From emergency to sustainability: shifting objectives in the US Government’s HIV response in Tanzania

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ABSTRACT
The US President’s Emergency Plan for AIDS Relief (PEPFAR) was originally designed as an emergency initiative, operating with considerable funds, immediate roll-out, fast scale-up, and top-down technocratic administration. In a more recent iteration, PEPFAR shifted its focus from an emergency response to more closely account for healthcare sustainability. This transition came on the heels of the 2008 financial crisis, which threatened to stall the ‘marvellous momentum’ of the 2000s boom in donor aid for global health overall. Now many programmes are having to do more with less as funding flattens or decreases. This paper examines how this transition took shape in Tanzania in 2011–2012, and the successes and challenges associated with it, using participant observation and interview data from 20 months of fieldwork in rural and urban healthcare settings. In particular, I discuss (1) efforts to increase sustainability and country ownership of HIV programmes in Tanzania, focusing on the shift from PEPFAR-funded American non-governmental organisations to Tanzanian partner organisations; (2) principal challenges stakeholders encountered during the transition, including fragmented systems of healthcare delivery and a weakened healthcare workforce; and (3) strategies informants identified to better integrate services in order to build a stronger, more equitable, and sustainable health system in Tanzania.

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Introduction

The ‘golden age of global health’ emerged from a substantial increase in political support united behind the United Nations (UN)’s Millennium Development Goals and efforts to combat the expanding HIV epidemic (Messac & Prabhu, 2013, p. 111). It was characterised by dramatic increases in development assistance for health (DAH) – a nearly fivefold growth from 1990, from US$ 5.59 to 26.9 billion in 2010 – and by the increasing number of non-governmental organisations (NGOs), private foundations, and initiatives involved in global health, both as donors and as implementers tasked with rolling out targeted programmes (Gostin, 2014; Ravishankar et al., 2009; Van Olmen, Marchal, van Damme, Kegels, & Hill, 2012). The US President’s Emergency Plan for AIDS Relief (PEPFAR) was one of these initiatives, notable as being the ‘largest financial commitment ever, by
any nation, for a major international health initiative dedicated to a single disease’ (PEPFAR, 2014).

The global financial crisis of 2008 led to stagnation in DAH, however, ending the ‘golden age’ and ushering in the current ‘no-growth’ period beginning in 2010 – DAH declined by US$53 million in 2012, down 0.19% from the US$28.1 billion disbursed in 2010 (IHME, 2012, p. 10). Health systems in sub-Saharan African countries are particularly vulnerable to fluctuations in donor aid. The region is largely dependent on DAH for funding healthcare services (UNAIDS, 2012); it receives the majority of total global DAH (28.7%) (IHME, 2012), and has experienced a 5% decline in official development assistance disbursed through bilateral agencies since 2013 (The Organization for Economic Co-Operation and Development [OECD], 2015). Like most sub-Saharan African countries, Tanzania has been categorised as having ‘high volatility’ in DAH and high dependency on health aid (Lane & Glassman, 2008, p. 5).

Mirroring global patterns in DAH commitments, PEPFAR funding increased dramatically during the first eight years of the initiative, then decreased or flattened in many sub-Saharan African countries experiencing generalised HIV epidemics. In Tanzania, a total of US$2.86 billion in PEPFAR aid was dedicated to HIV programming over the period 2004–2014 (PEPFAR, 2015c). After years of increased funding, however, in 2012, Tanzania’s planned PEPFAR budget decreased by 19% from its 2011 budgeted amount (US$357 million), and then in 2013, rose again to reach 97% of its 2011 peak budget (PEPFAR, 2015c).

These shifts in donor aid were accompanied by changes in PEPFAR’s policies and programme priorities. PEPFAR’s initial emergency mandate was dedicated to rapid roll-out of programmes and services (Institute of Medicine [ION] 2013; United States Government [USG], 2003). At the same time as the flattening of funds, PEPFAR shifted its objectives to focus more on sustainability, emphasising country ownership of programming, and, in many cases, an expectation for countries to take over at least partial funding of programmes (Goosby, Von Zinkernagel, Holmes, Haroz, & Walsh, 2012; Palen et al., 2012; PEPFAR, 2013b; USG, 2008). The effects of these shifts in HIV funding and in PEPFAR’s mandate have varied across sub-Saharan Africa, with significant attention focused on Namibia and South Africa, which are set to experience the most dramatic decreases in funding for HIV care – 69% and 50%, respectively (Cairney & Kapilashrami, 2014; Katz, Bassett, & Wright, 2013). In upper middle-income countries like these, governments are expected to take over a more significant share of financing their HIV programmes.

From 2014, US Global AIDS Coordinator Ambassador Deborah Birx prioritised PEPFAR’s scale-up of antiretroviral therapy (ART) to control the global epidemic, responding to recommendations to increase the number of patients starting ART to prevent disease spread (National Institutes of Health [NIH], 2015; WHO, 2011). Tanzania is one of PEPFAR’s 16 ‘90–90–90’ long-term strategy countries, working to achieve ‘90% of people with HIV diagnosed, 90% of them on ART and 90% of them virally suppressed by 2020’ (The Office of the US Global AIDS Coordinator [OGAC], 2014, p. 6). The number of people living with HIV (PLHIV) in Tanzania on ART – the largest PEPFAR budget item – increased by 35% in just two years, from 289,443 Tanzanians on ART in 2011 to 444,368 in 2013 (PEPFAR, 2015b, 2015c). With limited funds and increased numbers of PLHIV on ART, however, PEPFAR funding used towards palliative care
and social services has decreased, reducing the total number of individuals receiving care and support in Tanzania by 19% between 2011 and 2013 (PEPFAR, 2015b).

This paper examines the shifting policy and funding landscape of PEPFAR’s initiative in Tanzania, focusing on the changes that occurred over the course of 2011–2012, the years that experienced the steepest decline in PEPFAR funding in Tanzania. During this time, the six original American NGOs that implemented PEPFAR’s HIV response in Tanzania underwent a period of transition in which they handed over responsibilities for services to local Tanzanian NGOs in an effort to build a more sustainable, country-led HIV programme.

Using Sheikh et al.’s (2011) conceptual framework for Health Policy and Systems Research as a guide, I outline the steps employed by several of these PEPFAR-funded American NGOs in the transition to local state and NGO ownership. Sheikh et al. (2011) demonstrate that health systems must be understood as complex, multilayered, and dynamic, and not only constitute the tangible ‘hardware’ of systems – human resources, infrastructure, equipment, financing, information systems, and effective leadership (see World Health Organization [WHO], 2007) – but also include what they term ‘software’, or the shifting ideas, interests, conventions, values, agendas, and power structures circulating within systems as well. Social and political context informs these dynamic processes as well, and serves as an important backdrop to global health policy and planning (see also Van Olmen, Criel, et al., 2012). In this paper, I illustrate some of the decision-making processes involved – the ‘software’ that influenced policies and programme decisions in health systems – and the political-economic context that informed them. Additionally, I explain some of the limitations in ‘hardware’ informants highlighted, focusing on challenges in building up the healthcare workforce and the training of healthcare workers that have hindered health system strengthening in Tanzania. Finally, I describe the ideas offered and efforts undertaken by informants to make the best use of current funding to build up more sustainable healthcare in Tanzania.

Methods

This paper is part of a larger ethnographic examination of the effects of donor scale-down and global health policy changes on the lives and well-being of PLHIV and healthcare workers in Tanzania. Data presented here draw on 20 months of multi-sited ethnographic research conducted in 2009, 2011, and 2012 in Dar es Salaam, the commercial capital of Tanzania, and in Haydom, a small town in the north, which is home to Haydom Lutheran Hospital (HLH). Findings presented in this paper draw principally from 28 semi-structured interviews completed with healthcare workers and administrators who were familiar or affiliated with PEPFAR in various ways.

Fifteen of the interviews were with key informants in Dar es Salaam, whom I recruited based on their involvement with the PEPFAR transition in Tanzania and in efforts to build more sustainable HIV programmes. Among the key informants were directors and employees of NGOs on both ‘sides’ of the transition, that is, American NGOs who initially implemented PEPFAR’s programmes, and local Tanzanian partner organisations tasked with taking over services and programmes. Seven informants included managing directors and transition and sustainability coordinators for the American NGOs or local transition partner organisations. Three key informants worked as administrators with PEPFAR or
The United States Agency for International Development (USAID) in Dar es Salaam. Only two informants were employed by the Tanzanian government or worked exclusively within the public health sector, which is a limitation of this work. One of these informants was a programme adviser at the Ministry of Health and Social Welfare (MoH&SW), and the second worked at Muhimbili School of Allied and Health Sciences as a physician and medical school professor. The remaining three informants included current and former employees at other PEPFAR-funded NGOs in Dar es Salaam, or those who had worked in a clinic or hospital that received PEPFAR funds. I also relied on data acquired during six months of participant observation and informal and unstructured interviews in Dar es Salaam with members of American and Tanzanian HIV organisations.

In Haydom, 12 key informants were recruited as part of a larger HIV clinic ethnography that examined the local effects of global policy and funding changes. Interviews were conducted during a 14-month period of participant observation that took place in 2009 and 2011–2012. I conducted semi-structured interviews with all HIV clinic nurses, medical attendants, and data managers, six in total, as well as with six of HLH’s administrators and managers working with PEPFAR-funded programming, or working with a clinic in part funded by PEPFAR. Finally, one informant worked as an administrator at a bilateral organisation in Dar es Salaam that principally funds HLH’s operating budget and part of its HIV clinic. Of the 28 total informants, 19 were Tanzanian, and the remaining 9 were expatriate professionals, 4 of whom were from the USA.

Interview questions focused broadly on sustainability in healthcare and, more specifically, on how stakeholders conducted and experienced PEPFAR’s transition to more sustainable care. I sought to better understand how people working in Dar es Salaam and in Haydom conceptualised sustainability as it relates to health and HIV care, and asked questions about what in particular was being sustained, what the imagined ‘sustainable’ future might look like, and to identify the principal challenges impeding a sustainable health system and national HIV programme. Using PEPFAR’s transition to sustainability as a point of inquiry, I was able to witness these processes in action, and document how multiple stakeholders prioritised services in the face of budget cuts, and planned and implemented strategies to build a more sustainable system.

I conducted interviews in Kiswahili and English. In most cases, I audio-recorded and transcribed the interviews, and translated them into English when necessary. I took notes by hand in all interviews, and coded interview transcripts and field notes with MAXQDA and Dedoose qualitative analysis software. Research was conducted in accordance with IRB regulations at the University of Florida, and given clearance by the National Institute for Medical Research and the Commission for Science and Technology in Tanzania. Finally, I obtained verbal informed consent from all informants, and in this manuscript have used pseudonyms for all personal names to ensure anonymity.

**Background: PEPFAR and healthcare sustainability**

PEPFAR was first introduced in President George W. Bush’s State of the Union Address in 2003, and signed into law that May, following two other large-scale HIV global initiatives – The Global Fund to Fight AIDS, Malaria, and Tuberculosis (United Nations [UN], 2001), and the World Health Organization’s 3 × 5 initiative (WHO, 2003). PEPFAR was initially a five-year, US$15 billion initiative to expand HIV prevention, care, and treatment services
to 15 focus countries, mostly in sub-Saharan Africa. PEPFAR was scaled up quickly – as of 2014, over US$59 billion has been allocated to HIV programmes and initiatives, as well as support for tuberculosis, malaria, and maternal and child health (PEPFAR, 2015a).

After several years of ‘marvelous momentum’ in combating the epidemic (Garrett, 2007, p. 19), donor aid for HIV was confronted with the financial crises of 2008 and 2010, which caused great concern for the potential cancellation of aid commitments from bilateral, multilateral, and private donors, and the future impacts this may have on global population health (Garrett, 2009; Mills, Ford, Nabiryo, Cooper, & Montaner, 2010; Van Olmen, Marchal, et al., 2012). UNAIDS (2012) issued a report on the ‘AIDS dependency crisis’, warning that since many African governments were largely dependent on external support for their HIV programmes, HIV care and treatment were at great risk for failing should donor funds dry up. In 2014, for example, donors funded 94.9% of Tanzania’s HIV programmes (United Republic of Tanzania [URT], 2014).

Principal goals of sustainability in health vary, but researchers and practitioners often focus their attention on finding ways to overcome the profusion of short-term aid for vertical programmes that have little investment in long-term care, and addressing ‘root causes of health problems rather than to palliate their symptoms’ (Yang, Farmer, & McGahan, 2010, p. 129). Prescriptions for sustainability in healthcare are often anchored in the ideals of the WHO’s ‘health for all’ movement promoting universal and equitable access to primary healthcare, and encouraging local participation and inter-sectoral action in strengthening health systems (Chan, 2008; Lancet, 2008; Van Olmen, Marchal, et al., 2012; WHO, 2000). Human rights frameworks also feature prominently in discussions of sustainability in health – including discussions involved in drafting the UN’s Sustainable Development Goals (UN, 2014) – and often emphasise the legal obligation of states to take ‘concrete steps’ in fulfilling citizens’ rights to ‘the highest attainable standard of physical and mental health’ (Gruskin et al., 2012, p. 340; UN, 1966) and promote sustainable financing mechanisms that ensure predictable and scalable funds for health systems (Gostin, 2014).

The WHO’s definition of a health system includes ‘all the activities whose primary purpose is to promote, restore or maintain health’ (WHO, 2000, p. 3). Within this broad conceptualisation, Sheikh et al.’s (2011) framework highlights the dynamic interactions among people, objects, and operations – the ‘hardware’ and ‘software’ that constitute health systems – and the social and political context that determines in large part which activities are promoted within health systems. Despite efforts to strengthen health systems, Tanzania and other resource-poor countries have made modest improvements in realising these goals. During the windfall of donor aid for health in the 2000s, significant strides were made towards achieving specific health goals – expanding HIV treatment and prevention in particular – with some improvement to the functioning of public health sectors alongside it (Goosby et al., 2012; Palen et al., 2012; Pfeiffer, 2013). Central to building sustainability in PEPFAR’s policies was the expansion of country ownership, which was defined ‘by the continuum of actions taken by political and institutional stakeholders in partner countries to plan, oversee, manage, deliver and finance their health sector’ (PEPFAR, 2013b, p. 6). PEPFAR’s stated transition towards a more sustainable approach to HIV service scale-up, for example, was principally operationalised by the establishment of Tanzanian NGOs – rather than direct funding to the government of Tanzania – to take over service provision from American implementing partners. This mirrors
a continuing trend of privatisation in global health funding – in this case, funnelling money towards NGOs instead of public sectors (Pfeiffer, 2013). In 1995, only 5% of DAH was dedicated to NGOs; by 2010, that percentage rose to 66% (Mbacke, 2013). Between 2004 and 2010, PEPFAR on average dedicated 17% of global funding to ‘governmental prime partners’, and the remaining funded non-profits (49%), academic partners (20%), for-profit partners (13%), and multilateral organisations (1%) (IOM, 2013, p. 128; see also Mbacke, 2013). This pattern of funding can lead to the fragmentation of healthcare and the encouragement of parallel systems of care, leaving critical gaps in services and undermining government health systems (Sundewall et al., 2011).

**Research findings and discussion**

**PEPFAR’s emergency roll-out in Tanzania**

In Tanzania, there were six primary PEPFAR implementing partners: Family Health International (FHI); AIDS Relief (part of Catholic Relief Services); the International Center for AIDS Care and Treatment Programs (ICAP); Muhimbili, Dar es Salaam City Council & Harvard (MDH); the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF); and the Clinton Health Alliance Initiative. These implementing partners provided care and treatment services to PLHIV according to what one PEPFAR administrator called the ‘regionalisation’ of treatment, in which each US implementing agency partnered with the government to manage services in their designated areas (usually four to five regions each, of the 30 regions in the country), under the direction of PEPFAR and in coordination with the Tanzanian MoH&SW National AIDS Control Programme. This strategy was implemented in part to ‘eliminate inter-agency bickering’ over responsibilities, and to reduce the confusion over which agency was tasked with handling which services.

Several PEPFAR, USAID, and American and Tanzanian NGO administrators reflected on the beginning of PEPFAR in Tanzania, and remarked that despite significant achievements, the initial emergency phase of the PEPFAR roll-out was so large, and was conducted so quickly, that it could not be absorbed well by the country’s public health system and patchwork of NGOs (see also Cairney & Kapilashrami, 2014). One administrator at an American health NGO in Tanzania explained that this early focus on emergency roll-out engendered an ill-conceived focus on quantitative targets, rather than establishing high-quality HIV care in careful collaboration with the public sector:

> There was so much money, and you have to spend it quick, and now we see the disadvantage – there’s a huge pipeline (of donor funds) … millions of dollars have not been spent … It was not realistic to expect that you could spend so much money, because the absorption capacity of Tanzania is not there. You can’t just push (your agenda) through their throats, in order to reach your targets, you have to get quality.

Others echoed this sentiment. Initial goals of PEPFAR’s emergency roll-out, as another informant described, were dedicated to ‘scale up, scale up, scale up’, while an administrator at a US organisation remarked ‘there was more money than programming sense’ in regard to establishing effective care. An administrator at PEPFAR, remembering his own experience as a PEPFAR-funded programme officer, said:
When it was rolled out, that first $15 billion, (the thinking was) let’s get it out there, let’s get it out as quickly as we can. A lot of it was trial and error. I remember being on the ground on the implementer side as it was first announced and we were like ‘how do we actually spend all that money?’

Finally, one respondent at USAID candidly noted that for PEPFAR officers, the early days may have inspired a somewhat cavalier attitude – ‘they had more money than they knew what to do with … (it was like) “we’ve got 20 million dollars, what are we going to do with this? Hey Bob, find something!”’

‘They just kind of transition to themselves’

After the initial five-year emergency roll-out period, PEPFAR’s second five-year strategy focused on the transition from an emergency response to the promotion of sustainable country programmes (USG, 2008). To do so, PEPFAR and each target country created a Partnership Framework (PF) that outlines how a sustainable HIV response can best take root in each country. The PFs operationalise PEPFAR’s ‘new directions’ for the transition – an emphasis on country ownership, capacity building, and health systems strengthening (PEPFAR, 2009, 2010).

In Tanzania’s PF, the transition strategy required the American NGO partners to either identify an existing Tanzanian NGO able to take over service provision for their designated regions, or create a new local NGO. Those that started their own Tanzanian NGOs were MDH, which created Management & Development for Health; ICAP, which established Tanzania Health Promotion Support; and EGPAF, which started the Ariel Glaser Pediatric AIDS Healthcare Initiative. AIDS Relief chose to work with the already existing Christian Social Services Commission, and FHI chose several smaller NGOs already working in HIV care.

The American and Tanzanian partner NGOs were all in varying states of transition during fieldwork in 2011–2012, with one American NGO preparing to give over all operations to their Tanzanian partner, a few slowly handing over responsibilities on a region-by-region basis, and others in the beginning stages of mapping out their transition strategy. Tanzanian partner NGOs providing care and treatment were funded predominantly by the US Government through the CDC, Department of Defense, or USAID. A separate PEPFAR-funded project, the countrywide blood safety programme, was the closest to being transitioned completely, and was being handed over to the Tanzanian government. One informant from the PEPFAR office in Dar es Salaam said that this programme was ready for transition because

It is at a maturity level, and the government is at an investment level, where they can take that on themselves. So we’ve been working over the past two years to make that strictly government funded.

Key informants at the American and local partner NGOs discussed their perceptions of the potential for PEPFAR to develop sustainable country programmes. Regarding the transition in general, one respondent noted that as an emergency intervention, PEPFAR ‘was never intended to be sustainable’ and is still principally focused on rapid scale-up. Another Tanzanian NGO director said that ‘everything was dropped from the top’ at the beginning, and it was only ‘after six years that we started talking about sustainability’.
The potential of the different NGOs’ transition strategies to be sustainable was discussed at length among the larger partners as well. Those who chose to start their own Tanzanian NGO were sometimes criticised for adhering to the letter, but not the spirit, of the transition. Because many of those newly created NGOs were staffed by people who had worked for the American partners for years, some questioned how ‘country owned’ the new NGOs were. One American NGO administrator noted that in cases like these, ‘they just kind of transition to themselves’.

Further, the relationship of the names of the Tanzanian NGOs to their American partner NGOs one informant described as ‘cheeky’, while another said the naming convention ensured the perpetuation of their ‘brand’ – recognition among the global health community as being affiliated with that particular American partner.

I discussed these processes with numerous informants at the American and Tanzanian PEPFAR-funded NGOs, all of whom outlined their strategies for transitioning programme operations to Tanzanian NGOs. In mid-2012, I interviewed an administrator, Anne, at an American NGO that was transitioning services to an established Tanzanian NGO partner. She described for me their four-step transition plan: first, their organisation worked to identify already existing NGO partners they could most effectively work with, and second, they conducted several internal and external evaluations of those NGOs to assess their ability and readiness to take over services. The third step was the development of comprehensive capacity-building plans with the new partner or partners, and the fourth was the transition, ‘once we feel they’re ready’. The transition of services was often conducted on a district-by-district basis, with the ultimate goal to hand over responsibilities for entire regions to these Tanzanian NGOs. In this case, however, the CDC urged the organisation to transition more quickly to their partner NGOs, which Anne believed hindered their ability to build capacity.

Across town, the director of a Tanzanian NGO, George, outlined the process his organisation (and their American partner) had taken to transition responsibility for services. In this case, the American NGO had established the Tanzanian NGO, and had been in the process of preparing and transitioning services for the previous two years. The American NGO had laid out a detailed plan with a ‘big checklist’ to assess ‘all areas, including the management, finance and administration, the technical piece … they are looking everywhere’, to determine when his organisation was ready to take on full responsibility. Like at Anne’s organisation, handing over responsibility to the Tanzanian NGO was completed in a phased process, which had already included a shift in funding by the time of our interview in late 2011. Instead of funding channelled through the American NGO itself via the CDC, George’s NGO received direct funding from the CDC, which he described ‘as a way of preparing us and testing whether we can do it’, including better management of funds.

George outlined a few significant hurdles to creating a more sustainable programme during this process. First, because HIV ‘is a new disease’, with changing best practices and programming ideas, George said:
We are depending so much on foreign expertise to provide information and technical assistance (TA) … it’s not easy. In our program, we thought we would have to devote a percentage of money to subcontract to (the university affiliated with original American NGO) to continue to provide TA so that we don’t lose (Our technical expertise).

Long-term financial assistance was also a concern George had, particularly for funding essential services and staff (see also Gostin, 2014). As PEPFAR funding decreases and organisations sought funds from different donors, coordinating aid from multiple sources resulted in funding gaps. In George’s case, that year his organisation had a

Six month gap where we have no money … so we had to make sure that we don’t finish all the money we got (from one organization) to make sure that we sustain our operations until October when we get the new funding.

**Principal challenges in building sustainability**

Numerous challenges and concerns such as these in establishing a sustainable system were identified by other informants, including the need for better equipment and infrastructure, the competition among donors for funds, and concerns about accountability, responsibility, and coordination among donors and governments. Other broader concerns included those regarding the disconnect between philosophies of best practices in aid and in the practical implementation of projects and the potential erosion of trust and confidence in biomedical healthcare.

Like in many other low-income countries with underfunded health systems, most informants identified the importance of strong health systems to effectively deliver targeted health programmes (see Travis et al., 2004). Also much like in many other countries, critical shortages in the healthcare workforce presented immediate challenges for informants. In 2015, Tanzania had 0.467 healthcare workers (physicians, nurses, and midwives) for every 1000 people (WHO, 2015), significantly lower than the WHO’s recommended target of 2.28 healthcare workers per 1000 people (Kinfu, Dal Poz, Mercer, & Evans, 2009). In a countrywide assessment of Tanzania’s health system, the MoH&SW (2009) reported a 65% total shortage of health workers in the public sector in 2006 based on the Ministry’s estimate of required staff, with the largest deficiencies experienced at training institutions (74% shortage of staff) and village dispensaries (69% shortage) (Musau et al., 2011). Private sector facilities are more severely understaffed, with an estimated 85.9% shortage of health staff (Musau et al., 2011).

Several informants identified the internal brain drain of skilled healthcare workers as being particularly problematic (see also Pfeiffer et al., 2008; Sherr et al., 2012). Informants described the internal brain drain happening in two principal ways. First, healthcare workers at institutions providing primary healthcare (PHC) services were often recruited to work in ‘enclaved’ HIV clinics, sometimes within the same health institution, providing treatment, counselling, and prevention services for a growing number of patients (see Sullivan, 2011). This process left fewer doctors providing PHC services, one Tanzanian NGO director noted, and could lead to fewer doctors aspiring to work in PHC in general. Second, the recruitment of healthcare workers to the private and NGO sectors can reduce the number of practitioners working in clinics and hospitals. Two Tanzanian medical doctors, one of whom worked in the public sector and another at a Tanzanian
NGO, described at length the internal brain drain and its effects on the Tanzanian health system. As one said:

The thing that makes me weep every month, without a doubt, is the good people we lose to NGOs. The internal brain drain is bigger than the external brain drain and more destructive. (Those who leave the public sector) are not working at (the national teaching hospital), so they’re not training new doctors, they’re not working in the district hospitals in Dar let alone out in the middle of nowhere. They’re working for an NGO, and they’re doing paperwork.

Another issue many Tanzanian and international NGO administrators noted was the extensive use of in-service trainings, which they perceived to be taking clinicians out of clinics and stretched thin an already overburdened healthcare workforce. For example, in a survey of the effects of trainings on numbers of available clinic staff in southern Tanzania, Manzi et al. (2012) found that 46% of available staff was out of the clinic for seminars and long-term trainings on the day of the survey.

Trainings were a principal way to update healthcare workers on new treatment protocols, and were often viewed as necessary income to supplement low salaries. A Tanzanian NGO director noted that for many, ‘trainings are (considered) income instead of building capacity’. Indeed, tensions were high in Dar es Salaam in early 2012 as a series of doctors’ strikes shut down hospitals and clinics across the country, with protesters contesting low wages and benefits for public sector doctors (Tanzania Daily News, 2012). One informant at the MoH&SW worried that in-service trainings would hinder future efforts to establish continuing medical education in Tanzania, noting that ‘people won’t be able to continue doing those services because they’re used to the money’ paid out at trainings, even though these services are ‘part and parcel of what we’re supposed to be doing daily’.

One American NGO director noted that in-service trainings can have other effects as well:

When we talk about sustainability, the key thing is money, and in-service training costs a lot of money. If we are thinking of having a sustainable program in the country, a poor country, you cannot leave it to in-service training, you must switch it to pre-service training in medical school, to become competent (in HIV care).

The impacts these funding and policy changes were having on PLHIV were the principal focus of ethnographic research in Haydom, described elsewhere (Marten, 2014). Several informants in both Haydom and Dar es Salaam stressed that the loss of HIV patients from care and treatment was increasing nationally; overall, an estimated 36% of PLHIV are lost to follow-up after three years of treatment (Somi et al., 2012). One administrator at an American NGO in Dar es Salaam believed that this was principally due to the perceived emphasis on quantitative targets among PEPFAR policy-makers to the detriment of quality of services.

We went too much for quantity, and now we see the results. Attrition rates are very high, adherence, luckily, is reasonably well, but we still lose a lot of people completely. Loss to follow up is very, very high because it was always quantitative targets, quantitative targets … we have to reach so many people. Quality was not mentioned … Put (focus) a little bit more on quality, and a little bit less on quantity.

Finding ways to support PLHIV already in care was a principal concern of healthcare workers in HLH. Services that were reduced due to decreasing funds included food
support and transportation reimbursements, which help to increase access to services and support ART adherence. The head nurse of HLH’s HIV clinic discussed with me her concerns over decreases in funds, in a process she described as ‘weaning, weaning, weaning, until we’ll be standing on our own!’ These cutbacks also worried many of her patients, she explained, who increasingly missed clinic appointments. Many PLHIV went to see the popular faith healer Babu Loliondo, who claimed to be able to cure HIV and other chronic diseases with a single cup of tea (see Malebo & Mbwambo, 2011). As Thielman et al. (2014) describe, Babu’s popularity among PLHIV in Moshi, Tanzania, was correlated with a short-term decrease in antiretroviral (ARV) adherence, as visiting Babu ‘presented an attractive opportunity for patients facing a lifetime of medication to maintain health’ (p. e107).

**Best practices for service integration**

Several Tanzanian and American informants commented at length about the multiple benefits PEPFAR in particular had on improving the health sector in Tanzania. These included the improved management of care, particularly for chronic diseases; strengthened supply chain mechanisms supporting patient care; improvements in monitoring and evaluation of health programmes; and the expansion of infrastructure, commodities, and equipment.

In an attempt to better support health system strengthening, about 10% of the annual PEPFAR budgets were allocated specifically to health system strengthening between 2009 and 2011 (Palen et al., 2012). This included funds for laboratories and systems development, which focuses on financing, capacity building, and supply chain management (PEPFAR, 2013a). These operational strategies for health system strengthening underline some core principles of the US Government’s Global Health Initiative (GHI), of which PEPFAR is now a part, which expands the focus from an HIV-specific initiative to include other important health goals, including improving maternal and child health services, and programmes to combat neglected tropical diseases (GHI, 2013). This process of expansion ‘leveraged’ PEPFAR’s investments in HIV programmes to better address the needs of the entire health system in spite of a levelling off of funds (PEPFAR, 2009), and included training more healthcare workers and management personnel and working with The Global Fund to procure ARVs (El-Sadr et al., 2012). Part of the rationale for leveraging (or implementing diagonal programming, see Ooms, Van Damme, Baker, Zeitz, & Schrecker, 2008) includes the assumption that, in resource-poor and aid-dependent countries, the waves of funding would continue to ebb and flow, and donor interests would continue to shift. Lucia, an MD and medical school professor in Dar es Salaam, remembered one case as exemplary of this process:

When the HIV money came … they wanted to build a center of excellence in HIV. They said ‘we want to build outpatient services and seminar rooms and labs’. But the hospital said, ‘no, HIV patients are not just isolated, they will have complications, so outpatient clinics should be outpatient clinics for everyone, don’t segregate them’. And the good thing about (this) is that it allows HIV money to pull out because … as the HIV money goes down whatever other funding that comes up will still be part of the whole system. You have to strengthen the whole system. And we have a national lab now! And my colleagues, when they come, they are envious, and even (those) from outside (countries), they are envious of that lab.
Many informants had similar ideas for how to better integrate HIV services into the broader health system. One Tanzanian NGO administrator proposed that NGOs could designate time for their healthcare worker employees to continue practising in clinics and hospitals, in order to curb some of the internal brain drain encountered in the public sector. Another informant, a director of one of the American NGOs, described how his organisation subcontracted local government health institutions to provide care and services to PLHIV, thereby integrating the private and public sectors to better ensure sustainability and local ownership of a programme. This, he noted, was the long-term priority.

The transition to the local NGO is not the end, it is an interim (phase). The final transition should be moving into the government system, not from international NGO to local NGO, to NGO. No, it’s not like that. But to reach from here to there, you have to pass through these kinds of things. But it’s not saying we transition to the local NGOs and then sit down. We have to really see it to the end – that is the sustainable thing, to put it into the government system.

**Conclusion**

Some of the most dramatic shifts in global health policy and delivery occur during periods of global economic expansions and downturns (Van Olmen, Marchal, et al., 2012). This paper presents an overview of how those shifts are negotiated on the ground by multiple stakeholders, including those tasked with sustaining high-quality care for PLHIV in Tanzania.

Study respondents were anxious to resolve the critical issues they encountered, and to create a more integrated and collaborative system of healthcare delivery that addressed the unique challenges in Tanzania. The fragmentation of some HIV services, including funding and programming, was frequently mentioned as a critical hurdle, in addition to continuing problems building up a strong, well-trained healthcare workforce. Similar problems are outlined in other research of HIV interventions in sub-Saharan Africa (Pfeiffer, 2013; Pfeiffer et al., 2008; Sherr et al., 2012), as is a focus on diagonal programmes and integration of resources and programmes for health system strengthening (Ooms et al., 2008).

This paper addresses some of the research gaps in understanding the processes health systems undergo over time. It also emphasises the complexity of global health problems and solutions in situations with multiple actors and competing agendas, against a backdrop of rapidly changing economic realities. Amidst this complexity, there is some consensus around principal challenges, in addition to a sense that progress towards sustainable solutions is possible. While PEPFAR operates in a context of increasingly limited funds, it still enjoys enormous support and considerable resources (Pfeiffer, 2013). Advocating for health systems strengthening while funds are still plentiful is a principal strategy for building health systems better able to deliver more sustainable, equitable care.

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