Critical Public Health

ISSN: 0958-1596 (Print) 1469-3682 (Online) Journal homepage: http://www.tandfonline.com/loi/ccph20

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To cite this article: Noelle Sullivan (2017) Multiple accountabilities: development cooperation, transparency, and the politics of unknowing in Tanzania's health sector, Critical Public Health, 27:2, 193-204, DOI: 10.1080/09581596.2016.1264572

To link to this article: http://dx.doi.org/10.1080/09581596.2016.1264572

CRITICAL PUBLIC HEALTH, 2017
VOL. 27, NO. 2, 193–204
http://dx.doi.org/10.1080/09581596.2016.1264572

Taylor & Francis
Taylor & Francis Group

RESEARCH PAPER

Multiple accountabilities: development cooperation, transparency, and the politics of unknowing in Tanzania's health sector

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ABSTRACT

Accountability and transparency are considered best practices within development cooperation frameworks characteristic of global health practice today. In this article, I ask: How do accountability and transparency work, and for whom? I develop three main arguments. Drawing on Geissler's concept 'unknowing,' I first demonstrate that global health actors are aware, yet strategically obscure, the instabilities and problematics of data and indicators in Tanzania. Second, I suggest that multiple and contradictory forms of accountability are pursued by global health actors, while this multiplicity is often unspoken in order to render accountability frameworks legitimate to sustain the existing development cooperation system. Third, I argue that foreign and Tanzanian actors within the health sector perpetuate accountability and development cooperation frameworks which are neither cooperative, nor accountable to citizens and purported beneficiaries of aid, because doing so allows actors to pursue interests often unrelated to formal policy goals.

ARTICLE HISTORY
Received 30 April 2016
Accepted 20 November 2016

KEYWORDS
Tanzania; accountability; transparency; global health; ethnographic fieldwork

Introduction

The terms 'accountability' and 'transparency' within development and global health emerged during the early 1990s with the World Bank's drive towards results-based metrics and bilateral donors' shift to performance-based financing.[1] Today, these terms are ubiquitous in transnational and national policy documents. Measuring performance became a central tenet of aid efficacy, along with 'development cooperation' and 'mutual accountability' – ideas later formalized in the Paris Declaration (OECD, 2005/2008). Development cooperation is a means by which stakeholders (donors, recipient governments, private sector actors, and others) collaborate through financial, technical, and technological means to achieve national or international development goals. Mutual accountability is a commitment by donors, government, and other stakeholders to be transparent about their activities in recipient countries.

Many best practices in development cooperation were first conceptualized in Tanzania, nearly a decade before the signing of the Paris Declaration.[2] The country is thus an important site from which to inquire: How do accountability and transparency work through development cooperation, and for whom? I open this exploration with an observed scene from my fieldwork in Tanzania in 2008.

On October 8, in a grandiose conference room within the luxurious Kunduchi Hotel in Dar es Salaam, over two hundred people attended the Joint Annual Health Sector Review (JAHSR) meeting – an annual

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event in which participants, both Tanzanian and foreign, collectively evaluate and plan for the health sector. The diversity of meeting delegates was dizzying: high-level Tanzanian government officials; donor country representatives; delegates from the World Bank and United Nations; myriad transnational and local NGOs; ambassadors from Thailand, Ireland, Switzerland, and the Netherlands; Tanzanian public and private health sector workers; and one anthropologist. JAHSR meetings have taken place in Tanzania annually since 1999. However, this meeting had a special purpose: to review, and hopefully ratify, the *Health Sector Strategic Plan III* (HSSP3), the policy document to govern the sector from 2009 to 2015.

Dr. Rik Peeperkorn,[3] the Chair of Tanzania's Development Partners Group for Health (DPG Health), made the opening statement,[4] emphasizing the need for mutual accountability: 'How do we successfully *hold each other accountable* for the implementation and progress of this Strategic Plan?'. Near the speech's end, he underscored, 'Crucial for the success of the HSSP will be how the government and the stakeholders will monitor the implementation. […] do we, based on *available evidence*, adapt, re-focus, or consolidate and strengthen our investments and support?'[5] On the surface, accountability occurs when powerful actors allow their actions to be scrutinized by others, whether a selective or a wide audience; transparency is necessary to enable accountability to function, meant to render information available to various audiences, whether private stakeholders or the public writ large.[6]

Dr. Peeperkorn implied that donors, government, and other stakeholders should be transparent about what they were doing, publicly, *to one another*, demonstrating their interventions achieved results aligned with the strategic plan. As an anthropologist who spent countless hours observing Tanzanian public hospital staff collect data for donors and the Tanzanian government, the phrase 'available evidence' seemed remarkable. Over-burdened with patients, lacking sufficient technological, infrastructural, or human resources, health workers were often unable to keep up with reporting burdens. Often, inputs were guessed at, rather than scrupulously counted or measured. To me, Tanzanian health workers' data inputs said more about reporting burdens than health. As discussed below, in the course of the JAHSR, it was clear delegates were only too aware that data reported by health facilities was notoriously unreliable.

Meanwhile, what was said publicly at JAHSR differed tremendously from what delegates told me privately. Interviews with government representatives, bilateral aid officers, and NGO officials revealed practices surrounding accountability, transparency, and data often misaligned with the development cooperation 'best practices' these entities purportedly supported. In practice, accountability and transparency concealed more than revealed.

This article extends Geissler's concept of 'unknowing' (2013) to global health governance practice in Tanzania.[7] Unknowing, or the strategic obfuscation of inequalities, instabilities and uncertainties characteristic of practices of scientific knowledge production in Africa, can be similarly applied to development cooperation practices in Tanzania. Below I develop three main arguments. First, I demonstrate that actors within policy-making circles, such as those present at the JAHSR, are aware that the metrics they employed or aspired to are uncertain (Biruk, 2012) or even inapplicable, but problematic data is deliberately unknown (Geissler, 2013) in order to enable actors to pursue interests often unrelated to goals outlined in documents such as the Strategic Plan (see also Adams, 2016). Second, I suggest that in global health practice, accountability is multiple (and often partial), while its multiplicity is often unspoken in order to render accountability frameworks legitimate. Global health actors actively negotiate and foster opacity within the transparency upon which accountability relies. Third, I argue that foreign and Tanzanian health sector actors are occupied more with *performing* sufficient accountability than attending to locally relevant health needs.

Following a brief overview of methods, I consider how unknowing contributes to development cooperation and evidence-making in global health practice. I next juxtapose JAHSR discussions with interview data to demonstrate how global health actors unknow data's uncertainties. I then describe internal accountabilities, and how they challenge mutual accountability best practices. Finally, I describe why differently situated actors in the Tanzanian health sector perpetuate development cooperation and accountability frameworks that undermine possible benefits to populations and communities targeted by their efforts.

Researching health governance

This article draws upon 11 months of ethnographic fieldwork in Tanzania in 2008, primarily conducted within a public hospital in the north of the country. In this project, I observed reporting, meeting, and care practices at a 120-bed hospital in a district with a population of approximately 200,000. I explored how health sector reform and donor funding mechanisms shaped and were shaped by hospital routines. As most government and donor offices are in Dar es Salaam, I went to the city on several occasions, attending meetings and conducting interviews with various actors, from Ministry of Health officials to bilateral donor representatives. One Ministry official invited me to attend the JAHSR, to further inform my understanding of how health sector governance operated in practice. While the analysis below draws significantly from fieldwork conducted in 2008, subsequent field visits in 2011 and 2013–2015 confirm that the accountability system described remains, and has expanded in some respects.[8]

It was through encounters with Tanzanian and foreign actors operating at different scales (local, national, transnational), that I grasped a seemingly unwieldy governance system, and understood its contours as resulting from situated interests, actions, and relationships. Governance and administration may seem boring, mundane or overwhelming; however, research in such arenas can unearth insights about how power operates in practice, and complexities of situated interests at play. As global health is ever more infused with combined logics of science, business, and measurement, attention to the stakes of such shifts, and their implications in practice, is increasingly urgent (Erikson, 2016; Esser, 2014; Green, 2015).

Multiple accountabilities and unknown knowns

Several scholars demonstrate global health and humanitarian interventions, and the discourses that attend them, often depart significantly from stated aims. Keshavjee terms these departures 'realms of neoliberal programmatic blindness', wherein local needs are subsumed to spread neoliberal agendas (2014, p. 15). James (2010) equates opacities of bureaucratic practices and technologies employed in humanitarian aid to 'realms of ritual secrecy' (p. 180); intervening agents manipulate bureaucratic techniques for their own purposes, inciting rumor and accusations among aid recipients. Biruk (2012) demonstrates that 'blind spots' are produced in daily HIV survey data collection, wherein 'Uncertainties and everyday social interactions and practices stand behind and are obscured by numerical claims' (p. 362). While programmatic blindness, rumor and accusation, and data 'blind spots', are salient issues in global health practices in Tanzania (see for instance Sullivan, 2011, 2012), these approaches did not fully explain how global health actors navigated accountability and transparency within development cooperation frameworks.

For instance, all actors, whether hospital staff, government representatives, or donor officials, were aware multiple forms of accountability existed in Tanzania. One type derived from 'public data,' collected in communities and health facilities, depicting the state of health and health systems in Tanzania to the public writ large through surveys, reports, budgets, and websites. The second type was either internal, or public-by-proxy. Bilateral donors, and the contractors implementing their programs, compiled data for limited circulation to stakeholders. Contractors reported internal data to their donors. Annual reports of internal data circulated to government entities in donor home countries – public-by-proxy because data was released to the government representing citizens, but not to citizens themselves. Hospital staff compiled both public data meant for wide circulation, and internal data meant for select audiences. Public data collected for the Tanzanian government and the public differed significantly from data meant for donors and contracting organizations. Thus, some forms of accountability were to be transparent to public scrutiny; other accountabilities were selective and closely guarded. Given their awareness of multiple accountability frameworks, how might JAHSR delegates have understood Dr. Peeperkorn's statement about 'available evidence'? That is, what is the nature of accountability and transparency if stakeholders are actively engaged in strategically obfuscating or skirting the very transparency on which mutual accountability relies?

Wenzel Geissler's concept of 'unknowing' is particularly useful for analyzing the chasm between discourse and practice within development cooperation frameworks. Geissler (2013) argues that 'unknown knowns' are actively produced and inherent within scientific knowledge making.[9] In Geissler's analysis, collaborators are aware of inequalities characterizing scientific knowledge production, but this knowledge is 'unarticulated, sometimes silenced, excluded from public conversation and official record, and restrained to particular situations – "unknown"' (p. 19). Unknowing enables consensus and sustains working relationships between differently situated actors collaborating across significant material differences.[10]

If unknowing is characteristic of collaborative scientific knowledge production in Africa, it is also pervasive in accountability practices of stakeholders involved in the health sector in Tanzania. Below, I extend Geissler's concept of unknowing to the active practices through which global health actors selectively obscure or reveal the quality, existence, or circulation of particular forms of data in order to legitimize themselves to various others. In so doing, global health actors uphold the development cooperation system, despite practices of unknowing undermining the very tenets of accountability and transparency on which best practices of development cooperation rely.

Unknowing was perceptible in how accountability and data were discussed, produced, and selectively circulated among global health actors in Tanzania. Max Weber argued that administrations excluded the public in order to avoid public scrutiny (1978, p. 992). However, in the world of development cooperation and global health, the public is not necessarily excluded so much as strategically and partially included through a complex web of multiple yet differently circulating accountability frameworks. Some data are revealed for wide public scrutiny, rendering actors seemingly accountable to citizens and various others. Internal data is collected, but actively unknown, unacknowledged, or excluded from view.

Rather than taking development reports, policies, and official statements at face value, attention to actors deliberately unknowing, variously skirting, or strategically informing official best practices uncovers how they negotiate and animate global health systems, to what ends, and the stakes in so doing. Unknowing simultaneously permits development actors to *appear* cooperatively aligned with best practices for effective aid, while allowing individual actors to avoid scrutiny of fellow actors or the public writ large. To openly acknowledge that accountabilities are multiple in such settings – that all parties present compile their own internal data and actively foster opacity, rendering transparency strategically partial (Jerven, 2014) – would undermine possibilities for cooperating on common strategic goals.

Unknowing is similarly applied to how health sector actors envisioned, aspired to, or collected and compiled data. The dubiousness of evidence was known; yet the instability of evidence was rarely revealed in publicly available documents and reports (Jerven, 2014). This suggests metrics and forms of counting and accounting are not necessarily hegemonic; rather, the hegemony is in public displays of '*trust* in numbers' (Porter, 1996), despite unspoken knowledge that numbers could not be trusted (Adams, 2016).

The ability to appear accountable and transparent despite processes of unknowing were possible in part due to the nature of the terms themselves. While ubiquitous within policies at transnational and national levels, accountability and transparency are rarely defined, enabling these words 'to shelter multiple meanings,' while enveloping actors mobilizing the terms in moral authority, shielding them from critique (Cornwall & Brock, 2005, p. 1056). Cornwall and Brock call these terms 'buzzwords': words providing 'legitimacy that development actors need to justify their interventions' (2005, p. 1048). Although their contours are vague in practice, buzzwords nonetheless do considerable work within development cooperation, benefitting variously situated actors in different ways.

Unknowing the uncertainties of indicators

On day two of the JAHSR meeting, the Health Sector Strategic Plan III was outlined in a 45-minute PowerPoint. The floor then opened for discussion. The overall tone in the room was tense. HSSP3 would

govern the government's activities within the health sector; in addition, Development Partners and stakeholders were expected to adhere to this document in planning their selectively funded health sector activities. Foreign delegates therefore had a stake in ensuring that the Strategic Plan represented their interests (see also Hunsmann, 2012).

During discussion, the Monitoring and Evaluation table within the HSSP3 – that is, the table outlining precisely which indicators would be measured to show 'progress' and therefore reveal how the country accountably pursued strategic goals – was the subject of vigorous debate among foreign and Tanzanian delegates alike. The Swiss Agency for Development and Cooperation representative stated that the table was not sophisticated enough 'to reflect the actual system.' The British agency officer noted some indicators had been disaggregated by gender; she felt *more* indicators should be similarly disaggregated. The Irish delegate retorted that only indicators that could be measured statistically and annually should be included. In response, Dr. Faustin Njau, a high-level Ministry of Health official heavily involved in drafting the HSSP3, explained several indicators on the table reflected the Millennium Development Goals (MDGs). Since Tanzania and most donors present were MDG signatories, they had to retain these indicators, even if they were not measurable. In other words, *unmeasurable indicators* must be maintained to appear accountable to the MDGs, even if they could not be counted.

A Tanzanian physician highlighted challenges for local governments (Councils) collecting data and compiling reports for the Health Management Information System (HMIS), the program for compiling administrative data in the sector: 'we really need to be informed about the progress at the Council level to participate even on the reporting. Are we getting [Council] reports? Are we informing them *really* at the Council level?' Subsequent discussion confirmed that delegates knew most administrative data were incomplete. Understaffed and overburdened with patients, remote districts found it difficult to adhere to reporting timelines, let alone capture the multiplicity of different data points demanded by government and other organizations funding programs in their facilities. One delegate suggested additional funding for districts least able to meet reporting requirements.

The second day of the JAHSR revealed multiple and divergent logics of indicators, and the scales they aimed to represent. Some delegates felt data should be made useful to local levels where it was compiled. For others, data should be reliably measured annually, and 'reflect the actual system' on a national scale. Still other indicators had to be maintained because Tanzania was a signatory to transnational policies like the MDGs and the Paris Declaration, which required accountability despite some indicators being unmeasurable. The comments reflected the challenges of creating accountability frameworks relevant to local, national, and transnational scales simultaneously. No one could decipher how to design a measurement system relevant across scales. Instead, comments highlighted how indicators could not be accountable to all scales at once; often they were incomplete, uncountable, or inappropriate even at the scale they were supposed to represent – aspects of transparency and accountability actively unknown in order for all of the actors to work with the approved HSSP3 in future. The Permanent Secretary of the Ministry of Health's closing statement was a quip rendering unreliable data 'reliable': 'Figures never lie. But liars figure.' Data were sound, he suggested – only problematic when manipulated to say something other than intended. Data's instabilities were strategically unspoken.

Conversely, in interviews and casual conversations, bilateral agency and Ministry of Health representatives described the complexities of data collected in Tanzania, suggesting that data do, in fact, lie. In an interview, John,[11] an expatriate employee of the Ministry of Health,[12] said:

> The problem at the moment is that we – dammit! – we don't know what is going on. […] We have no clue! Point at anywhere on the map and you can't say, 'this is the health situation there' because we don't know if we can rely on the data or not.

He expanded:

> We don't have a very precise health information system in Tanzania because we have not been able to create very effective mechanisms to secure timely and high quality data. […] Don't tell Dr. Njau because he refuses this, but if you go to the districts in many developing countries at the sub-district level facilities, you will find that sometimes they are not filling in the forms. And then you ask yourself: Okay, if they don't fill in the forms, what then? What happens? Who made those figures? And how? And you will find out that they do as many other places, they just

> copy from [the last] time when they actually filled in the figure. So it happens, it's not half of the facilities, that's not what I am saying, but it's pretty often that you see it. […] It takes a hell of a lot of time if you are a nurse or someone working out there in a dispensary, it takes a long time compiling all those data and maybe they're not that good at it, and if there's no one to control it you can just send them any figure. Why the heck all that trouble? […] I don't trust the figures, I must say. (Interview, 23 September 2008)

John suggested that, indeed, figures lied. Yet the government governed with these figures, which to John had major implications ('What then? What happens?'). Untrustworthy data threatened sound governance. Meanwhile, in asking me not to mention inaccurate data to Dr. Njau, John simultaneously enlisted me to unspeak the issue, while implying Dr. Njau did so himself – he 'refuses' to acknowledge data as inaccurate, despite known omissions and fabrications. A study published in 2008 confirmed that others within the Tanzanian Ministry of Health shared John's sentiments. Officers interviewed mistrusted HMIS administrative data: 'They [Ministry of Health officers] believe that at the end of each month the health workers hazard a guess at the appropriate data and fill in the HMIS books accordingly' (Smith, Madon, Anifalaje, Lazarro-Malecela, & Michael, 2008, p. 9; see also McKay, 2012).

Political complexity of data collection was similarly expressed in an email I received from Robert, a USAID Tanzania representative working in Tanzania in 2008, but who retired in 2010. I asked him the origin of data in the Country Profiles published on WHO's website. I quote his response at length:

> God only knows where WHO and UNICEF get their data. They try to use similar sources all over the world, so they can compare apples with apples, and since UN Agencies (including WHO) are governed by the countries as a whole, they do use a lot of HMIS data. In most of the countries where I worked, HMIS data is garbage, with data which is fabricated, or just not collected in over half the facilities. Garbage in, garbage out.
>
> USAID uses (where it can) DHS [Demographic and Health Survey] data, that we have some control, for the big picture. That is considered the 'Gold standard' of information, but does have plenty of problems. It is only done every 4–5 years and is national averages which can be difficult to interpret on a local level, and there can be big variations within a country.
>
> We also have our contractors collect data locally where they work, either through community surveys or facility-based. This is important for local programming, but may not (and usually does not) represent national averages.
>
> We do constantly look at data, and compare national reported information with the local information and one survey with another and all with HMIS. But it is not easy.
>
> One example, the GOT [Government of Tanzania] and PMI [US-based President's Malaria Initiative] wanted to know 'what is the national prevalence of malaria this year'. We did six or seven surveys in 2008. These were all good surveys. But not all were national, and they were taken at different times of the year. As you know, malaria is regional, and seasonal, and seasonal regionally. The results were all over the place. […] The MOH [Ministry of Health] and PMI were so upset that no prevalence studies were done in 2010. This is stupid because we need data, we just have to acknowledge that it doesn't make sense to state a number for yearly average of national data. (Email communication, 27 September 2010. Parentheses in original)

Robert's email encompasses the complexities and challenges of accountability in practice. Significant anxieties surround measuring impacts of funded interventions in aid-recipient countries (Brown, 2015; McKay, 2012). While survey data quality could be good, HMIS administrative data was flawed. Unlike surveys, which were independently funded and often highly controlled, both John and Robert acknowledged that administrative data were largely skewed because it was not possible to exert 'some control' over their collection.

Meanwhile, Robert highlighted the limitations of surveys, despite being the 'Gold standard': some ailments were 'regional, and seasonal, and seasonal regionally.' Tellingly, Robert's email refers to something unknown in order to make data collection, and its forms of accountability, appear to work: data are unstable representations capable of falling apart if applied too broadly or scrutinized too closely. Despite clamors for *more* evidence within global health spheres, actors working in Tanzania were well aware of the perils of rendering data representative, accountable, or even countable. They had to negotiate these perils in order to appear collaborative and sustain development cooperation frameworks to which they were adherents.

'The question is far from simple': opaque transparencies

Donors and their contractors were 'required to produce certain outcomes' (James, 2012, p. 61). In practice, this obligation was complex. On 9 October 2008, en route to the JAHSR meeting, I shared a car with two USAID officers: Robert, and his colleague, Clara, who worked for a parallel USAID office handling the President's Emergency Plan for AIDS Relief (PEPFAR) activities in Tanzania. In 2008, with over US$313 million (PEPFAR, 2008), PEPFAR funding in Tanzania outstripped USAID funding for all other health issues combined. Clara said PEPFAR's biggest success in Africa was not its impact on HIV/AIDS, but rather its database, created at considerable expense.

Robert explained how, in the early stages, members of Congress paid close attention to PEPFAR, given the amount of taxpayer money invested. Congress asked a seemingly simple question: how many people are working for PEPFAR in Tanzania? Clara chimed in, 'the question is far from simple!' PEPFAR allocates funds to contractors, who implement programs. In Tanzania in 2008, a few American-based NGOs, Peace Corps, the U.S. Department of Defense, and several American universities held PEPFAR contracts. Many contractors implemented programs through local health facilities and NGOs, creating a complex landscape of people who 'work' for PEPFAR in-country. Congress was dissatisfied with this response to their 'simple question,' expecting full transparency and accountability (Hyden, 2008; James, 2010). Robert elaborated that the PEPFAR database was developed specifically to answer Congress' questions; the database was not helpful for tracking aid efficiency or designing programs locally, but rather was for *performing* accountability to a Congress that he felt did not understand the processes by which USAID allocated funding and tracked impact. Robert remarked that now, with the data system in place, 'Congress *loves* PEPFAR'. When this conversation took place, PEPFAR Tanzania's report for 2007–2008 to Congress was recently completed; it was 1600 pages long.

PEPFAR was not alone in compiling internal data of this sort. Most high income countries have bilateral foreign aid entities operating in low- and middle-income countries. Each of these agencies must demonstrate outcomes through providing annual reports of data meant to render the system transparent to stakeholders in their home government. Future funding depended on appearing accountable (James, 2010). According to John, the expatriate consultant for the Tanzanian Ministry of Health and Social Welfare:

> [Bilateral donors] are reporting on certain indicators that nobody in their own constituency understands. And it is, by the way, *never* presented to the taxpayers. It is something internal in the Ministry of Foreign Affairs in that country or that development ministry or whatever. It's something internal, they will produce a book every year in most development agencies. (interview, 23 September 2008, emphasis added)

This form of accountability, in which foreign aid agencies compile internal data for their own governments, was not mentioned at JAHSR. Doing so would erode the foundation of development cooperation JAHSR represented, and call into question delegates' status as signatories to the Paris Declaration.

Exchanges with John, Robert and Clara reveal paradoxes of unknowing within global health and development governance. Firstly, foreign aid agencies are made accountable to others (Congress, Ministry of Foreign Affairs, other members of the 'constituency') who are, these participants felt, ill-equipped to comprehend, let alone evaluate, what they do. For John, 'we don't know what is going on,' but nonetheless must appear to know through internal annual reports, despite uncertainty as to whether the reports' audiences are able to understand the data presented, let alone whether the data is reliable. In this sense, accountabilities were understood as more performative than informative (Cornwall & Brock, 2005).

Secondly, taxpayers from donor and recipient countries may access public reports outlining budget allocations, but they do not have access to internal data to scrutinize what is actually being done. Bilateral donor agencies are accountable to their governments, contractors are accountable to funding bilateral agencies, but neither is directly accountable to the citizens whose money they allocate or those who are meant to benefit. To wit, within transnational governance there is 'an ongoing exercise to limit donors' accountabilities internationally and, in the case of public agencies, also nationally' (Esser, 2014, p. 44; see also Keshavjee, 2014). Describing USAID's accountability structures, James argues that

contractors 'serve as examples of USAID's successes and scapegoats for its failures, often at the same moment' (2010, p. 186), enabling accountability structures to defer blame onto others, furthering the donor's legitimacy in the process.

However, Development Partners – of which bilateral donor agencies are a part – expect the Tanzanian government will be transparent to them, and to Tanzanian citizens, as a best practice of effective development. *Mutual* accountability remains a rarely actualized yet oft-cited best practice (Hyden, 2008). Indeed, merely being present at JAHSR showcased delegates as invested in development cooperation and mutual accountability, all while each engaged in internal accountabilities strategically unspoken at JAHSR; to speak these parallel accountabilities would undermine premises of cooperation and partnership.

Thirdly, these multiple forms of accountability – data variously obscured or revealed depending on audience – bring into question Dr. Peeperkorn's opening statement at the JAHSR: 'do we, based on available evidence, adapt, re-focus, or consolidate and strengthen our investments and support?' To speak of 'available evidence' at JAHSR is to unknow that most delegates have access to multiple forms of data. Much of these data are internal, not shared. Some internal data might be useful to the Government of Tanzania or its Development Partners in order to better grasp global health activities and health outcomes in the country, and improve coordination of stakeholder initiatives. For instance, internal data might reveal how programs or districts differ, highlighting which programmatic successes or failures are location-specific, what alternatives might be considered, or which initiatives show wider promise. As outlined below, key global health actors in Tanzania had a vested interest in avoiding the kinds of accountability that would 'reflect the actual system', if even this were possible.

'They want to see the numbers go up': incentivized accountability and fostered opacity

Given the multiple accountabilities of the donor cooperation framework in Tanzania, and the fact that data employed as 'evidence' is often unstable and unrepresentative, what do accountability and transparency *do* for actors investing in them (Cornwall & Brock, 2005)? This issue was brought up in interviews across the health sector, from Tanzanian hospital staff compiling donor and government reports, to variously situated global health actors in Dar es Salaam. Their responses affirm how accountability practices 'can produce multiple forms of capital for both the aid giver and the recipient of charitable and development gifts' (James, 2012, p. 58).

Foreign aid agency officers tie data to career possibilities. This was mentioned by bilateral donor officials in interviews, and during informal conversations. It was also a finding in Hunsmann's (2012) study of bilateral and government workers in Tanzania. On 23 September 2008, I interviewed Robert in his home. He told me, 'Washington is always asking for numbers, they want numbers, they want to see the numbers go up.' Expanding, he said,

> There are an awful lot of health officers at USAID that say 'Look, my promotion is on the line, I have to be able to get this number of whatever we're doing *up* [so] that I can prove to the people in Washington that we're successful. And if you scatter all the money around all over the place […] it's going to be very difficult to measure [any increase] in the short amount of time I have here. But if we take *all* the money and put it in one district, we're going to look beautiful, I'm going to get my promotion, everything is going to be great.' Well, yeah, but it ain't 'development.'

Several USAID officers concentrated efforts in specific regions rather than spreading resources through the entire health system. Robert explained, 'we know what works': those programs that could be nationalized were most likely to have sustained impact. Yet, the over US$313 million in PEPFAR funds for Tanzania in 2008 was concentrated in select districts so that it could, as Robert stated, 'show a lot of impact in the short term.' Concentrating funding in particular districts would exhibit impact to Washington, for which officers could claim credit. 'Looking beautiful' gave officers a pathway to promotion. Meanwhile, 'there are big chunks of this country that are getting nothing for HIV. That's no way to run a development program!' For Robert, tying numbers to promotions was not what USAID was in Tanzania to do. It wasn't 'development,' although focusing and tracking funding and outputs in this

way enabled USAID officers to perform accountability to Washington (see also Hunsmann, 2012). Good data begat more funds, possibly affording professional benefits for employees.

The Tanzanian government also fostered opaque forms of transparency. While at the JAHSR, government representatives provided significant data to the audience. However, according to John, the government's goal was to appear *sufficiently* accountable and transparent to donors, without necessarily being transparent. In working within the Ministry of Health, John observed:

> The area where we [at the Ministry] can make our own decisions without being influenced by all other Development Partners and the Ministry of Finance is much bigger when the system is not transparent. […] As soon as we make it transparent, it's also transparent for those guys. […] By not revealing, by not knowing where the money ends, for instance, you make sure that the other stakeholders are not qualified to have an opinion. They cannot build insight into any discussion because they don't know what is going on. (Interview, 23 September 2008)

John felt the Ministry of Health actively concealed its activities, not only from Development Partners, but also from other ministries. By strategically obscuring aspects of the health system from stakeholder scrutiny, the Ministry preserved a degree of power over the system. A non-comprehending stakeholder allowed the Ministry more flexibility and influence. Despite considerable efforts to effect accountability structures in Tanzania, DPG representatives complained that information from individual Tanzanian ministries was difficult to obtain; they often relied on politicians' willingness to share information (Hyden, 2008). Fostering strategic forms of opacity while performing sufficient accountability was a strategy employed by many entities involved in development cooperation. Doing so allowed stakeholders to maintain their influence on the health system while appearing cooperative with other stakeholders.

Grappling with multiple donor and government report obligations simultaneously, local health facilities shouldered significant data burdens. Yet they, too, invested in perpetuating the system. Staff compiled reports for each entity operating programs within their facilities – and there were dozens (see also Brown, 2015; McKay, 2012). For staff at a hospital in northern Tanzania, completing multiple forms of reporting for government, donors, and contractors was a means of securing and maintaining funding. Without proper and timely reporting, the Ministry, donors or contractors could stall or halt funding to the hospital. The wider sentiment of hospital staff was well represented in what Frida, a reproductive health clinic nurse, told me about challenges of compiling so many reports. She said:

> [With reduced reporting burdens] you could be without more work, and patients would not get services. You could relax. But is it not better you suffer, you do more of your work but you help society? I think if it is possible that all programs are coordinated together, that is, [if] those verticals weren't here, but still […] even if they were not vertical, you would have to give them reports […] If they were at the Ministry [level], and still you are giving them reports. [Maybe] it is possible to format them so that maybe they were not very different [than] those of the donor, I do not know. […] But to me, if those programs bring improvements, for me to get more work is not a problem. (Interview, 16 July 2008)

Compliance with reporting demands was important, not for the data itself, but because reporting compliance encouraged government and donors to continue investing resources in facilities (see also Li, 2005). Frida did not suggest that reports were relevant to health services in her district. The reports' importance was tied to how 'verticals' (donor-funded projects tied to one particular issue like HIV or maternal health) could account to their stakeholders (McKay, 2012). Further, making 'verticals' happy was a means to other resources for health workers – possibilities for additional training with lavish per diems. However, while personally or professionally beneficial, these benefits were often distributed inequitably between staff, inciting rumor and resentment (Sullivan, 2011). Frida suggested it would be better to have all stakeholders (government, 'vertical' contractors, donors) require the same data so she did not have to compile multiple reports, but she was not convinced it was possible.

For health sector actors working at local, national, and donor levels, the work accomplished by accountabilities and data reporting differed depending on where they were situated in the system. For local health practitioners, being accountable simultaneously to the government, myriad donors and contractors, was a means of maintaining access to funding and opportunities professionally, institutionally, or personally. The Ministry of Health demonstrated progress on MDG indicators to appear accountable to donors, partners and the public simultaneously, which maintained donor and citizen investment. For development agency workers, providing desirable numbers held possibilities for

potential promotion. Overall, the combined activities of these actors perpetuated the development cooperation system and lent credibility to transnational policies like the Paris Declaration – initiatives seemingly laudable, and filled with buzzwords shrouding actors' strategic interests in moral authority.

Conclusion

While accountability and transparency endure within prominent ideas about aid effectiveness and development cooperation, they nonetheless remain buzzwords (Cornwall & Brock, 2005), shrouding development activities in a moral authority belying the unaccountable and often uncountable nature of their activities on the ground. Transparency and accountability on the public, transnational stage, enable various development entities to *appear* legitimate in the eyes of one another and the world. As buzzwords, these terms conceal practices undermining the very tenets of development cooperation: mutual accountability and transparency (see also Erikson, 2012; Green, 2015).

Without the possibility of skirting realities through practices of unknowing, development cooperation as a framework would break down. Engaging in multiple accountability contradicts the mutual accountability tenet of the Paris Declaration, to which most actors are signatories. To preserve the appearance of upholding such transnational policies, foreign and Tanzanian health sector actors strategically unspeak their knowledge that donors and contractors pursue multiple accountabilities, instead speaking of 'mutual accountability' using 'available evidence.' Discourses of accountability and transparency enable variously situated actors to reveal sufficiently recognizable data to public audiences to legitimize them (Cornwall & Brock, 2005; Mercer, 2003), while concealing other modes of accountability that, if shared, could open spaces for scrutiny, critique, and adaptation.

Foreign and Tanzanian actors in the health sector similarly must unknow the instabilities, omissions and inapplicabilities of data in order to invest in it. Susan Erikson argues,

> hollowness in the numbers – the numbers are inaccurate or are too disparate from people's bodies, human complexities, or communities to be meaningful representations – may not matter as much to the participants as the fact that statistics enable other things of value, like gainful employment and profit-making. (2012, p. 373)

This was certainly the case for foreign and domestic global health actors in Tanzania. Publicly available data enabled organizations and governments to demonstrate laudable progress on indicators like those tied to the MDGs; similar measurement will likely be a feature of the Sustainable Development Goals, which contain more targets than the MDGs (Jerven, 2014). Meanwhile, data collected internally within organizations convinced their stakeholders – often 'public' entities back home that nonetheless conceal internal information from public view – of the efficacy of their interventions. For health sector employees collecting government data and internal data for a plethora of NGOs and their donors, providing timely, proper reports were a means of performing their worth for further resources, despite health sector workers and citizens having minimal input into global health priorities (Esser, 2014; James, 2012; Keshavjee, 2014; Sullivan, 2012).

Tanzania shares the dilemma of poor quality data with other low and middle income countries. Yet such data is commonly compiled within publicly available transnational reports, often mixed with statistical estimates or projections to bridge omissions within available data (Jerven, 2014; Wendland, 2016). Despite an awareness that data presented as objective are actually made up of estimates and simplifications, these data, once published, matter in highly political ways. Performing 'progress' on an indicator can inform which interventions are deemed successful or fundable. They may also provide actors with political clout, ensuring a re-election, a promotion, or a contract (Wendland, 2016). That is, whether or not evidence can make particular actors appear accountable to variously situated others can have important stakes for everyone involved. Due to the benefits that different actors accrue personally, professionally, or institutionally, 'Hundreds of people in Dar es Salaam, Washington, London, Stockholm and elsewhere work long hours to ensure that this system is maintained' (Gould, 2005, p. 69), even though it does not necessarily produce better outcomes for the purported beneficiaries of global health and development in Tanzania (James, 2010; Keshavjee, 2014). That is, accountability and transparency *work* in global health. The question asked here is for whom, and to what ends?

Notes

1. The turn toward evidence-based metrics emerged in the early 1990s to increase aid accountability and evaluate disease burdens. This was exemplified in the World Bank's invention of the DALY (Disability Adjusted Life Year) metric to quantify disease burden and cost-effectiveness simultaneously (Adams, 2016). James (2010) outlines the history of the shift of the American government toward results – and performance-based financing and its effects on USAID.
2. Aspects of the Paris Declaration (mutual accountability, sharing data, government ownership) were foreshadowed in Tanzania's Helleiner Report (Helleiner, Killick, Lipumba, Ndulu, & Svendsen, 1995), which outlined ways to reduce tensions between donors and the Tanzanian government.
3. I employ the real names of public figures, as their attendance and statements are public record.
4. Established in 2004, DPG Health is a multi-stakeholder initiative promoting 'aid effectiveness' in Tanzania's health sector, in accordance with transnational policies.
5. A digital copy of this speech is available within the minutes of the Ministry of Health and Social Welfare, Tanzania's (2008) *9th Joint Annual Health Sector Review 89th-10th October 2008*, Annex 2, pp. 29–33.
6. There is a rich literature contemplating the notion of 'publics' (see for instance Langwick, 2015; Warner, 2002). Warner (2002) argues that the public is not a particular group of people, but rather a form of address to strangers, who may or may not take up the possibility of becoming an audience. By 'public writ large,' I mean that the information is made available through media sources or websites for anyone with an interest in becoming an audience, and who has access to an internet connection or media sources through which to do so. Even then, whether or not an audience will interpret the information as intended is never assured.
7. As this paper relates primarily to actors working in the health sector, I utilize the term 'global health actors' from this point forward. However, development actors outside of health operate with similar frameworks and best practices, so much of what is outlined here would be similar in other development practice contexts.
8. As of 2015, some bilateral donors funded efforts to digitize data collection through a series of 'apps', but due to frequent electrical outages, the paper system was maintained, thereby duplicating data collection burdens. See also Erikson (2016) and Green (2015).
9. For a thorough review of scholarly engagement with 'not knowing', see Geissler (2013).
10. Analise Riles (2000) notes a similar form of unknowing during negotiations of an intergovernmental agreement in Fiji. When negotiations about language and meaning were complete, the document was thought of as 'concrete' – able to move from local to national to global level and produce other documents. Yet she footnotes, 'the entire game of the negotiation consisted in lulling oneself and others into an apprehension of the concreteness of language even as one knew that meanings must fail to hold' (fn. 14, pp. 200–201).
11. The identity of participants who were not public figures, such as 'John', have been anonymized.
12. John worked directly for the Ministry of Health to improve governance capacity. His salary was paid by a bilateral agency, but the agency had no input into his work at the Ministry; he considered himself part of the Ministry's staff rather than a donor employee.

Acknowledgements

This research could not have been completed without the support of Dr. Faustin Njau. The project was approved by the University of Florida's Institutional Review Board, and by the Tanzanian Commission for Science and Technology. I am grateful to Susan Erikson, Amanda Logan, Peter Locke, guest editors and anonymous reviewers for insightful feedback. Remaining shortcomings are my own.

Disclosure statement

No potential conflict of interest was reported by the author.

Funding

This work was funded by a Fulbright Hays Doctoral Dissertation Research Abroad Fellowship [grant number P022A070066].

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