

Haydom Lutheran Hospital: A Sustainable Health-Providing Organization or a 'White Elephant'?

As an Xtrata CSR objective, what best practices does HLH have that can be transferred to other areas in Tanzania?

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This Master's Thesis is carried out as a part of the education at the University of Agder and is therefore approved as a part of this education. However, this does not imply that the University answers for the methods that are used or the conclusions that are drawn.

University of Agder, [2011]

Faculty of [Economics and Social Sciences]

Department of [Development Studies]

Abstract

This paper provides an analysis of the sustainability of Haydom Lutheran Hospital (HLH) in Tanzania. Moreover, it discusses the local community's dependency on the hospital. A smaller second part of the paper looks at Xstrata's decision to use HLH as a corporate social responsibility (CSR) objective. The thesis further explores what services can be seen as best practices from HLH and therefore transferable to Xstrata's possible mining site in Kabanga, Tanzania.

HLH has since its inauguration by Norwegian missionaries in 1955 been highly funded by public and private financial, human and technological resources from abroad, especially from Norway. The open-system model, which consists of three main components—contextual, activity level and organizational capacity—is identified as the best analytical framework with which to assess the sustainability of health organizations. The empirical findings show that HLH has become too dependent on the Royal Norwegian Embassy, and has wrongly seen it as a secured long-term funding source. The activity level has been continuously increasing, though the financial resources have been unclear. Even though quality of care is higher at HLH than at most other mission hospital in Tanzania, a question arose within the paper about the cost of adhering to such high quality. The organizational structure has moreover been overly dependent on one person—the ardent soul—leaving a gap with him leaving this position.

In the thesis' second part the activity of reproductive, children health and maternity related services is found to be what should be initiated by Xstrata in Kabanga. Yet, it is also suggested that Xstrata has the possibility to adhere to strategic philanthropy CSR, instead of add-on philanthropy, and that this could have a greater social and economic development impact on its local community.

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Abbreviations

BN	The Norwegian Mission in Development
ELCT	Evangelical Lutheran Church of Tanzania
CMI	Christian Michelsen Institute
CSR	Corporate Social Responsibility
FoH	Friends of Haydom
GoT	Government of Tanzania
HLH	Haydom Lutheran Hospital
HoD	Head of Division
IIED	International Institute for Environment and Development
MoU	Memorandum of Understanding
NLM	Norwegian Lutheran Mission
NORAD	Norwegian Agency of Development Cooperation
PD	Paris Declaration on Aid Effectiveness
RBMM	Result Based Management Model
RCHS	Reproductive and Child Health Services
RCMHS	Reproductive Child and Maternal Health Services
RNE	The Royal Norwegian Embassy [in Tanzania]
TB	Tuberculosis
SWAp	Sector Wide Approach
UN	United Nations
UiA	University of Agder
WHO	World Health Organization

Acknowledgement

“Alice in Wonderland was told that, ‘If you don’t know where you’re going, any road will get you there’” (NORAD 2008: 9).

As an introduction I would like to write some few words to clarify my reasons and intentions behind this project.

I’ve held a keen interest in Africa, international development and aid as a tool to reduce poverty in the developing world, all since my school year in South Africa in 1999. Thus, the path of studying Development Management at University of Agder (UiA), with the program’s focus on fieldwork and practical experience, was an appropriate choice in pursuing a master degree. I moreover believe that I have learnt much through my two years at UiA and the school’s practical teaching of international development.

The most important change between my first and second year at UiA, which eventually led to my fieldwork and writing of this thesis, is that I became more reflected and started questioning with which tools and with what intentions development can be created. In other words, from being merely good intentioned, I started asking questions and wanting better insights into what resources were required to produce different development outcomes.

I set out writing this thesis because I’m curious and I wish for as many people as possible to experience development. While being allowed to study the Haydom Lutheran Hospital (HLH) as a development project, my primary wish was to analyze HLH’s operations and determine whether these activities are the most efficient way of using aid money. Evaluations of financial, technical and human resource use are guiding principles to ensure the best use of aid money. It is clear that HLH is helping hundreds of thousands of people, yet, with my newly acquired knowledge from UiA, I was curious if these people were the maximum people able to be helped with HLH’s resources, or whether there’s a possibility that other—and more—people could be helped.

There are many people that have earned their right to be acknowledged here. Many have played important roles in helping me develop this thesis.

Firstly, I would like to thank my excellent advisor Kjell Havnevik for guiding me, and helping me understand what I actually should be doing. He also added valuable input and at the right moments asked the right questions that helped me write, hopefully, a better thesis. It has been

inspiring to learn from your in depth knowledge of Tanzania, aid and development. Thank you!

Secondly, I would like to thank my husband for tolerating me through my ups and downs writing this thesis. Moreover, for tirelessly reading and commenting on my writing. This thesis would not have looked the same without you!

Thirdly, I owe great thanks to Harald Eik and Xstrata Nikkelverket in Kristiansand for supporting me for a pre-trip and my final fieldwork to Tanzania. I hope the outcome of this thesis can be of use to you. It sure has made a big impact and changed my view on many development challenges.

Fourthly, I'd like to offer a big thank you to employees, administration and volunteers at Haydom Lutheran Hospital. This thesis became possible because of your input. I am mightily impressed by the work that you are all doing. The fruits of your dedication are visible all throughout HLH's catchment area and it was a life changing experience for me to be allowed to study your work.

Fifthly, I believe the director of my program Pâsan Øyhus deserves to be mentioned. He put me in contact with Xstrata and came with me, Xstrata and a co-student for the pre-trip to Tanzania in 2010. It was an incredible experience for me, especially as Pâsan explained and related his more than 30 years of work in the aid-field to situations we encountered.

There are clearly many others that have played important roles throughout my studies, fieldtrips, analysis and finalization of this thesis. Though, I cannot mention you all I would like you to know that I'm as grateful and thankful as it is possible to be. You all pushed me forward and believed in me, when I did not, and because of that I'm happy to say—I did it!

Chapter 1- Background

1.1 Introduction

Today there is a debate within the foreign aid industry which states that health-promoting aid projects should be independent both at a financial and technological level (Shediac-Rizkallah and Bone 1998; Bergh 1995; Olsen 1998). The debate about single health-promoting organizations relates to whether these organizations, if continuously depending on foreign aid, can be classified as sustainable, or should they rather be understood as *white elephant projects*? White elephants are characterized as foreign aid project which are continuously absorbing national and international financial resources without creating the wanted social and economic development that they were set up to construct (Robinson and Torsvik 2004; Olsen 1998; Flessa 2005).

For this thesis the Haydom Lutheran Hospital (HLH) in Mbulu, Tanzania will be examined and its efficiency to promote development, together with its own sustainability will be studied. Today HLH is much more than just a hospital and has since its beginning in 1955 become a development organization which promotes a “holistic approach to health care for its patients, attempting to meet the ‘total needs of the person’ including spiritual, social, and health needs” (Olsen 2005).

The sustainability of the hospital is examined by analyzing HLH based on three different factors: contextual, organizational capacity and activity profile. An underlying assumption from using all three factors is that sustainability is more broadly defined than just securing long-term financial survival (Olsen 1998). Factors such as creating capacity within the organization and local community are part of the sustainability, the different mix of services that the organization provides is part of the framework, and the flexibility of the organization is important, amongst others. However, this does not mean that securing long-term financial resources is not important; quite the opposite. Several academics promote the view that health organizations operating in developing countries will probably for a long time be dependent on external funding. This relates to national governments’ often-weak economic position and the patients’ inability in many circumstances to pay for their treatment. Exactly because of these financial limitations, is it imperative that sustainability is created in other activities within the organization, and examining this will be part of this report.

HLH is furthermore used as a corporate social responsibility (CSR) objective by Xstrata Nikkelverket i Kristiansand, Norway. Xstrata Plc is a publicly listed mining company,

operating in 19 different countries and employing more than 56.000 people (Xstrata Plc 2009). CSR is another debated concept but is often understood as including “a mode of business engagement and value creation, allowing to meet and even exceed legal, ethical, and public societal expectations” (Jamali 2007: 1) within its countries of operation. Today the debate about CSR is taken further and deals with how CSR can create sustainable development within developing countries (Hopkins 2007; and Jamali 2007).

If both the definition of CSR and the expanded view of seeing CSR as a tool for development are agreed upon, there still remains a question on what a well-functioning CSR project looks like and how a CSR project is decided upon. With this in mind, Xstrata’s engagement with HLH will be studied. What kind of CSR project does HLH actually represent to Xstrata, and how closely does it adhere to Xstrata’s CSR policy and to “[activities that] exceed societal expectations” (Jamali 2007: 1) within the local communities? The thesis will further examine whether HLH has any characteristics, which could be used as a template for starting similar CSR projects at other locations within Tanzania, most notably at Kabanga in northwestern Tanzania.

1.2 Objectives of the Research

The main objective and greater part of the paper will be to examine whether Haydom Lutheran Hospital can be understood as a sustainable health-promoting organization. The framework for what constitutes sustainability has been briefly explained in the introduction and comprises three distinct factors: contextual, organizational capacity, and activity level. The argument is that all of these factors have to be present for sustainability to take shape.

A smaller component of the paper will be dedicated to looking at the HLH as a CSR project, and will (1) investigate the reasons behind Xstrata Plc choosing the HLH as its CSR project, (2) how well the CSR project aligns itself with the greater CSR objectives of Xstrata, and (3) if HLH can serve as a template for future CSR projects within Tanzania.

1.3 Research Questions

1. Do the locals perceive Haydom as a development tool for the area?
2. Is the Activity Profile of Haydom Sustainable?
3. Are the Contextual Factors of Haydom Sustainable?
4. Is the Organizational Capacity of Haydom Sustainable?
5. How ideal is the Haydom Hospital as a CSR object?

5.1 Who and Why was the decision taken to use HLH as a CRS project?

6. What are the goals regarding Xstrata's investment in HLH?

6.1 What type of CSR project for Xstrata can Haydom be understood as?

7. To what extent is it possible to transfer ideas and practices from Haydom to other CSR projects?

1.4 Thesis Outline

Chapter 1 presents the background of the research project, provides the objectives of this thesis, and states the research questions.

Chapter 2 provides the background of the area of study. It summarizes the contextual history, socio-economic background, and political situation. It furthermore introduces the Haydom Lutheran Hospital, and briefly touches upon HLH's main historical achievements and its operations. It moreover presents Xstrata Plc and Xstrata Nickel's operations in Kabanga.

Chapter 3 presents the literature review, which includes prior research on the different themes, and suggested frameworks and methodologies applicable to this thesis. Historical importance and evolution of missionary hospitals within the developing world, together with an historical outline of the concepts of CSR are also presented.

Chapter 4 explains the methodology chosen for this research. It provides justification for the design, strategy, sampling and data collection methods chosen.

Chapter 5 provides the empirical findings and analysis of Haydom Lutheran Hospital. It moreover relates any findings to the frameworks presented in Chapter 3. The Chapter is further divided into three main components: the Contextual factors, Activity Level, and Organizational Capacity.

Chapter 6 presents the empirical findings and analysis of Xstrata's CSR projects in Kabanga and the use of Haydom Lutheran Hospital as its main CSR object in Tanzania.

Chapter 7 provides some concluding recommendations and suggestions for future studies of HLH.

Chapter 8 outlines the limitations of this thesis.

Chapter 2 – Area of Research

2.1 Tanzania

Figure 1: Map of Tanzania



Location: Eastern Africa between the Indian Ocean, Kenya and Mozambique.

Capital: Dodoma;

Population: 41,892,895, 43% is between the age of 0-14, and 54.1% between the age of 15-64;

Main employment sector: Agriculture: 80% of employment;

Infant mortality rate: 68.1/1.000 live births;

Fertility rate: 4.3 children/woman; HIV/AIDS: 6.2% of population;

GDP per Capita: \$1.400;

Population below poverty line: 36% (2002 est);

Ethnic Groups: African 99% (of which 95% are Bantu consisting of more than 130 tribes); **Religion:** Christian 30%, Muslim 35%, indigenous beliefs 35%; **Languages:** Kiswahili or Swahili (official), Kiunguja (name for Swahili in Zanzibar), English (official, primary language of commerce, administration, and higher education), Arabic (widely spoken in Zanzibar), many local languages (all statistic and map from CIA 2010).

2.1.1 “The Cradle of Man Kind”

Tanzania has been called ‘The Cradle of Man Kind’, as some of the oldest fossils in the world, dating back approximately 3.5 million years, were discovered in the Northern parts of the country (Leraand 2009). The current Tanzanian population stems from different bantu tribes that arrived in Tanzania through the northern parts of the country more than 2.000 years ago. They spread around the nation, although the majority settled down in the center parts of what we today call Tanzania (Leraand 2009).

During the aftermath of the Berlin Conference in 1884-85 the European powers divided the African continent between themselves. Tanganyika, which was the name of mainland Tanzania at that time, came under German protectorate. Due to conflicts between the German-Eastern Trade Company and the locals, the German government established an office in Dar es Salaam in 1889 (US State Department 2010). Similarly, two years earlier, Zanzibar had become a British protectorate (Leraand 2009). The German defeat in World War I meant that

the Tanganyika territory became British after the mandate of the League of Nations (Leraand 2009; US State Department 2010). Moreover, after World War II the country became a UN trust territory under British Control (US State Department 2010).

2.1.2 Independence

In 1961 Tanganyika held its first free election and was further the first East-African country to achieve its autonomy. The following year the country became a republic with Julius Nyerere as President. However, not before 1964 was the United Republic of Tanzania ‘born’, after the union of Tanganyika and Zanzibar. According to some authors, Tanzania had two comparative advantages when it gained its independence. Firstly, the country was rather homogenous in that 80 percent of the population lived in rural areas. Secondly “in President Julius Nyerere, who had led Tanzania to independence, the country had a widely respected leader—not only in Tanzania but also among donors and generally on the international scene” (Selbervik 1999: 20).

In 1967 President Nyerere drew up his future vision for Tanzania in the *Arusha Declaration*. Within it Nyerere noted the difficulties for Tanzania to follow the neo-liberal policies prominent in the Western world by stating: “[I]n fact we do not possess [financial resources]. It is therefore a complete illusion to think that money will solve the problems...it comes from taxes, and these cannot be increased” (cited in Selbervik 1999: 20).

Accordingly, Nyerere proposed the implementation of a fully socialist state and nationalization of banks and all export industries, while also introducing collectives known as *ujamaa*. The *ujamaa* included a health clinic, an educational institution and a church. Nyerere’s vision was that this would make social development available to greater parts of the population. People that did not want to move into the *ujamaa* were forcefully moved there (Leraand 2009; Schweigman 2001). It has later been argued that the quick implementation of the *ujamaa* policy during a five-year period from 1968 until 1973, and the fact that people were forced to move against their will, reduced the success of the policy (Leraand 2009; NORAD 2003).

Tanzania found itself in dire economic trouble by the 1980s after the *ujamaa* policy had failed to create the economic growth desired. Agricultural output had been decreasing with the move to collective farms, (Schweigman 2001: 117-118), and state controlled processing, marketing and prices of the output reduced economic gains. Coupled with a global oil crisis in the end of

the 1970s and a corresponding fall in export prices meant financial catastrophe for Tanzania by the 1980s (Shiner 2003; Schweigman 2001).

Throughout the 1980s and 1990s both the International Monetary Fund and the World Bank promoted more liberalization and privatization policies, trying to increase the economic performance of the country (NORAD 2003). The Tanzanian government did accordingly initiate different economic reforms. However, the continued deterioration of the economy, and unhappiness about the meager future economic outlook among the local population, made Nyerere step down in 1985.

The relationship between the Government of Tanzania (GoT) and donors reached a low in the beginning of the 1990s. The GoT felt that donors were interfering too much and reducing ownership of development efforts, while the donors questioned the GoT's implementation and actual mobilization of national resource to support any development efforts (Selbervik 1990; Wangwe 2010: 207-208). To improve relationship between the two sides and increase development outcomes an independent expert group was asked to analyze the situation and come with recommendations. One of the recommendations was the Tanzania Assistance Strategy (TAS). “[TAS] provides the framework for stringing donor coordination, harmonization, partnerships and national ownership in the development process” (Wangwe 2010: 208).

Following the TAS, the *basket fund* was initiated by the national government and its donors with the initiation of a Sector Wide Approach (SWAp) to development in 1998. The focus of the SWAp was that the planning and execution role of any health policy would be held by the national government. Donors would only provide technical and financial support. The signing donors—of which Norway was a part—would moreover deposit their monetary support into a national governmental bank account, which the government would control and use to distribute funds out to the districts. This bank account is called the *Health Basket Fund* (Mapundo 2003).

2.1.4 Tanzania Today

It is clear today that any system targeted at increasing the economic and social development of Tanzania has not managed to pull the country out of poverty. Tanzania is today in the bottom 10 percent of the worlds' economies (CIA 2010), and thus regarded as a least-developed country (LDC). On the human development index (HDI), Tanzania is ranked 148 out of 176 countries (UNDP 2010). Fortunately, the country's economic crises have not

created the expected internal struggles and conflicts that have often been seen in other economically challenged African nations. “[Tanzania] has had the privilege of being a peaceful multi-ethnic and multi-religious society ever since Independence” (NORAD 2003a: 7).

The Tanzanian economy has always been, and continues today to be, heavily based on agriculture. The agricultural sector accounts for 40 percent of GDP, employs 85 percent of the population and counts for 80 percent of exports (CIA 2010). The industrial sector in Tanzania is one of the smallest within any African country. The sector is furthermore highly steered towards the domestic market. This can be related to an unfriendly foreign-investment climate (US State Department 2010). Poor infrastructure and the lack of electricity have also served as obstacles to foreign investment in Tanzania. The possibilities within the industrial sector are quite significant, however, as the country holds large deposits of minerals, gas and oil (NORAD 2003). Moreover, “[at] the end of the 2000s, minerals...not agriculture emerged as the major export earning sector” (Havnevik 2010: 268). It is further noted that the export of these minerals is led by foreign companies, and thus “the Tanzanian government and society have less control over the income and profits generated in these sectors” (Havnevik 2010: 268).

2.2 Haydom Lutheran Hospital

Figure 2: Map of Haydom’s location



Haydom Lutheran Hospital (HLH) is a first-referral hospital in the Mbulu District, Tanzania. HLH was established by the Norwegian Lutheran Mission in 1953, and officially opened in 1955 (Interview A0; Olsen and Daudi 2010). The hospital was handed over to the Evangelical Lutheran Church of Tanzania in 1964 (Mæstad and Mwisongo 2009), yet continues to employ Norwegian head doctors.

(Source: Dickson 2007)

HLH has, since its small beginning, become a well-known, highly equipped and important hospital within the Tanzanian health system. HLH's mission is to serve as a development agent through its holistic understanding of health provision: "To cater for the needs of the whole human being, i.e. physically, mentally, spiritually and socially" (Mæstad and Brehony 2007: 3). It furthermore means that HLH today provides and participates in diverse development activities. This makes HLH "one of the largest and most comprehensive development projects in Tanzania" (HLH 2008: 4). The vision of HLH is broken down into four objectives: (1) Reduce the burden of disease, (2) poverty alleviation, (3) institutional capacity building of HLH and partners, and (4) improve collaboration with similar institutions (HLH 2008).

2.2.1 History and Milestones

In 1953 it was the wish of the British Colonial leaders that people would move into the Haydom area. They therefore encouraged the Norwegian Lutheran Missionaries to set up a hospital there (Olsen and Daudi 2010: 21). At this time the village had only two to three huts due to the uninhabitable environment made up of bushes filled with tsetse flies (Interview A0).

HLH opened up in 1955 with 50 beds, a number which already from the beginning was found to be too small. "There are continuously 80 inpatients. That is twice as many as we had expected" (cited in Enes 2004:72 translated by author). This was reported by Alfred Lien, one of the first Norwegian doctors at the hospital, back to the Norwegian Lutheran Mission (NLM) three months after the opening of the hospital. This would be one of many correspondences from HLH back to Norway, asking for increased funding, and human and technology resources to ensure HLH's ability to provide services in rural Tanzania. Despite issues of space, lack of finances, lack of electricity and water, the Norwegian missionaries and medical doctors continued expanding the health services provided to the local community.

The Norwegian Lutheran Mission (NLM) handed HLH over to the Evangelical Lutheran Church of Tanzania (ELCT) in 1964. However, the NLM continued to financially support HLH. Dr. Ole Halgrim Olsen, who has been called the father of HLH, carried on as the director, which demonstrates the continual strong ties that HLH had and would continue to have with Norway. Dr. Olsen has been the Medical Director in charge of HLH in four different periods: 1961-1967, 1969-1973, 1977-1981, and 1989-2005 (Olsen and Daudi 2010:24).

2.2.2 Haydom Lutheran Hospital Today

The HLH is today one of the biggest rural hospitals in Tanzania with 429 beds. During the last years approximately 7.000 inpatients and more than 72.000 outpatients have been treated. HLH performs more than 4.600 child deliveries a year together with 1.500 major surgeries. At any given time there are between six and 15 doctors working at HLH, with a total staff number of approximately 580 (Olsen and Daudi 2010: 1-2; HLH 2009).

The direct catchment area to HLH is estimated at 287.000 people. They live within three different districts: Mbulu, Hanang and Iramba. The wider catchment area serves approximately 1.976.000 people from seven different districts: Mbulu, Hanange, Iramba, Meatu, Karatu, Singida Urban and Singida Rural (Malleyeck 2010: 4). However, increasingly patients are arriving from even further away.

2.2.3 HLH as a Development Actor

The initiating of a pre-nursing school in 1971 and a nursing school in 1984 was just two of several ideas that Dr. Olsen had to secure HLH's sustainability. Another such self-reliance structure was the purchase of a farm in 1972. Later other farms have been bought. The main goal was to produce food for the hospital, earn income on the sale of produce to the local community and furthermore introduce new and better drought resistant plants to the area (Enes 2004: 11). Furthermore, a workshop/garage was initiated on the hospital grounds to help with maintenance of cars, tractors, electrical equipment and construction of some furniture for the community and for the hospital (Enes 2004: 124).

Acknowledging that the hospital was not managing to reach out to the entire Mbulu district, and therefore was not fulfilling its mission, HLH initiated its first three mobile clinics in 1973 (HLH 1973). The number of these mobile clinics has since increased, and today HLH has 26 such programs. Six clinics are reached by airplane, while 20 stations are reached by car (Mæstad and Mwisongo 2009: 8).

In synchronization with the expanding hospital, the Haydom Village was growing in size. To enable the hospital to serve the increasing population, and to improve the quality of care provided, the hospital was expanded in 1981 with special donations from the German Evangelische Zentral Stelle. During this expansion a laboratory and a pediatric ward were built (Olsen and Daudi 2010: 1, 23). A further expansion of HLH took place in 2003. With funding from Friends of Haydom (FoH), a registered group of supporters from mainly southern Norway, and a special donation from a private donor from southern Norway a 100-

bed pediatric ward was added that same year. In addition to this, HLH has added “an eye department, psychiatric clinic, epileptic clinic, and diabetic clinic together with a clinic for alcohol and narcotic addicts” (Olsen and Daudi 2010: 1). HLH is also operating several health centers, dispensaries, mobile mother-children health clinics within the district, and a Voluntary AIDS Control Program (Olsen and Daudi 2010: 1).

2.2.4 Socio-Economic Development Haydom’s Catchment Area

HLH prides itself in working for and together with the local community to ensure the socio-economic development of the area around the hospital. “The hospital maintains that it is an important actor within the civil-society sector and functions as a catalyst for development and a change agent within the community” (Olsen and Daudi 2010: 9). As noted in the 1979 Annual Report: “the hospital has grown up with the people in the area” (p. 5). It is furthermore clear that the town of Haydom has grown substantially and today is the home to approximately 20.000 people (Interview A0).

The hospital has been and continues to be a main employer in the town. It is also the institution that people go to when infrastructure, social or economic troubles become too difficult and people need advice or just plain help (Enes 2004: 208; Interview A0; Interview A8). This is exemplified with HLH’s role in building roads, water and electricity infrastructure across the district (Olsen and Daudi 2010; Interview A0). This does not mean, however, that HLH has provided all this for free. The work has frequently been done in collaboration with the local community. Also, in years of draught and hunger HLH has administrated *Food for Work* programs. HLH has also gathered donor support and finances for the construction of several primary schools within HLH’s catchment area, together with a secondary school in Haydom that opened in 1995.

2.3 Xstrata Plc

Xstrata Plc (Xstrata) is a global mining company. It was established in 2002 and operates in 19 different countries. Xstrata is listed on both the Swiss- and London-Stock Exchanges. The company has a diversified portfolio and today mines for copper, nickel, alloys, zinc and coal. Xstrata also operates one technology and one general business unit (Xstrata Plc 2009). Each unit has “responsibility from exploration to post closure obligations and from revenue to EBIT” (Xstrata Plc 2009: 16). This decentralized system is favored with the belief that local knowledge within each unit can be better exploited. The company employs 58.681 workers

(36.710 fulltime and 21.971 contractors) (Xstrata Plc 2009). This makes Xstrata the world's fifth largest mining company.

2.3.1 CSR Framework

Xstrata's CSR framework is outlined within its *Business Principles, the Sustainability Development Policy* and the *Sustainable Development Standards*. These schemes adhere to internationally recognized standards and regulations such as the Global Reporting Initiative, United National Global Compact, Dow Jones Sustainability Index and OECD Guidelines for Multinational Enterprises (Xstrata Plc 2009c: 18).

The business principles incorporate the ethical paradigm—the responsibilities and accountability standards that Xstrata's operations have to follow. The ethical paradigm notes the importance that all parts of the Xstrata business are operating morally and ethically. This means that there is no corruption, that human rights for indigenous and other local communities are prioritized, and that the company is adhering to good corporate governance (Xstrata Plc 2009a). Acting sustainably responsible and adhering to sustainable development is another important focus for Xstrata. According to the company its social, environmental and economic environment are always taken into consideration when managing company operations (Xstrata Plc 2009a: 3).

Openness and transparency involves the company “communicat[ing] in advance the potential impacts and benefits of all...our operations...to all relevant stakeholders in a transparent, comprehensive and culturally appropriate manner” (Xstrata Plc 2009a: 4). To ensure this transparency Xstrata is committed through their *Business Principle Standard* to engage in an open, two-way communication with its stakeholders. Xstrata defines its stakeholders as: “the investment community, employees, contractors, unions, national, regional and local governments, intergovernmental bodies, regulators, communities associated with our operations, business and JV partners, non-governmental and development organisations, suppliers, customers and media” (Xstrata Plc 2009d: 24).

Xstrata has committed, with its Sustainable Development Standard, that a minimum of 1 percent of its profits before tax should be used for CSR purposes. This money should “fund initiatives that benefit the communities associated with [Xstrata's] operations, particularly those located in remote areas or in regions with a lower level of social and economic development and infrastructure” (Xstrata Plc 2008).

The investment should furthermore be dedicated to areas such as education, health, sports, community development and job creation (Xstrata Plc 2009: 101).

2.3.2 Xstrata Nickel

Xstrata Nickel has its headquarters in Toronto, Canada. Xstrata Nickel is the world’s fifth largest nickel producer and refiner, and has operations within five different countries, in five different continents. In 2010 the operating profit of Xstrata Nickel was US\$ 508 million (Xstrata 2010).

Xstrata Nikkelverk in Kristiansand, Norway, was established when Xstrata Plc bought Nikkelverk from Falconbridge Nickel Mines Ltd in 2006. Nikkelverk refines nickel and has been doing so since its launch in 1910. Nikkelverket has approximately 500 workers, and produces approximately 92.000 tons of nickel each year (Xstrata Nikkelverket 2011).

The Kabanga Nickel project was started in April 2005, with the signing of a 50-50 joint-venture agreement between Xstrata and the Barrick Gold Corporation. The Kabanga mine is situated in the northwestern part of Tanzania in the Ngara District.

Figure 3: Map Kabanga’s location



There has been exploration work at the Kabanga site as far back as 1990. Yet, it was not until 2004 that the actual amount of resources at Kabanga was realized. Today, the Kabanga site is believed to be the world’s largest unexplored nickel deposit (Eik 2010).

(Source: Xstrata Nickel 2007: 11)

The Kabanga mine could potentially be a long-term mine site for Xstrata. This implies an operational life of minimum 30 years, with the possibility of mining at the site for up to 50 years (Kohlsmith and Wikedzi 2010). Kabanga Nickel is still in the initial exploration stages, and the feasibility study of the mining operations, together with a baseline study of the local community, have been delayed from mid-end 2010 until the mid of 2011. Based on the conclusions of these studies, and the situation at that point, a final decision of whether fully fledged mining operations will be initiated can be taken (Eik 2010; Xstrata Plc 2009: 83).

2.3.4 CSR Activities Related to the Kabanga Mine

Despite only engaging in explorative activities at Kabanga, Xstrata has participated in town-hall meetings, visited different areas in the local community, used local radio and met with local leaders to inform the public about the company's operations. These reunions have furthermore been an opportunity for the local community to voice their opinions. "The project is welcomed by the local community" (Kohlsmith and Wikedzi 2010), as locals see it as a source of increased employment and infrastructure to the area (Kohlsmith and Wikedzi 2010).

Yet, with no final decision made whether full scale mining will be initiated or not, the company has been adhering to a CSR scheme and communication with locals that will not promote an overenthusiastic sentiment in the community (Kohlsmith and Wikedzi 2010). Hitherto, it has been important for Xstrata to work on increasing capacity building within the community, a trait that can be valuable for the long-term welfare increase of the community, and not dependent on Xstrata for its sustainability (Kohlsmith and Wikedzi 2010). The local community has been defined as four wards surrounding the mining site. It is within these four wards where the community work is carried out. Moreover, to ensure that Xstrata is not mistaken for a donor bank to the local community, local ideas and ownership has been characteristics underlying all projects. The local community explicitly has to ask for help to start any activities before Xstrata will initiate it. Moreover, the local community has to actively participate in the implementation and running of any project.

Xstrata has donated books, chairs, building materials and bed nets (to make sure that the bed nets are used, Xstrata employees visit user homes); initiated collaboration between police and community leaders to ensure a safer environment; trained health workers; promoted road safety and implemented speed limits; managed the fauna by capturing animals that are inhabiting the mining site and releasing them in safe areas; helped in vegetation management by rehabilitating and vegetating old drill holes.

Chapter 3 - Literature Review and Theoretical Framework

Many developing countries' health systems are based and dependent on church-related hospitals, outreach and health offices (Flessa 2005: 236; Green *et al.* 2002: 336). In Africa, weak governmental structures and the lack of financial and human resources have often meant that national health systems have been created around, together with, or nearly solely by religious groups often sent as missionaries from Europe and the United States of America. These missionaries mainly arrived on the African continent during colonial times, though they were also present before colonialism and are still going there today. Engaging in health-promoting activities was seen as a way of preaching the gospel and showing compassion and love (Flessa 2005: 236-237). Combining evangelism and health care, the typical mission station within Africa therefore often included a church, a school and a hospital (Green *et al.* 2002: 336-337).

3.1 Historical Importance of Missionary Hospitals

During the 19th and beginning of the 20th centuries western missionaries set up hospitals and dispensaries throughout the developing world, providing primary care either for free or at very affordable costs for poor and marginalized groups (Flessa 2005: 240). Health stations were often set up in very rural areas trying to reach the poorest and provided services to groups, which the government seemingly did not reach. Throughout these health stations pioneering work was done in regards to operations, care and health improving work based on limited funds, manpower and technical resources (Green *et al.* 2002: 237).

Yet, the amount of people actively being catered to was often restricted to the hospitals' or dispensaries' nearer catchment area, meaning that the marginalized groups living far from any hospital was not being served. The cost for rural groups to get to the hospital was just too great. Furthermore, "[the missions'] personnel and financial resources were not sufficient to extend their services to the unreached majority" (Flessa 2005: 240). Despite the problem of reaching the marginalized groups, it is clear that by the time of independence, missionary supported health stations, hospitals and dispensaries were a significant part of the health systems of African countries (Green *et al.* 2002: 238).

During independence from colonial rule there was a strong movement within Africa of handing over the missionary hospitals to the local churches. This movement was strongly related to the thought of development, democratization and local independence (Green *et al.* 2002: 238). The importance of mission hospitals to the African health system, however, did

not diminish, but rather changed its form. Firstly, missionary health stations are today—thanks to the handing over to local churches—part of a complex health system within the different African countries. These health systems often consist of public and private nonprofit and for-profit actors. Secondly, missionary hospitals are administrated by local churches and often not staffed with expatriate personnel. Thirdly, financial resources are not solely based on resources from the mother church but are increasingly coming from international donors, bilateral agreements, governmental funds, user fees, and private funds (Green *et al.* 2002: 238).

Schmid *et al.* (2008) note the difficulty that private non- and for-profit health organizations within Africa often are confronted with: “[The] mission to serve the poor and marginalized comes into direct conflict with financial survival” (p. 88). Schmid *et al.* (2008) further found during a study of faith-based hospitals in Africa that these organizations are experiencing overdependence on external funding. “There is concern over the growing dependence of [faith-based organizations] on not-always-reliable foreign assistance” (Schmid *et al.* 2008: 89). Green *et al.* 2002 support this view, yet find that funding of mission hospitals today is more diversified than what it was during the initiation of the mission hospitals.

A World Bank study from 2003 of religious institutions providing health care in Uganda found that “only 3 out of 44 nonprofit dispensaries received funding from private sources and only 2 out of 44 received funds from the donor community in fiscal year 1999/2000” (Reinikka and Svensson 2003: 8-9). On the other hand, Gill and Carlough (2008) argue that mission hospitals very often keep in touch with their mother institutions and continue to receive funding from these sources “resulting in donations of money and medical supplies far beyond what is locally available” (p. 200). The contact and the availability of funds from external sources are, however, higher when expatriates are employed in the administration of the organization than if only locals are present (Green *et al.* 2002: 34). This possibly confirms the findings of Gill and Carlough (2008) that expatriates often function as a bridge of contact between the mother church from which the expatriate is sent and the local church which is operating the health facility. Reinikka and Svensson (2003) further argue that the availability of external funding from external donors/mother churches creates a ‘can do’ attitude and autonomy sentiment amongst the administration. This made mission hospitals’ administration more risk averse, even though the income from governmental funding was uncertain (Gill and Carlough 2008: 200-201).

The authors have not explored whether this can be related to the lack of administrative training for the leaders within religious health organization. Green *et al.* (2002) found that the management of health organizations often lacks formal administrative training. This reduced their ability to implement new policies and to manage their institutions efficiently, and with high quality (p. 350). This does not, however, reduce their willingness to look for solutions to both financial and technological problems. “[Churches’] management may be more proactive in directing activity and in obtaining external funding” (Green *et al.* 2002: 345). Interestingly, Green *et al.* (2002) found that the priorities of the administration of church hospitals often were to secure continuous operation of the facility, and ensure their own perks (housing, good salary and car), instead of thinking about staffing and patient welfare (p. 344).

Green *et al.* (2002) further argue that there has been a belief by donors that “[C]hurch health services [have the]...capacity for efficient and ethical use of resources; a commitment to quality of care even with limited resources; access to external funds and a diversity of income sources; a sympathy with, and support from, the local community” (p. 346). Yet, Green *et al.* (2002: 346) find no hard evidence to support this viewpoint. Conversely, Baht *et al.* (2001) cite a study by Valdemanies (1992), which found that public hospitals actually are more efficient due to their budgetary constraints from the government, than nonprofit hospitals/health facilities. The diversified donor base makes nonprofit hospitals less efficient due to the bureaucracy that comes with having to relate to many different funding sources (Baht *et al.* 2001: 167-168). Thus, time is spent on writing applications, along with monitoring, evaluating and reviewing reports.

Both Reinekke and Svensson (2003) and Green *et al.* (2002) mention the operation constraints of mission hospitals because of delayed or not given governmental grants. This uncertainty has become a growing problem, as mission hospitals are moving into national-health systems and thus base budgets and plans on the continuous support on national governmental funding. Even though such payments are noted in policy, public deficit or bad governance might prevent the release of such funds. This creates administrative stress on the health organizations and reduces their ability to operate efficiently and could in the long run reduce their sustainability.

There is consensus within the literature that most health workers in mission hospitals are partly driven by their faith and wish of ‘doing good for others’. This ‘religious premium’ allows nonprofit institutions to hire below market price (Reinekke and Svensson 2003: 21).

However, there is still a lack of health personnel within Africa, both in public and faith-based institutions (Reinekke and Svensson 2003: 8; Green *et al.* 2002: 349). For religious organizations the often-rural setting and the low pay have created a severe health-worker crisis. Overall the nonprofit sector, which includes religious healthcare facilities, was only staffed with 40 percent medical personnel (Reinikka and Svensson 2003: 8).

Schmid *et al.* (2008) and Gill and Carlough (2008) found that religious for-profit and nonprofit health institutions were likely to charge less than governmental hospitals. This could be due to the stronger autonomy of mission hospitals, as they usually receive external funding. This allows for “flexibility in patient charges, including sliding scale fees or free care for those who cannot pay” (Gill and Carlough 2008: 200). Most mission health organizations, moreover, have as their main objective to serve the poor through compassion and love. This overrides the focus on financial considerations (Gill and Carlough 2008). Moreover, the financial support the different health-providing organizations receive is often based on current international aid-trends—mother and children treatment, vaccination, HIV/AIDS—and are not necessarily reflective of the needs within each local community (Gill and Carlough 2008: 199). The mixture might not even be the optimal when it comes to operational efficiency and resource use within each organization. Gilson (1995) argues that “[r]eduction in the range of service provision may appear to compromise quality, defined as service availability, but could be worthwhile if that reduction can be compensated by more productive and higher quality provision of the reduced package i.e. by the provision of more cost-effective services” (p. 703). Any such decision should be made based on the need within the community, the health facility’s availability of trained staff and other resources (Gilson 1995; CCHI 2000; Bergh 1995). Yet, often it becomes a decision made singularly by the donors or by the donors and health organization without clear communication with the local community.

The services provided by religious health organizations are found to resemble the mix that public hospitals are providing. Reinikka and Svensson’s (2003) data, from a study of nonprofit and public health-providing institutions in Uganda, showed that governmental health facilities were more likely to provide out-reach than nonprofit organizations, though, “those that do provide more of it” (p. 24). Reinikka and Svensson (2003) do not describe whether the health facilities were found in rural or urban areas. As noted by Green *et al.* (2008: 344), it could be generalized, that mission hospitals more often than not are based in rural areas, while governmental hospitals are situated in more densely populated districts. The

situation of the hospital will be important when it comes to which services are provided, and should therefore be included into the analysis of any findings.

Often the situation of the institution will serve as a guide to the diversification of services provided. Schmid *et al.* (2008), accordingly, found that faith-based institutions often have expanded their services to not only adhere to long-term health programs within their community but also to “short-term responses meeting the immediate crisis of food security” (p. 50). This view is echoed by Green *et al.* (2002), who find that many mission hospitals possess a need for providing preventive work within the community (p. 344). This is often seen as part of the mission to increase general welfare within the different communities. Yet, Schmid *et al.* (2008) question the motivation behind these expanded programs, and whether they are born out of an altruistic thinking, if it is donor driven and vertical in nature, or if these extended services are based on demands from the community. However, “others note that religious-health responses often emerge well in advance of any systematic effort from outside to organize, train or resource them” (Schmid *et al.* 2008: 50-51). Thus, showing the ability of religious groups to increase capacity building within their local communities. Others, again, find that this multifaceted development approach is part of the religious groups’ motivation for ‘doing good’, which extends beyond just merely providing health care.

3.2 Missionary Hospitals in Tanzania

Within Tanzania, faith-based hospitals and health-promoting programs are still an important part of the public-health system. “Churches run about 41 percent of hospitals and provide 46 percent of hospital beds” (cited in Flessa 2005: 236). The Tanzanian government has a policy where church-run hospitals, with their often-remote location and catering to marginalized groups living within rural districts, are included into the public-health system by becoming designated district hospitals. This provides the church hospitals with the possibility to participate in district policy negotiations and provides them with a consultation position (Green *et al.* 2002: 343). A *District Hospital* is defined as a ‘hub’ with higher level care, higher level of technology and human resources than what dispensaries and health stations provide (English *et al.* 2006: 1212). The dispensaries can send patients to the district hospital in the cases where the personnel are not resourced or have the expertise to treat the patients. In contrast, other African countries, such as Mozambique, have banned church hospitals (Gill and Carlough 2008: 199).

Hospitals are often seen as expensive aid institution to run (Flessa 2005: 345). The President of Ethiopia Meles Zenawi noted that:

[Hospital care] is a very expensive way of providing health work, and it fits badly in countries where greater part of the population lives in rural areas. Even though donors have wanted to give money to [hospitals], we've experienced that small clinics in the villages give much more value for the money" (cited in Sahel 2010: 5, translated by author).

Before the 1950s the health institutions operated by missionaries within Tanzania were predominantly small health clinics in rural areas. There were some hospitals too; however, the biggest ones had no more than 100 beds (Flessa 2005: 234). Yet, with a greater influx of missionaries during the 1950s, who had prior hospital experience from Asia, the focus of the health programs became hospital-based. The missionaries "continued what they had done in China [hospital and surgery based care], although there was no well-functioning system of internal medicine as they had known in China" (Flessa 2005: 234). This was done despite the lower cost of operating preventive and primary care through small clinics in rural areas (Green *et al.* 2002).

The missionaries were often not fully concerned about the running cost of the institutions as "they received grants from their home churches to do their work. In this way they could offer their services at very low prices, sometimes free of charge" (Flessa 2005: 242, 246). Flessa (2005) further attributes this to the early missionary hospitals being fully administrated and controlled from overseas, with little stakeholder input, and also their religious foundation (p. 242-243).

3.3 'White Elephant' Projects

Within the academic literature the concept of a white elephant project has been given to aid projects that fail to create the wanted social and economic benefit. Even more, a white elephant project is often understood as an activity which continuously receives financial and technological support, despite it not providing the wanted social and economic benefits to its receivers. The project also very often experiences great financial losses (Robinson and Torvik 2004: 200). Thus the project implicitly becomes a continuous drain on both national resources and donor money. Flessa (2005) understands white elephant projects as aid projects that are fully based and sustained by external donor support, administered and executed by expatriates and which lack involvement by local stakeholders (p. 242). Consequently, it is not important

for the aid project that it is continually stating losses, as it perpetually receives funds. Flessa (2001) also notes the increased concern between donors and recipients of donations, that the increased dependence on external sources is creating adverse development processes (p. 352). With the consistent inflow of donor money, a dependency relationship between recipient country and local community to the donor is created. This effect can be reversed if capacity building and stakeholder participation within the different project are promoted. Hylland Eriksen (1998) uses a much stronger and concrete definition of a white elephant project: “[A] big, costly and completely unsuccessful aid project” (p. 7).

Arguably, a connected question for understanding why aid projects become successful or unsuccessful is related to their motivation for being initiated. Are the projects donor driven and therefore supply motivated, or are they provided due to demands from the local population? The literature further ponders on the idea of what an unsuccessful project constitutes, what impacts it has on a local community, and whether such a project should be discontinued (Shediac-Rizkallah and Bone 1998: 88; Swerissen 2007). Shediac-Rizkallah and Bone (1998) entertain this idea when they note: “Clearly, there are circumstances under which the discontinuation of a program is appropriate” (p. 88). Especially in circumstances “when a validated, more efficacious, more suitable or more cost-effective means for meeting a given problem comes to light, the former *modus operandi* very appropriately may be supplanted” (Shediac-Rizkallah and Bone 1998: 88). Or as noted by Bergh (1995): “Needs can be never ending—both regarding amount of services and their level—as often is the case in health care. But for a project to be sustainable it has to live with the necessity to limit its services to what can be sustained by locally or nationally mobilized resources” (p. 29).

3.4 Sustainability of Health Organizations

Sustainable development is one of the most significant concepts introduced into the academic and practical world of development during the past 25 years. Originally the term was related to environmental issues yet with the development field widening in scope—health, good governance, human rights—the concept of sustainability has been attached to these new areas within the development paradigm (Flessa 2001: 350-351). The sustainability term is most often defined as “development that meets the needs of the present without compromising the ability of future generations to meet their own needs” (Brundtland 1987: 43), as noted in the report *Our Common Future* by the Brundtland Commission.

The concrete definition of sustainability in relation to health-promoting organizations in developing countries is still evolving. Academics such as LaFond *et al.* 2002, Shediac-Rizkallah and Bond 1998, and Olsen 1998 have all provided different versions. Some of these views are more extensive than others. What they all share in common is “the ability of the system to produce benefits to end users and stakeholders from a system which has ensured resources to continue activities with long-term benefits” (Olsen 1998: 288). Resources in this definition include finances, human resources and institutional capacity.

Flessa (1998) makes no distinction between the sustainability concept in development economics and for aid-based health projects. He argues that “an economy or an institution should have the ability to survive for a long time without major support from outside, especially from donors” (p. 406). However, the problem with this definition is that the concept of ‘long time’ is vague and can be interpreted differently by different stakeholders. Thus, Flessa’s (2001) definition is easier to adhere to: “The ability of a system to provide services in the present without sacrificing the provision of services in the future” (p. 351).

Sarriot *et al.* (2008), amongst others, investigate the sustainability and viability of aid projects. The authors, without using the phrase ‘white elephant’, note how continuous long-term funding “[decreases] the prospect of sustainability to some extent because of the poverty of evaluation systems supporting the decision-making” (p. 3). Flessa (2005) echoes this view when he notes that many church-based hospitals within Africa have been sustained by external support from western churches for such a long time that many come to believe that this is a sustainable source for continuing operations. Therefore, if sufficient long-term funding is acquired, sustainability is believed to have been reached.

The overdependence on external funding also makes organizations highly vulnerable to changes in the commitment by donors. The external donor is influenced by its political and economic environment, and priorities could therefore change. This could leave the aid project with a significantly reduced funding stream. Furthermore, aid projects relying extensively on donors could find themselves compromised by the wishes of the donor. These demands could go against the vision and mission of the organization. Moreover, the goals of the organization could be understood as less important (Diskett and Nickson 1991: 49-50).

During the 1980s and the beginning of the 1990s the predominant understanding of health projects’ sustainability was narrowly defined by having secured long-term funding (Olsen 1998: 289). Today the sustainability of health organizations is understood more as “a

combination of processes [and] refers to multiple inter-dependent dimensions” (Sarriot *et al.* 2004: 25). As developing countries continue to rely on external donor money, due to their unfavorable economic outlook, Olsen (1998) argues that health organizations within these countries “have to become self-reliant in other areas than finances” (p. 288). Diskett and Nickson (1991) present a similar view by arguing that “some degree of self-financing which reduces dependency on donors and governments is necessary, but total self-sufficiency or self-financing is neither possible in the current economic climate nor desirable” (p. 49). The poverty of the population in developing countries does not allow for the financial sustainability of health projects; especially as it is often the poor and marginalized who are the targets of these projects. For health organizations to become completely self-financed, patients would have to pay a higher fee for treatment. Within developing countries this would mean a reduced ability for the poorest to secure healthcare.

To enable the continuous development of benefits and to link together the various sustainability processes, institutionalization is encouraged (Shediac-Rizkallah and Bond 1998; Hodgkin *et al.* 1994; Swerissen 2007). “Institutional capacity is an essential condition for maintaining the flow of project benefits. Institutional strengthening includes attention to structure, policy, and staff training” (Hodgkin *et al.* 1994: 18). However, this understanding should not be confused with Shediac-Rizkallah and Bone’s (1998) debate about sustainability being equalized with institutionalization. In the case of aligning sustainability with institutionalization a common misunderstanding is to evaluate the organization as dependent on constant certainties in its greater environment. Therefore, sustainability is similar to inflexibility (Shediac-Rizkallah and Bone 1998: 92). This is opposed to the contemporary understanding of sustainability, which sees flexibility and the ability to adapt to the environment as two of its main pillars (Olsen 1998; Swerissen 2007; LaFond *et al.* 2001; Shediac-Rizkallah and Bone 1998).

Most definitions of sustainability relate to Shediac-Rizkallah and Bone’s (1998) notion of community participation. Sustainability can more easily be achieved by integrating the health organizations into the local community. “Community ‘participation’ enhances community ‘ownership’; in turn, ‘ownership’ leads to increased ‘capacity’ (or ‘competence’) and promotes program maintenance” (Shediac-Rizkallah and Bone 1998: 95). The focus on community participation often relates to specific health programs that a health organization is running. It is argued that without the community’s input and ability to state their needs and situation, health interventions will be unsustainable. This is because any behavioral change

which can secure an explicit and enduring change in a society's health pattern is hard to ensure without a two-way communication channel between the community and the health institutions (Shediac-Rizkallah and Bone 1998: 95; Diskett and Nickson 1991: 50). Bossert (1990) on the other hand found that community participation only is important for the sustainability of health programs in the cases where "the cost-recovery mechanisms were a major form of funding for the project activities" (p. 1021). He further argued that this was the case of health projects within Zaire and Tanzania, compared to health projects in Central America.

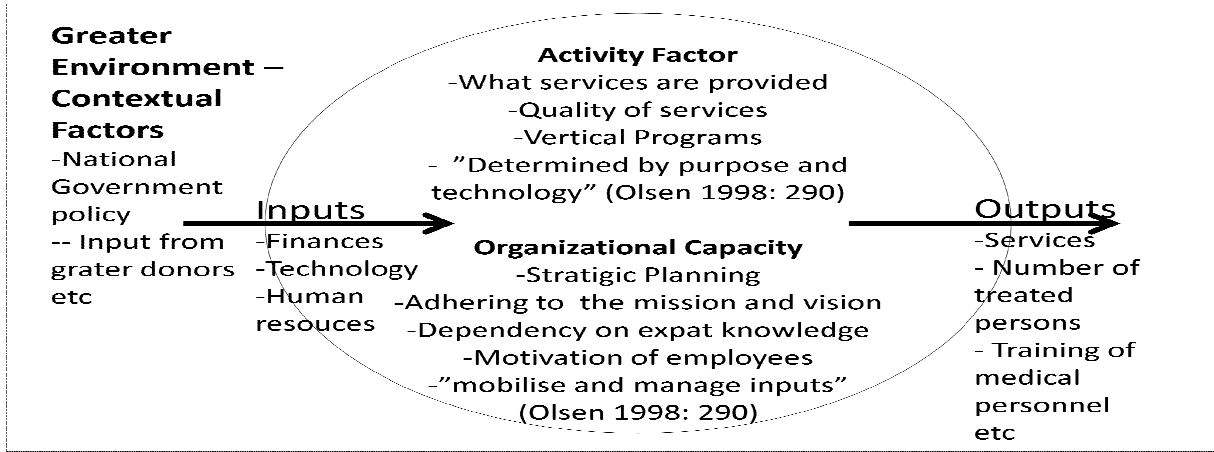
To ensure sustainability of a health project, LaFond *et al.* (2002) consider "capacity to play a critical role" (p. 3). It can help minimize dependence on external funding (Swerissen 2007). There exists no single definition of *capacity* as a concept. Nonetheless, LaFond *et al.* (2001) attempt to make a designation: "[C]apacity exists for the purpose of performing a certain action or enabling performance... In the health sector, capacity is believed to play a prominent role in securing health system performance" (LaFond *et al.* 2001: 11). Furthermore, the related and just as unclear concept of *capacity building* is mentioned as important for the sustainability of health organizations. LaFond *et al.* (2001) define capacity building as "a process that improves the ability of a person, group, organization, or system to meet its objectives or to perform better" (p. 11).

3.5 Analyzing Framework

There exists an agreement within the academic literature that for health-providing organizations to be continuously successful they need to be flexible and adapt to their external environment (Shediac-Rizkallah and Bone 1998; Sarriot *et al.* 2004; Swerissen 2007; Gruen *et al.* 2008; Olsen 1998). This is arguably because sustainability has its roots in systems theory (Swerissen 2007: 1), where the ability of inputs to create outputs requires openness, flexibility and adaptability to the organization's wider environment.

Swerissen (2007), Bergh (1995), and Olsen (1998) propose the open-system model as a framework with which to analyze the sustainability of a health project. The open-system model was defined by Katz and Kahn (1995) and is based on understanding an organization as a living organism, which is open and needs to adapt to its internal and external environment for survival (cited in Olsen 1998: 289).

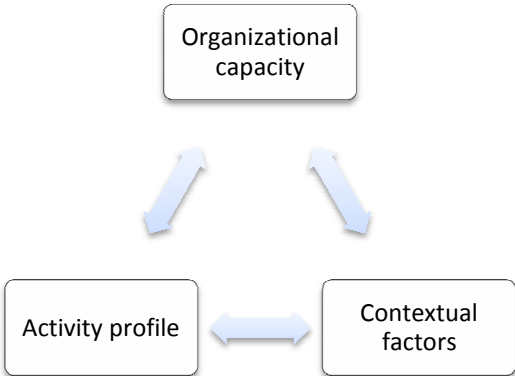
Figure 4: The open-system model



(Source: Adapted from Olsen 1998: 290)

The open-system model presented by Olsen (1998) is grouped into three main divisions: (1) context, (2) activity profile, and (3) organizational capacity (p. 289). The three divisions are codependent and interact with each other in different ways. To ensure the sustainability of a health organization all three factors have to be analyzed and their interaction understood (Olsen 1998: 289 and Bergh1995: 25).

Figure 5: Groupings for analyzing sustainability



(Source: Adapted from Olsen 1998; Bergh 1995)

3.6 Contextual Factors

The *contextual factor* relates to the greater economic and social environment that the health organization is operating in. The contextual factors cannot normally be controlled by the organization (Olsen 1998; Sarriot *et al.* 2004; Hodgkin *et al.* 1994). If the contextual factors should greatly change—political and financial support for the project be increased or reduced greatly—the project would need to change its own position in order to operate sustainably (Olsen 1998: 290; Flessa 2001; Swerissen 2007). Shediac-Rizkallah and Bone (1998) note

that financing provided by the external environment is probably the most prominent factor to measure sustainability by. Bossert (1990) however argue that a minimal level of resources is necessary for sustainability to be reached. Yet in both instances the lack of changing the organization's position if external donors cut their support, will automatically lead to lack of sustainability. "Thus the organization has to be dynamic rather than static in order to be sustainable" (Flessa 2001: 356). Sarriot *et al.* (2004) call this dimension the *Community and Social Ecological Condition*. They further mention the importance of studying cultural acceptance of the health organization within the local community when analyzing the contextual dimension.

3.7 Activity Factors

The *activity factors* are the services provided by the health organization. These activities will be guided by the level of resources—manpower, technology, finances—available to the organization (Olsen 1998: 290). The activity factors describe the spread of operations that the organization can deliver. The stretch of operations is guided by the organization's capacity level. "Choices are generally based on the perceived needs and resources available, and may be more or less relevant or appropriate" (Olsen 1998: 290). Bergh (1995: 26) and Hodgkin *et al.* (1994) emphasize the importance that the activities are demanded by its beneficiaries. Depending on the organization's dependence on external resources and administration, the activity factors could—if dependence is high—be strongly influenced by donors (Olsen 1998: 290).

Sarriot *et al.* (2004) have named this dimension *Health and Health Services*. It includes what services are provided, what quality the services have and at what costs they are provided. Thus, an important part of the activity factors will be the benefits that the health organization is providing to its population and their explicit need for the services provided (Swerissen 2007: 1-2). Torpey *et al.* (2010) describe the activity factor as *operational sustainability*, which is a combination of technical sustainability and program sustainability. Technical sustainability refers to continuous provision of services adhering to the given national level, while program sustainability refers to the management of scarce resources, and well-functioning logistic systems.

Bossert (1990) found that the sustainability of the activity factor is dependent on the type of activity that the organization is providing. Preventative-health activities were harder to sustain with national financial resources, than what was the case for infrastructural development. A

similar view is noted by Bergh (1995), Schmid *et al.* (2008) and Stefanini (1995). They argue that it is harder securing external support for reoccurring costs, such as maintenance of building and infrastructure, continuation of programs, and staff training, than securing finances for new development programs. The donor agencies argue that funding reoccurring costs creates dependency (Bergh 1995: 18). Yet, sustainability and efficiency of health organizations could be hindered by this view. Lack of maintenance of the organizations' facilities as well as capacity of the health organizations to efficiently service their patients could be reduced as the institutions continuously diversify their activities to adhere to the wishes of the donors. Schmid *et al.* (2008) note that private donors to religious groups providing health care in sub-Saharan Africa need to “maintain and reassess their support not only for capital investments but also for recurrent costs” (p. 88). However, from a sustainability view: “Technologies must be chosen with due consideration for the management system that will oversee the operation, maintenance, repair, and financing of a system” (Hodgkin *et al.* 1994: viii).

3.7.1 Vertical Programs

A vertical program is a distinct activity within a health organization that either is added during the operation of the organization or from the very beginning. However, such activities are often ‘stand-alone’ projects that secure resources and follow well-defined goals, but with little direct connection to the overall mission of the organization. “Vertical (i.e. stand alone or self-contained) programs are less likely to be sustained than programs that are well integrated with existing systems” (Shediac-Rizkallah and Bone 1998: 102). “[V]ertical projects are vulnerable. The vertical hierarchy often relies heavily on foreign funding during the life of the project, making it harder to gain national funding when the foreign sources cease” (Bossert 1990: 1020). Gill and Carlough (2008) note that financial support for health programs to the different health-providing organizations often are based on current international trends, and not necessarily on what is needed within each local community (p. 199). Namely, as current trends in donor-supported projects are constantly changing, managing to fully integrate vertical programs becomes unachievable.

The addition of vertical projects might not even be the most optimal choice when it comes to efficiency within the health organization. Vertical programs often extract managerial and human capital for their completion, which could reduce the efficiency and quality of the main operation of the health organization (Shediac-Rizkallah and Bone 1998: 102). This doubtlessly puts pressure on the administrative infrastructure of any hospitals.

3.8 Organizational Capacity

The *organizational capacity* explains how well the organization performs and how well programs are being delivered in relation to the organization's values and mission (Sarriot *et al.* 2004; LaFond *et al.* 2002; Olsen 1998). It incorporates organizational leadership and strategies, networking abilities, and human-resource development, amongst others (Olsen 1998: 290-291; LaFond *et al.* 2002: 8-9). Bossert (1990) found that organizational capacity supports sustainability. "Institutions which were well integrated, had goal structures that were consistent with the project goals, and had strong leadership and relatively high skill levels" (Bossert 1990: 1018). Swerissen (2007) and Olsen (1998) explain the importance of organizational capacity for creating sustainability by noting that organizations that are missing knowledge, skills or attitudes, will have problems with changing their operations to adhere to environmental changes.

3.8.1 Expatriate Knowledge

Several academics and institutions conclude that the organizational capacity of health organizations in developing countries should not be dependent on expats. Additionally, securing sustainability is difficult if the organization is dependent on one single leader (Bergh 1995: 18-20; Green *et al.* 2002). Shediak-Rizkallah and Bone (1998) do argue for the use of a *program champion/leader*—a person who connects an organization with its political environment to secure inclusion of the organization into the wider health structure (p. 102-103). Yet by relying excessively on such a figure, especially if he or she is an expatriate, a vacuum can arise when this resource is no longer available (Bergh 1995).

3.8.2 Planning

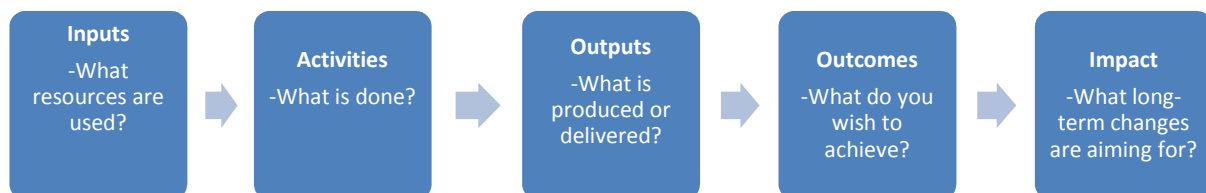
To secure sustainability of an organization, the organization needs to plan for its long-term activity level, future organizational demands, and what specific capacities that are needed (Swerissen 2007: 1, 7). There might be a desire by the organization's leaders to continue its operations or for them to wish the organization's sustainability was a fact, yet, if this is not planned out and encouraged throughout initiation, implementation and operation, sustainability will not occur (Shediak-Rizkallah and Bone 1998). Bergh (1995) links this to many health organizations within the developing world which "have little tradition in formal planning and strategy development. Planning is mainly done when submitting project proposals for funding approval" (p. 20).

3.9 Result Based Management Model

The Result Based Management Model (RBMM) is a tool used within the aid industry to evaluate aid programs and projects. It demands clear measurable goals and impacts to enable the evaluation of the effectiveness and actual results of any aid intervention. “A results approach involves shifting management attention away from a focus on inputs, activities and processes to a focus on benefits—from what you have done to what you have achieved” (NORAD 2008: 9). According to the World Bank and the UN, the RBMM can help both public and private organizations provide its stakeholders with clear and measureable outcomes as “[s]takeholders are no longer solely interested in organizational activities and outputs; they are now more than ever interested in actual *outcomes*. Have policies, programs, and projects led to the desired results and outcomes?...How can we tell success from failure?” (Kusak and Risk 2004: 2-3).

The RBMM is based on five different steps, as shown in the model below. However, though the process is laid out linear in reality the process is more circular. Outcomes are continuously reviewed and if the given objectives are not met, the circle goes back to the input and activity level to see what can be changed, before the process continues.

Figure 6: Result Based Management Model



(Source: NORAD 2008; Kusak and Risk 2004)

3.10 Landing on a Definition of Sustainability

Having explained the different factors, which should be present when defining an health organization’s sustainability, the operational definition for sustainability within this paper will be:

A health organization that has managed to adapt to its contextual environment by creating a strong, institutionalized organizational structure that supports the provision of high-quality community-demanded services today without reducing the availability of it for future generations.

3.11 Corporate Social Responsibility (CSR)

The discussion of CSR in different forms can be traced back until the first century BC. During this time pre-Christian thinkers promoted business activities which based themselves on moral principles (Blowfield and Fryan 2005). Yet, the debate of CSR as we know it today originated during the 1950s. The concept was made prominent by the book *Social Responsibilities of the Businessman* by Howard R. Bowen published in 1953. In the book Bowen promotes the wider social responsibility that company managers should take: “[B]usinessmen [are] responsible for the consequences of their actions in a sphere somewhat wider than that covered by their profit-and-loss statements “(cited in Carroll 1999: 270). This recognition of responsibility was born out of the belief that several hundred large companies were centers of power and in charge of making decisions, which had repercussions for society at large (Carroll 1999: 269-270; Whellams 2007: 25-26).

During the 1960s a growing body of literature and researchers tried to formalize the understanding and concept of CSR. In 1960 Keith Davis defined CSR as “businessmen’s decisions and actions taken for reasons at least partially beyond the firm’s direct economic or technical interest” (cited in Carroll 1999: 271). Steiner (1971), however, argued that CSR was just a tool for self-interested companies to increase their long-run profits, instead of an earlier focus on narrow short-run thinking (cited in Carroll 1999: 275-276). This view resembles current critical voices, which argue that CSR is a ‘good-will’ seeking activity, which distracts the public’s attention away from any social negativity that companies might cause.

During the 1980s and 1990s focus was set on redefining earlier definitions of CSR. Jones (1980) described CSR as an obligation of companies to voluntary adapt social programs that extended to the greater stakeholders and not just to the stockholders. Though obligation and voluntary seem to be contradictory terms, Jones found that “the obligation must be voluntarily adopted; behavior influenced by the coercive forces of law or union contract is not voluntary” (cited in Carroll 1999: 284) and will not be sustainable. The debate about the volunteerism of CSR is furthermore apparent within contemporary research on CSR. Critics argue for a lack of consistency and real impact of a voluntary scheme, because companies’ main focus on creating profits overrides their ability to think about the greater good of the society (Rogan 2009: 15; Blowfield and Frynas 2005: 502). However, it is clear that to a certain degree voluntary CSR would be beneficial for developing countries’ governments as “it promises to

reduce the financial burden of enforcement from cash strapped governments, theoretically freeing up funds for development initiatives” (Blowfield 2004: 63).

In 1979 Carroll proposed a CSR pyramid as a framework to analyze the concept. The pyramid was redefined and changed in 1991 (Jamali 2007: 5). This framework is today the most widely used system with which to analyze CSR (Lindgren *et al.* 2009: 430). The pyramid is based on the economic foundation of which the other three categories—legal, ethical and philanthropic—are built upon. Carroll (1991) defined CSR based on the pyramid view. “The CSR firm should strive to make a profit, obey the law, be ethical, and be a good corporate citizen” (cited in Carroll 1999: 289). The CSR pyramid will be further explored below.

Additionally, Carroll (1991) incorporated stakeholder management into the CSR debate. “There is a natural fit between the idea of corporate social responsibility and an organization’s stakeholders” (cited in Carroll 1999: 290). It is, furthermore, a clear understanding in current debates of CSR that for companies to succeed with their CSR programs, stakeholders need to be clearly identified. The most significant definition of who the stakeholders are to an organization is Freeman’s (1984) designation: “A stakeholder in an organization is (by definition) any group or individual who can affect or is affected by the achievement of the organization’s objectives” (cited in Vos 2003: 143). A company’s stakeholders are further divided into two groups: Primary stakeholders are those groups that are imperative for the survival of an organization, while this is not the case for secondary stakeholders (cited in Vos 2003: 144).

In relation to the contemporary CSR discussion the stakeholders have been designated several roles within the planning and implementation stage of CSR programs. However, the participation is often executed as a limited form of consultation and information sharing activity, with the stakeholders having little direct influence over the company’s CSR projects (Bendell and Murphy 1998; Bendell 2000). Moreover, in developing countries local communities often fall short of the power of global mining corporations. “Whereas most companies are happy to declare a commitment that communities’ ‘well-being is safeguarded and where possible enhanced” (Rio Tinto 2000 cited in Hamann 2003: 248), Banerjee (2007: 34) argues that “without exception, the social, cultural, economic and environmental impacts on [indigenous] communities have been devastating”. It is, however, argued that for CSR programs to have a clear positive societal impact, a closer and more extensive relationship

between company and stakeholders is needed (Bendell 2000). “Managers should acknowledge the validity of diverse stakeholder interests and should attempt to respond” (Vos 2003: 144).

3.12 Contemporary CSR

Milton Friedman famously stated in 1970 that corporations had only one responsibility: to generate as much profits as possible for its stakeholders (Friedman 1970). Furthermore, corporations would not be capable of responding to social issues within communities, and that any such issues should be the responsibility of the government, and not be the work of corporations. Hamann (2003) cites a case of such mindsets still being present today: “Managers are concerned that any activity that goes beyond the immediate goals of the company may lead to the company becoming enmeshed in local political struggles or community conflict” (p. 241). The example shows the constant clash between profits and CSR. Friedman’s view is challenged by today’s increased focus on sustainable development and the importance that private enterprises together with the public sphere have in promoting this agenda. Furthermore, Hamann (2003) and McMahon and Remy (2001) argue that the fact that more and more companies are following a policy of CSR, in any form, shows the limits of Friedman’s position.

3.13 The Business Case for CSR

A prominent position in relation to CSR is the *business case*. This viewpoint rests on the assumption that CSR is good for the company as it can be a tool for generating profits (Blowfield and Frynas 2005: 512). Hamann (2003) finds that many researchers and businessmen argue this position as the main reason for companies to follow CSR. “It can be used to avoid risk and to benefit from external opportunities” (Blowfield and Frynas 2005: 512). Drucker (1984) promoted the idea that companies and stakeholders could not operate indifferently, and as businesses have to relate to their stakeholders, creating this into a business opportunity is the only right decision to make.

Hamann (2003), however, presents the business case more as an environmental ‘protection’ for the company: “The initial argument of this sort was the hypothesis that effective environmental management would increase the efficiency of the production process—in terms of less energy and material needs—and hence increase bottom line profits” (p. 242). This leads to the understanding that CSR is difficult to combine with responsibility for the society at large. Blowfield and Frynas (2005: 512) therefore, question the ethical paradigm of this

position as it is based on a western mindset of neo-liberal theories, and with business profits deciding the use of CSR for the company.

Related to this argument is the notion that private enterprises set up businesses in developing countries due to their poorer environmental and labor regulations. However, both Blowfield and Frynas (2005: 518) and McMahon and Remy (2001: 4) criticize this argument and argue that mining companies today are using the same operational standards within developing and developed countries. This would often mean that mining companies would adhere to stricter labor laws, than what the particular developing country demands. However as noted by Adams (2009: 123-124): “There has been an increasing engagement in CSR...with regards to human rights, social development and environment, although such commitments can be much easier to draft than to implement”.

3.14 The CSR ‘Middle Way’

The need for mining companies operating in the developing world to find a CSR ‘middle way’, which both generate profits for the company’s stakeholders and adhere to local communities’ sustainable development are mentioned by both Blowfield and Frynas (2005) and Hamann (2003). Several environmental catastrophes and human rights incidents within the mining industry the last 40 years questioned the industries’ reputation (Hamann, 2003: 249), and a strategy to improve ‘good will’ has been explored by private enterprises. Rio Tinto’s chief economist is quoted in Hamann (2003: 242) expressing this sentiment: “Everything a company now does it does in the public gaze”.

This ‘middle way’ holds that “companies have a responsibility for their impact on society and the natural environment, sometimes beyond legal compliance and the liability of individuals” (Blowfield and Frynas 2005: 503). Hamann (2003) further argues the connection between a mining company’s good reputation and its profitability. This is one of the reasons companies are to a greater degree adhering to CSR related activities today. “A good reputation will enhance a company’s performance from the local project level, through improved community and worker relations, right up to the international level, through improved access to mining concessions and finances” (Hamann 2003: 242). This shows the interconnectedness of CSR operations in developing countries to company performance on a global level.

3.15 A CSR Definition

There exist no single definition of CSR, but it is commonly referred to as business activities which adhere or even exceed a company’s economic, legal and ethical responsibilities, in

order to enhance its stakeholders' wishes and needs (Jamali 2007: 1). As noted above Carroll's (1991) CSR pyramid is one of the most cited figures describing the responsibilities that corporations adhere to, and the priorities that corporation give to them. From bottom to top the pyramid has four levels—economic, legal, ethical, and philanthropic.

Figure 7: The CSR Pyramid



(Source: adapted from Visser 2006: 31 and Helg 2007)

The economic responsibility of a company means the responsibility to perform well and be profitable (Helg 2007: 20). It further includes “[creating] jobs, discovering new resources, innovation and use of new technology” (Jamali 2007: 2). The legal responsibility represents the company’s adherence to legal rules and regulations (Helg 2007; Jamali 2007). The ethical responsibility signifies that the company should operate ethically and morally right. At its most basic it would mean operating without harming the greater environment or any stakeholders (Helg 2007: 20). Philanthropic responsibility implies that companies should be ‘good citizens’ and “business is expected to contribute financial and human resources to the community and to improve their quality of life” (Helg 2007: 20).

3.16 Corporate Social Responsibility in Africa

Visser (2006) and Amaeshi *et al.* (2006) studied the African socio-economic context and companies’ operational activities within the continent. They found that in Africa the levels within Carroll’s (1971) CSR pyramid were switched around. Philanthropy, instead of legal responsibility, was found to be the second most important level.

Figure 8: CSR Pyramid in Africa



(Source: adapted from Helg 2007: 35 and Visser 2006)

The economic responsibilities are the main building block of the CSR pyramid in Africa as in the west. This is arguably related to the weak economic position of many African countries and the importance that business is said to have in shaping the economic future of the continent (Visser 2006; Lindgren *et al.* 2009). Companies operating in Africa are not only providing direct tax income to governments but are lowering unemployment numbers, adding valuable training and capabilities to local communities, and spreading infrastructure (Visser 2006: 38).

The philanthropic responsibilities within Africa are valued higher than what is the case within the Western world. There are several reasons for this focus on philanthropy, notably the weak social-economic situation within Africa where ‘donations’ have become the expected norm when companies set up business (Visser 2006: 40). Blowfield and Frynas (2005) further argue that within contemporary development thinking business is seen as being the solver of economic problems, HIV/AIDS epidemic, and a tool for reducing poverty (p. 499). Secondly, many companies realize that they cannot succeed in communities that are failing. With ‘philanthropy’ being the most direct way of supporting the endurance of the community, companies engage in such activities to ensure their own sustainability (Helg 2007; Visser 2006). Thirdly, Africans are accustomed to foreign aid, which Visser (2006) argues, has created an ingrained culture of expected philanthropy in Africa. Fourthly, CSR is still in its primary stages of maturity in Africa (Visser 2006: 40), and is therefore sometimes equated with philanthropy. A philanthropic CSR project can be understood as a “charitable or philanthropic donation to a ‘good’ cause in a developing country” (Hopkins 2007). Jamali (2007) defines it as “making voluntary contributions to society, by giving time and money to

social activities” (p. 6). Educational activities and health improving actions are commonly used as philanthropic projects for companies operating in the developing world (Visser 2006; Jamali 2007; Hopkins 2007).

Hamann (2003), however, notes that CSR should be followed to a degree that exceeds ‘add-on philanthropy’. Furthermore, for mining companies to incorporate sustainable development into their overall operations, better utilization of the company’s know-how and resources should be applied (p. 243-244). Whellams (2007) argues that the strictly hand-out and giving-away CSR projects have been reduced greatly the last years, due to the realization by businesses that such programs do not create long-term development (p. 35). Yet, Helg (2007) also notes that corporations supporting increased social development within their countries of operations do in fact also benefit directly. This win-win situation extends to, for example, the provision of HIV/AIDS medicine to a company’s employees (Visser 2006a: 143-144). “...the response by business is essentially philanthropic but clearly in companies’ own economic interests” (Helg 2007: 35). Moreover, “is the issue of HIV/AIDS treatment primarily an economic responsibility (given the medium to long-term effects on the workforce and economy), or is it ethical (because HIV/AIDS sufferers have basic human rights), or is it philanthropic (HIV/AIDS is not an occupational disease, so surely treatment amounts to charity)” (Visser 2006: 47).

Legal responsibilities have lower importance in Africa than what is the case in the Western world. This does not mean that companies are neglecting legal regulations. It rather mirrors the fact that many African countries have a weak legal system and lack institutions that control the implementation and administration of the legal framework. Secondly, not all African countries have incorporated human rights and labor standards into their legal framework (Visser 2006: 42). Visser (2006) notes that: “The point is not so much the company’s commitment to legal compliance, but rather that it is given relatively less importance as a driver in the pursuit of CSR” (p. 43).

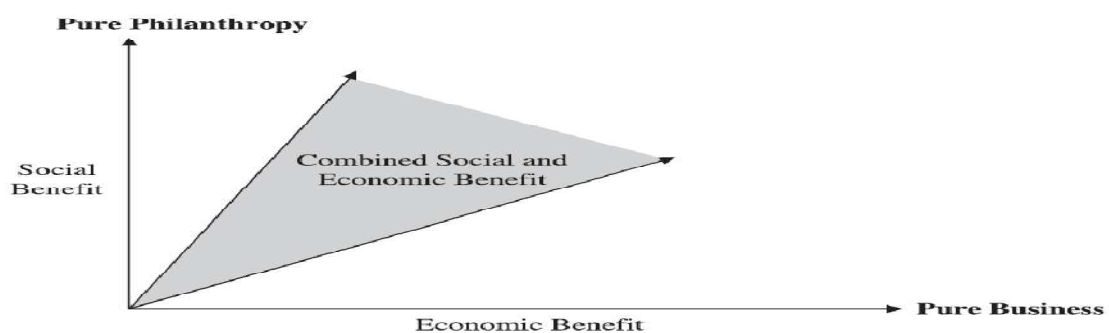
Ethical responsibility is the least prioritized point for businesses working in Africa. Visser (2006) provides examples of how some few multinationals are trying to adhere to Western ethical norms and good governance while doing business in Africa. Yet many companies are hampered by the reality of corruption, lack of transparency and accountability, which makes the ethical paradigm difficult to follow. Blowfield (2007) on the other hand argue that “[T]here is a serious shortage of capacity in some regions, not least in developing countries, to

monitor, inspect and verify company performance” (p. 692). Thus, knowing whether companies are actively adhering to ethical responsibilities becomes hard to assess.

3.17 Strategic Philanthropy CSR

Strategic Philanthropy is a different form of CSR, which moves beyond the normal altruistic CSR of providing education or money gift to local communities. Strategic Philanthropy are planned to yield long-term benefits for the business, by exploiting the company’s competencies, and simultaneously provide increased social welfare for the stakeholders (Jamali 2007).

Figure 9: Strategic Philanthropy



(Source: Jamali 2007: 9).

Consequently, planning for such strategic CSR projects would mean that “uncoordinated CSR and philanthropic activities disconnected from the company’s strategy that neither make any meaningful social impact nor strengthen the firm’s long-term competitiveness” (Porter and Kramer 2006: 6), could be reduced. The challenge, however, is for the business to find activities that both adhere to the strategic plan of the business, and can enhance the welfare of one or more stakeholders.

3.18 Mining and Corporate Social Responsibility

There is a distinct notion that mining operations both by private and public enterprises increases development within local communities in developing countries. “In many cases, the mine is the local economy’s primary provider of income, employment, and services” (World Bank and the International Financial Corporation 2002: 1). Hamann (2003), however, argues that mining operations often increase a country’s economic development on a national plan, but that local communities are often left with the social, economic and cultural cost of such operations. Citing research from Latin America it was found that “...in most cases the boom in mining investment in the 1990s was accompanied by a gradual increase in level of extreme

poverty in regions where mining projects were developed” (Whellmas 2007: 23). Hamann (2003), however, argues that mining companies today will try to reduce their negative social and environmental impacts on their surroundings, while striving for profits, “in short, contributing to sustainable development” (Hamann 2003: 237).

3.18.1 Economic Impact of Mining

The economic impact that the private enterprise will have on the local community can be divided into *direct* and *indirect*. “Large mines create employment directly in both the construction and operating phases” (McMahon and Remy 2001: 3), often attracting both local and foreign workers. The *indirect employment* opportunities are employment activities and services that are somehow related to the construction and operation of the mine. “The indirect employment effects are often extremely important” (McMahon and Remy 2001: 14-15). The indirect employment opportunities could be: employment needed for infrastructure building in relation to the mine site as well as the construction of the mine; running of shops, health offices, education, and other services that are being set up to cater for the area around the mine. A study from Peru showed that mining-related indirect employment was 14 times the number of workers directly employed in the mine (McMahon and Remy 2001: 14-15).

Non-mining-related indirect employment has a similar multiplier effect of 2.5 (McMahon and Remy 2001: 15). These employment opportunities should—theoretically—be managed by national authorities, yet with many developing countries’ weak governments, this is not always the case. Furthermore, with proactive engagement by the mining company, the multiplier effect has been seen to be greater and more rapidly occurring, than if only the government is promoting it (McMahon and Remy 2001: 15). If a company directly involves itself in such indirect employment activities, such activities could be understood as philanthropic CSR projects (Helg 2005; Hopkins 2007). Raynar and Forstater (2002) further found that such strategic involvement by companies is important for a company’s continuous growth in the developing world (p. 30-31). It helps create a stronger employment base and furthermore generates ‘good-will’ with the local community as well as building positive relationship with the national government.

Some of the financial benefits from the mine to both the local government and the community can be harvested through taxation. To encourage foreign investment, many developing countries have reduced the taxation burden and promoted other stimuli tools, however, there is still taxation income to be earned from a mines operation (McMahon and Remy 2001).

Countries have various degrees of fiscal centralization and redistribution of tax money. In Kenya it was showed that mining taxes provided better economic possibility for the central government, than for the local community to the mine (Newell and Garvey 2005: 393).

3.18.2 Social Impact of Mining

Banks (2005) talks about how the introduction of mining operations to a local community often coincides with increased social issues, such as alcoholism, prostitution, gambling and violence within the area. These social issues are highly related to the influx of migrant workers who increases the pressure on local infrastructure. “[G]rowth of bars and prostitution, easier access to the area due to road development, and deficient educational and medical facilities” (McMahon and Remy 2001: 5) fuels social challenges. There is also a clear agreement in the literature that “mining operations have been associated with rising rates of infectious diseases such as HIV/AIDS, mostly when large numbers of migrant workers are involved in an operation” (World Bank and International Financial Corporation 2002: 14). Curbing such spread of diseases and increase education levels of the stakeholders to the mining companies are becoming increasingly important to the different mining companies (McMahon and Remy 2001: 18).

The importance of such social welfare programs is the realization that their operations cannot succeed in societies that fail (Visser 2006). Strengthening the social capital moreover increases the goodwill and reputation of the company as well as its possible pool of workers. Hamann (2004), however, questions the implications of some philanthropic activities as they mostly are provided to the formal structures within the mining communities, and do not address the social problems within informal societal structures, for example squatter camps. This could create a great divide and conflict within the local community (World Bank and International Financial Corporation 2002a: 14; McMahon and Remy 2001:18-22; UN 2010: 6).

Furthermore, if the national government is weak, any such social activity is more likely to succeed when mining companies set up foundations to execute such programs. “Foundations set up by the mining companies play a very important role in structuring, coordinating and funding the activities that make such positive externalities possible” (McMahon and Remy 2001:18). Foundations are often independent from the mining company itself. This can however cause some difficulties. The foundation might operate against the strategic vision of

the company, and can therefore receive financial resources from other sources than just the mining company (McMahon and Remy 2001: 19).

3.18.3 Environmental Impact of Mining

It is clear that CSR projects within developing countries have been focused on environmental issues due to the many accidents throughout the years, and the often very direct and noticeable impact that mining operations can have on the local community (Hamann 2003; McMahon and Remy 2001). Mining operations explicitly use land areas and the environment directly in the exploration phase and in the storage of the minerals and its waste disposal. There is also often increased infrastructure being build in relation to the mine (McMahon and Remy 2001; IIED 2002; UN 2010: 9). Furthermore, indirect impacts of such environmental changes can “adversely affect the health and livelihood of the poor and vulnerable groups living near mining operations and sometimes at significant distances from extraction sites” (UN 2010: 9).

The waste generation from mining operations are noted by several academics and institutions to be one of the biggest negative environmental impacts the company has on local communities, if not managed correctly (UN 2010; IIED 2002; Blowfield 2005). The different ways of pollution is related to air, water, land and vegetation destruction (Amoha 2003: 37-45).

Chapter 4 - Methodology

4.1 Research Design and Strategy

A research design sets the framework for the research project and guides the collection of data, and how it is analyzed. For this thesis a case study design was applied. A case study demands a “detailed and intensive analysis of a single case” (Bryman 2008: 52), with the researcher collecting both quantitative and qualitative data (Creswell 2003: 15). By employing the case-study approach it is possible to study each actor independently, yet also see how the different actors interact (Rogan 2009: 33; Tellis 1997).

Due to the case study being carried out in a particular social setting, and the research being performed to highlight the specific realities of HLH, the study could be understood as *idiographic*. When an idiographic approach is used, it is further impossible to generalize the findings to other locations. Yet, case study researchers “do not think that a case study is a sample of one” (Bryman 2008: 55). The main goal is to look at one specific case, and not others.

The ‘leading’ research method will be qualitative, where words, description and narratives of HLH’s sustainability, and its function as a CSR object will be gathered. However, there will also be quantitative parts. Mixed-method research is argued to allow the researcher to capitalize the various strengths of the two methods while possibly offset some of the weaknesses found within each research strategy (Bryman 2008: 603). The proposed definition of the sustainability is based on the framework provided in Chapter 2. Qualitative research is a favored method when using a case study design due to its nature of generating extensive and detailed information (Bryman 2008: 53). The nature of the qualitative method and the collecting of data, moreover, make the case study based on an *inductive approach*. “The emphasis is placed on the generation of theories” (Bryman 2008: 22). Moreover, with the leading method being qualitative it is natural for the researcher to adhere to the *ontological* diagram of *constructivism*. Constructivism means that the activities of a social entity are in constant change and that these changes are dependent on the events in the environment around it (Bryman 2008: 19). The *epistemological* diagram will further be based on *interpretivism*. Interpretivism promotes the view that social entities are distinct from natural phenomenon and therefore “requires a different logic of research procedure” (Bryman 2008: 15). Accordingly, “the researcher has to adopt an empathetic stance. The challenge here is to

enter the social world of our research subjects and understand their world from their point of view” (Saunders *et al.* 2009: 116).

The nature of the case study and a ‘leading’ qualitative research diagram gives way to the use of *purposive sampling*. This entails that the entire sample has relevant connection to the research questions (Bryman 2008: 458). This will help the efficiency of investigating the research questions, and reduce time ‘wasted’ on collecting data from sources not relevant to the study. The theory of *snowball sampling* has been employed in this case study. This demanded that during the interviewing of the initial sample, the ‘network’ of these interviewees who has relation to the research question will be established and interviewed thereafter (Bryman 2008: 184). Moreover, as the use of case-study design was employed to generate a better understanding of the *how*, *what* and *when* of HLH, the use of *triangulation* was employed. Within triangulation several data collection techniques are used “to ensure that the data is telling you what you think it is telling you” (Saunders *et al.* 2009: 146).

4.2 Data Collection

The primary data collection took place during a five-week stay in January and February 2011 at HLH. There was also a two-week pre-trip between October and November 2010 to both HLH and Xstrata’s mining site in Kabanga, Tanzania. At the pre-trip contacts within each institution were made and an initial introduction to the work of both Xstrata Plc and HLH was presented. During the five-week fieldwork in 2011, I spent seven days in the local community visiting 47 different homes. The rest of the days were spent interviewing staff and administration at HLH, interviewing village leaders from the Haydom Village Council, reading through HLH’s Annual Reports dating back to 1976, and perform unofficial interviews with employees and volunteers to HLH.

4.3 Location of Research

The interviews carried out in the Haydom Village were done with the help of an interpreter. The interviews of staff and administration at HLH were done without an interpreter. In Haydom Village the respondents were contacted in their homes and were encouraged to answer questions following a pre-made interview guide (see also Chapter 8). During the interview I tried not to interrupt the respondents too much, thus not disrupting the flow and stories told by the respondents. I further tried to keep long pauses and not jump-start the next question, to indicate that I wanted the respondent to explain and elaborate more extensively (Saunders *et al.* 2009: 340).

At HLH staff members were interviewed during their ‘breaks’ from work. To a greater degree than in the village a stricter structured-interview guide was used. This limited the chance of the interview ending up as a conversation. One of the reasons for this was the respondents’ greater ability to analyze and reflect on their own personal situation, than what was the case in the village, and it was therefore argued that the extensive use of ‘rambling’ was not necessary for me to obtain the wanted data. However, the last three questions of the questionnaire were fully open-ended which gave the workers the possibility of freely speaking out about their concerns relating to their work situation, and their future plans. As the staff and administration at HLH was on the hospital’s premises most of the days of the week, I luckily had the possibility of going back and asking more questions if something was unclear from the first interview with them. However, I mostly went back for clarification with the respondents from administration. I’ve also had the chance to stay in contact via e-mail with parts of the administration of HLH.

4.4 Qualitative Data Collection

The key data collection methods for qualitative research are: interviews, participation observation, and secondary literature analysis (Bryman 2008; Saunders *et al.* 2009).

4.4.1 Interviews

Interviews can take the form of unstructured, semi structured or structured. For this thesis *semi-structured* and *unstructured interviews*, as well as *open-ended questions* were utilized: “Key respondents are asked to comment about certain events. They may propose solutions or provide insight” (Tellis 1997). Due to my interest in understanding the impact that HLH has on the local community, HLHs sustainability, and also HLH’s applicability as a CSR object, the focus was on gathering “rich, detailed answers” (Bryman 2008: 437) from the interviewees’ experiences to these matters. “Open question is designed to encourage the interviewee to provide an extensive and developmental answer, and may be used to reveal attitude of obtain facts” (Saunders *et al.* 2009: 337).

This research strategy is rather time consuming and generates a lot of data, however, it gives a much clearer understanding of the ‘situation’, than if structured and closed questions were employed (Bryman 2008: 436-37). Moreover, as argued by Bryman (2008: 437) “when interviewees are allowed to ‘ramble off’, the researcher might be made aware of new important sides of an issue, which could not have emerged if the interviews were closed”. However, to secure the viability of any information it was important that I did not “[become]

dependent on a single informant, and seek the same data from other sources to verify its authenticity” (Tellis 1997).

It became apparent during the piloting of the semi-structured interview guides for the community, that many questions often did not provide the wanted “rich, detailed answers” (Bryman 2008: 436). The research strategy was therefore shifted from being *semi-structured* to frequently being carried out as fully *unstructured interviews*. This often led to interviewees appearing more as *conversations* than interviews.

Several reasons were found to request such a change in research strategy. Firstly, the villagers were often skeptic to my intentions, and it often took a lot of talking around various topics, before any wanted information was generated. Secondly, most respondents did not really answer the question I was asking. The respondent’s often started with long digresses and it could often be hard to ‘guide’ them back on track. Thus, many interviewees were done in a ‘on and off mood’ when it came to topic related data. Strictly adhering to semi-structured interview scheme became difficult. Thirdly, for many of the questions there also seemed to be confusion of what I really was asking. To the question: “Have you ever been a patient at HLH?” A great amount of the respondent said ‘no’. Yet, when probing more the respondents did indeed note that ‘they had given birth at HLH. Thus, I looked at giving birth at the hospital as the respondent being a patient at the hospital, while the interviewee did not relate child birth with being a hospital patient. Fourthly, the ability of respondents to fully reflect on their past and future was furthermore greatly overestimated (also see Chapter 8). Even with open-ended questions it was hard for interviewees to analyze their past, or provide thoughts for their wishes of the future. This is contradictory to what Bryman (2008: 388) notes: “[Reflections] can also be achieved through semi-structured and unstructured interviewing, by asking participants to reflect on the processes leading up to or following on from an event.

Table 1: Overview of method, sample size and number of interviews

Date		What kind of methodology	Answered	Not Answered	Second Interview	Referenced as
14.01.2011	Community Leader	Interview	1			CL
14.01.2011	Community members	Interview	4			CM 1
17.01.2011	Community members	Interview	6			CM 2
18.01.2011	Community members	Interview	7	2		CM 3
19.01.2011	Community members	Interview	6	1		CM 4
20.01.2011	Community members	Interview	8	4		CM 5
21.01.2011	Community members	Interview	8	0		CM 6
22.01.2011	Community members	Interview	7	0		CM 7
	TOTAL		47	6		
29.10.2011	Staff	Interview	1			S 0
24.02.2011	Staff	Interview	2	4	X	S 1
25.02.2011	Staff	Interview	5	2		S 2
26.02.2011	Staff	Interview	3			S 3
27.02.2011	Staff	Interview	9	0	X	S 4
28.02.2011	Staff	Interview	10	1		S 5
30.01.2011	Staff	Interview	2	1		S 6
31.01.2011	Staff	Interview	3	0		S 7
01.02.2011	Staff	Interview	4	0		S 8
02.02.2011	Staff	Interview	6	2		S 9
	TOTAL		45	10		
03.11.2010	Administration	Interview	1		X	A 0
11.01.2011	Administration	Interview	1	1	X	A 1
24.01.2011	Administration	Interview	1			A 2
26.01.2011	Administration	Interview	2			A 3
28.01.2011	Administration	Interview	1	2		A 4
30.01.2011	Administration	Interview	1		X	A 5
31.01.2011	Administration	Interview	1		X	A 6
01.02.2011	Administration	Interview	1		X	A 7
03.02.2011	Administration	Interview	1		X	A 8
04.02.2011	Administration	Interview	1		X	A 9
	TOTAL		11	3		
31.01.2011	Focus Group with members of staff		6			FG 1
02.01.2011	Focus Group with leaders of ethnic group		4			FG 2
01.03.2011	Xstrata Plc	Mailed Questionnaire	1	0	X	XP 1
05.03.2011	Xstrata Plc	Mailed Questionnaire	1			XP 2
09.03.2011	Former consultant to HLH, Board members and former director of HLH	Mailed Questionnaire	1	2		FO 1
	TOTAL		13			
GRAND TOTAL			116	21		

4.4.2 Participation Observation

Participation Observation is a way for the researcher to ‘see through the eyes of the interviewees’ (Bryman 2008: 465-466). Observing participants in their natural environment can further enable the researcher to better “allow the context of people’s behavior to be

mapped out fully” (Bryman 2008: 466). During the interviews in Haydom Village I visited each respondent in his or her home. This allowed for a personal understanding of the living conditions, hardship and challenges in the life of each respondent. Though, I did not actively participate in the work of the respondents, I was taken to the *shambas* (i.e., plots used for farming) to see where income is generated from, I visited small shops which serve as the life-line for some community members, and I was guided around to see where the cattle is grazing to show how hard work it is to herd them. Thus it can be argued that I’ve actively have participated as an *Observer-as-participant*. “In this role, the researcher is mainly an interviewer. There is some observation, very little of it involves any participation” (Bryman 2008: 410). This furthermore helped limit the disadvantage of participation observation that Bryman (2008) notes to be *abnormal activity*. Such actions are sometimes experienced when individuals take part in unlikely activities because they are being observed.

I have not actively participated as either a nurse or a doctor, but I have done some observing. Accordingly, this could also be defined as observation-as-participation. The small observation I did, gave me a glimpse of the staff’s responsibilities, their daily work, their time-management and their interaction between themselves and with patients. “...role concentrated on gather two types of data: ‘naturally occurring inter-office talk’ and ‘detailed description of how officers handled “live” incidents’ (Bryman 2008:410). I’ve furthermore participated in tours of the hospital, learning more about all the different department and services that HLH is offering.

4.4.3 Document Analysis

The use of private documents from different private and public sources has furthermore been of uttermost importance for this thesis. The private documents include HLH’s Annual Reports, its newest strategic plan, and the document outlining the strategic reorganization of the hospital in 2007. Disappointingly, though I’ve been given access to HLH and its staff, “certain documents that are not in the public domain will not be available to [the researcher]” (Bryman 2008: 522). I’ve only had the possibility of looking into the newest strategic plan for HLH—*Haydom Lutheran Hospital Strategic Plan 2015*. The lack of access to earlier reports is in my opinion two fold. Firstly, there seems to be little control or knowledge at the administration at HLH or at its donors, where any earlier documents, financial reports, strategic plans or internal notes are kept—or if there are any at all. As noted in Chapter 8, I’ve been in e-mail contract with different donors, as well as asking around at HLH premises for any such documentation. Secondly, several interviewees noted that “Dr. Olsen kept his office

in his front-pocket” (Interview A0), thus a lot of information was lost with his passing in 2005. From a sustainability point of view the reliance on one individual for the continuity of an institution when such a person leaves the position can be very difficult (Bergh 1995).

While analyzing such private documents of which Bryman (2008) notes that Annual Reports are of utmost importance for case studies, it is emphasized that “...such documents need to be evaluated using Scott’s four criteria” (p. 522). Those four criteria are authenticity, meaning, credibility, and representativeness. The authenticity of the reports is quite clearly present, however, when analyzing Annual Reports the implication of the paper has to be considered. As noted by one interviewer: “Our Annual Reports...are our fundraising document” (Interview A4). This further relates to the points about credibility and representativeness of the documents. Particularly, as I’ve been dealing with Annual Reports I’ve had to take into consideration that they have not been written in an objective environment. “[D]ocuments cannot be regard as provided objective accounts of a state of affairs” (Bryman 2008: 523). The documentation should therefore be examined and compared to other sources, in order to verify its content.

To a certain degree such verification has been done with the comparison of Annual Reports to documentation from NORAD, and evaluation reports from independent third parties. Yet, it has to be noted that much of the viewpoints within the Annual Reports have been taken as the basis of this thesis, due to limited availability of other reports. Moreover, as the Annual Reports from 1973 until 1999 was kept in storage at HLH, I had limited time to examine them. They did, however, give me a good understanding of the work of HLH over time, as well as their challenges, though presented from the objective view of the hospital.

Earlier evaluation reports of HLH have, as noted before, proved as another source of documentation for my thesis. This is particularly true for the last evaluation report carried out for the Royal Norwegian Embassy in Tanzania (RNE) by the Christian Michelsen Institute (CMI) in Bergen in 2007 and the follow-up report from 2009. The only other evaluation I could find was a 1988 report completed by NLM. I was not able to retrieve the report from HLH, NLM or NORAD, yet after sending an e-mail to one of the authors, Mrs. Massi, she confirmed that she had kept a copy of the document. Due to the late availability of this evaluation, I’ve only had limited possibility to thoroughly analyze it. Yet, it has still been important for my greater knowledge base of HLH’s work.

4.5 Quantitative Research

The most common forms of quantitative data collection are self-completion questionnaires, structured interviewees and structured observation, as well as numerical data (Saunders *et al.* 2009: 151).

4.5.1 Self-Completion Questionnaire

The self-completion questionnaire comes in many forms with the mailed-questionnaire being the most common type (Bryman 2008: 216). For this research the respondents from Xstrata Plc. was provided with a self-completion questionnaire. There was also self-completion questionnaires sent to the former director of HLH, a former consultant to HLH, as well as to the Diocese of Mbulu. The former director and the Diocese of Mbulu never returned the survey. This is a common issue with mailed questionnaires (Bryman 2008: 218-219). By using self-completion questioners the respondent could use the time they need to fill out the survey (Bryman 2008: 217). Moreover, with a long approval process for the Xstrata Plc's questionnaires, I found it more productive to provide them with the possibility of writing answers to the questions, having them approved by their bosses, and then sent to me.

The questionnaires were kept in an 'easy-to-follow' format with straightforward question and no filter questions that could make respondents confused (Bryman 2008: 217). The question was kept open ended, and in the e-mail that the questionnaire was sent with, the respondents were encouraged to write as much information as possible to each question.

Other quantitative data sources, which I wanted to use were historical and current financial and budget numbers from HLH. However, the ability to retrieve these numbers proved to be challenging due to lack of knowledge to where such numbers are kept (see also Chapter 8).

4.6 Ethical Considerations

To follow ethical standards set out by both the University of Agder and HLH, I applied for a temporary work visa in Tanzania and obtained a written letter of consent from the Haydom Village Council to perform social study within the local community and HLH.

I furthermore did not intrude in villagers' lives, and always asked for permission to interview each individual. Respondents both within the village and the hospital were told upfront about the main objectives of the research and also about their full anonymity if they were to participate. Secondly, the respondents were explained that the participation in the interview would not give them any monetary or other gains. Despite this clarification, quite a few times did the interviewees ask for money after the interview was finished.

Chapter 5 - Empirical Findings and Analysis - Haydom Lutheran Hospital

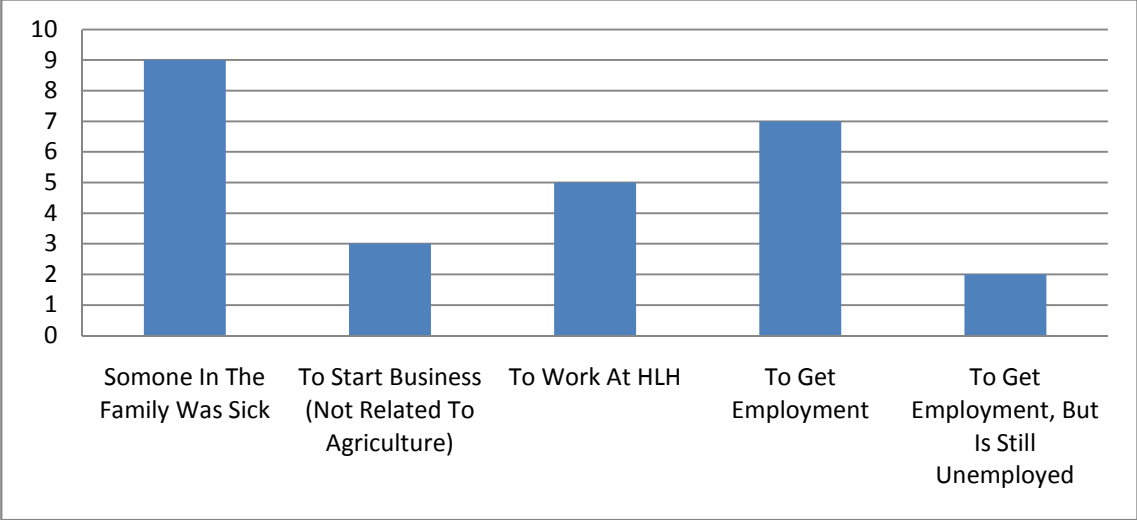
The literature review with the presentation of missionary hospitals' importance and history within the developing world; the open system framework with its three distinct factors; and the background, historic and current work at HLH serves as the base for this thesis analysis.

5.1 HLH as a Development Agent

There exists a strong relationship between the local community and HLH. The linkage between HLH and the community was described as “the two entities are hard to separate” (Interview A3). The relationship had been strengthened by the work of Dr. Olsen. Immediate and long-term challenges for the community have, according to Annual Reports and interviews within the village, often been helped or even solved by Dr. Olsen. “With Dr. Olsen we could always get advice and help if we had problems” (Interview C3). “During famine when Dr. Olsen was alive, Olsen and the government gave food. With [the new Medical Director] the development is still to be seen” (Interview CM5). Dr. Olsen and HLH have furthermore helped negotiate donor support, and connected the community with different NGOs and other organizations that have secured roads, water system, several schools and electricity to the village (Interview A3). However, when asking community members 67 percent argued that it was the Tanzanian government that has provided the greatest amounts of infrastructure to Haydom. It is unclear why this was the belief within the community, but the answer might reflect the community's wish for independence and unwillingness to show any weakness. One respondent who worked within the local government did however argue that 90 percent of the work of the local government is dependent on HLH (Interview CM7).

Yet, categorically saying that infrastructure would not have become available to the village if HLH had not promoted them is impossible to argue. The village would probably not have been created if it wasn't for HLH. The village, with its rural situation, has a high level of infrastructure and development compared to other similar areas in Tanzania, and this is probably due to HLH. There is, moreover, a great pride at the hospital of the development they have created in the Haydom Village and the surrounding area.

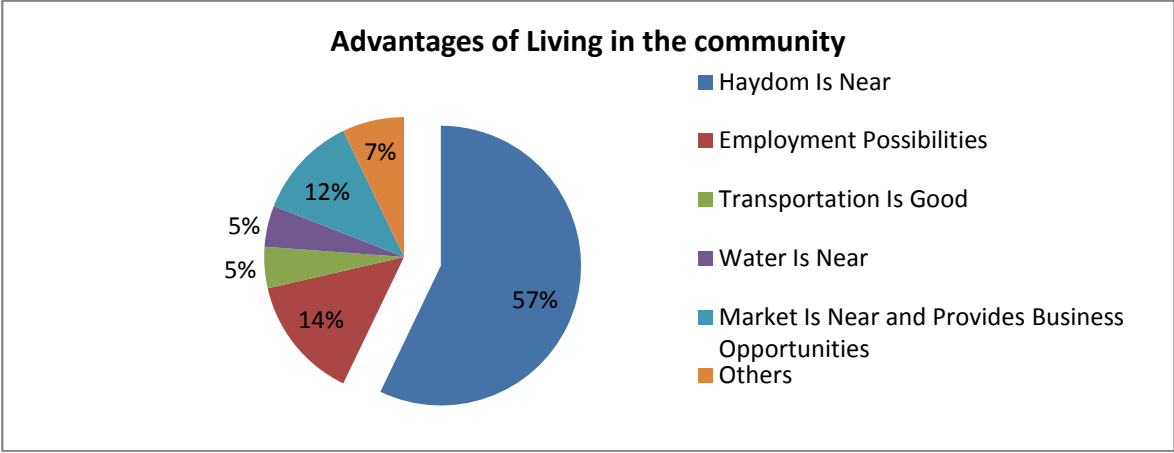
Figure 10: Why did you move to Haydom Village?



(Source: fieldwork returns n=26)

Seeing that the greatest reason for moving into HLH is that someone in the family was sick, the finding that the biggest advantage of living in the village is the closeness to HLH should not come as a surprise. However, it should be noted that also people who had lived in HLH their entire life saw HLH’s proximity as the biggest advantage of living in the village.

Figure 11: Advantage of living in Haydom Village



(Source: Fieldwork n=42)

For the future it is questionable if HLH will be able to provide greater development infrastructure. Firstly, questions were asked whether HLH could manage to attract as much donations and funds for development projects, as has been the norm with Dr. Olsen (Interview A2; Interview A3). This was especially seen as a challenge with the aid-policy changes around the world where donor countries generally are moving away from supporting single projects, and instead focus on strengthening national governments (Interview A3). This

comment is an imprecise summarization of the Paris Declaration (PD) of 2005. The PD put importance on improving aid effectiveness, and donors agreed to shift the aid system away from individual project and programmes in direction of balance of payment support, support to sector wide approaches coupled with basket funding (Havnevik 2011). Secondly:

The people [of Haydom] are used to Dr. Olsen straightening out every ones problems, and Mama Kari paying out money. I cannot hand-out money, I'm not a bank. The people of Haydom have to learn. The people of Haydom have to straighten out their own problems. People must be allowed to take responsibility (Interview A8).

Similarly, the focus group noted the lack of initiative by many individuals within the village as they had been accustomed to getting help at all times (Interview FG1). These statements further replicate the argumentation that in the future HLH plans to focus on health and not greater development efforts (see Chapter 5.12.1).

For the members of the community, however, this change in strategy might be hard to understand. There are a constant flow of individuals asking for monetary help from expatriates at HLH. I did however interview three community members that had moved into the village because they saw a business opportunity there. "The village has been growing very rapidly, I'm expanding my business" (Interview C5).

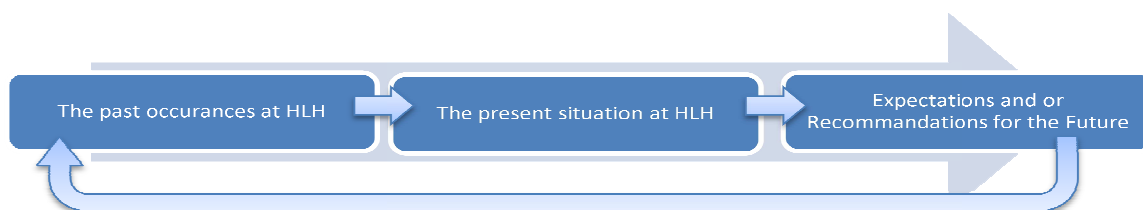
Other interviewees argued that HLH could and moreover should create better education facilities and employment for the community (Interview CM7). A divergence from the respondents notion that infrastructure has been created by the government. It was argued that education and employment are primary steps towards development. It was also noted by several respondents that greater development efforts such as schools would generate employment. Moreover, educated individuals would easier find work, and employment would reduce the abuse of alcohol and in the long run reduce crime in the village (Interview CM1; Interview CM3; Interview CM7). To a certain degree HLH is helping with such development. HLH has gathered financial support to build a vocational training center. Unfortunately, the school is being built without any teachers having been secured. As the availability of land around the village was becoming scarce, farming your own food was becoming difficult, and new ways of generating income had to be found. Arguably, some respondents noted that the future of their children would be outside of the village in areas where shambas are available.

5.2 Contextual Factors

Research question two asked whether HLH's contextual factors were sustainable. I've defined HLH's contextual factors as the inputs from the Norwegian Government, inputs from the national and local government in Tanzania, the availability of doctors, the income of patient fees and the input and dedication of a highly motivated employee. The contextual factors are imperative for the promotion of sustainability at HLH as they explain the hospital's greater environment and how HLH is adapting to its surroundings.

The result based management model noted that measurable and easy to evaluate indicators are used as benchmarks of which a project's performance and improvements are assessed. HLH has not, to my knowledge, such concrete goals or objectives. The objectives are instead vague and grand: "[To] reduce the burden of disease" (HLH 2009). I have therefore created my own evaluation system. It is an objective linear system where exploring the past, and pitting these observations with the present state of HLH, gives room to predict the future. Building sustainability is not a linear process and all process is highly interrelated; there are therefore arrows both between the different parts and between the 'future' and the past to show this dependency relationship.

Figure 12: Adapted Result Based Management Model

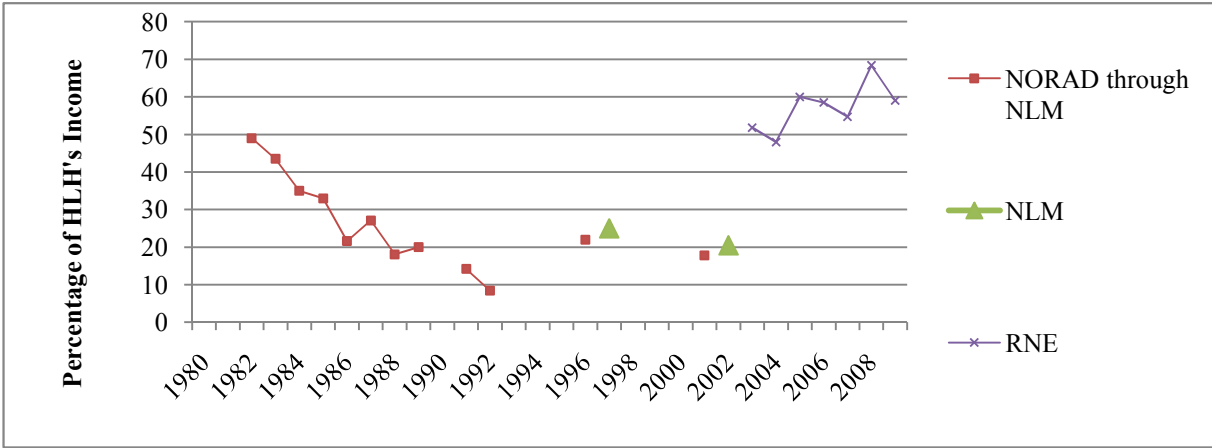


5.2.1 NORD and The Royal Norwegian Embassy

The Norwegian State—through The Norwegian Agency for Development (NORAD) and the Royal Norwegian Embassy (RNE)—has historically and continues today to be the biggest donor to HLH. The monetary support has been channeled through different organizations, most prominently the Norwegian Lutheran Mission (NLM) and the Norwegian Missions in Development (BN). Additional support has also been provided continuously since the inauguration of the hospital in 1955. The relationship between HLH and the Norwegian State is described by respondents from the administration as “a long relationship, we are somehow dependent on them” (Interview A3), while others argued that HLH is “too dependent” (Interview FO1) on RNE. Such a dependency relationship clearly goes against the literature's understanding of sustainability.

In HLH’s Annual Reports from 1981, 1983, 1984, 1987, 1988 and 1989 it is argued that HLH has to reduce its dependency on Norwegian foreign-aid money and diversify its funding sources. This moreover coincide with the Norwegian aid policy towards Tanzania during the 1980s where priority was put on “help[ing] the productive sectors and [construction of] physical infrastructure” (Havnevik m.fl., 1988 translated by author cited in Utenriksdepartementet 1995) and little importance was placed on strengthening the social sector. Reflectively, figure 13 shows the reduction of Norwegian aid money to HLH during the 1980s and beginning of the 1990s.

Figure 13: Support Given by NORAD and RNE



(Source: HLH’s Annual Reports from 1982 to 2009)

In 1998 the outlook of future funding from NORAD changed: “NML and NORAD have shown interest in continuing supporting the HLH” (Annual Report 1998). The need to diversify and increase the different ways and number of donors to HLH is also mentioned. Yet, that same year NORAD became part of the donor countries that agreed to support Tanzania’s health efforts through the basket fund, which should theoretically have meant that NORAD would reduce funding for single projects such as HLH (Mapundo 2003). Due to ‘El Niño’, “[HLH] got a special grant for 1999 and 2000 from NORAD which enabled HLH to continue work, yet it should be stopped for 2001” (HLH 2000). However, as the graph above shows, RNE increased its funding considerably the next years. Both in 2004 and 2005 contributed RNE extra budgetary support to HLH “due to the hospital’s weak financial situation” (HLH 2005).

The historical Annual Reports show the written intention of creating sustainability by diversifying HLH’s donor base. There is however little evidence of such diversification actively being executed. With HLH’s overdependence on NORAD, the hospital has been

vulnerable to changes in the Norwegian aid policy. Arguably, the realization of its vulnerability should have led HLH to diversify its funding base to improve its financial position for the future. Questions, however, can also be raised about the background for the increased funding to HLH from RNE. I have found little written explanation for the increased donations, except for the fact that HLH was suffering major financial constraints due to governmental imposed increases in wages (HLH 2005). Questions about both the transparency of the support to HLH from RNE, and RNE's alignment with the Norwegian Government's aid-policy towards Tanzania, should therefore be raised. I can only wonder if RNE follows Green *et al.* 2002 argument that donations to mission hospitals often have been based on the belief that: “[C]hurch health services...[have the] capacity for efficient and ethical use of resources; a commitment to quality of care even with limited resources” (p. 346). Moreover, it was argued in the literature that continuous financial support decreases sustainability building as long funding decreasing the prospect of sustainability because of the poverty of evaluation systems supporting the decision-making (Sarriot *et al.* 2008: 3).

Currently, HLH is within its last five-year contract with RNE. Significantly “one of the clauses within the contract is that [HLH] cannot apply for renewal of financial support” (Interview A8). Others within the administration seemed to have a more hopeful outlook on the future: “We will try to apply for more grants” (Interview A5). “RNE is saying that the Tanzanian government and that the church have to step up. However, RNE does not want to put pressure on the Tanzanian government, and HLH cannot put pressure on the Tanzanian government, we are not in such a position” (Interview A3). My assessment is that at least parts of the administration expressed surprise to the Norwegian government's decision to end its budgetary support to HLH. It became impossible for me not to question whether HLH had started understanding the Norwegian aid-support as a sustainable financial donor. Flessa (2005) argued that long-term dependency on one external source—he noted the dependency on the mother church—leads mission hospitals to equalize this with the institution having reached sustainability.

The significance of the Norwegian government's decision to end budget support to HLH, though the hospital can apply for special project grants (Interview A4), should in my opinion not have come as a surprise. For decades it has been noted that self-sufficiency and diversification of donors have to be promoted. One respondent argued that “RNE might continue support after the five year period [is over] in fear of losing face to the [Norwegian] public if the hospital goes down” (Interview A2). I find this reasonable, seeing that RNE has

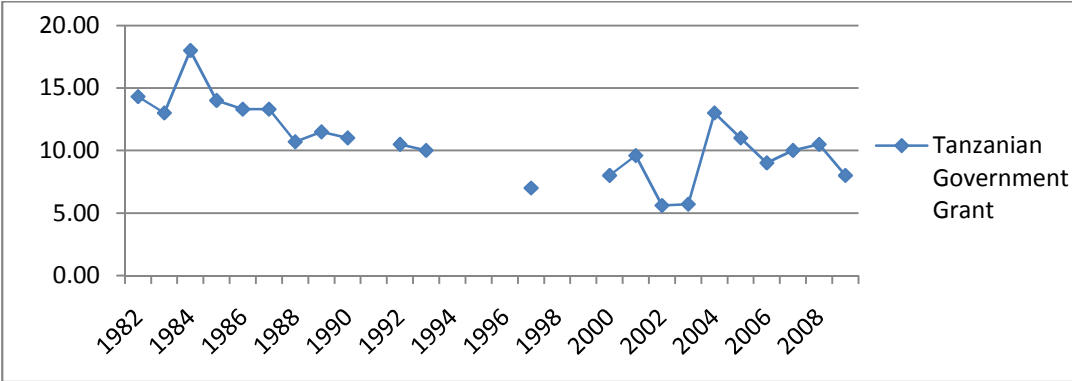
several times before said it would end its financial support, while never actually following up on its threats.

5.3 The Tanzanian Government

Sustainability of any aid project is dependent on a good relationship as well as the national government’s interest in upholding and running the project. HLH has been part of the national health system since 1964, and has at all times had a good relationship with the national government. “The fact that the President sleeps here when he comes to these parts of the country, shows the good cooperation we have with the government. He has also been present at several big occasions” (Interview A4).

Despite this good relationship HLH has been given little direct monetary support. The financial grants have over time only averaged 10,68 percent of the operational income of HLH (from the data available to me, see graph below). However, Flessa (1998: 403) found that the national government on average only provided 2,23 percent of the income of ELCT’s hospitals.

Figure 14: Financial Support, in percentage, by the Tanzanian Government



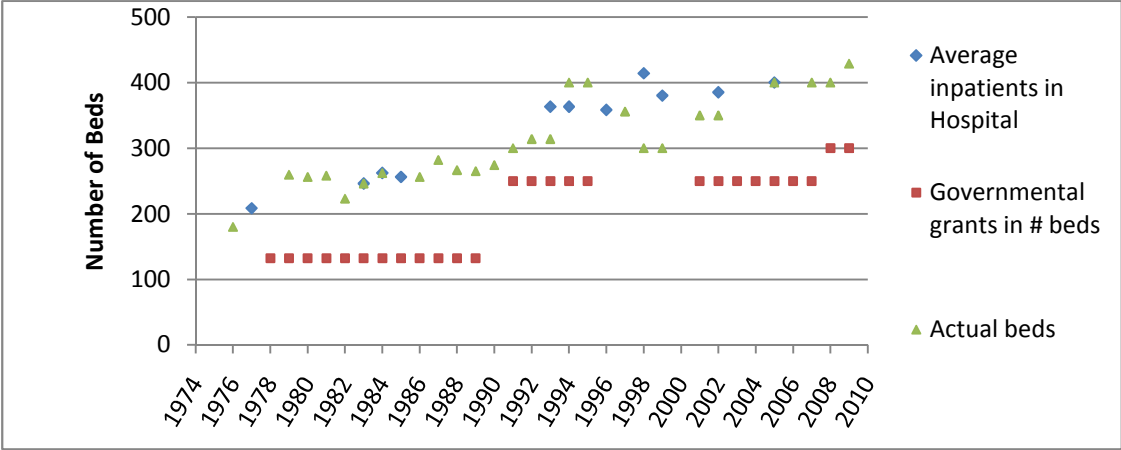
(Source: HLH’s Annual Reports 1982 -2009)

5.3.1 The Financial Support

Currently the financial support from the Tanzanian government is divided into three different sources, a bed and staff grant, and the basket fund. The bed grant is “50.000 t-shilling per bed per annum” (Interview A3; Interview A8) given to one bed for any 1.000 people within the districts that the hospital serves (Flessa 1998). Several respondents and also historic Annual Reports have argued that population surveys do not give the right base of how many patients HLH is catering to. Patients are arriving to HLH from much farther away than the official catchment area. Currently, the official number of bed grants at HLH is 300. The staff grant is

currently 82 (Mæstad and Mwisongo 2009:12). Yet, within my findings HLH has always operated with more beds than what the official number has been (Annual Reports 1976-2009). Moreover, confusingly for any researcher, the official and the actual number of beds and thus the amount of governmental grants, are indiscreetly mentioned within the Annual Reports.

Figure 15: Number of Beds at HLH



(Source: HLH’s Annual Reports 1982 -2009)

Several respondents and also historic Annual Reports have argued that population surveys do not give the right base of how many patients HLH is catering to. Patients are arriving to HLH from much further away than the official catchment area. For HLH another inconsistency in relation to the level of funds provided “is [that we] have two patients in each bed” (Interview A3). This inconsistency between the official and actual number of beds within HLH is directly related to the mission of HLH which is to never refuse anyone treatment (Interview A3; Interview A0). Staff however argued that lack of beds was mostly a challenge during the rainy season.

5.3.2 Referral Hospital

In June 2010 HLH was promoted from a district hospital to a second-degree referral hospital. In contradiction to the literature that argues that institutions do not have the ability to control their contextual factors, it is argued by respondents that the upgrading of HLH came about after a year-long lobbying process initiated by the later Dr. Olsen (Interview A6). One interviewee, however, argued that “the fact that the upgrading actually was approved came as a surprise” (Interview A3). It was however seen as a sign of increased recognition by the government.

[It] allows the hospital to apply for bigger bed and staff grants. We have applied for a new bed grant which covers 430 beds and an increase in staff of 130. Being a referral hospital also entitles HLH to apply for cheaper medication for a greater number of patients (Interview A9).

It was also argued that becoming a referral hospital would reduce the number of patients arriving to HLH (Interview FG1; Interview A8). Yet, HLH had still not received the gazette that certifies the change in status. “So we cannot claim any extra benefits or support. The future is still debatable” (Interview A8). To retrieve the gazette pressure was put on the national government by sending monthly letters and e-mails to the national health department.

5.3.3 Payment Delays

Another challenge has been that governmental funds have been severely delayed or not reached HLH at all. “[In] 2010 we only received about 2 million T-shillings out of the 5.10 million T-shillings we were supposed to be getting” (Interview A3). A similar view is noted in the Annual Reports from 1989, 1997, 2000, 2001 and 2002. Flessa (1998) found similar cases during a study of seven Lutheran Hospitals in Tanzania. “The Ministry of Health had not fulfilled its financial pledge but owed money to ELCT hospitals” (p. 403). Green *et al.* (2002) and Reinekke and Svensson (2003) argued that the stress and uncertainty of such delays could reduce the sustainability of missionary hospitals. My empirical findings argue that this is the case for HLH.

Based on the historical relationship between HLH and the national government where grants consistently have been small and also delayed, it seems unlikely that such occurrences will not also be the case for the future. It is argued within the literature, and was also noted by interviewees, that the national government realize that HLH is more or less operated with donated and gifted financial resources from Norway (Interview A2; Interview A3). It therefore feels little reason to prioritize resources for the continuous operation of the hospital (Deloitte: 10). Arguably, it was also noted that the health ministry was skeptical towards religious organizations and therefore purposely delayed payments (Interview A3; Interview A9).

Employees from the administration further argued that the hospital had little bargaining power towards the national government. “[P]olicies are dictated from above, we can only implement” (Interview A3; Interview A4). Yet, contradictory it was argued that it was the lobbying process that had led to the upgrading of the hospital, thus challenging the notion that

HLH operates in a vacuum without ability to influence the national government. Moreover, the literature found that mission hospitals within Tanzania could participate in health policy negotiations (Green *et al.* 2002: 343). For the future sustainability of HLH, adaption to the reality of limited financial support and adjustments in services and programs provided by HLH, is recommended by the literature as a stabilizing factor for its long-term operations.”When faced with contextual factors likely to undermine sustainability, project...managers might modify the project so as to reduce the effect of these conditions” (Bossert 1990: 1017). Contradictory, few employees at the administration argued that reducing health activities was a future plan, however, it was noted a wish to reduce the extra development efforts (see Chapter 5.12.1).

5.4 Local Community and Local Government

Historically it is clear that HLH has been the pillar behind the growth and development of Haydom Village. A representative from the village argued that: “the community is dependent on HLH” (Interview CO). A similar understanding was presented by interviewees from HLH, yet a change in relationship for the future was argued for. “There is mutual respect, but probably the local community is working towards more ‘freedom’” (Interview FO1).

The relationship with the local government was seen as reciprocal: “We depend on each other. [The villagers] are poor/low income and we give free treatment. If we need land, the village leaders have plots to give us” (Interview A5). It is clear however that provision of such plots of land, that often has been worked by members of the community at times have been controversial and could be a source of conflict for the future (Interview CM6). Another employee quite eagerly noted that “[w]e have a very good communication with local politicians, they are even employees at HLH” (Interview A4). Conversely, several respondents from the community noted wariness about the double position of members of the local council. It was argued that politicians saw it as a competitive advantage to work at HLH during election time, and it was questioned whether individuals could perform two jobs efficiently (Interview C7). This negative sentiment from the community could possibly for the future create conflicts between HLH and the villagers, and should therefore be carefully looked into. I also believe that it would be in the interest of HLH to have workers fully engaged in their position and responsibility at the hospital, and not having employees that are semi-occupied by other projects. There is however a need to consider the background for any employees decision to take up several positions. Tanzania has a weak pension system and

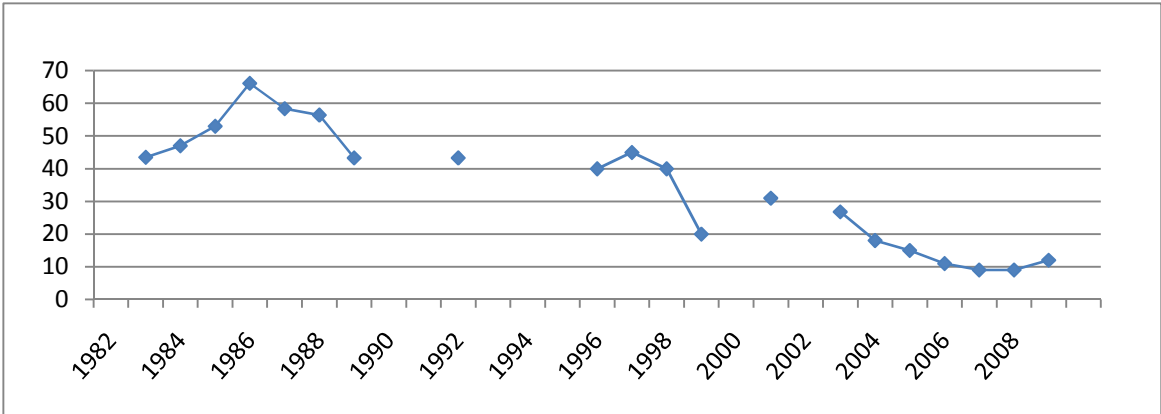
holding several positions can be seen as a way to secure the future for the employee themselves and their families.

It does not appear that HLH can expect much more financial support from the local government, than what the national government is handing down to them through the basket fund. Rather, it became clear that the local government was asking HLH—or individuals connected to HLH—for financial support for its development. Some expatriates working at HLH simultaneous take up a sort of donor and consultant position towards the local community. This creates a confusion about which institution these individuals actually are representing. This could put HLH in a difficult position and could cause negative sentiments towards HLH if these single individuals do end up with a constrained relationship with the local community. Thus, clearer guidelines and contracts to separate HLH and individual’s activities within Haydom Village should be initiated.

5.5 Patient Fees

Historically and today HLH has served a very poor and rural population. Accordingly, the level of income from patients’ fees has always been limited. Figure 16 shows that the patient fees have fallen quite drastically during the period from 1982 to 2009. Interestingly, the peak in 1986 came after the hospital decided to halve the patient fee, and thus received an increased number of patients (Annual Report 1986).

Figure 16: Percentage of HLH’s Budget From Patient Fees



(Source: HLH’s Annual Reports 1982 -2009)

At HLH no patients are asked to pay upfront for treatment. HLH is one of few hospitals in Tanzania that has this policy. The price of treatment at HLH has always been below the governmental level, similarly to what the literature argued (Gill and Carlough 2008: 200). Patients who have not been able to pay for their treatment have been given the option to work

at HLH as a way of paying their debt. Despite this, HLH had to write off 17 million T-shillings as bad debt last year from patients that could not pay (Interview A4). “I paid for the treatment because I’m too old so I cannot work my debt off as I did before” (Interview CM5). This shows the sentiment that individuals would rather work, than pay directly for their treatment, despite having the money to do so. Another challenge for HLH is how patients cannot be discharged without paying, and if there is no work for them, situations where patients keep staying for months at HLH have occurred (Interview FG1; Interview A5).

Several respondents argued for the need to ‘teach’ users to pay for their treatment (Interview A9; Interview A5). It was mentioned that users often would be willing to pay local witch doctors with cows, but unwilling to pay at HLH. Contradictory, only one of the persons interviewed from the community argued that she did not have the resources to pay for treatment at HLH. The majority argued that HLH was expensive, but cheaper than governmental hospitals. The community did not however find resources to pay for the drug/alcohol addiction treatment. Arguably, some individuals will always be too poor to pay for any treatment.

“HLH will never reach sustainability if they don’t ask for at least a small upfront payment” (Interview FO1). It was moreover argued that such a payment could reduce the number of unnecessary admittances to HLH, and thus increase the hospital’s efficiency. Employees further argued for the introduction of a level system at HLH, where patients are given the option of paying a premium for ‘special treatment’ and private room (Interview FO1). Such a system has never been discussed within the administration as it goes against the mission of HLH (Interview A9). However, with HLH today attracting patients from bigger cities, I would argue that such a scheme could work. It does not have to reduce HLH’s mission of serving the poor rural population, it merely would reflect today’s situation. If HLH wants to continue to cater to big-city patients, why could it not also open up for charging patients, possibly willing and able to pay premium for their stay at HLH. Another suggested idea is introducing an insurance scheme (see Chapter 5.11.3).

5.6 Xstrata

A clear challenge for HLH, according to three respondents within the administration, is the commercial donors’ focus on tangible and measureable projects. Thus according to one respondent during the negotiations with Xstrata, about what donated money should be used for, HLH was wanting part of it for staff grants and maintenance of buildings, while Xstrata

wanted it to be used for capacity building and further education (Interview A3; Interview XP1). The notion of commercial donors wanting clear tangible projects is in line with the literature of CSR. The literature on foreign aid project also argues for the use of clear and measureable goals and objectives, I would therefore argue that HLH could use this new experience with Xstrata as a step towards a better monitor and evaluation system.

5.6.1 The Need for Managerial Capacity to Attract Commercial Donors

Another challenge for HLH that I was informed about was the ability of HLH to fully take advantage of the commercial-donor market due to little professional managerial experience at HLH (Interview A2; Interview A3). This point is supported by the literature that argues that missionary hospitals often lack professional administrators (Green *et al.* 2002). There is only one person from the administration today that has higher education within the administrative and managerial field, though some have former experience with managerial work.

[Xstrata is] very important as it is our first commercial donor. It gives a great opportunity for us to link us together with other commercial companies within Norway. It also asks for special care and we need to set up a structured system for reports so that they feel valued. We need to work on communication with donors (Interview A3).

In relation to commercial donors the lack of administrative education reduces HLH's ability to perform lobbying and public relations work. This point is underscored by the Deloitte Fund Raising report, which noted that: "Haydom exhibits limited ability to conduct marketing campaigns and execute fundraising strategy" (p. 10). Deloitte has completed pro-forma work for HLH.

5.7 Number of Doctors

The literature notes that attracting medical personnel is one of challenges when operating hospitals in rural parts of Africa (Reinikka and Svensson 2003: 8). HLH is a case in point. Unfortunately, it has been impossible to find any exact numbers of how many doctors and also general personnel have been and are currently employed at HLH (see also Chapter 8). The lack of clear figures is in accordance with what the Christian Michelsen Institute (CMI) noted in their review of HLH: "It was not easy to obtain data on the number of staff in a format that is suitable for presentation and analysis" (Mæstad and Mwisongo 2009: viii).

Respondents both from the administration and from staff noted that the sustainability of care at HLH is generally based on expatriate doctors coming to HLH on short-term volunteer

basis. The challenge of using short-term expatriate doctors is that: “[F]ollow up of patients is not possible” (Interview S1), and the ‘beginner mistakes’ are being done over and over again, by new staff, as there is no continuity. Such quick turnover of staff is not helping to build sustainability (Interview A9; Interview A2; Interview FO1). However, several respondents did note that expatriate doctors often come back, and that this enables them to arrive and go straight into the operation theater, without the normal introduction and time spent on learning new routines (Interview A3; Interview A9; Interview A0).

Seventeen staff members noted that expatriates were *very important* for the daily activities of HLH, while 24 said they are *important*. “[Without expatriates we would have] big problems. If possible we should increase the number of foreign doctors” (Interview S9). This underscores any sustainability theory where local participation and capacity building is seen as imperative. Other respondents argued that HLH could be running without expatriates, yet both motivation of local workers and quality of care at HLH would be “reduced to ‘African’ level” (Interview A3). The notion ‘African’ level was defined by reduced level of care, mostly due to lack of educated staff, lack of medicines, and lack of equipment.

5.7.1 HLH As A Referral Hospital

With the upgrading to a referral hospital, national intern doctors and specialists are sent to HLH from the government. This is believed to reduce the dependency on expatriates (Interview A5; Interview FO1). Six intern doctors have arrived and are working at HLH. Yet the four specialists have not arrived (Interview A6; Interview A4). Interviewees from the administration and staff noted that the specialists were not arriving at HLH due to its rural location. Worryingly for HLH, several intern doctors noted that they would not encourage future interns to come to HLH, as long as there were no specialists present (Interview FG1). This could make the availability of doctors even scarcer for HLH in the future.

On the other hand, two of the intern doctors said they had chosen HLH specifically as they were offered free housing. This could arguably be used as an incentive for the specialist as well. Moreover, the respondents suggested the use of a special grant as an incentive. At least “HLH should follow the government’s pension policy [which is higher than the pension paid out at HLH]” (Interview FG1). Respondents from the administration argued that it was hard to switch pension funds from one scheme to another (Interview A7).

5.8 Ardent Soul – Dr. Olsen

The later Dr. Olsen is seen as the father of HLH. He first came to HLH in 1961, and spent the majority of his life there. Dr. Olsen passed away in 2005 while being the Medical Director of HLH (Olsen and Daudi 2010: 24). Employees and community members still sought for the era of Dr. Olsen to return; motivation of employees was high, quality of care was the greatest, staff followed orders, communication between administration and staff was better functioning and ethnical conflicts were not present (Interview S4; Interview A3). “Today the African doctors ask for corruption. It did not happen before because Dr. Olsen would fire them” (Interview CM6).

It is a paradox that staff look to the time of later Dr Olsen, as he was like a good dictator. He could freely dismiss the bad workers. It is different today with the unions and strict labor laws. Yet the Tanzanians like working under such people (Interview A3).

5.8.1 HLH Without Dr. Olsen

As noted in the literature review missionaries often have another work ethic based on Western evangelic standards that historically emphasizes high work ethics as a goal in religious practice. Due to the ardent soul’s often full control of all operations—administrative work, contact with donors, operations, community relations—there is a risk that the connection to supporters are reduced, and the sustainability of the institutions can diminish when this person leaves the position (Bergh 1995: 18-20). Both workers and administration at HLH confirmed this was the case with the passing of Dr. Olsen. I would argue that Dr. Olsen resembles what Shediak-Rizkallah and Bone (1998: 102-103) call *project champion*. This is a person who connects an organization to its greater environment. Dr. Olsen had a very close connection to both donors in southern Norway, and civil servants both in Norway and in Tanzania. He utilized his charisma and connection with these groups to increase the funding and support for HLH. Yet, securing sustainability is difficult if the organization is dependent on one single leader, especially if this leader is an expatriates (Bergh 1995: 18-20).

I would however argue that the new Medical Director also is greatly dedicated to HLH. Especially, knowing that by February 2011 he had still not received any wages for his work since September 2010. The Medical Director is paid by the ELCT. This contradicts the literature that argued that priorities of administrations of church hospitals often were to secure continuous operation of the facility, and ensure their own perks (housing, good salary and car), instead of thinking about staffing and patient welfare (Green *et al.* 2002: 344).

5.9 Summary of the Contextual Factors

When summarizing findings within the different contextual factors clear trends appear. Mainly, there seems to be no major changes in HLH's sustainability building today, than what has been done historically.

HLH's dependency on RNE is possibly higher today, than it has been historically. Despite the knowledge and continuous messages of reducing the dependency, the situation today mirrors the past. In the literature this lack of adhering to the contextual environment is argued to show that the institution is static and thus unsustainable. From the point of view of RNE it can be argued that continuous support, despite threatening to end it, has made HLH believe that RNE is a sustainable long-term donor. It could furthermore be raised questions to how the continues financial support to HLH has been decided upon. Since the inauguration of HLH in 1955, the Norwegian Government has only had two publicly available evaluations of the hospital, meaning that support must have been based on other criteria than written evaluations. Moreover, one of the evaluations—*Report on Haydom Lutheran Hospital, Mbulu Synod of ELCT Project Review 1988*—is not even found within the Norwegian government's library system.

HLH's income from the Tanzanian government has been and is still limited. The payments have been and continue to be delayed. The funds, furthermore, have never and do not currently reflect the actual number of beds and inpatients at HLH. From the point of view of the Tanzanian government HLH is providing health care to its population at a very limited cost for them, as the hospital is funded from abroad. HLH argues that they are in no position to impact the financial resources given to it. With RNE's reduction in financial resources the position of HLH towards the national government could possibly be strengthened. Arguably, continuing operating HLH at today's level without the support of RNE will be difficult (Interview A6), and thus the importance of improving the input from the national government.

With the upgrading to a referral hospital theoretically the Tanzanian government has to increase its funding for HLH. Yet, as of today, the official gazette has not arrived, and the situation is therefore fairly similar to earlier decades. The change in position does show attempts by HLH to improve its sustainability by taking control and influencing its contextual environment. However, without the gazette there is little change between HLH in the past and HLH today.

The level of patient fees as part of HLH's income has been falling since the inauguration. It is clear that the ability of patients to pay for treatment is strongly related to the general economic situation in Tanzania. However, it is argued that community members have been accustomed to not paying for treatment. The empirical findings furthermore argue that it is feasible both to increase and demand a small upfront payment for treatment. Though not enabling the full financial sustainability of HLH, it would add extra resources. Moreover, better defining to whom HLH wants to cater to could help in planning any new patient-fee schemes.

The hospital has historically and continues today to be in dire lack of doctors and specialists. Once again, the upgrading to referral hospital should help. Several respondents argued for clearer incentives being provided—monetary, housing, transportation costs—as a way of attracting local specialist to HLH. With the difficult financial situation at HLH this could be seen as impossible incentives to make. Yet if the choice is to have or not have qualified specialists at HLH steps should be taken to ensure financial resources to cover this. The continuous use of expatriate doctors is not creating sustainability and provides little ability to plan for future activities either.

The biggest change between HLH's past and its future has been the introduction of a commercial donor. Arguably, this has been a positive change for HLH and shows willingness to think new. The challenge for the future is to attract more commercial donors, and ensure that the managerial level of HLH is in accordance with what such donors expect from their investments. However, the lack of management systems at HLH undermines any of these plans. With the little ability of HLH to show their actual success with clear figures and numbers, donors might feel wary about investing in HLH. A hindrance to clear objectives and control is the lack of managerial background of the administration at HLH.

Smaller aid projects can often be too dependent on one very dedicated employee. Both the community and administration argue that HLH is too dependent on Dr. Olsen. As HLH today is a full-sized hospital, new stronger managerial structures are needed. However, providing responsibility to employees with little knowledge and education can be problematic. It is however imperative that steps be taken to create a wider management base.

5.10 Activity Level

It is argued within the sustainability literature that any project that plans on becoming sustainable needs to provide services that are in demand from its community, it needs to be

accepted by the same community and furthermore needs to provide services, processes and activities that are financially feasible to continue into the future. As such the activity level is highly interrelated with the contextual factors.

5.10.1 New Programs

Respondents noted that the need for any new programs became apparent naturally, by studying the patients arriving to the hospital. “[The demand] comes from what we see of need from the influx of people. [We] try to reach many people with our programs” (Interview A3). Historically, the experienced need within the communities has included the building of roads and bridges to make it possible to reach villagers with the ambulance services, and expansion of the hospital services (Interview A3; Interview A0). The literature appears divided on the motivation behind missionary hospitals operating multi-purpose development programs and whether it enables the most efficient use of resources. HLH however has as a mission to work as a development agent (HLH 2009). Arguably both the literature, interviewees and Annual Reports noted that many of the extra development efforts by faith-based organizations, and also HLH, has later been recognized as national strategies for poverty reduction and health improvement strategies (Schmid *et al.* 2008: 50-51; Interview A3).

5.10.2 Influence of Donors on New Programs

There was a unified response that donors do not decide new programs or services at HLH. “They can come with suggestions” (Interview A3; Interview A4), but cannot demand. This is contrary to what the literature argued. However, many of the road, ambulance and hospital services provided at HLH would not have come about if it was not for the donor support for such activities (Annual Report 1992; Olsen and Daudi 2010). Thus, I would argue that donors do in fact indirectly decide what services HLH are providing.

5.10.3 Vertical Programs

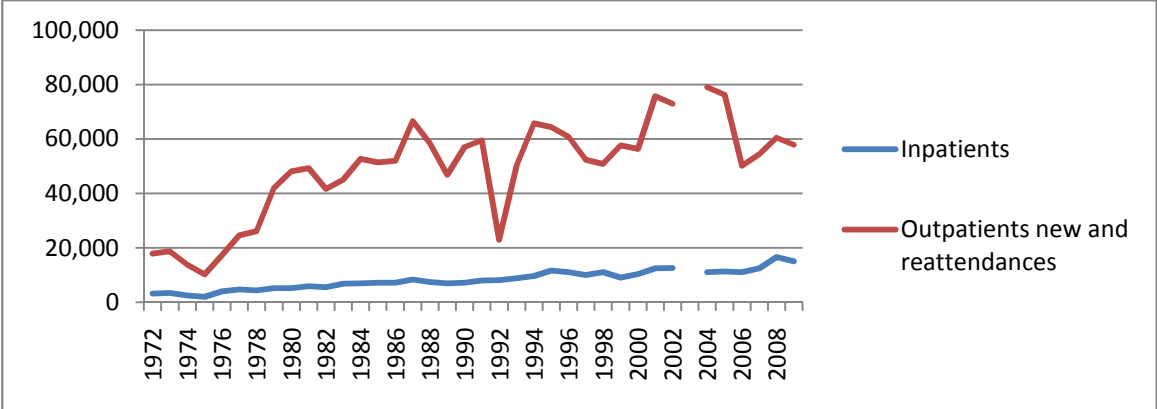
Four respondents from the administration said that the hospital does not have any vertical programs. One respondent, however, noted that to a certain degree it could be argued that some of the research programs carried out at HLH were more favorable to the *mzungus* (i.e., foreigners) than to the locals (Interview A3). However, it was specified that this research part had to be seen as a minor part of HLH’s overall operations. The number of research projects could be related to the former director’s wish of supporting the financial situation of HLH by international research collaboration (Interview A3). Yet, to show the complete change in today’s strategy one respondent noted that: “I don’t think HLH can be sustainable and financially survive based on research projects” (Interview A9).

There was information, however unconfirmed, about HLH starting up a brain surgery department. To me the brain surgery appears out of place in a rural hospital in Tanzania. Moreover, there is only one hospital in Dar es Saalam providing such operations. It was argued that: “we want to try, but maybe there is no local demand for this. However, this is not a main focus – like general surgery. The program was initiated by the US – if it is not paid for by HLH it is no problem. But if it is taken out human resources it can become a problem” (Interview A3). It is hard not to question if such a project would not take out some resources from HLH, for example theater time, which could be used for more needed surgeries within the Haydom community.

5.10.4 The Perceived Need in the Community

The expansion of the hospital, its services and number of patients, is said by 31 individuals from the staff and by several respondents from the administration to show that HLH is responding to the local needs. This is a complete divergence with what the Result Based Management Model (RBMM) argues. RBMM works by defining concrete qualitative and quantitative goals that are used as benchmarks. Bergh (1995) further argued that needs often are never ending for health organizations but for the organization to be sustainable it has to adapt to local needs and the local and national mobilized resources (p. 29).

Figure 17: Number of Patients at HLH (1973-2008)



(Source: HLH’s Annual Reports 1973 -2009)

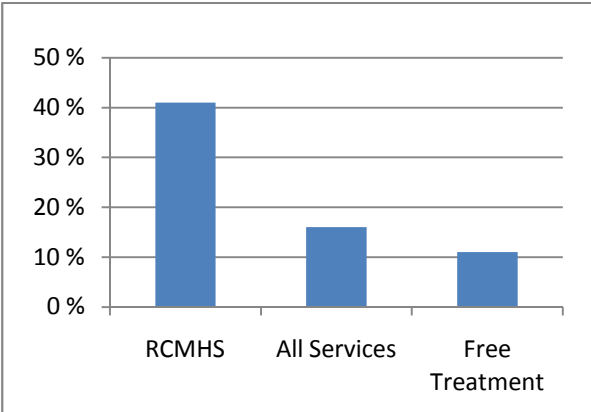
The greater increase in outpatients than inpatients has several reasons. First of all, the knowledge of the HLH has increased in the local communities. Related to this is the increase in infrastructure, making it easier for patients to arrive to HLH. Moreover, today patients are arriving from as far away as Dar es Salaam. I’ve not been able to find the reason for the sharp drop in patients in 1992. The number of inpatients has not increased as much. This is probably due to the number of beds acting as a limiting factor.

5.10.5 High Number and Long Stay of Patients

Several employees mentioned the little efficient use of beds at HLH. Some inpatients are admitted “with a head ache” (Interview FG1). This reduces the efficiency and keeps beds occupied when sicker individuals arrive; ‘wastes’ the doctors’ time (Interview FG1); and increases costs for HLH. Already during the evaluation of HLH in 1988 was it noted that: “Many of the [inpatients] at the HLH are admitted not due to the severity of their illness but because they come from very far away and do not have any place to stay” (Sand *et al.* 1988: 46). To me it appears that the problem is the same today as in 1988. Respondents from both staff and administration furthermore noted the challenge of HLH not discharging patients after their treatment period is over if the patients cannot pay. This creates challenges for HLH’s financial sustainability, and the ability of the hospital to treat as many patients as possible.

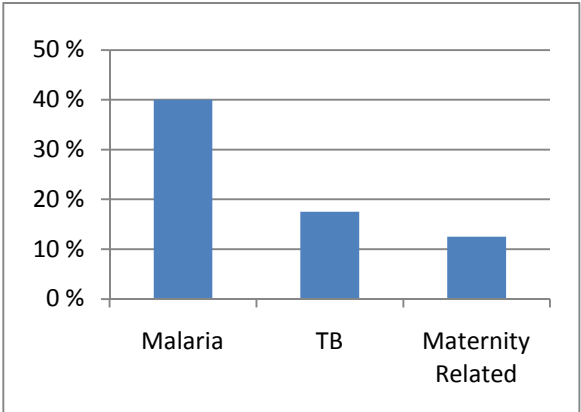
5.10.6 The Actual Need in the Community

Figure 18: Most Important Services according to HLH



(Source: Fieldwork n= 44)

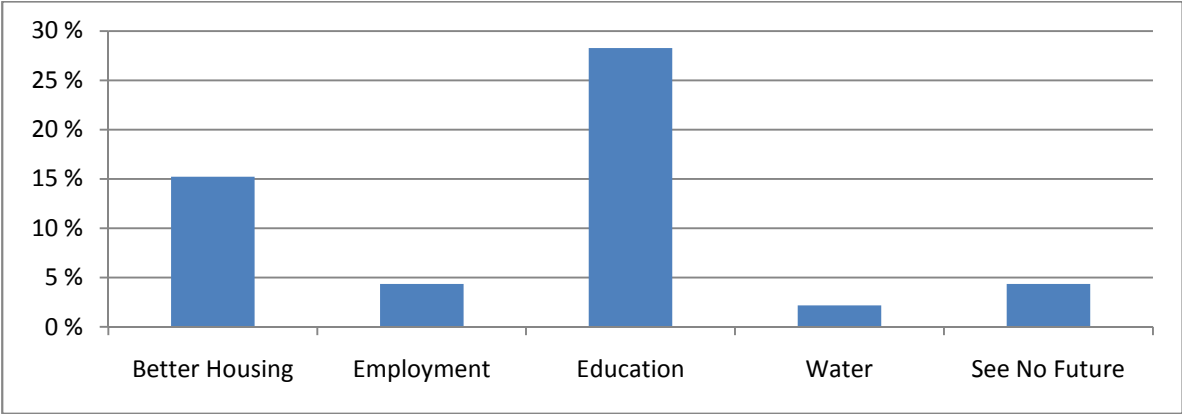
Figure 19: Most Needed Health Services according to Community



(Source: Fieldwork n= 40)

The issue of alcoholism was further noted by 63 percent of the villagers during some stage of the interview. Alcoholism was however understood more as a social and economic issue where lack of employment and education fueled the number of alcoholics. Interestingly, no respondent from the village mentioned the need for any health related activity, when asked about the future development needs for the village. This is possibly due to their proximity to HLH.

Figure 20: Development Need in the Community



(Source: Fieldwork n=46)

In my assessment, based on my findings and observations, HLH could in many ways rather be seen more as a development agent than a health-providing organization. This could cause conflict in the future, with individuals from the administration arguing that the hospital should reduce its development efforts and focus on health issues (Interview A8; Interview A9). However, from a sustainability view this might be a necessary step for securing the future operations of HLH.

5.10.7 The Amani Ward

One of two clear links between my empirical findings in the community and new services provided by HLH, was the initiation of the Alcohol and Substance Abuse Treatment Unit (Amani ward) in 2007. “We have 13 treatment places, however, we are not fully booked. Therefore, we are not planning on expanding this department” (Interview A9). Staff from the Amani ward noted that patients often arrive from Dar es Salaam and Arusha. It was argued that the higher education level, knowledge of alcohol’s negative economic and social effects, and the higher income level there made the population more likely to seek treatment (Interview S2; Interview S4). Yet, the empirical findings show that there is knowledge of the social and economic damages that alcohol abuse causes within Haydom Village. My findings argue, rather, that the cost of the treatment at HLH is too high for the local population. This raises question of whom HLH actually is targeting with its services. The second need communicated by the villagers, of which I would argue that HLH is responding to, is the call for services related to the maternity and care for pregnant women. HLH has secured funding for expanding the maternity department and thus increase the availability of this service.

5.10.8 HLH a Highly Equipped Hospital

Enquiring into whether the HLH had the equipment it needed to operate at its best, three-fourths of the administration said yes, while only 13 individuals from the staff noted the same. Twenty-four interviewees noted that HLH has most of the equipment needed. However, it often lacked basic equipment such as oxygen, sterilized gloves and syringes. The staff did emphasize, however, that HLH is very well equipped compared to other hospitals in Tanzania. With some respondents arguing that they primarily are at HLH because of the hospital's high level of equipment. Having visited other rural hospitals, I've seen first-hand how well equipped HLH is. This is furthermore in agreement with the literature which argues that mission hospitals often are much better equipped than governmental hospital (Gill and Carlough 2008: 200), due to their connection to mother churches and governments overseas.

HLH is one of only six hospitals in Tanzania that has a CT-scanner (Interview A7). "We have treatment options and equipment that are not available at other hospitals, so [the government] want us to function as a relief hospital for other hospitals" (Interview A9). This strengthens the overall national health system, yet, questions can be asked whether HLH is providing too high quality treatment, than what the national health system is ready to support. Financially, it is difficult to maintain highly technical equipment; there are also few local human resources available to operate such apparatus. If there are no financial or human resources available to continue such activities in the future, the activity must be judged unsustainable (Shediac-Rizkallah and Bone 1998; Bossert 1990). Within the literature it was argued that ending activities might be a needed step, if better use of resources and other activities might increase a health organization's ability to positively influence its users (Shediac-Rizkallah and Bone 1998). One respondent however argued that ECG-machines can work as a substitute for laboratories, and therefore is a needed part of a rural hospital (Interview A8).

5.10.9 Maintenance and Storage of Equipment

Recurrent costs, salary and maintenance of buildings and equipment are important parts of the operation of HLH that we need to generate funding for (Interview A9, Interview A3). The literature noted a lessened efficiency at hospitals where maintenance was an issue, while others argued that donors were reluctant to support reoccurring costs as it was believed this created dependency (Bergh 1995. Flessa (2002) further argued that the actual recurrent costs of operating a hospital, makes the use of such aid methods less suitable than rather adhering to smaller dispensaries and primary health care.

Table 2: Level of Maintenance at HLH

Level of Maintenance	Frequency (n = 46)	Responses (in percentage)
50/50	4	9,52
Some	4	9,52
Not sufficient	16	39,1
It is good	18	42,86
No response	4	9,52
Total	46	100

To maintain the CT-scanner experts have to fly in from Europe (Interview A7). Until now, maintenance has fallen under a ‘sponsor agreement’. However, worries were raised by several staff and administration workers about the future cost of maintaining the CT-scanner when the sponsorship agreement ends. Another example of equipment being out of function was one of the oxygen machines. However, the equipment was still used, according to expatriate nurses “actually making the patients even sicker than if it was not applied” (Interview S0).

It was further noted that HLH was lacking a storage system. Both equipment in need of repairs and functioning ones were stored together. Moreover, different parts of the same equipment were sometimes stored knowingly or unknowingly at different locations. According to employees this could lead to situations where the patients were not getting help in a timely manner (Interview S0; Interview S1).

Throughout HLH’s area there are containers full of donations—clothes, medical equipment. Not until the end of my stay was a list found that showed that stock inventories of the containers were taken as far back as in 2008. However, since 2008 not much has been done about the containers and questions were therefore asked by staff and volunteers whether the inventory in the containers is still usable. Especially medical and technical equipment can be damaged by moisture and heat. There has also, been a ‘unwritten’ law at HLH, that everything should be stored, in case of bad times, yet with no control over what and where donations are kept (Interview A3; Interview A0).

I would not judge this lack of control of inventory to reduce the activity factor of HLH, but it does show challenges within the administrative system. Moreover, with HLH being dependent on donors it is important that care is taken to value the inputs from these supporters. ‘Good will’ is important for aid projects, especially for projects not able to financially support themselves. If it was known that costly technical medical equipment possibly are being ruined by moisture because it is kept in a container for 3 years, HLH could easily get a bad

reputation, which could lead to reduced donations from abroad. Arguably, situations where equipment is bought unnecessarily as donations of the same equipment are stored unknowingly in the containers could also happen. This would then represent an unnecessary financial cost for HLH.

5.10.10 What Programs Are Easier To Attract Funding To

A great example of an easy way to raise money is the maternity department... you can take beautiful pictures of happy mothers and babies and it is easy to ‘sell’ (Interview A3; Interview A9). HLH provides great amounts of outreach programs and reproductive health education. This aligns itself with the literature that argued that if mission hospitals provide preventive work it often does so in a much greater scale than governmental hospital (Reinikka and Svensson 2003: 23). However, for the future HLH would reduce its level of ‘outreach’ work (see Chapter 5.12.1).

5.10.11 Time Spent On Report Writing

In addition to HLH’s Annual Report, the hospital only needs to write one other report to RNE. The other donors do not request such documentation (Interview A9). This is contradictory to what the literature finds; where donor supported health projects often spend time and resources on writing reports to several donors (Baht *et al.* 2001:167-168). However, the respondent argued for difficulties and unnecessary time being spent on the RNE report, due to it being based on a project format, which does not fit with HLH’s business form (Interview A3; Interview FO1). Interestingly, one of the respondents noted that the mere lack of ability to write reports should be seen as HLH’s biggest problem. “HLH is a sinking ship they cannot make reports, except for the one RNE is asking for” (Interview A2). The interviewee expressed that the administration’s limited practice, as well as limited managerial background and qualification as reasons for the challenges of administrative work at HLH.

5.10.12 Quality of Care at HLH

“Nursing care” of which the human side of treating patients, following up of responsibilities was what eleven of the staff and three respondents from the administration noted as being the measurement of quality of care. Ten of respondents from the staff specifically noted that quality of care is better at HLH, than in any other governmental or mission hospital. However, with this statement the high level of equipment and availability of medicines at HLH, compared to other hospitals within Tanzania, was often included. It is my belief that all respondents in fact would agree that HLH is better on care than most other hospitals in Tanzania.

Nineteen respondents said quality was not perfect due to lack of staff, seven interviewees specifically noted the lack of specialists, while five respondents argued that lack of employee motivation was reducing the quality of care. The evaluation report of HLH from 1988 agreed that HLH provided quality of care but noted that “to keep the care level, a maximum rate of ...230 beds [is suggested]” (Sand *et al.* 1988: 34). This was suggested so to not overwork the staff. It is clear that HLH since 1988 has expanded its facilities and that the official number of beds has increased. However, with the lack of staff and often crowded number of patients, setting a lock on the total number of inpatients is a recommended step towards keeping the quality of care at a wanted level.

There was however a trend among the respondents agreeing that the quality of care today, was better than what it had been in the years 2005-2010 (Interview A3). Yet, the level was not as high as it had been before 2005 when Dr. Olsen died. Another prominent reason for quality of care not being rated as fully good was according to four of the respondent the lack of training and education of the staff. “If you do what you know to the highest level, it is high quality of care. You cannot do what you don't know, this is the problem here” (Interview S6). One respondent from the administration argued that increasing quality care was one of the main activities for the future (Interview A8).

5.10.13 HLH as a Development Agent

Historically, HLH has added several activities, often outside of the hospital, to increase its cash flow. Some of these activities have in fact added and continue to add extra income to HLH, while others have added to the economic burden of the hospital (Sand *et al.* 1988). I believe one of the challenges both historically and today is the administration's lack of knowledge of running for-profit activities in an efficient manner.

The farms are one of these income-generating activities. For many years the farms did not provide profits but instead ended up as a cost for HLH, while other years small profits have been generated. The last farm to be bought was the Mulbadaw farm. However, due to conflict between HLH, the local populations and the former administrative-team at Mulbadaw, I was discouraged from including any discussion of the farm into this thesis (Interview A9).

Moreover, during the pre-visit to HLH, it became apparent that the Medical Director did not know that he was part of the board at Mulbadaw. To me the lack of transparency, willingness to discuss the farm and lack of knowledge about responsibilities towards the farm, questions the actual processes behind the conflict and how it is handled by the management at HLH (see

Chapter 8). It is also my belief that not being proactive towards the conflict and going into dialogue with the local population could threaten the future sustainability of HLH.

HLH has also for many years produced all or parts of its own intravenous fluids, and it has employed its own sewers. There is also a vegetable garden and milk production at HLH. However, there is little or no mentioning of these activities within the Annual Reports from the 1970s, 1980s or 1990s, and thus the actual income that they are generating for whom are not known.

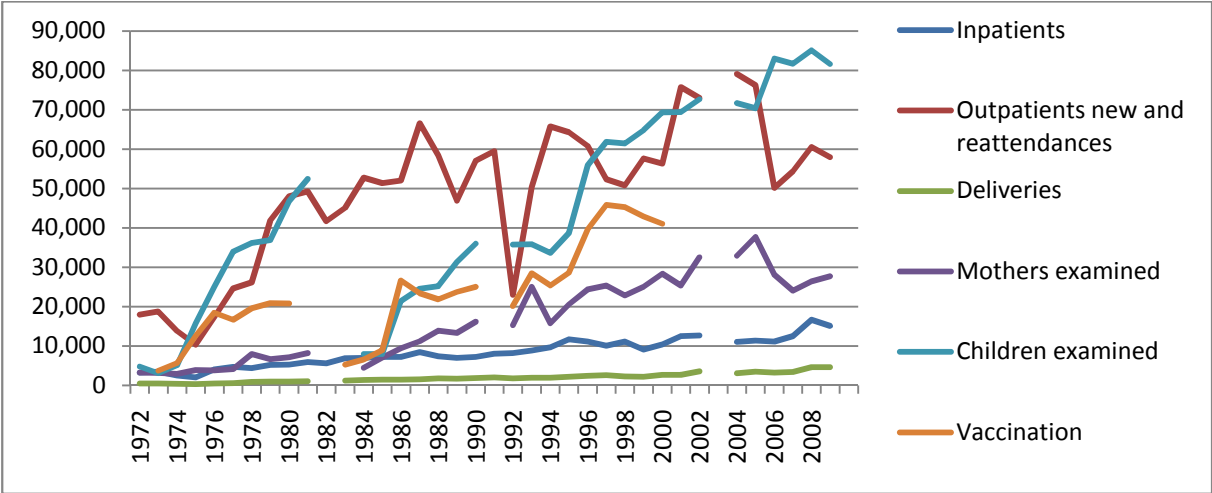
Tractors donated to HLH are rented out to the employees and the community. However, there are “[p]roblems with the amount [gained by HLH] as there are ‘special deals’ in between workers themselves. Workers are only paying for one hour of work by the tractor, but the work actually lasts eight to ten hours” (Interview A3). Trying to reduce some of these outflows of financial resources, the hospital had changed the Head of Division (HoD) of the garage as well as started planning a stricter internal control system (Interview A3; Interview A9). Yet, respondents argued for challenges in monitoring such intangible features as mileage and gas-use on the tractors and cars. Moreover, being able to trust and give the responsibility to monitor any internal processes to local employees where mentioned as difficult (Interview A3).

5.11 Summary of the Activity Level

There are trends within HLH’s activity level when looking at HLH’s past and present situation, which map out what can be expected for the future. However, I do question how to interpret any findings due to HLH’s lack of concrete objectives or benchmark numbers. The lack of such goals makes it difficult to evaluate the differences between the past and today. However, with the given information and empirical findings some synthesized points can be prepared.

The activity level at HLH has increased if the number of patients, vaccinations and operations are used as measures.

Figure 21: Total Work by HLH



(Source: Annual Reports 1973-2009)

However, whether this means that HLH is actually operating more efficiently is impossible to assess, due to limited financial as well as human resource numbers. It is clear that HLH today is catering to a much greater area than what it was historically and that this could be seen as one of the factors for the increased patient number. It should be noted that CMI (2009) found that efficiency has increased between 2007 and 2008. CMI (2009) used a Standard Output Unit (SOU) framework to measure the efficiency. However, it is argued that the findings must be interpreted with great care as human resource costs for all services provided at HLH were not available (Mæstad and Mwisongo 2009: 7, 50-51). For my own empirical work the use of the SOU was not possible as I did not have access to all the needed data; number of family planning consultations; HLH’s historical expenditure or full budgets; human resource numbers.

HLH is receiving patients from all over Tanzania. This contradicts the mission of HLH, which states that it is to cater to its community. However, HLH also has within its vision to not refuse anyone treatment, and clearly HLH is increasing the health care for Tanzania as a whole, and the hospital is thus fulfilling its mission.

However, a clear notion of what is the mission of HLH and to whom and for whom do they want to provide services for should be clarified. Questions should, moreover, be asked whether the efficiency of the operations at HLH is monitored well enough. Could there be possibilities for treating more patients, or is HLH operating at its maximum? Related to this is the finding that HLH is not providing as high quality care as it used to. Clearer steps towards

understanding the underlying reasons for this should be explored (see also the Chapter on organizational capacity).

It was mentioned that with the upgrading to referral hospital, HLH would reduce the number of inpatients, and treating a greater number of patients as outpatients. Only patients with a referral would be accepted as inpatients. However, these changes are not implementable during the next few years and it furthermore demands a better outpatient system at HLH.

There has never been surveyed for what services the community wants from HLH. Instead, both historically and currently the fact that number of patients is rising is used as a validation for HLH providing the correct service-package. Among the staff and administration reproductive health and maternity were seen as the most important service for HLH to provide for its community. For the community malaria, maternity and TB treatment were seen as imperative, together with alcohol treatment. Visiting community members in their home and seeing that the average family had seven children, it seems imperative to increase the level of reproductive education in the community to ensure a sound development. Moreover, basic health education and prevention methods could be emphasized.

It has historically and currently been argued for a more efficient use of the beds at HLH. Long stays were occurring due to patients' lack of ability to pay their treatment. There is a cost-benefit analysis that has to be taken when patients are being kept at the hospitals for several months due to lack of ability to pay. However, several of these cases were not looked into, as there was nobody who took responsibility and addressed the issue towards the administration. With these two points in mind I would argue that despite the emphasis on these challenges already in 1988 (Sand *et al.* 1988), not much has changed. Inflexibility and lack of responsibility are seen as the biggest reasons for this.

Since HLH's inauguration and up until today HLH has been known for being one of the best-equipped hospitals in Tanzania. Historically, this equipment has been donated to the hospital from abroad. Today, some of this equipment are so advanced that there is no Tanzanians with the expertise to maintain it. Questions were thus asked of the cost of adhering to such equipment. Expatriates working at HLH noted that focus should be put on training that allows for as high quality care as possible, with as little technical help as possible (Interview S1 and Interview S9). This was argued to be a necessity as long as the maintenance and lack of care towards equipment were shown by many employees at HLH. For smaller technical apparatuses the control over where each such technical item is stored, if any parts of it are

missing or if any parts are malfunctioning were argued to be a problem. There appeared to be little control as to who had responsibility for ensuring that all apparatus were functioning and in order.

Historically and currently containers with donations have been arriving to HLH. Little control over what these containers store, or if the articles actually could be of use for HLH can be presented. The managerial capacity and delegation of responsibility have not and continue to not be present.

The lack of funding for maintenance is found to be a challenge for HLH today. Historically, it might also have been a problem, however, “focus was on building new” (Interview A3) instead of maintaining old facilities. For the future focus should be placed on the maintenance of both buildings and equipment. This could increase the value of HLH and its ability to provide quality care.

5.12 Organizational Capacity

It is a clear understanding within the literature that direct and clear plans for future activities and capacity needed to perform these tasks, are the backbone of an organization’s sustainability. There might be a want by the organization’s leaders to continue its operations or for them to wish the organization’s sustainability was a fact, yet, if this is not planned out and encouraged throughout initiation, implementation and operation, sustainability will not occur (Shediak-Rizkallah and Bone 1998). Moreover, as organizational capacity should be used as a means for administration and donors to evaluate the organization’s performance, not having clear assessable goals and objectives reduces the ability of any evaluation to take place. This again, reduces the ability of the organization to realize whether it is actually operating sustainably or not (Sarriot *et al.* 2004, LaFond *et al.* 2002 and Olsen 1998).

5.12.1 Long-term Planning of Future Activities

Not often, while interviewing staff and administration at HLH was the notion of concrete future plans mentioned. However, the *Strategic Plan 2015* was cited as the strategy by some respondents. Furthermore, direct process of how to reach any future goals did not seem to be clear either. There was however one employee that said: “I cannot remember how many plans we made, but it was many” (Interview S5). Moreover, with the lack of surveying for the need within the community and instead adhere to trends seen from patients arriving to HLH, future planning becomes difficult.

Despite the urgency of the matter, one respondent noted that little is done as “there are carved out paths within the administration, and nobody wants to change” (Interview A2). I was however told by others that the fact that the new administration had only been employed for four months meant that it was too early for them to do any great changes or provide any clear objectives for the future at this point (Interview A9). At the most, the inputs given for what the future activities were to constitute was inconsistently articulated by the different respondents.

Firstly, a need to consistently follow governmental policies is mentioned by two respondents (Interview A9; Interview A5). As HLH has operated more than 45 years within the governmental health system, I would believe that this theoretically should not be a *new* plan. However, to do this, another respondent noted that HLH was in need of another reorganization (Interview A5).

Secondly, making HLH into a niche hospital for services that are not so popular with other hospitals, for example treatment for physically and mentally handicapped people (Interview A9). The fundraising report argued that the Amani ward should be used as a niche (Deloitte 2010: 12). Connecting the empirical findings from the community with already held expertise within HLH, would mean that focusing on the alcohol unit seems more realistic than initiating the former suggestion.

Thirdly, HLH should move away from adhering to greater development efforts and focus primarily on health issues (Interview A9). Both the fundraising paper by Deloitte and other respondent from the administration argued similarly (Interview A2; Interview A3). This point goes against the mission of HLH, and moreover contradicts the stated needs of the community according to my interviews. I do however find this to be a possible way for HLH to operate more efficiently. Strategically it would moreover be easier for HLH to promote itself as a hospital than a development agent towards new and current donors. The task of managing a hospital is moreover more manageable than operating a full development agenda. The move away from greater development efforts would further signify a ‘forced’ reduction of the dependency of the community on HLH.

Fourthly, starting health-education program at The Centre for Educational Development in Health (CEDH) in Arusha, Tanzania (Interview A9). To me it seems difficult to find enough teachers to do this work. Moreover, it would spread HLH’s operations more, contradicting the idea of niche hospital and focusing on health implies. Yet, with Norwegian aid policy

focusing on capacity building and greater sustainability efforts, there could be a possibility to attract donations for such programs.

Fifthly, upgrading and educating other hospitals' health personnel so that they can take over parts of HLH's outreach activity. "[For them] to run already started outreach stations but also start new ones. Today, [HLH] is possibly too spread out, and we've taken on too much" (Interview A9). Based on both the lack of human and financial resources within HLH, this seems like a positive step for future sustainability creation. Moreover, it would mean that the overall health services in Tanzania would increase, while the work of HLH could be reduced and better reflect the hospital's contextual and activity level.

5.12.2 Future Funding

Talking about HLH's history one of the respondents noted that "There was no planning, we lived from day to day based on the notion that *God will provide*" (Interview A0). Conversely, all interviewees from the administration as well as 43,3 percent of the staff mentioned, in one way or another, the importance of HLH securing future funding. Not only was this seen as important for the self-sufficiency of the hospital but many noted the relationship of future financial resourced, and the ability of HLH to attract medical staff that can provide quality care. This clearly shows the connections between the three different factors within the open system model. Yet, as with the long-term planning of future activities how to secure these financial resources seemed vaguely mapped out. I am unsure whether the lack of planning is due to the lack of secured future funding, or if the lack of clear future income has reduced the ability to plan for the hospitals' future activities.

5.12.3 Little Concrete Plans

"Before long-term planning was not necessary. But today you have to structure better and make sure that good processes are in place. It is more complicated today than before" (Interview A3). Despite this comment few goals and objectives were presented. The concrete examples of how new funding could be attracted were:

"We have a five-year strategic plan, which spells out the plan for how HLH can become self-sufficient by 2015" (Interview A5; Interview A3; Interview A6). Yet several respondents noted that the 'nice words' within this report was non-reachable for HLH (Interview A3; Interview FO1). It was argued that the lack of managerial capacity within HLH, the lack of planning and the challenge of operating a rural hospital in a poor area of Africa underscored the limited possibility of HLH reaching the goals of the strategic plan. From a managerial

point of view, having a strategic plan that the administration does not believe in reduces the effect and any success of such a scheme.

“We’re looking at starting an insurance scheme that will pay for patients that are not employed [at HLH]. Bwindi Hospital in Uganda has started with this quite successfully. The premium is greater in the beginning before getting smaller and smaller. This is meant to make patients used to using insurance.” (Interview A9). Arguably, it would mean a step towards greater financial security, though several respondents noted wariness about villagers’ willingness to pay into such a scheme.

There are plans of reorganizing HLH into a Foundation to attract more external donations from individuals and institutions that might be reluctant to support mission hospitals (Interview A3; Interview A0). It was however made clear that a change to a foundation would merely be a change in contract status and that HLH was to continue to be owned and operated by ELCT. It was pointed out by some of the Xstrata employees that supporting a church hospital could be difficult to justify. There is little reason to believe that this is not the case for other donors too, thus moving towards a Foundation could be imperative for future donations from private individuals and companies. The Deloitte report also mentions the wish of transforming HLH into a foundation (p. 10), however, its argument is that this will help HLH attract more funding from national government. The church was, conversely, seen as negative to the idea, and it was moreover noted that the proposal of making HLH into a foundation had initiated conflict between the former Medical Director and the Church (Interview A3). This reduces my belief that such a change will be initiated in the near future.

Better internal control of income generating activities (Interview A3; Interview A8; Interview A9). “The point is that it is difficult to track and trace supplies at HLH – you never know what has been used or not. We want to start internal audit to strengthen check and balances” (Interview A3). Moreover, several times during my stay it was argued that employees and administrative members’ use of HLH’s cars and equipment, with little control of the cost of this for the hospital.

Introducing an *Adopt a patient* scheme (Interview A9). Private and commercial donors would get the chance to pay for the treatment of a patient. My concern would be the fact that such a program bases itself on the belief by the donors that the patient can and will be treated and become well again. This puts clear demands on HLH to ensure that the patients survive their illnesses or operations. With stories of neglect and lack of responsibility, the fear is that HLH

does not have the correct system in place to successfully implement such a scheme, without losing ‘good will’. However, these concerns can easily be turned around with HLH ensuring that patients introduced into this program are provided with the best treatment possible and by increasing quality of care at HLH in general.

5.12.4 HLH Dependent on Expatriates

The administration at HLH is a mix of expatriates and local staff. The need for expats within the administration was found by respondents to be of great importance for the running of the hospital (Interview A2; Interview A3; Interview A4). The dependence was related to competence, and “expats sitting closer to the funding sources” (Interview A2). This reflects the findings in the literature, where expatriates are seen as an important part of the administration due to its close ties to both mother church and the expatriates’ national government (Flessa 1998).

Yet according to another respondent within the administration whether the leadership position is Tanzanian or expatriates “plays a lesser role—what is important is that there is trust and cooperation between the different employees. If a Tanzanian is the leader and cooperation and trust would be there it would not be much different” (Interview A4). With the noted possibility and presence of conflict both in the local community and between staff, presented later in this paper, and with lack of trust and transparency it is my assessment that a change to a local leader would reduce the quality of HLH operations and moreover divide the hospital and the community. To reduce the possibility of conflict employing a Tanzanian from another part of the country was given as an option (Interview A8; Interview A9). Yet, the direct link between HLH and the Norwegian missionary community would be reduced and could possibly reduce level of income, as well as expatriate doctors arriving to HLH.

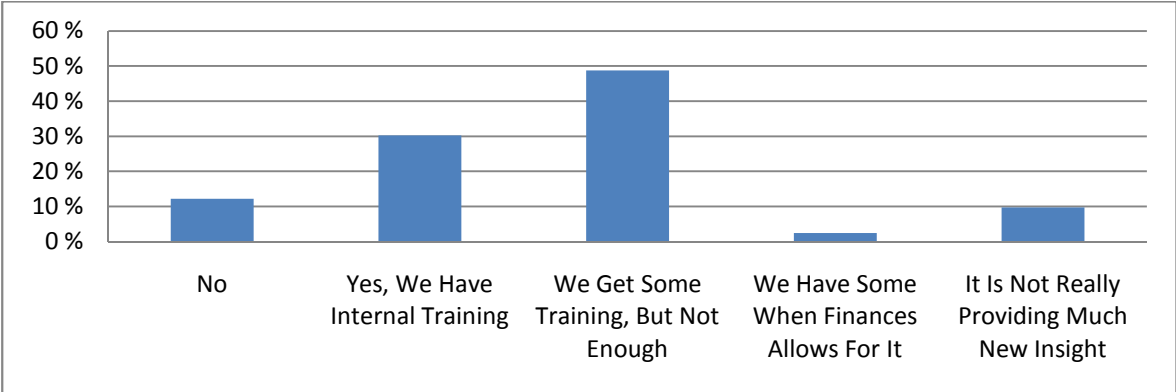
According to several respondents the use of expats within the administration 56 years after the inauguration of HLH was not the initial plan (Interview A9). Yet, to me it appears that for the former directors at HLH creating local leadership was never really encouraged, since they so actively kept control of all operations of HLH. This has been done with good intentions and authentic motivation to help the population of Haydom. Yet, in practical terms there is in many circumstances a divide between the locals and the expatriates. Several respondents argued for the need of an expatriate director at HLH for up to five more decades if HLH was to continue providing care and services as it does today (Interview A3, Interview A5 and Interview FO1). There were interviewees within the staff, however, that expressed their want

to lead HLH in the future. If these respondents actually will in the future be able to follow up those wishes is unclear.

5.12.5 Creation of Internal Capacity

According to several respondents within the administration, HLH is providing continuous education every Thursday to its employees. “We also send staff to seminars and courses within Tanzania” (Interview A4). The employees were however less satisfied with the provision of internal training.

Figure 22: Is Internal Training Provided at HLH?



(Source: Fieldwork n= 41)

The outcome [of the continuous education] is questionable. The topics chosen are often ‘old news’ like malaria. But we know about malaria treatment. The speech should be short and clear—much like what the RCH is doing. The RCH is very good on education (Interview S4).

An expatriate also argued for the lack of formal classes: “[I] feel that there is minimal of internal education inside of the hospital. HLH could use more time on training its nurses and doctors” (Interview S1).

For the question: “If you were in charge of the hospital what services or process would you prioritize?”, the most common reply from the staff was training and education of staff. The lack of further education made respondent not local to the Haydom area, argue that they did not see themselves at HLH in the future since there was little possibility of being promoted with the lack of further education. This was also related to the tribal conflicts within HLH (see Chapter 5.12.13).

5.12.6 Reorganization of HLH

Historically the organizational structure of HLH has been highly centralized, with Dr. Olsen keeping control of most activities both outside and inside of HLH. Many respondents argued that this is what has kept and made HLH successful. Yet, the literature argued that a too centralized structure undermines sustainability building (Bossert 1990). In 2007, a re-organization was initiated, and a new divisional structure was introduced at HLH. Each division would be led by a Head of Division (HoD) that generally would be the only employee reporting to the Medical Director. The pressure on the Medical Director would accordingly be reduced (Wahlstedt 2004). Yet during interviews, respondents argued the need of another re-organization. Several other respondents moreover argued the difficulties and less success of the organizational scheme in place now, due to the rapid and little-transparent implementation process (Interview FO1; Interview A3).

5.12.7 Outline of Work Description

To ensure sustainability of the organizational capacity clear leadership and a concrete strategy have to be present. I've noted within Chapter 8 that there is no human-resource database at HLH. HLH is however in the process of writing up one, but it "has taken longer and is more difficult than expected" (Interview A3). For a leader to manage and direct an organization, a minimum requirement is the knowledge of how many employees and what their actual tasks are within the institution. Only with this information available can the management take decisions, which are based on a sustainable strategy. Though HLH primarily is a hospital, it was argued by several respondents that up to two-thirds of the workforce is employed in the garage.

5.12.8 The Motivation of Staff

The literature argues for mission hospitals' often highly motivated staff. Motivation and dedication are pillars to create sustainable organizations from. Conversely 13 of the respondents from the staff noted that the motivation of staff was not good enough at HLH. Six of the 13 respondents linked this to the lack of staff. "Motivation is just 50/50 as people are working too much" (Interview S7). In my observation, during my short period at the hospital, as much as HLH is lacking staff, the time management and work ethics of employees could be improved. Similar views were noted by expat volunteers that argued that some employees were merely physically present (Interview S1). However, local staff argued contradictory: "Lack of staff is reducing motivation. Those few who are working are working very hard. The hospital is not following governmental guidelines about how many

nurses/patients” (Interview S5). I’ve unfortunately not been able to find out if HLH in fact is breaking governmental guidelines in relation to nurses/patients.

5.12.9 Motivation by Christian Belief

Contrary to what the literature review noted only 4 of the respondents said that they were motivated by their Christian belief. This point was further echoed by one of the staff from the administration: “Before staff was motivated by the Christian faith, but not today. Before doctors would do work here out of willingness and kindness, today it is more professionalism and about profits” (Interview A4). With governmental institutions having more funds today than before and thus being able to pay staff salaries, workers like to work there instead of in rural hospitals. Furthermore the terminal and pension funds are not paid by [HLH], but they are so at governmental institutions (Interview A8). All these factors are, according to the interviewee, pulling workers away from HLH and into cities and governmental hospitals.

The CMI (2009) estimated that “[for] a person with 30 years of service and a salary of 400,000 upon retirement, the difference amounts to 12 mill Tsh. [between the pension being paid at HLH and that paid to employees in governmental hospitals]” (Mæstad and Mwisongo 2009: ix). The challenges of having different pension schemes in governmental and nonprofit institutions have according to my findings been presented to the national government (Olsen and Daudi 2010: 20). The issue of pension schemes shows the change in challenges for HLH. Before it could attract dedicated and motivated staff by promoting its Christian vision, today monetary gains is what attracts workers. It is clear that pension funds serve as workers retirement fund and are imperative for both motivation and moral for employees. Having said this, it is clear that HLH has struggled with attracting enough manpower due to its rural situation since the inauguration.

5.12.10 Efficiency and Quality of Care

There were further interviewees arguing that staff neglected and did not follow-up their responsibilities towards patients. It was noted instances where nurses left the care of the patients to their families. Moreover, expatriate doctors argued for little control over how, when and if medication was given to patients, as staff seldom signed off on the medical papers (Interview A9; Interview S1). It was moreover noted that operations were purposively delayed so that the employees could work ‘over-time’ (Interview S1; Interview A9), and there had been instances of patients being slapped during surgery (Interview S1). In 2009 CMI questioned the efficiency of the theater at HLH: “[o]ne of the issues that has been brought up

repeatedly at the division meetings is how to reduce delays in the execution of operations” (Mæstad and Mwisongo: 2009: 7). The administration argued for little control over what was done in the theater, but that great over-time payments were being paid to this division (Interview A4; Interview A9). This shows that some employees have little respect and limited moral towards HLH.

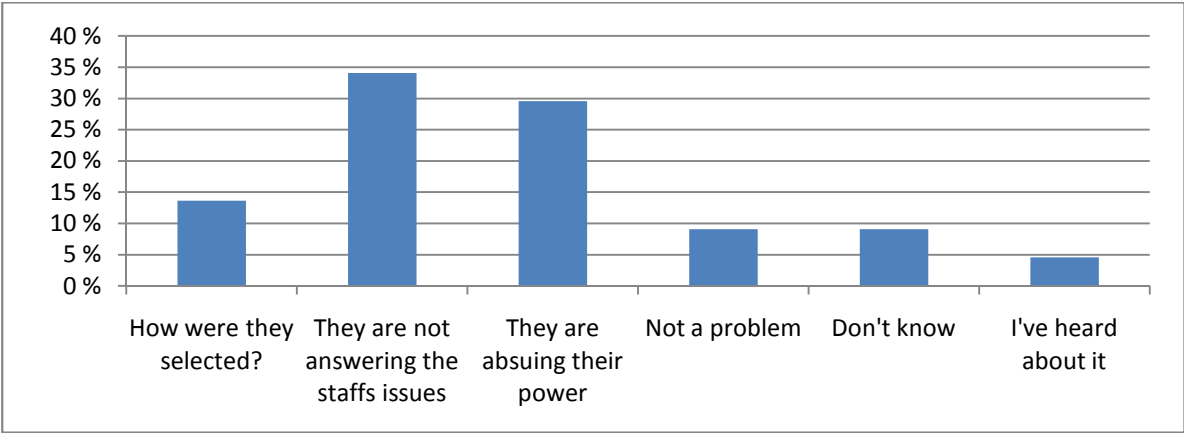
The administration introduced a three-shift schedule at the theater during my five week stay at HLH. This resulted in doctors illegally taking out sick leave, boycotting this new system. The workers were not willing to change their working pattern, as well as seeing their wages reduced. This could have several underlying reasons, though I was not able to explore them fully. To me the question is rather how long this lack of responsibility has been going on, how many patients have been suffering because of this, how much over-time pay has been given to these ‘go-slow’ doctors, resulting in other parts of HLH not receiving much needed resources. Moreover, where is the managerial system, which should have revealed this unethical working pattern?

5.12.11 Lack of Communication

Another concern for the employees at HLH was the miscommunication or lack of communication between staff and administration. “People are not happy about the way they are treated and they complain a lot about the administration. This dissatisfaction will be a big problem in the future. There needs to be better communication between staff and administration” (Interview S7). Four respondents would prioritize the communication if they were in charge of the hospital. This point does however seem to be interrelated with the employees’ wish of returning to the era of Dr. Olsen. With the expansion of HLH and the sheer number of employees it is unreasonable to believe that each employee can communicate directly with the Medical Director, as was the case when Dr. Olsen was in charge. Yet, there needs to be a system in place where each employee feels valued and can freely express his or her concern to the HoD with the assurance that this concern will be forwarded to the board or Medical Director. Today this is not the case.

5.12.12 Head of Divisions

Figure 23: What Are the Challenges With the Head of Division?



(Source: Fieldwork n= 44)

“The HoD has too much power and cannot control it. They even fired two staff members. This was before the new director” (Interview S5). This allegation was denied by the administration. Six interviewees from the staff further questioned the way in which the HoD had been selected. “There is no knowledge of how long they will they stay in the position. There is no evaluation, nobody knows” (Interview S4). Several respondents from the administration noted that “Head of Division is a post which you apply for” (Interview A4). While one argued that “This was a system that the former Medical Director introduced and he chose some of the people he believed he could trust” (Interview A9). The last respondent’s comment underscores the employees concern of transparency. It was said that there might be a change in this system in the near future (Interview A9).

5.12.13 Conflict Between Different Tribes

Nine of the respondent from the staff noted that the organization had an issue with conflicts between different tribes. It was moreover argued for ‘mafia like’ situations at HLH, where iraqwes would only employ family (Interview A2). It was also made a link between tribal connections and the high number of workers within the garage. In the community there was a reoccurring articulation that iraqwes were getting better and faster hospital care than others; staff disagreed with this. “There is a lot of corruption [at HLH] with priority being given to own tribe” (Interview CM7). It was several times during interviews noted that the tribal conflict inside of HLH merely was a reflection of the conflict in Haydom Village (Interview A4; Interview A3; Interview A9). The community argued similarly: “HLH has only made life

better for its employees [iraqw] and society has been split between those inside and outside of HLH” (Interview CM5).

5.13 Summary of the Organizational Capacity

The noted ambiguous future planning and its diversity possibly reflect the different viewpoints of the individuals within the administration. It could moreover be that the administration’s wariness of sharing information with me, gave room for them to provide me with inconsistent ideas. It is further clear that a five week stay is limited time to fully explore and get an understanding for HLH’s future planning. However, a main contributing factor to organizational capacity is the institutions ability to set up plans, mid-term goals and expected outcomes that can guide the process of creating sustainability. There is moreover no reason for this not to be publicly available. Arguably, making core goals public provides a stronger incentive for the organization to reach those goals. Strategic plans furthermore provide employees with the notion of where the hospital is going and allows for their input to help the organization reach its goals. It was at no time during my interviewees or my second-hand research of the Annual Reports presented clear goals or clear future plans. It has also been argued that lack of managerial capacity within the administration reduces its ability to create clear and reasonable future plans. Upgrading of personnel and a more professional administration should therefore be sought after, as the current situation does not enable me to see the administration creating sustainable capacity to the organization.

It should be worked towards lesser dependency on expatriates both in administration and in staff, something that the upgrading and further education could help with. Yet to secure the future sustainability of HLH the removal of expatriates from HLH seems improbable within the next decades. After 56 years of operations this enables me to question the organizational sustainability of HLH, and why such measures have not been planned for earlier. In my assessment one of the reasons is the connection between the expatriates and Norway and the fear that this connection would be reduced with the reduction in expats at HLH.

Upgrading and increasing staff’s knowledge level have further been found to be a way to increase motivation and dedication to HLH by its employees. To ensure that HLH has staff available for its future operations, measure such as these will have to be taken. Currently, the sustainability of the human resources seems unsecured and conflicts are closer to divide the hospital than what was the case under Dr. Olsen.

There is a notion of division between different tribes both with HLH and in the community. The use of transparent systems for hiring of workers, promotion and a system to ensure that at no point in time is different care provided to different ethnic groups. Both for the sustainability of HLH, and for the upholding of a relationship between the hospital and the community.

Chapter 6 – Empirical Findings and Analysis – Xstrata Plc

6.1 What is Xstrata looking for from its CSR projects?

As noted in Chapter 3, CSR is seen as an integrated part of Xstrata's operations. "[CSR] is of vital importance for Xstrata. It is not something we do in addition to mining and refining—it is how [the owners] want their managers to run their assets" (Interview XP1). This stand was also emphasized several times during the pre-trip to Kabanga in October-November 2010. Embracing CSR is furthermore argued to be a way for Xstrata to "create new opportunities for business—a competitive advantage" (Interview XP1) and to "generate social development in our areas of operation" (Interview XP2). Arguably, this shows a middle-way adherence to CSR. The business opportunity is seen as important, while the actual positive social impact on the society is also considered.

When asked what CSR activities are found to be of special importance in Kabanga it was noted that "[f]ocus is directed at strengthening the health care system in the area. The area lacks key health facilities; Community has poor knowledge on health issues" (Interview XP2). It should be noted that these comments were made before a baseline study was performed. Yet, respondents clarified that the needs had been found by close collaboration with local governments, the local population and NGOs operating in the area. The literature argues that in the long run such two-way communication can increase the goodwill and success of the mining companies not only locally but also internationally (Bendell 2000 and Vos 2003).

6.2 Why was HLH Chosen?

Xstrata's CSR policy demands that CSR resources shall "fund initiatives that benefit the *communities associated with our operations*, particularly those located in remote areas or in regions with a lower level of social and economic development and infrastructure" (Xstrata Plc 2008 emphasis added by author). Yet, HLH is at least 2.5 hours by plane from Kabanga, and at least 13 hours by plane from Kristiansand. This makes me question the actual reasoning behind supporting HLH by Xstrata Nikkelverket. Arguably, Nikkelverket has divided its CSR resources between HLH and UiA. Thirty percent of the resources are given as support to the Development faculty at the University of Agder in Kristiansand.

It was interesting [for Xstrata] with local ownership in FoH, and [HLH] located in Tanzania, and [Tanzania being an] important development partner for Norway, and a current and future country for Xstrata investments (Interview XP1).

However, it is my assessment that Xstrata chose HLH as a CSR project mainly due to personal contacts between Xstrata Nikkelverket in Kristiansand and individuals related to HLH and FoH. FoH has members on the board of HLH. It is noted in the analysis of HLH how the hospital has strong ties to the southern part of Norway, and there is little reason to not assume that personal motivations from individuals connected to both Nikkelverket and HLH have played important roles in the decision of using HLH as a CSR project. Having said this, it should also be noted that Nikkelverket has been given clearance by the headquarters in Canada to support HLH.

6.2.1 What is the Match between HLH and Xstrata?

Many of HLH's operations do in fact fit with Xstrata's requirements for its CSR programs. "The [CSR] investment should...be invested in areas such as education, health, sports, and community development and job creation (Xstrata Plc 2009: 101). HLH is today adhering to most of these criteria (Interview A7; Interview A9; Interview S4). "HLH has qualities that stand out. This is obvious when you look around the remote and rural part of Tanzania that it is providing health services to. This area is very equivalent to...the potential new site in Kabanga" (Interview XP1). Moreover, it was argued that Xstrata's vision of "health and safety above all, honesty and integrity, responsibility, entrepreneurship, passion, courage and involvement" (Interview XP1), showed direct links to the work and organization of HLH. I do agree that most of these traits are found at HLH. There needs however to be asked questions about the transparency of HLH and whether it aligns itself with the mission of Xstrata. Another question is if HLH lack of direct planning adheres to Xstrata's CSR framework: "CSR activities are planned to be sustainable and long-term" (Interview XP2).

From the CSR theory Xstrata does, to a great degree, follow the literature's findings that educational and health CSR projects often are favored in Africa (Visser 2006; Jamali 2007; Hopkins 2007). It seems to be little uncertainty that HLH falls under such a definition. Especially as Xstrata's impact on social and economic life in Haydom, has no direct link to the economic and social possibilities for the population at Kabanga or for the operations of the mining site.

However, for Xstrata the goal of the three-year contract with HLH is twofold. Xstrata wants "[1] to sustainably assist in the development of a rural area with regards to health and environment; [2] build and transfer knowledge between the partners of Kabanga, Haydom and UiA, and possible other sites and interested parties" (Interview XP1). The first point is a

rather common CSR notion and fits clearly in within the philanthropic CSR diagram. Moreover, by the respondent not including ‘*local rural area*’, Xstrata is fulfilling its first point, as their donations to HLH most likely will provide social development at Haydom. The fact that HLH is supported, instead of only supporting local projects in Kabanga, is defended by Xstrata by arguing that Kabanga is still in an early explorative stage and currently not an operating mine. Moreover, there is a fear of creating expectations within the local community that cannot be fulfilled, if the exploration does not actually start. Arguably, this is highly linked to companies focus on creating ‘good will’ and reputation both within the local community but also within Tanzania at large. Yet, smaller CSR projects have been started (see Chapter 2). Respondents from HLH noted, in regards to the already initiated projects in Kabanga: “They are good because they are helping the society becoming sustainable. And it will help encourage collaboration between the mine and people. But they should focus more on providing water and health” (Interview A6).

By supporting and wanting to learn from HLH’s more than 50 years of experience, Xstrata is possibly adhering to its second point. Arguably for the best knowledge transfer, HLH should be open and share its successes as well as challenges and failures. Only with such transparency can the institution’s values and best practices be explored. As argued in Chapter 7 one of the findings from the fieldwork was the resistance by administration to discuss some of HLH challenges. In light of this, it seems odd for Xstrata to fully rely on HLH as their only template to successfully create well functioning CSR projects within Africa.

Several authors have discouraged companies from adhering to add-on philanthropic activities, due to their lack of sustainability and little long-term effect for the local communities (Hamann 2003; Whellams 2007). A three year CSR investment period is short, but argued to be a normal investment period for Xstrata early in the investment time-frame (Interview XP1). The respondent moreover said that: “[HLH] is one of the more long term projects we would be involved in, and hope to extend this initiative towards Kabanga if this site gets started” (Interview XP1). In its current state HLH could be defined limited sustainable (see Chapter 6). The financial input from Xstrata is thus undoubtedly valuable to HLH. HLH could in fact be helped towards short-term financial sustainability with Xstrata’s resources. Yet, any long-term sustainability is also dependent on other factors such as availability of human resources, managerial capacity and HLH’s actual activities.

Aligning itself with the literature, I would thus argue that there is a possibility of Xstrata adhering to *strategic philanthropy CSR* when working with HLH. Strategic philanthropy are planned to yield long-term benefits for the business, by exploiting the company's competencies, and simultaneously provide increased social welfare for the stakeholders (Jamali 2007). Xstrata could use their knowledge of management, human-resource systems, lobbying and public relations, and could train administrators and increase this knowledge at HLH. This, I would argue, could greatly improve the ability of HLH to become sustainable and possibly increase its impact on its catchment area.

One Xstrata employee further noted the belief that the company's operations at Kabanga would positively increase infrastructure locally and regionally (Interview XP1). Xstrata has experience and knowledge of building infrastructure; I would therefore argue that this is another area that could be used as a strategic philanthropic CSR scheme within the catchment area of Haydom. With better infrastructure more people could be helped as ambulances, private and public transport could reach HLH faster. Also accessibility to outreach clinics would be increased. It would moreover enable better economic possibilities within the area, with better access to markets for the population.

According to respondents the CSR donations to HLH are used on "competency and health support" (Interview XP1). The competency is meant to support the capacity building of the employees at HLH. Depending on what this increased funding is used for, any increased training of staff aligns itself with the empirical findings from HLH. Better quality internal education was one of the most sought after activities by the employees at the hospital.

It is argued by one respondent from Xstrata that most of HLH's health related activities can in principle be transferred and are indeed needed within the Kabanga area (Interview XP2). Yet, the activity most attractive is "[t]he health outreach program...bearing in mind that the area has challenges on health infrastructure. For most of the people accessibility to health services is a problem" (Interview XP2). Respondent from HLH argued similarly and promoted smaller health clinics as a way to improve life for people in Kabanga (Interview A6). The majority of staff at HLH further praised the work of the RCHS department. The method of "short and clear health education" as well as vaccinations and other health related activities (Interview S2), and the ability of reaching out to a great number of people made RCHS the noted flagship activity of HLH. Arguably, increasing such health personnel knowledge was one of the mentioned future plans for HLH (Interview A9).

Questions were however raised by one Xstrata employee about Kabanga providing outreach work out of churches, which is how HLH often is doing these activities (Xstrata XP2). I've also been skeptic to this, but finding that patients coming to HLH's outreach centers are actually bypassing governmental clinics to reach HLH's outreach, makes me less afraid that this system is reducing the ability of HLH to provide care to *everyone*. Another Xstrata employee argued that:

Xstrata do not support any religious activity as we are neutral on this subject. However, we also know that the most effective institutions often have a religious background and philosophy. Therefore it is important to state that we could support any religious hospital, given that they have the same inclusive values as HLH (Interview XP1).

Xstrata also placed importance on adhering to another implementation model, for any ongoing or future activities in Kabanga, than what HLH has used. "In most cases Haydom initiates programs i.e. own the program and depends on external donors to run the programs while [Xstrata] is just supporting existing community initiatives which have been identified and prioritized by [the locals] themselves" (Interview XP2). According to the literature this will improve the chances of the projects becoming self-sustainable (Shediac-Rizkallah and Bone 1998). Arguably, even employees from HLH were in favor of the local ownership model used by Xstrata. "It is a good approach [Xstrata] has chosen when asking the community what they want and need [of development]" (Interview A6). Initiating child and mother education and health care, much like the RCHC is however argued as a primary starting point by respondents from HLH's administration (Interview A3; Interview A6; Interview A4; Interview A9).

The empirical findings from HLH's local community, moreover, argued for the need of both education and employment for a sound development of the community (Interview CM2; Interview A7). The lack of these two factors was argued to be the reason for the issues of alcoholism and crime in the village. It should be noted that this argument could be related to the presence of HLH, which makes community members less likely to ask for health interventions. The literature review further argued that as much as mining sites creates employment, it also often increases the issues of alcoholism and infection diseases due to influx of workers and others (Hamann 2003; McMahon and Remy 2001). Curbing such

spread of diseases by education and ensure employment not only for the workers but also for immigrants to the area should thus be areas of interest for Xstrata.

6.2.2 Best Practices

There seems to be consensus in the responses from both Xstrata and HLH that outreach work are needed programs to be promoted in Kabanga. There are however several lessons that Xstrata can learn from HLH when it comes to implementation of such projects.

Engagement with local community during implementation and encouraging small payments could enable a more likely sustainability of such projects, and would align itself with the local ownership implementation model that Xstrata already are promoting. Following and collaborating with national government is another step towards long-term sustainability of any outreach project.

It was argued several times that HLH had grown too big and that the administration did not have the managerial capacities to run the hospital efficiently. I did note that Xstrata would have a chance to participate in *strategic philanthropic CSR* by donating time and resources to managerial training of administration at HLH, yet focus has been put on philanthropic add-on CSR programs. In relation to Kabanga managerial training will also be important, however, making sure that the projects do not grow too big for locals to handle should be another factor that are scrutinized (Bergh 1995).

When talking about efficiency another lesson from HLH is the importance of making clear goals and benchmarks that are quantifiable. This is imperative to enable monitoring and evaluation of any health interventions' actual impact. Moreover with the catchment area already clearly defined by Xstrata such numbers should not be difficult to set. Arguably, such a system would also make individuals in charge responsible for explaining if any such goals are not met.

The literature review noted that mining companies could face conflict within communities by only providing CSR project to formal structure and not to informal structures such as squatter camps. Similarly, HLH's employees and the Haydom community argued for an increased division of the community between the iraqwes and other groups. Both employees and community noted that this caused decreased quality of care at HLH, decreased motivation of employees, increased corruption, it could be a factor for reduced community-HLH relationship in the future, and reduced HLH's sustainability building. These are important

issues of which both Xstrata and HLH have to respond to. Within any new institutions clear human-resource structures, comprehensible responsibility charts and transparent and democratic election process should be present, arguably similar to what any other Xstrata unit would adhere to.

Chapter 7 - Concluding Remarks and Recommendations

Tanzania, as a least-developed country, is highly dependent on aid and nonprofit organizations to provide health services for its citizens. The country has thus included missionary hospitals into its national health system, to reap the benefits of such institutions. Haydom Lutheran Hospital is an example. Since its inauguration in 1955 it has catered to the rural population of Tanzania, and from 1967 it has done so as part of the national health system. However, HLH has remained strongly connected to Norway at all times. Equipment, medical doctors, financial resources and future planning of the hospital have often come from and been performed overseas (Sand *et al.* 1988 and Olsen and Daudi 2010). The activities of HLH, which include many greater development efforts, have quite clearly made the local community fairly developed compared to other similar areas in Tanzania.

The overall question that this thesis set out to answer was whether HLH can be judged sustainable overall based on the operational definition provided in Chapter 3:

A health organization that has managed to adapt to its contextual environment by creating a strong, institutionalized organizational structure that supports the provision of high-quality, community-demanded services today without reducing the availability of it for future generations.

The contextual factors are the greater environment that an institution operates in. The literature argued that health institutions need to consider and align themselves with the greater environment, but not depend on it to create sustainability. The empirical findings, however, show that HLH, despite written intentions of the opposite, at least appears to have come to see RNE as a continuous donor that it could build sustainability by. Both literature and empirical findings noted that health organizations in developing countries cannot be expected to reach financial self-sufficiency, but this does not mean that dependency on one other factor should over time be increased. Rather a flexibility to adapt to the reality of reduced self-financing possibilities should be promoted. The paper has moreover shown that at least partly is the lack of financial sustainability related to lack of planning and lack of managerial skills. The literature noted that adaptation to the contextual realities and adjustments of activities to what national and local resources can sustain should be sought after (Bergh 1995). Contradictory, HLH has continuously expanded both its health and development operations.

The findings show that the biggest threat for HLH's continuity has been the loss of Dr. Olsen. Dr. Olsen as a life-long *champion* (Shediac-Rizkallah and Bone 1998) dedicated his life to HLH. Yet, the empirical findings argue that Dr. Olsen lacked managerial capabilities and administrative background. However, he was highly motivated, deeply dedicated and had the ability to attract great amounts of donations and support both from governmental sources, aid organizations and private individuals. The empirical findings do however question the sustainability creation of HLH, despite Dr. Olsen's dedication to the institution. There is not enough written documentation to fully explore how Dr. Olsen attracted all donors support. However, volunteers and administration continuously promoted Dr. Olsen's charismatic personality and in a book written for HLH's 50th anniversary, Else Berit Ekeland from NORAD noted that though NORAD would have liked for HLH to shift attention away from individualized aid focus to sustainability, the power of Dr. Olsen and Mama Kari to engage the Southerners of Norway have meant that "we have lost the battle" (Enes 2004: 180-181 translated by author). Conversely, what is clear is that HLH today is more dependent on financial support than before.

The Chapter on organizational capacity showed how the structure of HLH historically has been built around Dr. Olsen. However, it did show the ability of HLH to think anew and try to align itself better with its current reality—larger facilities, need for more professional administration, increased number of employees—by implementing a new organizational structure. Yet, with the limited managerial capacities and little transparency of the change processes, it was found that employees at HLH received this new organizational structure negatively. I'm moreover puzzled by the fact that the new organizational system was not aligned with national governmental structures. Arguably, from the point of view of seeing HLH as a more integrated part of the national health system, the change should have included the alignment with governmental schemes.

Another weakness for creating sustainability is the reduced motivation of employees at HLH. I've found that the reduced motivation, since the resignation of Dr. Olsen, can be related to three specific factors: (1) Overwork and lack of staff, (2) lack of internal training and upgrading and (3) the new organizational structure. HLH increases the level of staff by employing expatriate doctors and short-term medical volunteers. However, creating sustainability with high turnover and little secure manpower is hard. The new organizational structure might have been introduced to improve managerial capacities and future organizational capabilities of HLH, yet according to my findings it has deteriorate both

factors. There should however be no surprise that this could happen as the administrative board implementing the new system lacked administrative and managerial background. Moreover, it has been argued that the change was just partly wanted by the administration, reducing the ability to successfully implement these new systems.

Moreover, the quality of care at HLH was put into question within the organizational capacity Chapter. HLH was found to have a much higher care-level than other hospitals in Tanzania. It was however argued that quality had been better before 2005. The challenges of less motivated employees, lack of staff and moreover the share number of patients arriving to HLH, together with little efficient use of beds, were all contributing to the reduced quality. Questions were further asked whether HLH is adhering to a quality of care level, which does not provide the possibility of creating sustainability. Employees and administration feared that quality would fall to 'African level' if the financial situation would not be improved. At the same time the future maintenance cost of some of HLH's equipment, which makes HLH provide higher quality care, was questioned. There is possibly a need to find a care level that both satisfy the demand level, while also being feasible to continue in the future, if the hospital wants to become sustainable.

As argued evaluating the activity level was difficult especially due to limited quantifiable goals and benchmarks. I would argue for this both being because of and due to lack of managerial and administrative background of founders and administration at HLH. Focus has always been on increasing numbers, yet with no benchmark there is no possibility of knowing whether goals are reached or not. HLH's budgets have increased, number of in- and outpatients have increased, number of employees has increased, yet the main question for any aid organization cannot be answered. Has the efficiency and ability of HLH to answer to the needs of the community increased? This is moreover complicated by the lack of doing any surveying of the needs within the community. Without neither a survey nor benchmark to relate to, planning for future activities and thus sustainability appears difficult. I'm unclear if this is the reason for the spread-out ideas for what future activities of HLH are to constitute. However, what is clear is that by such a lack of consistent plans sustainability can hardly be created.

From my empirical findings and evaluations there seems to be little sustainability in any of the three indicators. There is a clear interaction between the three different factors—contextual, activity, organizational capacity—which is combined rightly provide the bases for

sustainability. However, the findings appear to show a lack of seeing the three factors together and how the interplay between them is what creates sustainability. Though the contextual factors have not been providing room for expansion, the continued increase in patients has made administration increase HLH's activity level. Moreover, except for a more direct control and administration of financial resources, forced by the RNE's five-year reduction plan, little direct action aiming at creation of sustainability has been found. This could however change when the new Medical Director gets a better overall insight of the hospital.

What is apparent is that HLH, though not sustainable, is improving lives and welfare of hundreds of thousands of inhabitants in its catchment area, and more recently for individuals from further away. There is no empirical reason to argue differently. There is, however, room for asking the question if the hospital is using its resources efficiently. Moreover, if HLH has accustomed its catchment area to financial and technological resources that overrides the ability of the area to take local ownership of these new developments. That would mean that foreign aid would for a considerable time have to flow to the local community for development to continue.

Introducing Reproductive, Maternal and Children Health Services (RMCHS) clinics at Kabanga was what the administration and staff at HLH found to be the possible most important and most efficiency way of providing health care with. The empirical findings further noted that though such activities are provided through religious buildings, it does not appear to reduce the number of people using them. The use of smaller health clinics further has the advantage of not causing greater administrative challenges, as the empirical findings have found to be an issue at HLH.

It has further been argued in the paper that a stronger alignment with strategic philanthropic CSR activities by Xstrata could have been a way for the company to have a greater impact on the sustainability and efficiency of HLH.

7.1 Critical Factors for the Future

Having found that HLH has been based on overseas resources and little direct input from local community, I've come to believe that several smaller changes could be imperative for the future sustainability building of HLH. There are many factors that have to be considered, yet some challenges are easier to eliminate and I believe they can have direct impact on HLH's current and future situation.

A better definition of whom HLH wants to provide health service to would moreover provide a better ground to plan future sustainability on. I've further argued that this possible could enable a patient-fee scheme that could allow for a bigger contribution of this factor to the income of HLH. But possibly more importantly it would allow HLH to set clearer benchmarks and goal structures, which could enable a better monitoring and evaluation process of the work that HLH is carrying out.

There is a need for administrative and managerial upgrading of the administrators of HLH. I've found that the majority of issues at HLH today—contextual, activity level and organizational capacity—relates back to the lack of such personnel at HLH. Operating a hospital with 490 beds cannot be done based on dedication and motivation, there is also a need for expertise and professionalism.

A human-resource base is another imperative factor, of which any educated administrator would probably demand, to enable the making of a sustainable strategic plan for the future. Such a scheme can moreover serve as a motivational factor for employees, as they would have a better understanding of what is demanded from them. It could possibly also uncover unnecessary workers and eliminate salary costs for HLH.

7.2 Recommendations

My short time for conducting field research at HLH, problems related to availability of and access to documents setting out future plans for HLH and a somewhat stressed relationship between the HLH administration and me, reduces the possibility to provide strong conclusions. It does, however, provide me with some insights as to what areas it would be interesting to examine more deeply in the future as regards sustainability issues related to HLH:

The actual number of financial resources and its explicit use would enable a better understanding of the financial sustainability of HLH. Any such study would need the full cooperation by the administration of HLH, a complete list of resources provided to HLH by Norwegian donors and a complete availability of financial systems at HLH.

The governance structure at HLH and if this structure is promoting sustainability within the organization. It was argued that the board of HLH resembles that of a church and not one that would enable the best control and strategic running of a hospital (Interview A1). In the end it is the board that decides the direction of HLH, and thus the full understanding of their wishes

is imperative to understand the future of HLH. Related to this is the question of whether there is a prominent wish by the governing body to employ a local Medical Director.

The community's direct dependency on HLH and whether the ability of the community to developed will be reduced with the reduction of development efforts by HLH. Moreover, what does this have to say for the relationship between HLH and the local community?

For donors—private, public and individuals—to continuously support HLH without any clear benchmarks to check the performance of their donations against provide the possibility to question the underlying reasons for any such contributions. It would be interesting to research more the importance of private individuals and private-network for the building and continuity of HLH.

Chapter 8 - Limitations

There were several limitations that significantly reduced the final outcome of my research. Some I had already planned for before leaving for my trip, yet others became clear during my five-week stay in Tanzania. Though the limitations might have reduced the viability of my findings, they did indeed increase my understanding of how challenging practical research is. The limitations have furthermore not necessarily reduced my own knowledge of the social and economic life in rural areas of Tanzania, or the political struggles within an aid supported hospital in the developing world. Yet finding clear and accurate data to give unambiguous conclusions has been hard if not impossible.

8.1 Lack of Knowledge of Local Language

The issue of not knowing the local language when interviewing and observing during fieldwork is noted by research academics to create an obvious limitation to any fieldwork (Bryman 2008). The lack of being able to participate in small talk and holding a conversation reduced the immediate connection between the interviewees and me. This posed as one of my biggest challenges when working in Haydom Village. To reduce the impact of this I made sure to learn about local customs before arriving to Tanzania, how to greet in the local language, and how to gesture to enable a friendly environment.

I used a translator during the interviews in the community. The translator was found and recommended by HLH. Though, he had not done any translation work before, he had an in-depth knowledge of the Haydom Village and communicated easily with me in English and with the interviewees in Swahili and Iraqw.

The use of a translator posed unexpected challenges to the research. For the interviews within the local community, I had prepared a semi-structured questionnaire, where the majority of the questions were closed ones. However, after the first-and-an-half day of interviewing, it became apparent that my translator was not only translating my questions to the interviewees but also giving them ‘suggestions’ for what answers to give in the open questions. I strongly believe that there was no agenda behind this activity; rather the interpreter was trying to be helpful. Yet, I decided to change research strategy after this fact became known to me. The rest of the interviews were performed using *simultaneous translation*. The translator would translate exactly my words, as simultaneously as possible as I said them, and he would not say anything else. I believe this improved my findings and the way questions were formed and presented to the interviewee objectives.

Another change to the research strategy was the increased use of extra and or follow-up questions. This became necessary as respondents did not understand or did not answer according to my initial meaning of a question. For example, when I asked if the household ever had been dependent on any others for its daily survival, the most common answer was: “No, we depend on own ability”. Yet, when asked if they had gotten any support from HLH or any others during the famine in 1998-2000, a greater proportion of the respondents would note that they indeed received some food from HLH during that period. Obviously, this last point relates to the households that had been living in HLH for a longer period.

8.2 Misunderstood Focus on the Past and the Future

Researching the wider social impacts of HLH on the local community as well as HLH’s role in the future, asked for an investigation into the villagers’ thoughts on the impact that HLH has had overtime, and their future wishes for the relationship between HLH and the community.

Yet, this part of the research proved complicated, as it was difficult for many of my interviewees to reflect much on this. Some even questioned my interest in the past and the future, “Why would we think about the past and the future, when we have enough challenges just surviving today?” My western mindset of planning for the future, which evidently also was necessary due to the research questions, did not always correspond with the local population’s mindset, or even way of living.

8.3 Skepticism by the Administration

Due to the subject of my research—sustainability of HLH—it should possibly have been clear to me that the administration and workers at the hospital questioned and were skeptical to the underlying intentions of the research. Yet, I did not foresee the limitations that this skepticism would have on my work.

Firstly, the research became very much time consuming as appointments, meetings and interviews were cancelled or delayed several hours and days numerous times during my fieldwork. Within the African continent time has another importance than what is the case in the West. Yet I experienced this more as unwillingness than as a cultural difference.

Moreover, two weeks into my fieldwork and after rumors were presented to me about the administration questioning my intentions of writing my thesis, I asked for a talk with the Medical Director. The rumors noted that I was not being honest with my intentions and that ‘I played with two drums’. When meeting with the Medical Director I presented what I had

heard and explained that the wish of the research was not to ‘hurt’ HLH and pinpoint its negativities, but rather trying to find out what is being done at HLH and link it to sustainability. Moreover, it could be used as a method of uncovering areas where HLH has the opportunity to improve its services and ability to work sustainably.

There was also unwillingness amongst administration, staff and volunteers to discuss parts of my initial thesis, notably the *Mulbadaw Farm*. The farm therefore had to be partly excluded from my thesis. However, I still firmly believe that the farm is of great importance when analyzing the future sustainability of HLH and HLH’s relationship with the local community. Especially, with the ongoing conflict of who is in charge and who is the owner of the farm. My point of view is that this conflict reduces the trustworthiness of HLH and therefore its future sustainability.

8.4 Lack of Financial Data

A great limitation to my analysis of the sustainability of HLH is the lack of financial data that have been available to me. I’ve been in contact with the financial department of HLH, the Norwegian Lutheran Organization, the Norwegian Agency for Development Cooperation, the Norwegian Royal Embassy in Tanzania, and the Norwegian Mission Organization, yet it has been impossible to gather full access to the hospital’s budgets from its initiation up until today.

HLH says that it does not have older budgets or numbers at their offices, as these have been sent to the hospital’s donors (Interview A2, Interview A3). I have, however, been given budgets from 2005 up until today. I was given access to older Annual Reports (from 1973 up until 1999). Within the majority of these there was some sort of mentioning of where HLH’s income was coming from. The numbers given were either in actual figures or in percentages. It was however often conflicting numbers presented, with income from the Tanzanian government being written down as 6 percent for year X, while within the next Annual Report it would be written down as only 4 percent in that same year X. It was, moreover, seldom noted what expenses HLH had. It was therefore hard to determine if HLH was operating with a profit or a loss.

RNE suggested getting the budgets, as they did not have budgets at the embassy in Dar es Salaam. Yet, NORAD has only been able to provide actual numbers from most years based on manual searches in their databases. The problem with this has been that with only single

numbers and no budget it is hard to compare what those amounts represent as there is no other numbers to compare them with.

After several e-mails, the Norwegian Missions in Development said that it might possibly have some budgets. However, due to the budgets being older they were not digitalized and moreover archived in the organization's cellar. I was invited to come and look for them, with guidance from an archivist; however, this has not been possible. The NLM did answer my e-mail requests, yet it was forwarded three times to different individuals within the organization that had better knowledge of the whereabouts of HLH's budgets. Unfortunately, in the end the e-mail was sent to the former director at HLH yet he never answered and thus the financial information from this institution has not been available.

8.5 Lack of Human-Resource Numbers

Another limitation when doing the analysis of HLH is the lack of historical and current overview of how many workers were and are employed at HLH and what positions they hold. While looking into this issue, I talked with individuals from the administration who sent me to the human-resource department, which again sent me to the accountants. The accountants moreover sent me to the different departments at the hospital, as I was told that each department has a list over who is working there. I was only able to find this list in three different departments, and the lists were only from the last month. I've understood that HLH is in the process of making a better human-resource system, yet it is surprising to me that a more complete list could not be provided. Especially, as I've found that the CMI report from 2009 actually does have a more or less comprehensive list.

Chapter 9 - References

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Appendix I – E-mail Correspondence with NLM

NLM sin støtte til Haydom Lutheran Hospital - Tanzania

6 messages

Hlin Irene Grung <hlinirene@gmail.com>

Tue, Dec 21, 2010 at 4:18 PM

To: hovedkontoret@nlm.no

Hei,

Mitt navn er Hlin Irene Sagen Grung og jeg er student ved Universitet i Agder. Jeg studerer Development Mangement og er i den forbindelse i gang med å skrive masteroppgaven min.

Masteroppgaven min er en analyse av Haydom Lutheran Hospital (HLH) som et "bærekraftig" utviklingsprosjekt. Jeg ønsker å se på HLH som en utviklingsorganisasjon med helse som sitt arbeidsfelt. Jeg ønsker videre å se på hva HLH har betydd for utviklingen av samfunnet rundt sykehuset.

Jeg har allerede vært på en snarvisitt til HLH, men skal ned igjen og gjøre feltarbeid i januar og februar 2011. Der skal jeg intervjuer, men mest høre på enkeltindividers synspunkter på HLH. Jeg har planlagt å snakke med mennesker fra administrasjonen, leger og sykepleiere og enkeltmennesker i byen rundt sykehuset og på denne måten få et bedre inntrykk av HLH som et utviklingsprosjekt.

Som ledd i forberedelsene til avreise prøver jeg å skaffe meg et bilde av HLH gjennom tidligere årsrapporter og annet materiale om HLH, samt lignende prosjekter/sykehus i Afrika. Da jeg besøkte HLH i slutten av oktober 2010, fikk jeg tilgang til årsrapporter helt tilbake til 1963, men det som manglet i disse rapportene var regnskapstall og budsjetter. Jeg spurte om dette og fikk til svar at disse mest sannsynlig var blitt sendt til donorene.

Regnskapstall er bare en del av det jeg ønsker å se på når det gjelder HLH. Like viktig er arbeidet HLH utfører og hva samfunnet rundt synes om dette arbeidet. Men regnskapet kan gi et bedre bilde av hvorledes HLH har "overlevd" og hvordan arbeidet er blitt utført. Jeg ønsker derfor å ta disse tallene med i min analyse.

Jeg skriver derfor for å forhøre meg om det finnes en oversikt over støtten som Norsk Luthersk Misjonssamband har gitt til HLH og eventuelt generelle regnskapstall som sier noe om HLH sine budsjetter og årsregnskap. Etter hva jeg forstår har Bistandsnemda (BN) gitt penger til HLH gjennom dere (NLM), men det er uklart for meg om disse midlene har vært øremerket HLH, eller om NLM selv har bestemt hvilke prosjekter pengene skulle brukes til. Jeg vet også at disse midlene fra BN er penger som er offentlig tilgjengelig, men jeg er usikker på om det samme gjelder for NLM sine regnskap.

Jeg ønsker primært og se på støtte gitt til Haydom fra midten av begynnelsen av 1970 tallet og så langt frem i tid som dere har støttet HLH.

Om det skulle være noen spørsmål eller uklarheter, kan jeg kontaktes på e-mail hlinirene@gmail.com. Jeg er fortiden boende i Spania, og har derfor ikke anledning og komme til kontoret selv, og håper dette kan ordnes over mail. Jeg kan eventuelt ringe dere, om det skulle være ønskelig.

Med vennlig hilsen
Hlin Irene Sagen Grung

People may not remember exactly what you did, or what you said, but they will always remember how you made them feel -Shafer

Hlin Irene Grung <hlinirene@gmail.com>

Thu, Jan 6, 2011 at 2:35 PM

To: akviserud@nlm.no

Hei,

Jeg sendte for en liten tid tilbake en e-mail til hovedkontoret@nlm.no (se e-mail under), men jeg er usikker på om den kom frem til økonomi avdelingen. Av den grunn sender jeg den direkte til dere her. Om det skulle være noen andre spørsmål så er jeg tilgjengelig på e-mail.

På forhånd tusen takk for hjelpen,

Med Vennlig Hilsen,

Hlin Irene Sagen Grung

[Quoted text hidden]

Etter hva jeg forstår har Bistandsnemda (BN) gitt penger til HLH gjennom dere (NLM), men det er uklart for meg om disse midlene har vært øremerket HLH, eller om NLM selv har bestemt hvilke prosjekter pengene skulle brukes til. Jeg vet også at disse midlene fra BN er penger som er offentlig tilgjengelig, men jeg er usikker på om det samme gjelder for NLM sine regnskap.

[Quoted text hidden]

Med vennlig hilsen

Hlin Irene Sagen Grung

[Quoted text hidden]

Hlin Irene Grung <hlinirene@gmail.com>

Thu, Jan 6, 2011 at 2:39 PM

To: mpettersen@nlm.no, hfidjeland@nlm.no

----- Forwarded message -----

From: **Hlin Irene Grung** <hlinirene@gmail.com>

Date: 2011/1/6

Subject: Fwd: NLM sin støtte til Haydom Lutheran Hospital - Tanzania

To: akviserud@nlm.no

Hei,

Jeg sendte for en liten tid tilbake en e-mail til hovedkontoret@nlm.no (se e-mail under), men jeg er usikker på om den kom frem til økonomi avdelingen. Av den grunn sender jeg den direkte til dere her.

Om det skulle være noen andre spørsmål så er jeg tilgjengelig på e-mail.

På forhånd tusen takk for hjelpen,

Med Vennlig Hilsen,

Hlin Irene Sagen Grung

----- Forwarded message -----

From: **Hlin Irene Grung** <hlinirene@gmail.com>

Date: 2010/12/21

Subject: NLM sin støtte til Haydom Lutheran Hospital - Tanzania

To: hovedkontoret@nlm.no

[Quoted text hidden]

Håvard Fidjeland <hfidjeland@nlm.no>

Thu, Jan 6, 2011 at 2:47 PM

To: Hlin Irene Grung <hlinirene@gmail.com>, Morten Pettersen <mpettersen@nlm.no>

Cc: Rune Mjølhus <rmjolhus@nlm.no>

Hei igjen

Nå er den mottatt..Kan ikke huske å ha sett denne før. Oversender den til Rune Mjøhus, som er leder for NLMs arbeid øst-afrika, så gir han deg en nærmere tilbakemelding.Lykke til med studiene!

Mvh

Håvard Fidjeland

Økonomileder

Fra: Hlin Irene Grung [mailto:hlinirene@gmail.com]

Sendt: 6. januar 2011 14:39

Til: Morten Pettersen; Håvard Fidjeland

Emne: Fwd: NLM sin støtte til Haydom Lutheran Hospital - Tanzania

[Quoted text hidden]

Hlin Irene Grung <hlinirene@gmail.com>

Thu, Jan 6, 2011 at 2:51 PM

To: Håvard Fidjeland <hfidjeland@nlm.no>

Tusen tusen takk for rask tilbakemelding. Og takk for lykkeønskninger, er veldig veldig kjekt og se hva organisasjoner slik som Haydom får til.

Mvh,

Hlin Irene Grung

[Quoted text hidden]

Rune Mjølhus <rmjolhus@nlm.no>

Mon, Jan 10, 2011 at 10:37 AM

To: "oeolsen@cih.uib.no" <oeolsen@cih.uib.no>

Cc: Håvard Fidjeland <hfidjeland@nlm.no>, Hlin Irene Grung <hlinirene@gmail.com>, Morten Pettersen <mpettersen@nlm.no>

Hei Øystein.

Du er vel rette mannen til å kunne svare på dette eller trykke på de rette knappene for at denne damen skal kunne få tilgang på den info hun etterspør? Må bare beklage å si at vi fra vår side ikke har arkiver som er relativt tilgjengelige så langt tilbake i tid. Kan du hjelpe? Hvor kan hun få info?

Mvh

Rune Mjølhus

Regionleder, NLM Utland

Fra: Håvard Fidjeland

Sendt: 6. januar 2011 14:48

Til: Hlin Irene Grung; Morten Pettersen

Kopi: Rune Mjølhus

Emne: SV: NLM sin støtte til Haydom Lutheran Hospital – Tanzania

[Quoted text hidden]