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'Like a real hospital': imagining hospital futures through homegrown public–private partnerships in Tanzania

Noelle Sullivan

Introduction

Administratively, Tanzania is divided into regions, and then districts, each of which is meant to house a government-operated district hospital[1] – the largest health facility at the district level. Local management of all health- and social service-related activities falls to a government-appointed District Medical Officer (DMO). In 2014, the DMO's office at Kiunga District Hospital[2] in northern Tanzania was somewhat remarkable. Its walls reflected a highly successful and widely recognized district: photographs of the DMO with the head of state of a country in the so-called global North, coupled with a hand signed letter of appreciation for hosting the official visit in 2008; a 2006 photograph of former president of Tanzania Jakaya Kikwete with the DMO; a government-issued first place certificate for best-quality health services in the region in 2013; a certificate of recognition for quality antenatal care for 2010–11 from the United States Agency for International Development (USAID) and several Tanzanian NGO collaborators; and a first place certificate of appreciation for having the best-quality HIV services in Tanzania, stamped with the logos of the Ministry of Health and several American-based entities funding services in the country. The photographs and certificates were material evidence of the district's success as a meaningful partner for donor-sponsored programmes.

On an adjacent wall, directly behind the DMO's desk, was a large rendering of the 'Master Plan of Kiunga District Hospital'. This topographical map suggested a possible future for the public hospital, if only partners could be found to help fund it. Drawn on the existing landscape was yearned-for infrastructure, including an expanded dental unit; a staff parking area; a two-storey general administration block; a five-storey administration building with library, conference hall and pharmacy; a two-storey medical department building, including a maternity ward, surgical and paediatric units; a two-storey radiology department building; a nursing school; and an expanded mortuary. This 'master plan' map was created in the

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[1]While all districts are supposed to have a public district hospital, this goal has not been achieved. When there is no government-owned district hospital, faith-based hospitals in those districts can apply for 'designated district hospital' status, and therefore government subsidies to support operating costs, given the absence of government-run options in the district.

[2]All names are pseudonyms.

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hope of successfully conjuring up support beyond restrictive donor targets and government budgets – a biomedical infrastructure imagined but as yet unseen (Street 2014; Wendland 2010). However, contrary to its title, the rendering was less a 'plan' than a collective dream of a hospital future. It was, in Susan Reynolds Whyte's words, a map in a 'subjunctive' tense: hopeful, uncertain, trying to engage despite possibilities (or even probabilities) that these attempts may fail (2002). In a regime of so-called 'global health', outsiders often articulated priorities and allocated most of the resources, thereby excluding the voices and needs of the very communities they purported to serve (Crane 2013; Elliott 2017). The materiality of the DMO's office was a call for inclusion.

Most visitors to Kiunga District Hospital (whether representatives from foreign NGOs or national ministry offices, foreign volunteers, donors or anthropologists) came to the DMO's office to sign the guest book. For these visitors, the walls attempted simultaneously to conjure past accomplishments and future aspirations. The certificates performed the institution's long-standing commitment to donor- and government-sponsored public health programmes, thus establishing the administration's legitimacy. At the same time, the walls beckoned visitors to become prospective participants in a collective dream of a future hospital as yet unrealized.

This article explores the possibilities to which staff at Kiunga District Hospital aspired, and the means by which they hoped such dreams might come to fruition. Prior to 2010, staff rarely imagined possibilities beyond the restrictive budgetary and programmatic priorities of donors and the government. Imposed austerity and the resulting exacerbated resource scarcity in the 1990s made such dreaming beyond reach (Bech *et al.* 2013; Lugalla 1995). Narrowly targeted global health funding in the early 2000s went disproportionately to projects focusing on services for HIV/AIDS, malaria, and reproductive and child health, neglecting the wider needs of health systems at a time when austerity was undermining government efforts to strengthen those systems (Pfeiffer *et al.* 2017). However, from 2003 to 2010, Kiunga staff managed to draw a small but not insignificant amount of outside attention to other institutional needs. Local fundraising efforts in the early 2000s enabled construction of a new maternity ward. A multinational floral company and a British missionary organization funded construction of new male and paediatric wards between 2005 and 2006. In the process of scaling up the President's Emergency Plan for AIDS Relief (PEPFAR) in 2007, the hospital administration convinced USAID's international NGO partner, REFLECT,[3] to fund a major expansion of the small building housing HIV/AIDS services. While most attempts to draw outside attention bore no fruit, by 2010 there had been enough success that the hospital management team began to collectively contemplate what they would like to build.

The possibility of entertaining such collective dreaming emerged due to two transformations: a shift in Tanzanian government policies enabling government institutions to initiate 'public–private partnerships' (PPPs) with non-state 'partners'; and Kiunga District Hospital's early successes in attracting (a few) partners, confirming that partnerships could actually produce desirable results. 'Partnership' became an important component of dream making, enabling

[3]This NGO name is a pseudonym.

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imaginings of certain kinds of futures, coupled with an acknowledgement that dreams might be compromised, or even fail to inspire others. Partnership was thus central to hospital staff's active pursuit of uncertain becoming.

Recent scholarly literature regarding PPPs yields insights about the distribution of power and resulting modes and dilemmas of governance, accountability and ethics (see, for instance, Kenworthy 2014; Miller 2016; Samsky 2012; Storeng and Béhague 2016). Much of this literature focuses on *global* PPPs, which often comprise a mixture of national governments, large corporations, international NGOs, bilateral or multilateral donors, philanthropic foundations, grant agencies and universities. Such unwieldy global PPPs have become ubiquitous within global health and development circles. Importantly, these PPPs' priorities and goals are also nearly always conceptualized at transnational and/or national levels, and then rolled out in various specific locations within the implementation country. The Global Fund to Fight AIDS, Tuberculosis and Malaria is perhaps the most well-known global PPP.

However, other forms of PPPs are desired and enacted within Tanzania, as well as in other aid-recipient countries. These PPPs – what I call homegrown PPPs – have drawn less scholarly attention (but see Citrin *et al*. 2018; Street 2014). Through Tanzania's national PPP policy, partnerships are encouraged between public, private, NGO or individual actors of any sort, in order to support public institutions and services in the absence of adequate government funding. Homegrown PPPs allow health-sector staff an opportunity (albeit a tenuous one) to circumvent limitations imposed by transnational agreements such as the Sustainable Development Goals,[4] inadequate government funding for the health sector (Strong 2017), and narrowly conceptualized global health partnerships that often eschew the critical capacity and infrastructural needs of the very health institutions on which those partnerships depend (see Herrick and Brooks 2018; Wendland 2016). Homegrown PPPs are thus a means by which health-sector staff actively pursue uncertain becoming (Biehl and Locke 2017) beyond the restrictive frames of national budgets, donor-sponsored initiatives (Pfeiffer *et al*. 2017) or global PPPs (Storeng and Béhague 2016).

Kiunga District Hospital has employed the PPP model to engage strategically – and often serendipitously – with prospective partners for just over a decade. Employees at Kiunga District Hospital take up what Alice Street terms 'visibility work' (2014: 13) – active practices aimed at garnering attention from and thereby fostering potential relationships with others who might help. The visibility work hospital staff at Kiunga undertook to generate partnerships was not only aimed at non-state actors, but also at drawing government attention to the institution's needs. Homegrown PPP efforts were a mode of visibility work through which Kiunga staff hoped to attract the attention and resources of anyone willing to listen.

In this article, I highlight the practices through which the PPP mechanism is taken up at Kiunga District Hospital, where staff have tinkered with and explored 'partnership' as one of the few conceivable trajectories by which institutional dreams might be realized. The visibility work through which staff attempted to

[4]Or, from 2000 to 2015, the Millennium Development Goals, towards which most donor-sponsored and national government initiatives had to demonstrate they were moving.

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forge PPPs was inherently subjunctive (Whyte 2002): staff expended considerable effort in trying out ideas with an array of visitors, but they were unable to predict who would become a partner, in what capacity, and for how long. In exploring aspired-to homegrown PPPs, this article builds on recent work highlighting the contingency and malleability of public and private within public health (McKay 2016; Prince and Marsland 2013; Prince 2013; Street 2014; Tousignant 2013). As the main vehicle through which hospital staff actively pursue their dreams, homegrown PPPs make new biomedical futures worth imagining, despite the possibilities that those futures may fail to become reality.

Conceptualizing and studying public–private partnership

During the late 1990s, international donor and public health circles popularized PPPs as a means of improving health sectors in economically disadvantaged countries. It was assumed that public sectors could learn from the expertise and efficiencies of the private sector, while distributing risks. The period since the late 1990s has been characterized as an 'era of "partnership"' (Mercer 2003: 743), in which donors of various sorts (high-income countries' development agencies, multinational organizations, private philanthropic foundations, etc.) and recipient countries are (ideally) meant to be more collaborative, aiming for expanded 'country ownership', allowing recipient governments to direct development policies and priorities (Abrahamsen 2004; Brown 2015; Gerrets 2015). As conceptualized, partnership in development should include the private sector (thereby expanding markets) while aligning with the recipient government's goals. However, from the outset, what PPPs actually entailed was ill understood (Ridley 2001), despite 'PPP' glossing a wide array of transnational configurations.

Ethnographic attention has recently turned to various forms of public privatization, including PPPs (Kenworthy 2016; Storeng and Béhague 2016). This growing literature unearths problematic assumptions and practices characteristic of 'partnership', noting that the term conceals significant inequalities between the actors involved (see, for instance, Brada 2011; Crane 2010; 2013; Prince 2013). Scholars note the effects of partnerships on institutions where PPP endeavours are rolled out, demonstrating that partnerships may inadvertently strain capacity within the institutions they aim to assist (Herrick and Brooks 2018; Okeke 2018; Wendland 2016). Others discuss foreign partners' creation of parallel or temporary shell administrative systems aimed at circumventing inefficiencies of African universities and government institutions; in doing so, partnerships may undermine aid-recipient countries' abilities to expand their administrative capacity (see Brown 2015; Crane *et al.* 2018). These studies highlight the inequities persistent in 'partnership', despite rhetorics suggesting unity and equity.

However, few studies empirically explore how specific actors on the ground shape or engage with partnerships (Gerrets 2015; Kamugumya and Olivier 2016; but see Brown 2015; Citrin *et al.* 2018; Herrick and Brooks 2018). In addition to drawing crucial attention to problematic inequalities shrouded in the term 'partnership', an ethnographic focus on the aspirations and practices of differently situated actors undertaken through 'partnership' unearths which capabilities might be imagined or opened up through this modality, and for whom. McKay

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argues that philanthropic and private actors and investments in health systems have re-made future possibilities and predicaments within public medical care (2016), while Street demonstrates that infrastructure is often an important aspect of the 'new dream zones' accompanying notions of 'partnership' in development (2014: 183). Given that most partnership goals are implemented by actors in varied institutional contexts, there is much to be learned from studying the multiple ways in which 'partnership' is enacted in practice, and the kinds of work done in its name (Taylor 2018).

Tanzania's partnership policy

The Tanzanian Ministry of Health has promoted the establishment of PPPs in the health sector since 2001. In 2003, the definition of PPP was somewhat restrictive:

> Public/Private Partnership is a transparent cooperation and collaboration mechanism between Public and Private Sectors with mutual understanding as equal partners for a common goal with clearly defined roles. Potential Partners include non-governmental, non-profit making institutions, faith based organization [*sic*], community associations and common-interest groups, private for-profit health facilities and providers, patient-support groups, as well as projects and institutions from outside the Health Sector including the media, employers, environmental protection groups, refugee relief groups, and other civil society groups. (United Republic of Tanzania 2003: 24)

This definition of PPP included notable limitations on who could be a 'partner' and where the private sector could fit in. NGOs, faith-based organizations and non-profit-making institutions are potential partners. For-profit health facilities might also become 'partners', but there was no mention of whether or not, or how, other private-sector actors could participate. Subsequently, in 2004, the Tanzanian government adopted the term 'development partners' to describe donors, whether multilateral, bilateral, foundation or corporate. As a result, the term 'donor' has been largely expunged from policy documents in favour of 'partner'.

As local governments struggled to understand the potential of PPPs, Tanzania adopted the National Public Private Partnership Policy of 2009, which specifically states that the management of PPPs falls to district councils (local government). According to Tanzania's Prime Minister's Office, 'PPPs can be initiated by private sector, individuals, public institutions or Non State Actors' (United Republic of Tanzania 2009: 15). Anyone could initiate such partnerships. Diverging from the 2003 policy, by 2009 PPPs included a wide array of potential engagements. The Ministry of Health's standing definition in their *Public Private Partnership: training manual* is similarly broad:

> Public Private Partnership is a contractual arrangement between public and private sector entities built on the expertise of each partner that best meets clearly defined public needs through the most appropriate allocation of resources, risks and rewards. The cooperation may involve construction, renovation, maintenance, management and provision of services. Public Private Partnership allows the public sector to harness the management and delivery capabilities of private providers and also raise additional funds to support specified services. (United Republic of Tanzania 2013: 2)

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'Transparency' is gone. 'Equal partners' is gone. Partnerships could be forged between any 'entities' needed 'to support specified services'. The current definition is less restrictive than 2003's in terms of permitted alliances. Provided the partnership could be argued to meet 'clearly defined public needs', it is allowable. This definition was meant to encourage local government institutions to seek out partnerships to fulfil public needs in the absence of sufficient government funding.

With donors now called 'partners' and a national PPP policy referring to any 'entities' as 'partners', differentiating a 'donor' from a 'partner' has become increasingly challenging. In Tanzania, this challenge is compounded by an existing ambiguity about the meaning of the term 'donor' itself. Tanzanians use remarkably similar vocabulary to talk about formal development projects and their own aspirations (Green 2014). Longstanding familiarity with large, donor-funded development projects shifted popular discourses and imaginings of the possible to a personal level. According to Green, the Swahili term for 'donor' (*mfadhili*/plural *wafadhili*) can potentially refer to any type of 'helper' or 'patron', from large foreign donor and NGO organizations to individual benefactors. Being affiliated to donor- or NGO-sponsored projects as an employee or beneficiary, or being personally networked to someone who is, is considered a means of achieving one's personal aspirations beyond the project's formal goals: resources to build a house, start a business, pay school fees. Relationships with various kinds of *wafadhili* are therefore highly valued. Thus, in Tanzania, boundaries between 'donor'/*mfadhili*, private benefactor, investor, helper and 'partner' are conceptually porous. At Kiunga District Hospital, it was not uncommon for the term 'partner' and 'donor' to be used interchangeably.[5]

The hospital partner

Kiunga District Hospital is located in northern Tanzania, and is the largest health facility in its district. Located approximately 20 kilometres from the nearest city, Arusha, in 2014 it offered government health services for a population of approximately 200,000. By 2017, the DMO estimated that the population in the district had expanded to nearly 300,000. Outpatient clinics at Kiunga included general outpatients, minor and major surgical theatres, radiology unit, dental unit, physical therapy unit and optometry clinic. The hospital had 150 inpatient beds, a number that has remained consistent for over a decade despite increased demand for services. As of 2006, donor-sponsored programmes supported an increasing number of outpatient clinics at the hospital, addressing targeted ailments or populations primarily relating to reproductive and child health, HIV/AIDS, malaria and, to a lesser extent, tuberculosis, cancer and diabetes.

I have been conducting research at hospitals in Arusha since 2008: twenty months of research over five field seasons. My 2008 doctoral research traced transformations at Kiunga District Hospital wrought by health-sector reforms and the introduction of donor-sponsored global health programmes (see Sullivan 2011; 2012). As evinced by successful partnering with entities such as a multinational

[5]Notably, while the staff primarily communicated in Swahili, the term 'partner' was usually said in English, whereas the term 'donor' would more often be said in Swahili.

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floral company, a UK-based missionary organization and the international NGO REFLECT, Kiunga District Hospital was an early adopter of the PPP initiative in Tanzania.

At Kiunga, while global PPPs sponsored HIV/AIDS, malaria and reproductive and child health services, hospital administrators also attempted to conjure up homegrown PPPs based on their own aspirations. Generally, partnerships were temporary (Okeke 2018). When Kiunga was successful in establishing a homegrown PPP, it was often tied to a specific goal, most often a resource or institutional need: to build or expand a building, or to purchase equipment. Once achieved, the partnership generally dissolved. Attempts at forging partnerships often went unrealized, and it was never certain that partnerships would align with the 'plan' on the DMO's office wall.

As indicated by the DMO's office, at Kiunga District Hospital, the main strategy employed to foster potential partnerships was through a conscious performance of the institution as a successful space of 'good governance' and success (Sullivan 2016; see also Street 2014). The entities hospital staff envisioned as prospective partners extended beyond the recognizable logos of large multinational corporations or NGOs. The staff also attempted to gauge partnership interest among smaller NGOs, foreign volunteers working within the hospital, religious groups, acquaintances, and others outside formal 'global health' channels. The seeds of partnership were sown widely. The hospital's successes in pleasing recognizable NGOs were displayed on the DMO's walls, deployed in the hope of convincing others of the institution's legitimacy. The district hospital's success in securing partnerships and thus investment from beyond the government was also a key form of 'visibility work' through which the hospital's needs could hopefully garner recognition from the government (see Street 2014). That is, the hospital had to demonstrate its successful partnership with various others in order to procure additional resources from the Ministry of Health or the local district council.

For staff at Kiunga District Hospital, any visitor, even the most unlikely, could become a prospective partner. As of 2010, Kiunga District Hospital staff regularly envisioned and actively sought out 'partnerships' in their dealings with outsiders. These endeavours suggest a somewhat different reading of PPPs than has been prevalent in the existing scholarly literature. While partnerships initiated by foreign partners (universities, bilateral or multilateral donors, multinational corporations) permit outsiders' priorities to be mapped onto existing institutions, homegrown PPPs enable staff to envision initiatives to which they might aspire, and to seek out their own partnerships to achieve those dreams. These partnership pursuits are simultaneously marked by uncertainty and by the hope that their efforts will bear fruit.[6]

[6]While national data tracing these forms of PPPs are lacking, Kiunga is not an anomaly. Prior to posting at Kiunga, the two DMOs discussed in this article successfully fostered homegrown PPPs to build infrastructure in their former, more remote posts in Tanzania. Kamugumya and Olivier (2016) highlight several similar forms of homegrown or 'informal' partnerships in health services in Bagamoyo District. Adrienne Strong discusses a case of an administrator losing a prospective donor for infrastructure at a different Tanzanian hospital, but, as noted above, given the considerable ambiguity surrounding the term for 'donor' in Swahili, it is possible that this relationship was part of a homegrown PPP that ultimately failed (2017: 220). Outside

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Homegrown partnership at Kiunga District Hospital

From 2008 to 2015, I observed countless occasions when Kiunga District Hospital staff, and in particular the facility's administrators, actively sought out prospective partnerships from a wide array of entities. At times, encounters between administrators and prospective partners were planned in advance. On other occasions, they were entirely serendipitous. Nonetheless, due in part to Kiunga District Hospital's location close to a major road, a city, an international airport and a tourist hotspot, the institution became a favoured site for visitors of all sorts. When visitors arrived, administrators and staff actively showcased their accomplishments and collective dreams, in the hope of enticing visitors into partnerships to support some aspect of that dream. Administrators were constantly prepared to present the hospital to visitors in a temporally layered way: demonstrating the institution's history of acknowledged successes, strategically drawing attention to dreams for the hospital, and then awaiting interest and possibly investment from outsiders. Rather than a donor–recipient relationship, hospital administrators specifically referred to these endeavours as attempts to generate partnership, and the work required to establish and maintain them was discussed frequently. The examples below illustrate the variety of prospective partnerships administrators tried to establish.

'We must celebrate our own hard work in bringing these things to the hospital!'

Early in 2008 at a monthly meeting of the entire hospital staff, two hospital workers pointed to infrastructure as a key impediment to providing effective care. The existing surgical theatre had only one operating room, jeopardizing patients if there was a surgical emergency while an operation was already under way. Meanwhile, the hospital mortuary was entirely insufficient. Despite serving an expanding population, the hospital's existing mortuary was a small, non-electrified building with no refrigerator – a sparse room merely housing two cots.

With my assistance, the DMO's office put together a proposal for a new mortuary and a new surgical theatre to distribute to visitors. The desired 'modern surgical theatre'[7] would have four operating rooms, two recovery rooms, a toilet, changing rooms and a doctors' room, budgeted at US$147,000. The proposed 'modern mortuary' would erect a new building and include a nine-cadaver

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Tanzania, Alice Street highlights how politicians and administrators also looked to partnership as a means of building infrastructure in Papua New Guinea (2014).

[7]The word 'modern' comes from the hospital's own surgical theatre and mortuary proposal, which was handed out to expatriate visitors and NGO representatives visiting the hospital. Street notes that in countries with poor state infrastructure, 'the dream of the modern hospital has never receded. Comparisons with the ideal hospitals supposedly existing in countries in the West continue to reinforce health workers' experience of their institutional environment as a place of disappointment and failure' (2014: 191). While politicians in Papua New Guinea looked to partnership to mobilize funds for hospital infrastructure, this option did not appear to be available to hospital staff in Street's case study. As the Tanzanian national PPP policy specifically outlined that institutions could seek out partners themselves, the PPP initiative may have been more available as a form of 'visibility work' to hospitals in Tanzania than they were in Papua New Guinea.

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refrigerator, budgeted at just over US$83,000. These institutional desires were taken up by the majority of staff, who, during interviews and in casual conversation in 2008, marvelled at what the hospital would be like were a new surgical theatre and mortuary built. For instance, Dr Ezra stated, 'A modern surgical theatre would really make this hospital look like a *real hospital*. Can you *imagine*? Yeah!'[8]

However, infrastructure dreams sometimes differed. Some workers imagined the aesthetics and capacities of a 'real hospital', whereas others pointed to pressing and more practical current needs. In 2008, the hospital matron's aspirations fell into the latter category. She prioritized a new laundry facility. Indeed, when visitors arrived, the matron was fond of showing the laundry building and the machines within it. At the time, the laundry room was attached to a defunct kitchen – a reminder of when the hospital provided food to patients, but it was now only used to make tea for staff. The laundry room itself was inadequate: about 150 square feet containing shelves to store clean sheets, and two domestic washing machines, one of which constantly broke down. Drying lines hung behind the laundry building. In rainy seasons, sheets and blankets rarely dried. Because one of the machines was broken, colourful plastic washing basins, containers of powdered soap and mounds of soiled sheets were often strewn behind the laundry building (see Figure 1). Staff washed most sheets by hand, and the matron was rightly concerned about risks to staff due to potentially hazardous bodily substances on the sheets. During hospital tours with visitors, she always spent extra time at the laundry facility, emphasizing the dire need for upgraded laundry machines and an extension to the building.

In March 2008, a group of Canadian university students toured Kiunga District Hospital with their professors, one of whom was a physician. Upon encountering me at the hospital, the physician, Dr Brown, asked about my research at the hospital and invited me to speak to his students. After his return to Canada, Dr Brown emailed me, telling me about a small NGO in Canada he had helped establish. He asked whether I knew of any small infrastructural projects in need of assistance in Tanzania. I responded that the hospital needed an extension to the laundry building to provide a covered drying area for use during rainy seasons. Dr Brown asked me to have the hospital administrators draw up a budget for the building, and the DMO and matron drafted a proposal. The next morning, during the staff meeting, the matron announced that they had found a donor/*mfadhili* to assist them in extending the laundry building, inciting happy comments and ululations from the staff. In response, the matron proclaimed: 'We should congratulate ourselves and the donors, since it was only because we have worked to tell visitors about our needs that we are getting all of these things donated. We must celebrate our own hard work in bringing these things to the hospital!' The matron's comment acknowledged the efforts the hospital administrators and staff actively exerted to locate partners to support the hospital. The administrators knew they needed staff to collectively invest in particular institutional desires. When staff believed in the possibilities of their facility,

[8]Interview in Swahili, 17 July 2008. Italics represent words spoken by the interviewee in English. By 'real hospital', Dr Ezra drew on his own imagining of the aesthetics of well-resourced hospitals elsewhere.

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FIGURE 1 Basins of laundry to be hand-washed near the outdoor drying lines during the rainy season at Kiunga District Hospital, 22 May 2008.

they worked with pride despite hardship. Their sense of professionalism was intimately linked to the perceived quality of their institution's present, and its perceived future.

The success in finding a partner for the laundry facility stirred staff imaginations relating to what the institutional biomedical future *could be*, and thus what kind of health professionals they could become, if only the right visitor took interest. When I returned in 2011, many doctors and nurses dreamed about what kind of surgical expertise they might be able to cultivate if only the 'modern surgical theatre' was built. Rather than what they called 'simple surgeries' such as caesarean sections and laparotomies, they might expand their professional expertise to other surgical procedures.[9] In particular, doctors wanted to access the tools and training necessary to do orthopaedic surgery, as many patients arrived at hospital with traumatic injuries the hospital could not currently treat.

By 2013, construction of the modern surgical theatre had begun. Over the years, the hospital had managed to squirrel away some funds from patient fees towards

[9]A laparotomy is a general medical term for surgery performed in the abdominal cavity using a full-size incision through the abdominal wall. 'Simple surgeries' refers to the degree of specialized equipment and training necessary for performing the surgery. In Tanzania in the 1960s, assistant medical officers (AMOs) started being given abbreviated training in 'simple surgeries' in the hope of mitigating the physician shortage, and AMOs still do the majority of surgical care in non-urban settings (see Rick and Moshi 2018). 'Simple surgeries' are those that an AMO would be considered qualified to do, whereas 'complex surgeries' such as cardiovascular or ocular surgeries would require the services of a surgeon MD at a more specialized facility.

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the project, but it was the arrival and expansion of foreign volunteer placements at the hospital (Sullivan 2016; 2018) that increased the facility's income sufficiently to start the project. With a good pool of starter funds from foreign volunteers and patient user fees, the hospital's head administrators advocated to the local government council for the theatre. They were successful: the district council decided to contribute matching funds. That is, while Ministry of Health budgets lacked capacity to build new infrastructure, Kiunga District Hospital was able to showcase its own investment in the project in order to draw the local government into a homegrown PPP. By 2014, the new 'modern' theatre was fully operational (see Figure 2), housing two operating rooms, a large sterilization area with new autoclave,[10] a staff lounge for completing patient paperwork, male and female changing rooms, a post-operative room, and even European sitting toilets instead of standard latrines – a significant symbol of 'modernity' among Tanzanians more broadly. The new theatre became an important reminder to staff that dreaming was a worthwhile endeavour, and that biomedical futures beyond the material and infrastructural present were possible.

'The question is a request/prayer'

On 18 July 2014, two representatives from the Helping Babies Breathe (HBB) initiative visited the DMO's office to discuss the outcomes of the HBB implementation in Kiunga District. HBB was itself a 'Global Development Alliance',[11] comprising a wide array of different 'stakeholders', including multilateral, bilateral, NGO and private corporation entities.[12] The HBB representatives, the matron and I sat at the long table attached to the desk, while the DMO sat at his desk, with the aspirational master plan map easily visible over his right shoulder. The HBB representatives were Tanzanian, hired by HBB to monitor and evaluate the success of the programme. They wore blue polo shirts with HBB, USAID and various other logos on the front and sleeves.

The exchange took place in a mixture of Swahili and English. The main representative, Mr Juma, informed the DMO and matron about how the HBB initiative worked and how they monitored progress. Health workers were trained to recognize foetal respiratory distress and were provided with neonatal-sized masks and

[10]Autoclaves are high heat pressure chambers used to sterilize hospital equipment.

[11]Global Development Alliances (GDAs) are a 'new model' for PPPs initiated by USAID. According to USAID, while most PPPs entail private sectors providing financial support to development initiatives, public–private 'alliances' leverage the assets, expertise and market access of strategic partners such as foundations and corporations to address areas where the US government and industry goals overlap in the interest of development in low-income countries. For more information, see USAID (2010).

[12]HBB has multiple stakeholders, including those responsible for the wider initiative, and those acting as 'implementing partner programmes'. Stakeholders in HBB include the American Academy of Pediatrics, USAID, Laerdal Medical (a Norwegian manufacturer and distributor of resuscitation devices), the US National Institute of Child and Human Development, Latter-Day Saint Charities, and the NGO Save the Children, which represents civil society in the alliance. USAID works with implementing partners including CORE Group, PATH, Healthcare Improvement, and Maternal and Child Health Integrated Program. The programme was developed in consultation with the World Health Organization and a variety of other global health stakeholders. For more information, see the Helping Babies Breathe brochure: <http://www.helpingbabiesbreathe.org/about.html>, accessed 14 October 2019.

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FIGURE 2 Two foreign volunteers and the head surgical nurse enter the newly completed major operating theatre of Kiunga District Hospital with a patient, 24 June 2014.

resuscitator bags[13] as well as a 'dummy' doll on which to practise resuscitation procedures. After four to six weeks, the HBB team returned to the district to test workers on their retention of what they had learned. Mr Juma reported that, of all the districts in Tanzania implementing HBB, Kiunga was the most successful: six weeks after the course, 60 per cent of trained Kiunga workers were able to recall the procedures they had learned.

Mr Juma asked what supplies the DMO needed to better serve the needs of vulnerable babies in the district. In response, the DMO pointed out the accomplishments documented on his wall, highlighting the hospital's successes in maternal and child health initiatives; their success in HBB was part of a wider trend. The DMO then responded, 'We need a NICU [neonatal intensive care unit] machine for warming babies. We bought one but it broke soon after. We also need food supplementation for premature babies. Infrastructure is indeed the problem we have here.' A NICU ward was part of the plan outlined on the master plan map on the DMO's wall. In pitching the NICU machine, the DMO catered to donors' stated aims, employing those goals as a platform to advocate for a partnership that would include wider resources the hospital lacked. With international NGOs and larger bilateral donors, administrators were careful to state their needs in terms of what would best further the donor's or NGO's goals.

Mr Juma did not respond directly, but instead asked if the matron or DMO had any questions. The DMO responded, '*Swali ni ombi*,' turning the inquiry on its head. In

[13]A resuscitator bag is a self-refilling bag/valve/mask unit used in manual ventilation of a patient requiring respiratory assistance. Their proprietary name is Ambu bag.

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Swahili, '*swali*' means 'question'. However, the translation for *ombi* can mean both 'prayer' and 'request'. While Mr Juma intended to ask whether they needed additional clarification about HBB's activities, the DMO's 'The question is a prayer/request' implied a hope, rather than a command or expectation, for the partner organization to extend its attentions beyond the narrow targets of HBB's technologies and to wider institutional aspirations (Redfield 2016). This was visibility work (Street 2014), to draw attention to opportunities that such narrowly focused global PPP initiatives missed. Kiunga District Hospital's materially displayed successes in maternal and child health service provision, coupled with the district's excellent performance in the HBB initiative, were foundations upon which the DMO attempted to engage a transnational partner in innovative, yet locally relevant, ways. This exchange was not a novel occurrence. In global PPPs, Kiunga District's role was as an implementing partner for a programme conceptualized from afar. Here, the DMO employed the meeting as an occasion to insert into the partnership wider needs beyond the narrow scope of HBB.[14] While this attempt was ultimately unsuccessful, a similar strategy had worked in the mid-2000s with the HIV/AIDS clinic, and I observed hospital administrators employ this approach with many visitors representing foreign *wafadhili* partners on multiple occasions.

This initiative is an important example of different modes of dreaming at play: in contrast to the topographical map depicting wider institutional possibilities, the HBB initiative's aspirations were narrow yet 'global', designed to work universally in all facilities where applied, attending to immediate needs at the point of care rather than wider institutional dreams (Redfield 2016). As global PPP representatives such as Mr Juma visited Kiunga District Hospital, administrators attempted to expand their partners' perception of the possible, to hopefully forge their own homegrown PPP in the hope of making at least portions of their institutional dreams a reality. The mode was always subjunctive; as prospective partners came and went, invested in the dream or not, what got built often varied from the aspirational map on the DMO's wall.

'I think we'll have to outsource it!': imagining partnership beyond donor priorities

From 2007 to 2014, under the same DMO's leadership, Kiunga District Hospital was remarkably successful at generating homegrown PPPs, so much so that the hospital doubled in size during the course of his tenure there. In 2015, due to his successes at Kiunga District Hospital, the DMO was transferred to a prestigious administrative position in Dar es Salaam. That year, I partnered with Kiunga's new DMO and local leaders on a training initiative of my own: from June to August I ran an undergraduate qualitative health research training programme in Tanzania. Local leaders and government representatives selected project topics, in our collective hope that students' projects might generate useful or appropriate data for the district. The programme included seven undergraduates from my university and four undergraduates from the University of Dar es Salaam, grouped in small teams that collaboratively designed and executed the projects under my supervision.

[14]This is echoed in Hannah Brown's work in western Kenya, where hospital staff used meetings as a key moment in which to negotiate for their needs with partners (2015: 347).

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One of the projects was a study of what improvements community members desired in local health services, and precisely what they would be willing to pay for those services.[15] Community interviews in Kiunga District revealed that the most desired service was an expanded mortuary with a cadaver fridge to be built at the district hospital. When a loved one passed away, it was incredibly difficult for community members to collect their remains within the twenty-four-hour holding period before the body started to deteriorate. Many families paid significant additional costs to transport the cadaver to a hospital with a fridge if they could not make funeral arrangements quickly – a considerable additional strain on family resources.

After the new DMO received the students' reports, we met. He was unsurprised by the results. The mortuary had been a hospital priority since 2008. But despite pitching the idea to foreign visitors, NGOs and even local government representatives, attempted partnership had failed thus far. Donor funds tied to the Millennium Development Goals, and later the Sustainable Development Goals, disproportionately favoured the living. I asked the DMO what he would do. He responded, 'You know, it's unfortunate, Noela. It's just not a donor priority. I think we'll have to outsource it.' He explained yet another, novel form of homegrown PPP: a private investor willing to run a contractual mortuary business, where the contractor would take on the risks but receive the profits from the business for a finite period before returning the business to the government. In 2016 the hospital located an investor – an elected politician who was a member of the political opposition party. Construction of the mortuary foundation started that year, but by early 2017 the project was abandoned (see Figure 3). Members of parliament felt that a politician operating a business within a public institution presented a conflict of interest. Some partnerships never bore fruit. Others, like this one, could be politically fraught (see also Kamugumya and Olivier 2016; Street 2014).

Conclusion

In Tanzania, homegrown partnership, like other forms of partnership, is best understood in practice (Taylor 2018). The government's definition of 'partnership' provides significant space in which local institutions can creatively forge relationships with a multiplicity of others. These relationships are often serendipitous. Some last long periods, others are fleeting. Since 2008, the staff at Kiunga have been ready with proposals for prospective visitors despite not knowing who will come through the hospital's gates. The staff sow seeds of partnership widely, in a subjunctive sense (Whyte 2002) – hoping amid uncertainty. Administrators never know which international NGO might agree to provide additional equipment or expanded infrastructure, which foreign volunteer might contribute

[15]Notably, until the mid-1990s, healthcare in the public system was free, although highly under-resourced (see Bech *et al*. 2013). In the wake of austerity and chronic underfunding, the government introduced cost sharing in 1993, rolled out in phases starting with referral hospitals, and years later to district hospitals, health centres and dispensaries (see Mubyazi *et al.* 2006). User fees were rolled out in Kiunga District in 2000.

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FIGURE 3 Foundations of the since abandoned modern mortuary project at Kiunga District Hospital, 27 July 2017.

funds to support them, or which private investors will see a business opportunity through homegrown partnership.

'Partnership' for employees of Kiunga District Hospital is not a state of being, but an active pursuit of uncertain becoming. Indeed, prospective partnerships have been the sole means by which the hospital has managed to bring attention to its considerable infrastructural and capacity needs. As *wafadhili* say 'yes' or 'no', choose to partner or decide to leave, the five-year plan will change. Partners may wish to expand an existing building rather than build a new one. They may donate equipment unsuitable for the infrastructure in the area, or arrive with skills and tools aligning with the staff's vision of future possibilities.

I have been inspired by recent scholarship that avoids 'disappearing' the state, and instead attends to ways in which the state continues to play an important – if significantly altered – role in public health (Brown 2015; Gerrets 2015; Prince and Marsland 2013; Street 2014; Geissler 2015). For hospital staff at Kiunga, the state continues to be important in terms of facilitating space in which dreaming of hospital futures now seems not just possible, but also possibly worthwhile.

In November 2008, near the end of my field season in Tanzania, I interviewed several staff members. Having experienced considerable hardship during the 1980s and 1990s (Bech *et al*. 2013), staff responses about the role of government since 2000 were overwhelmingly positive.[16] Rather than experiencing a sense of

[16]This is not to say that the interviews did not unearth critiques, but compared with what they had observed in the 1980s and 1990s, many felt that the government had enabled considerable positive change.

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abandonment by the state (Street 2014), the staff felt that the government had opened up possibilities for health workers to look *beyond* the state for potential resources – a dramatic shift from previous policy asserting the state as the main provider of healthcare (Iliffe 2002). Staff credited the central government for achievements in the health sector, acknowledged its shortcomings, and praised the Ministry of Health's role in coordinating the distribution of donor-sponsored health initiatives. The Ministry of Health was perceived as an entity that enabled prospective *wafadhili* partners to come to Tanzania, while allowing each government institution to pursue its own aspirational path. The response by a staff nurse, Monica, is illustrative:

> They [the government] are doing big work! Because indeed they are the ones who *coordinate*, right? I know their work is big because the Ministry of Health is indeed our mother and our father. Yes, they coordinate because the donors [*wafadhili*] cannot come here without their permission, right? They are doing the big work also of finding [partners].[17]

For Monica and her colleagues, the government's encouragement of homegrown PPPs was enabling, providing space in which they might dream of an institutional future beyond their existing constraints. Interviewees noted that the rapid transformations in Kiunga District Hospital's infrastructure would not have been possible without the policy changes brought about under health sector reform, and the emphasis on PPPs in particular. Kiunga was remarkably successful at attracting *wafadhili* partners, in no small part due to the willingness of administrators to take advantage of existing social ties, and forge new ones, with a wide array of actors who might be willing to help.

Kiunga District Hospital's successes in working with partners since 2010, materially showcased on the DMO's office walls, allow hospital administrators to perform legitimacy in the hope of securing homegrown partnerships. Possibilities to forge homegrown partnerships open up space for collective dreaming, even if there is never certainty about whether or not, or how, those dreams will be achieved. Most efforts to achieve their dreams will not lead in aspired-to directions. However, the staff have had just enough success in fostering PPPs to believe, despite multiple failures to incite the interest of others (Piot 2010), that a different future is possible, if only the right helpers can be found (Green 2014).

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[17]Interview in Swahili, 11 November 2008. Italicized word spoken in English.

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Abstract

This article traces a shift in how hospital workers at a Tanzanian public hospital thought about their workplace. In 2010, for the first time, staff began collectively imagining what they called 'a real hospital'. This collective dreaming of institutional possibilities emerged due to two transformations: a shift in Tanzanian government policies enabling government institutions to initiate their own 'public–private partnerships' (PPPs) with non-state 'partners' such as NGOs, private businesses, investors, missionary organizations and others; and the hospital's early successes in attracting (a few) partners. Unlike familiar global PPPs such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, Tanzania's PPP policy allowed health facilities to initiate their own partnerships in order to improve public services. Drawing on longitudinal ethnographic research in one government hospital, this article traces successful, failed and fraught partnership initiatives through which public-sector health workers tried to improve hospital infrastructure and capacity. In tracing institutional aspirations and local workers' efforts to achieve them through homegrown PPPs, this article highlights the contingency and malleability of public and private spheres operating within public health service provision in Tanzania, as well as the opportunities available to health workers and the constraints involved in attempting to improve hospital care.

Résumé

Cet article décrit un changement dans l'opinion du personnel hospitalier d'un hôpital public tanzanien sur leur lieu de travail. En 2010, pour la première fois, le personnel a commencé à imaginer collectivement ce qu'il appelait « un vrai hôpital ». L'émergence de ce rêve collectif de possibilités institutionnelles résultait de deux transformations : un changement dans les politiques publiques tanzaniennes permettant aux administrations publiques de mettre en place leurs propres « partenariats public-privé » (PPP) avec des « partenaires » non gouvernementaux tels qu'ONG, entreprises privées, investisseurs, organisations missionnaires et autres; et le succès de l'hôpital à attirer rapidement (quelques) partenaires. Contrairement aux PPP mondiaux bien connus comme le Fonds mondial de lutte contre le sida, la tuberculose et le paludisme, la politique de la Tanzanie en matière de PPP permettait à des établissements de santé de mettre en place leurs propres partenariats en vue d'améliorer les services publics. S'appuyant sur des études ethnographiques longitudinales menées dans un hôpital public, cet article décrit les initiatives de partenariat réussies, ratées et périlleuses par lesquelles les agents de santé du secteur public ont essayé d'améliorer l'infrastructure et la capacité de l'hôpital. En décrivant les aspirations institutionnelles et les efforts du personnel local à les réaliser à travers des PPP maison, cet article met en lumière la contingence et la malléabilité des sphères publique et privée évoluant dans l'action sanitaire publique en Tanzanie, ainsi que les opportunités dont disposent les agents de santé et les contraintes liées aux tentatives d'améliorer les soins hospitaliers.

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