania, UNICEF, 2018).

During the late 2000s, while Tanzania experienced some of the fastest economic growth on the continent, it also had some of the lowest tax revenues. While Tanzanian employees in formal sectors pay income

tax, expatriate aid workers and their families rarely do due to tax exemptions (Bräutigam and Knack, 2004; see also Steel et al., 2018). For instance, donor customs exemptions made up 17% of Tanzania's gross value of imports in 2005, presenting significant government revenue losses (Thuronyi, 2005). An African Development Bank Group report (2011) estimates tax exemptions and incentives make up 6% of Tanzania's GDP, and are a main cause of domestic revenue shortfalls. Due in part to inadequate tax revenue, the Tanzanian government's spending on the health sector has shrunk; in 2013/14 the health sector made up only 9.6% of Tanzania's national budget, and by 2018/2019, it was only 7%—far below the 15% Abuja target for health spending (Mamdani et al., 2018). Accordingly, due in part to high population growth stressing the system further, by 2014 out-of-pocket expenditures for health made up 23% of total country health expenditure (United Republic of Tanzania, UNICEF, 2018).

Nearly two decades of attempts to expand citizens' contributions to curative care amid inadequate federal funding made it clear: poor patients made poor customers, and a cash-strapped state could not alleviate the health sector's financial woes. The hospital case studies below highlight the perverse incentives emerging from combined effects of austerity, projectification, and market-based solutions over the last two decades. Inadequate state and citizens' inputs, combined with restrictions of donor-financed vertical projects, taught hospital administrators that to generate necessary income, they needed to attract wealthier clients—whether donors or consumers. Hospital administrators thus began looking beyond the government and the poor to address funding conundrums, devising side hustles in order to finance health services “in the meantime” (McKay, 2018), in the absence of sufficient revenues. Two side hustle strategies were prominent: establishing new time-delimited projects to attract donors, or creating side businesses marketed to middle- and upper-class customers. Both approaches aimed to generate additional hospital income to subsidize services to the poor.

#### 4. Research methods and source materials

The findings reported here emerge from our respective research on the Tanzanian health system over a decade. The qualitative case studies combine findings from longitudinal ethnographic research; close analysis of hospital reports describing strategies to address budgetary shortfalls; and document analysis reviewing Tanzanian health system policy, governance, and financing strategies from the colonial period to the present.

Sustained engagement with the same hospital fieldsites enables us to capture institutional change through time, as we observed and spoke with hospital administrators grappling with how to innovate upon or implement existing policies, programs and possibilities given shifting financial capacity at each institution. Qualitative methods employed during our respective projects included semi-structured interviews and informal conversations with hospital administrators, health workers, and patients, as well as thousands of hours of participant observation of the daily workings of health facilities and surrounding communities in the regions of Tanzania where we respectively worked. In order to protect the identity of the health facilities and participants, all formal names are pseudonyms.

Marten conducted 14 months of ethnographic research in 2011–2012 at Nguzo Hospital, a large and remote mission-founded facility in north central Tanzania. Marten's research examined patient experiences of volatile funding and decreased HIV services in the aftermath of the 2008 global economic crisis (Marten, forthcoming). This case also analyzes Nguzo Hospital's annual reports and audits for descriptions of funding dilemmas encountered since fieldwork concluded. Marten received ethical approval under the University of Florida's Institutional Review Board (protocol #2010-U-0596), obtained ethical approval from the Tanzanian National Institute for Medical Research, and was granted a research permit from the Tanzanian Commission for Science and Technology (COSTECH) (permit no.

2011-87-NA-2010-133). She also received permission from the Regional Medical Office and District Medical Office which oversee Nguzo Hospital, as well as from the mayor of Nguzo town and the Medical Director of Nguzo Hospital.

Sullivan conducted ethnographic research in northern Tanzania for 11 months in 2008 on the effects of health sector reform and foreign-funded global health initiatives on a government-owned facility she calls Kiunga District Hospital, with ethics approval from the University of Florida's Institutional Review Board (protocol #2007-U-902), a research permit from COSTECH (permit no. 2008-02-NA-2007-161), approval from the District Medical Officer of Kiunga, and from the Medical Officer In-charge of Kiunga District Hospital. Subsequent research took place on a separate project on international volunteering in Tanzanian health facilities, including semi-structured interviews, focus groups, and participant observation, at Kiunga and five other health facilities in the region over a total of six months spread between 2014, 2015 and 2017, from June–August each year. This research was conducted with appropriate ethics clearance from Northwestern University's IRB (protocol #'s STU00080617, STU00080617-MODCR0001, STU00205430), COSTECH research permits (2013-222-NA-2014-122; 2015-127-ER-2014-122; 2017-255-NA-2014-122), and letters of approval from the Regional Medical Officer, and the Medical Officers in Charge of each respective facility. Case studies described below draw from Sullivan's research at Kiunga, as well as a government-subsidized medium-sized missionary facility, Mandhari Hospital.

While literature on the Tanzanian health system describes the effects of austerity and resource shortages at specific health facilities or more generally (see for instance [Bech et al., 2013](#); [Strong, 2017](#)), below we focus on how hospital administrators envisioned means of addressing financial conundrums in the absence of adequate income. This article emerged organically as we exchanged insights from our research, including the history of the facilities where we respectively worked, following each facility's trajectories through time during and after our initial fieldwork. Through this process, we uncovered the patterns we describe below. In particular, we found that hospital administrators at each facility proposed or engaged in similar kinds of income-generating strategies in light of pervasive funding shortages and amid their commitments to maintaining or expanding care to those in need. Based on our long-term ethnographic research, we analyze the implications of “side hustles” for each facility, and the wider prospect of strengthening the health system to meet the goal of universal health care.

## 5. Tanzania's health system and the hospital fieldsites

Tanzania's public health sector employs a referral system through which patients should navigate from primary to more specialized care depending on their needs. Dispensaries offer basic health services at the village level, referring patients to increasingly specialized facilities as warranted: from health center, to district hospital, to regional hospital, to specialized/referral hospital. Most districts, but not all, have a government-run district hospital.

The government owns over 60% of Tanzania's health facilities, thus it is largest provider of health services in the country. While private health care was abolished in 1977, it was reintroduced in 1991 as part of health sector reforms. In 1992, the government began registering faith-based hospitals located in remote areas as “designated hospitals”, allocating government health care workers to these facilities, paying some salaries, and providing some pharmaceutical or financial support for essential services, so these facilities are also considered part of the public system. Two of the hospitals described below are faith-based, but have government designated status and therefore are officially considered part of the public system. The third, Kiunga District Hospital, is entirely government owned.

Many private for-profit facilities collaborate with the government on certain services such as reproductive health or vaccine provision,

further blurring the distinction between public and private services, but they are not generally considered part of the public system. Overall, while the faith-based sector enjoys a better reputation for quality of care, in practice, quality of care in public and private sectors can be wildly variable, with patients often relying on word of mouth to determine which facilities offer higher quality services ([Tibandabage et al., 2013](#)).

Nguzo Hospital is the largest mission-led and referral hospital in its catchment area of approximately 300,000 people in north-central Tanzania. Most people living in the area are poor rural pastoralists and agropastoralists. During fieldwork in 2012, while 59% of hospital operations at Nguzo Hospital were funded through a five-year block grant from a European bilateral organization, the facility received government subsidies primarily for worker salaries through its recognized status as a “designated referral hospital”. Additional income came from donor funding for global health initiatives, like the U.S. President's Emergency Plan for AIDS Relief, other international bilateral or missionary donors, and from private individuals supporting specific projects. A small sum derived from various sources of local income and through user fees.

Kiunga District Hospital and Mandhari Missionary Hospital both serve a catchment area of approximately 270,000 people, primarily engaged in subsistence agriculture. However, the area is home to an emerging middle class involved in a variety of businesses including trades, tourism, education and other ventures. Kiunga District Hospital is a government-owned 120-bed facility, mainly funded through federal and local government, as well as user fees. Kiunga also hosts several donor and international NGO-funded vertical projects primarily targeting HIV/AIDS, malaria, and reproductive health.

Mandhari is an 80-bed “designated district hospital” due to its remote location, and receives the bulk of its income through its affiliated church, with additional revenue from user fees and government subsidies for salaries and some services. Like at Kiunga and Nguzo, several donors finance vertical projects at Mandhari, primarily for reproductive and child health, and HIV/AIDS. Mandhari also hosts European mission-funded projects for some specialized pediatric care, and previously received funding for infrastructural improvements from church organizations and private donors in North America and Europe. Yet the financial crisis of 2008 coupled with population growth meant all three hospitals were increasingly cash-strapped as they attempted to finance operating costs, maintain infrastructure, or expand necessary services over subsequent years.

## 6. Side hustles in Tanzanian hospitals

Due to longstanding public sector financing shortfalls, from the early 2000s the Tanzanian government began formally encouraging public institutions to seek out their own partnerships and business-generating opportunities through a Public-Private Partnership model ([Sullivan, forthcoming](#)). Permission to seek partnerships and business ventures beyond the state allowed health facilities to become creative; however, our research shows that Tanzanian health facilities sometimes went to concerning ends to keep services available. As these case studies demonstrate, health facilities' efforts to generate income frequently emphasized short-term survival rather than long-term sustainability, prioritized donor preferences rather than local needs, and invested resources in the wealthy in hopes benefits would finance services for the poor.

### 6.1. Following the money: marketing to donors and the rich at Nguzo Hospital

In 2011–2012, Nguzo Hospital's main funding conundrum was the 2014 scheduled end of its five-year block grant from its main European bilateral donor, which financed the bulk of operating costs. Worryingly, the bilateral donor's 2010 interim report signaled its desire to gradually

phase out financial support for Nguzo Hospital, prompting an extensive (and urgent) hunt for alternate funding sources. With the looming possibility of a significant reduction in donor support, Nguzo's financial concerns were threefold: 1) how to attract and maintain donor interest, 2) how to sustain services when donors departed, and 3) how to generate additional income to fund necessary recurrent expenditures beyond donor interest.

At the time, the hospital hosted numerous vertical programs and global health research projects. These projects provided necessary, albeit narrowly-targeted, funding and services for limited periods. However, the projectification of health services had drawbacks. In an interview, Nguzo Hospital Director Fredrik, a European physician who was head administrator at Nguzo, noted shortcomings of donor-sponsored programs. First were conundrums created by time-delimited donor projects. Said Fredrik, "This is a problem with these projects coming in ... because it is a lot of money, and we are big [health care] providers ... and then suddenly they drop the bag and that's it" (Interview, 19 June 2012). Fredrik's recognition that vertical programs constituted "a lot of money" in the hospital budget was countered by the frustrations incurred by donors' tendency to "drop the bag and that's it", meaning they would cease funding services at the end of the agreed-upon project term (Marten, *forthcoming*). This created a dilemma of how to fund those services once donor support ended, particularly as patients now relied on those services. For example, Fredrik mentioned the palliative care program, donor support for which came to an end in 2011:

We have the palliative care team started by financing from the U.S., and running for 3–4 years, it stopped last year in April. And well of course we could stop giving the service, but when you already have all those sick people you can't just drop off, so we are trying to increase our income from other sources.

Time-delimited projects meant administrators often agonized over which projects to continue funding and how. As Fredrik suggested, donor-supported services could be essential, so when donors ended support, those services were often prioritized in fundraising efforts. He lamented, "when you have all those sick people you can't just drop off" and shutter the program. Importantly, in the hospital's funding-scarce environment, extending programs required additional fundraising efforts, or diverting funds from other hospital services, limiting the effectiveness of projectification as a means for financing basic operations, let alone strengthening the health system more broadly.

In another example, Nguzo hosted a five-year program funded by a European international aid agency to reduce maternal and infant mortality, which ended during Marten's field research in 2011. This program had been really successful; the number of hospital deliveries nearly doubled in two years, and according to a visiting WHO representative, Nguzo Hospital had achieved one of the lowest maternal death rates in Africa (see also Adams et al., 2016). The hospital decided to continue the program, but needed to divert funds from elsewhere in the hospital's budget to pay for it, despite its significant cost. "I should have shut down the mother and child [program] already" Fredrik noted, "It ended March 1 [2011], but we continue and pay for it and I tend to do that [for specific programs], because there must be money somewhere for it".

Despite administrative demands of multiple projects, and pressures to pay for project services once the donor departs, the perceived emergency of a substantial, impending budget crisis at Nguzo Hospital meant administrators were perversely incentivized to create new programs, thereby introducing new funding conundrums. In 2010, Nguzo's primary European donor commissioned an external auditing firm to propose strategies to "close the expected gap between revenues and expenditures" if the donor eliminated funding. The auditor report prioritized projectification side hustles as a chief prospect for generating additional donor funds. The report noted that "private donors represent the largest segment of the addressable market" and, similar to

the dilemma Dr. Leader Stirling highlighted back in 1977, ceded that "donors are more inclined to donate to concrete projects than to ongoing operations". External donors' preference for time-delineated projects echoes wider findings in Tanzania: donors prefer vertical projects because they can be more easily monitored and evaluated, and could be advertised to their stakeholders as successful (Hunsmann, 2012; Sullivan, 2017).

Yet in his 2011 conversation with Marten, Fredrik highlighted financial inefficiencies inherent to vertical health projects the donors preferred:

We can't ask [donors] for support without any plan. We can't just say 'it would be nice to have 10 million'. If [vertical programs] are what the donors want they can get it ... but it will be more administration. The easiest [thing] would be for people to come see the work, and see whatever [services] we provide, in fact what we do, because if you think about prices and what we can do for a small amount of money, it's amazing. The annual budget here is about the budget for one day in the [European] hospital where I come from.

For Fredrik, this comparison illustrated how cost-effective the hospital could be if given the freedom to do "what we can do for a small amount of money" – providing necessary services for a comparatively low cost. Funding operational costs for the wider hospital was not only a more effective means of service provision, Fredrik suggested it was also more *cost-effective* than funding projects because projects required "more administration", and therefore were more expensive than recurrent expenditures. Here was another paradox woven into projectification side hustles: administering multiple separate projects may be less economical than funding general operating budgets (see also Hunsmann, 2012). Marten heard similar statements from others comparing Nguzo Hospital's annual budget and the daily budget of a European hospital. At Nguzo, Europeans and Tanzanians alike underscored this comparison to express frustration about needing to justify their operating costs, when the same sum in a European context would seem nominal.

In 2014, Nguzo's primary European donor signed a new block grant financing hospital operations from 2015 to 2019, with an aggressive plan to reduce donor dependency over time, facilitating what many Nguzo administrators referred to as "standing on our own feet" (*simama kwa miguu yetu*). In 2012, donor contributions comprised approximately 60% of the total hospital budget; by 2017 they were down to 30%. To offset reduced donor funding, two phases of staff retrenchments were announced to reduce costs, despite a documented staff shortage. The Tanzanian government increased its funding to Nguzo by 2%, but contributions from user fees had to be increased, making up 23.4% of operating costs by 2015, and 32.5% by 2017.

However, raising user fees reduced the number of patients accessing services from 2015 to 2017, and worryingly, the hospital's death rate increased during this period from 5.98% to 8.58%, the majority of deaths being among people over age five. The 2018 block grant report highlighted "patients delaying seeking care because of increased user fees" as a main cause of increased mortality rates. Community members and hospital employees interviewed for the report were concerned, as people in the catchment area were mostly poor rural farmers with seasonally-fluctuating income, and few participated in health insurance schemes. Increased fees, respondents noted, likely shifted the order in which people sought care—seeking out traditional healers and going to dispensaries first, "which often delay them from receiving the right treatment in time". Above all, expanding user fees contradicted the principal mission of the hospital: to help the rural poor.

A stated objective of the 2018 report was, again, to identify alternate hospital revenue sources. The evaluators noted, "there are few donors—if any—who are willing to provide flexible core funding", which was necessary to finance ongoing services and staffing. The report highlighted a promising new market-based side hustle: creating pro-rich, private wards with higher standards of care, as other

Tanzanian facilities had done (Ellison, 2014; see also Stan and Toma, 2019). The report identified the hospital's mental health clinic, considered outside "core" services for a regional-level hospital, as a promising site for privatization: "Apparently, there is a market for ... developing more exclusive services for patients with an ability to pay for them" the evaluators noted, adding that it would require attracting "customers from far away" who could afford higher fees, and investing hospital resources in order to "renovate and expand the aging infrastructure".

This side hustle business notably envisions a new "market": wealthy health care consumers from outside the catchment area (and perhaps from other countries entirely). The evaluators' observation that "important investments" must be made to upgrade facilities to VIP standards suggested a short-term undermining of existing services in favor of constructing amenities for wealthier consumers. This proposal demonstrates the perverse incentives characteristic of neoliberal restructuring of weakened health systems: investing in pro-rich services in hopes income generated might subsidize health services for the poor in the long term may erode or compromise existing services, with poor patients bearing the brunt of the costs.

## 6.2. *Drugs, cadavers and brides: the politics of market-based side hustles at Kiunga and Mandhari Hospitals*

Sullivan's 2008 research at Kiunga District Hospital traced how the facility had successfully attracted foreign donors. From 2000 to 2009 Kiunga nearly doubled in size due to donor infrastructure investments. Health workers linked this success to two federal government policy changes: the rolling out of user fees, which facilities could use for operating costs; and since the early 2000s, encouraging facilities through Public-Private Partnerships to collaborate with private and donor entities to bolster services (see Sullivan, *forthcoming*). Eased restrictions on private investments in the health sector had brought Kiunga a few minor successes: a U.K.-based missionary group and a Kiunga-based transnational flower company funded new pediatric and male ward buildings; and the international NGO financing HIV/AIDS services agreed to expand the small HIV clinic building.

Yet in subsequent years, hospital income from the government, donors, and user fees remained inadequate to support recurrent expenses. Two problems were particularly acute. First, certain categories of patients (pregnant women, children under age five, patients over age 60, the chronically ill, and the insured) were entitled to receive free treatment at public health facilities. Yet the government's pharmaceutical distributor, the Medical Stores Department, rarely sent enough drugs and supplies to allow these promises to be met (see also Strong, 2017). Second, the hospital's mortuary was small, and lacked a cadaver refrigerator, so it could only hold two cadavers for two days maximum. Between 2014 and 2017, two of Kiunga's market-based side hustle ventures were meant to address these acute problems. Instead, the ventures inadvertently introduced new conundrums at the facility, undermining Kiunga's reputation in the catchment area, and within the wider political landscape in Tanzania.

Aware of their right to free care, fee-exempted and insured patients encountered long queues at Kiunga Hospital. Hours after arrival, when they finally got a prescription for their (supposedly free) drugs, they would walk to the on-site public pharmacy to find most prescribed drugs out of stock. Rumors of corrupt health workers proliferated, as many patients assumed health providers were selling government drugs in private pharmacies for personal profit. By 2016, in an effort to reduce costs and improve drug delivery, Tanzania's Minister of Health, Community Development, Gender, Elderly and Children announced the government would start procuring drugs directly from manufacturers rather than private sellers. However, the Minister urged local government leaders "to seek other sources of funds instead of waiting for the central government" (Athumani, 2016)—an allusion to the Public-Private Partnership model the government was actively promoting.

Eager to address pervasive drug shortages, Kiunga administrators proposed a side hustle business to generate income through which the facility could purchase drugs the government was unable to supply for fee-exempted and insured patients. As most patients—fee-exempted or not—had to purchase their drugs at private pharmacies due to hospital stockouts, why not build a hospital-owned private pharmacy? If patients had to go to private pharmacies to purchase drugs anyway, why not keep those profits at Kiunga to purchase drugs for the public pharmacy?

In 2014, Kiunga's administrators received a nearly US\$32,000 loan from the National Health Insurance Fund to construct and stock a hospital-owned private pharmacy. By April 2015 the private pharmacy was operating at the hospital gates, staffed by Kiunga nurses. In 2017 Kiunga was still repaying the loan. Administrators anticipated the pharmacy would be able to start turning a profit by 2018 once the loan was paid off. However, the business had significant drawbacks. When the pharmacy opened in 2015, gossip circulated in surrounding communities that some Kiunga staff were stealing drugs from the hospital's public pharmacy and selling them at the private pharmacy to line their own pockets. These rumors undermined Kiunga's reputation in the wider community—a particularly unfortunate outcome given how Kiunga's infrastructure expansions in previous years had improved community perceptions of the facility. The head Kiunga administrator felt patients were seeking services elsewhere due to the rumors, even though the business aimed to benefit patients in the absence of sufficient state funding.

Similarly, in 2015 community members complained about the hospital's lack of an adequate mortuary with cadaver fridge. When a relative passed away, people found it difficult to collect their loved one's remains within the two-day holding period. Many therefore had to pay significant additional costs to transport the cadaver to another health facility that had refrigeration, straining their already meager resources. Kiunga administrators had sought a donor for the mortuary since Sullivan's research in 2008, but up to 2016 no donors had expressed interest. Most transnational donor funds were tied to the MDGs, and later the SDGs—goals which neglected the dignity of caring for the dead. The estimated cost of the building and cadaver refrigerator was US\$90,000. In 2015, Kiunga's head administrator described the mortuary conundrum to Sullivan: "you know, it's unfortunate, Noela. It's just not a donor priority. I think we'll have to outsource it". He planned to locate an entrepreneur to build and run the mortuary as a time-delimited contractual business, with the plan of eventually returning the business to Kiunga Hospital ownership.

When Sullivan returned to Kiunga in 2017, the new mortuary foundation was built, but it was overgrown with grass. It had been abandoned. Sullivan learned that an elected politician offered to construct the mortuary, and also donated ambulances to the hospital emblazoned with his name. However, the politician was a member of Tanzania's major political opposition party, *Chama cha Demokrasia na Maendeleo* (CHADEMA). Tanzania's dominant political party, *Chama cha Mapinduzi* (CCM), maintained majority rule in parliament, and relationships between CCM and CHADEMA were tense. This put the hospital in a bind: their main source of funding was the CCM-dominated central government, and donations by a CHADEMA politician put the hospital in the central government's crosshairs. Ultimately, the mortuary plans were abandoned to preserve Kiunga's reputation with the central government.

Mandhari Hospital faced equally challenging financial circumstances, and also sought means of balancing their books while meeting patients' needs. Funding from the mission had dwindled as the population increased. Cost-sharing was increased to defer costs, but many patients left the hospital after receiving services without paying, escalating the fiscal crisis. By 2015, Mandhari was in such financial distress that the hospital and its affiliated health centers risked being shuttered for good. A new administrator was brought in to help the hospital stay afloat. She located foreign donors to fund a few projects (further

**Magauni ya harusi  
ya kukodisha**

- Pata gauni la ndoto yako
- Saidia watu katika jamii wenye magonjwa yasiyopona.
- Magauni mazuri ya pekee kutoka Ulaya
- Kwa bei nafuu.
- Tunapatikana kilomita 5 kutoka Chuo kikuu cha

Mawasiliano : Palliative Care, Hospital  
Telephone: \_\_\_\_\_  
e-mail: \_\_\_\_\_

**Fig. 1.** Advertisement for wedding gown rental in the palliative care unit of Mandhari Hospital. “Wedding gowns for rent. Find the dress of your dream; Help people in the community with chronic illnesses; Beautiful unique gowns from Europe; Good price; We are located 5 km from the university”. Image by Noelle Sullivan, June 27, 2017. Taken with permission, altered to protect facility anonymity.

projectifying the hospital), increased user fees, and adopted procedures to ensure patients paid for their care.

By 2017, Mandhari's financial outlook had improved, but it remained at risk. As administrators strategized on how to increase income to support daily operations, they came up with a new idea: a side hustle business renting wedding gowns to people in surrounding villages. Renting European-style white wedding gowns was a growing trend among middle- and upper-class women (see Fig. 1). The hospital purchased gowns from Europe, and set up the rental shop in the hospital's palliative care unit, run by the palliative care nurse (see Fig. 2). While

an innovative idea, the gown rental business showcases the perverse incentives of applying neoliberal logics to hospitals' chronic funding conundrums in the absence of sufficient donor and state funding: market-based side hustles can divert services and resources away from patient care in hopes of generating revenue to support wider primary care.

When health facilities' services or initiatives can readily be made into targeted projects appealing to donors, attendant services could generally run smoothly provided the donors maintained funding levels, albeit with additional administrative costs and burdens. However, costs



Fig. 2. Wedding gown display in Mandhari's Palliative Care Unit. Image by Noelle Sullivan, June 27, 2017. Taken with permission.

of wider primary health care, which served mainly poorer populations, required hospitals create side hustle businesses just to generate sufficient income to maintain general operations. They could outsource some of their services as private businesses, or they could create their own profit-making side-businesses. However, doing so undermined health services, siphoned human and financial resources out of hospitals, subjected facilities to gossip and rumor, and could be politically fraught.

## 7. Discussion

The case studies above exemplify the challenges of financing and

strengthening health systems in LICs in order to achieve robust universal health care. According to the WHO, health systems strengthening requires a strong health financing system which “raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them” (World Health Organization, 2007, p. vi). In the wake of austerity and projectification of the health sector, such a strong health financing system has been difficult to achieve in Tanzania. Over the last two decades, insurance schemes have had limited success, and the imposition of user fees has had a disproportionate burden on the poor, whose access to care is inhibited when they cannot afford to pay (Mtei et al., 2012). When the majority of a country's



constituents are poor, they tend to make up a poor market for investing in health care services.

In response to inadequate financing through the government, taxation, user fees, and insurance schemes, facility administrators are left with the burden of economic problem-solving rather than attending to the broader management of health services for their mainly poor constituents. They have to look beyond the government and the poor in hopes of generating income. As market-based “solutions” became taken-for-granted as a means of solving financial woes (see also Foley, 2010; Keshavjee, 2014), hospital administrators in the cases above began imagining and implementing side hustles to address their economic woes: projectification side hustles hoping to attract wealthy donors to time-delimited vertical projects, or market-based side hustle businesses aimed at wealthier consumers' interests. Health facilities were incentivized to create (and divert funding toward) these side-hustles with the assumption that they would ultimately generate enough income to support operating costs that are essential to strengthening health systems. Ultimately, appealing to donors through vertical projects, or the wealthy through privatized VIP services, pharmacies, or upscale European wedding gown rentals, does little to meet the needs of the poor, nor those of the health facilities meant to serve them over the long term.

The results of these endeavors illustrate the perverse incentives of using market-based solutions to address weak health financing systems in LICs; while on the surface, side hustles are commendable in their ingenuity, too often these endeavors not only fail to adequately fund facility operating budgets, but also undermine the very services they are meant to support. In some cases, the negative consequences of these efforts can be significant, ranging from the erosion of community trust and political reputation, to a sharp rise in mortality rates. By the time of this writing, none of the hospitals depicted in the cases above had found these side-hustles sufficiently lucrative to solve the very economic problems they aimed to alleviate. Ultimately, market-based “solutions”, rather than supplementing or bolstering publicly-funded health facilities, wasted time or eroded scarce resources in order to solve economic problems not of the hospitals' making.

These administrators' experiences endeavoring to meet the country's commitment to universal health care in the absence of sufficient budgetary capacity demonstrate the limits of market-based approaches to strengthening health systems in LICs. Rather, neoliberal models promoting the expansion of “markets” for health services as commodities imagine consumers with the financial means to use private services in order to access better care, bypass long lines, or purchase “exclusive services”. Such approaches apply poorly to contexts where the majority of people meant to consume those services are poor, and where the quality of services in both public and private sectors are wildly variable (Tibandebage et al., 2013). In response to economic and structural issues beyond their control, health facility administrators in Tanzania are undertaking financing schemes that undermine not only the quality of care, but also the ability of most individuals to access the care that is actually available. Case studies from Mandhari, Nguzo and Kiunga demonstrate clearly that a neoliberal model for health care financing in LICs offers little opportunity to achieve the WHO's Framework for health system strengthening, let alone to ensure that health is indeed a right to which citizens have meaningful access through universal health care.

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