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International trailblazer: Primary health care in Tanzania, 1920s-1990s

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Abstract

The paper analyses the emergence of Tanzania's primary health approach from the colonial to the postcolonial period. We argue that some British colonial health policies created favourable conditions for the postcolonial turn towards primary health. Based on official archival material, newspapers, interviews, and secondary literature, the paper describes how rural health dispensaries and public health education campaigns provided continuity from the colonial to the postcolonial era. In both periods, governments aimed at increasing the rural population's productivity by improving its health. However, much of this rural population was poor and settled across vast rural areas, bringing questions of cost and efficiency to the forefront. Even before the approaches' definition in the 1970s, primary health elements promised the best results and met many popular expectations. This long experience with primary health care elements allowed Tanzania to act as a trailblazer setting examples for the emerging international norm of primary health care. However, liberalisation policies in the 1990s undermined this system while leaving the question of adequate health services for the rural poor largely unanswered. As a contribution to the emerging literature on global social policy, the paper shows that the primary health care norm diffusion has been a multi-directional process.

Zusammenfassung

In diesem Arbeitspapier wird die Entstehung des Primary Health Care-Ansatzes in Tansania von den Anfängen in der kolonialen Periode bis zur Entfaltung nach der Unabhängigkeit analysiert. Wir argumentieren, dass in der britischen Kolonialzeit in ländlichen Gebieten Gesundheitsstrukturen geschaffen worden sind, die für die offizielle postkoloniale Politik der Primary Health Care wichtige Voraussetzungen geschaffen haben. Basierend auf offiziellem Archivmaterial, Zeitungen, Interviews und Sekundärliteratur beschreiben wir, wie ländliche Gesundheitseinrichtungen und Aufklärungskampagnen Kontinuität von der kolonialen in die postkoloniale Ära herstellten. In beiden Perioden zielten die Regierungen darauf ab, die Produktivität der ländlichen Bevölkerung durch Verbesserung ihrer Gesundheit zu steigern. Armut und die dünne Besiedlung weiter Landstriche rückte jedoch Kosten- und Effizienzfragen in den Vordergrund. Die staatlichen und populären Erwartungen konnten am ehesten mit Ansätzen erfüllt werden, die später in die offizielle Definition des Primary Health Care-Ansatzes aufgenommen wurden. Durch die langjährige Erfahrung mit Primary Health Care-Elementen wurde das Land international als ein Pionier und Vorbild für die Umsetzung der Strategie angesehen. Allerdings beschädigte die Liberalisierungspolitik in den 1990er Jahren das öffentliche Gesundheitssystem sehr stark, während die Frage nach einer angemessenen Gesundheitsversorgung für die arme Landbevölkerung weitgehend unbeantwortet bleibt. Aus theoretischer Sicht trägt das Arbeitspapier zur Literatur über Global Social Policy bei und zeigt, dass die Diffusion von internationalen Normen ein multi-direktionaler Prozess ist.

Contents

1. Introduction

This paper explores public primary health policies in mainland Tanzania[1] from the beginnings of public primary health services in the colonial period through their expansion during the independence and socialist period and their demise under economic strain and market liberalisation in the mid-1990s. Primary health care most generally refers to essential health services. As a specific health care approach propagated by the World Health Organisation (WHO), it emphasises the interrelations among physical, mental and social health. Rather than looking only at cures and treatments for specific diseases, a primary health care approach seeks to provide comprehensive care, turning preventive measures into essential healthcare policy elements. As codified in the WHO's Alma-Ata conference of 1978, the concept of primary health care is based on a commitment to social justice and equity. The conference defined primary health care as available to and accessible by all people regardless of income or wealth; participatory on a communal level; affordable in the respective economic context; and encompassing all areas that play a role in health. Thus, the primary health care approach includes many preventive public health elements, such as health education. While curative approaches are also part of primary health, the privileging of highly specialised health professionals, complex machinery and treatment, and accessibility restricted to the economically better-off strata of society are refused (WHO, n. d.; WHO, 1978; Turshen, 1989, p. 253; Massoud, 2008, p. 16; Bruchhausen, 2017). While the international definition of primary health care has been fixed in the late 1970s, this paper scrutinises how health policies in Tanzania, from the colonial period onwards, progressed into a primary health system "avant la lettre". Following Turshen's (1989, p. 50) approach, we define health policies as comprising governmental strategies, plans and goals for controlling diseases. Health policies also encompass government regulations for controlling certain groups as well as government decisions on providing health services to individuals or communities.

The paper traces how the colonial and post-colonial state has engaged and disengaged from public primary health services. It seeks to answer four questions: Which health care policies existed from colonial to post-colonial Tanzania until the mid-1990s? Why did Tanzania's colonial and post-colonial authorities engage or disengage in primary health care provision from the 1920s to the 1990s? How did governments organise the provision of medical interventions? Which domestic and global interactions developed between the Tanzanian trajectory, and the international process towards the primary health care approach?

The paper shows that primary health care policies and their implementation from colonial to post-colonial Tanzania underwent several changes and continuities. Among the latter, the cost of providing public health care to a poor population, spread across vast rural areas, preoccupied both British colonial and independent governments. Three major reasons why health care should be provided remained constant, too. First, public health was seen as a pre-condition for economic development. Second, the state used public health facilities to manifest its institutional presence across its territory. Third, local demand for public health care was enormous,

1 Starting in 1885, Germany colonized Tanganyika (Tanzania mainland) as part of German East Africa, while the Sultanate of Zanzibar became a British colony. After World War I, Tanganyika became a British-ruled trusteeship protectorate of the League of Nations and its successor organization, the United Nations. In 1961, Tanganyika gained independence. The United Republic of Tanzania was formed in 1964 as the union of Tanganyika and Zanzibar. However, as Zanzibar retained strong autonomy, e.g. regarding health policies, this paper focusses on colonial Tanganyika/mainland Tanzania.

creating both pressure and opportunities for a state in dire need of legitimacy.

Post-colonial authorities inherited some institutions from the colonial state which eased its focus on essential health services. While during colonial rule, health policy was curative-focussed, urban-centric and racialised, in the rural areas both the colonial and post-colonial state tried to provide locally-contextualised health care, paired with preventive interventions such as awareness campaigns, in a relatively decentralised setting and at low cost. The paper's central argument is that long before primary health care became an official WHO aspiration, and even before the post-colonial Ujamaa period, some primary health care elements had already been introduced in Tanzania. This longer history of primary health care approaches allowed Tanzania to act as a trailblazer, as part of a broader cluster of countries setting examples for the emerging international norm of primary health care.

Of course, there have also been many changes, some of which were fundamental. On the economic side, the British viewed public health provision primarily as a means to protect the migrant labour supply to the export-oriented plantations and cash-crop farms. In independent Tanzania, particularly in the Ujamaa period of rural socialism, the idea of development was much more centred on farmers staying and producing where they settled rather than moving them to plantations. Health services then served to make rural life and peasant agricultural production more attractive. Once this economic model failed, after a period of hesitation, the Tanzanian government acquiesced to financial and international institutional pressure and partly privatised health services. However, market forces could not remove the long-standing problem of financing health care in Tanzania. Many Tanzanian citizens, especially in rural regions, remain too poor to buy health care. Thus, public primary health care "for all" remained a social challenge and a political aim in Tanzania.

This paper contributes to the research on the provision of primary health care in Tanzania, particularly in a longer historical perspective. Many studies have attributed the application of primary health care approaches to post-colonial Tanzania, especially to the socialist *Ujamaa* period (Kilama et al., 1974; MoH, 1995; Msambichaka et al., 1997; Maliyamkono & Mason, 2006, pp. 447-448 and MoHSW, 2007, p. 1). *Ujamaa* began with the ruling party's Arusha Declaration in 1967, which envisaged the creation of a society based on the Swahili notion of community and kinship (*-jamaa*). As several authors note, during *Ujamaa*, preventive medicine was heavily emphasised by the Tanzanian state (Kilama et al., 1974; Msambichaka et al., 1997; Maliyamkono & Mason, 2006). As exemplified by education campaigns such as Mtu ni Afya (Man is Health), the preventive emphasis stressed the need to maintain personal hygiene and environmental sanitation and suppress the spread of communicable diseases. While these studies provide valuable insights into a core post-colonial historical development, they tend to overlook the early endeavours in primary health care provision during the colonial period. As a result, our understanding of public health care changes and continuities in Tanzania remains incomplete. The study also adds to existing research by moving beyond a national level analysis, reflecting the interplay of local, national, imperial and international forces, movements and ideas at work in the provision of primary health care in Tanzania. Thereby, the paper also contributes to the burgeoning literature on global social policy, particularly the role of diffusion. Much of this line of research concentrates on how welfare systems in the global South import rather than export norms and practices (Hamann, 2020; Kuhlmann et al., 2020; Devereux, 2020, but see Hanerieder, 2019 for a different example). In contrast, our paper highlights how ideas, norms and practices travelled back and forth

between imperial, national and international domains.

The paper engages with official documents, secondary literature and governmental declarations and statements found in government-controlled newspapers and additional primary sources. Many examples and experiences have been collected in the Mbeya region, and more specifically Mbozi district, where Sadock has been researching health in general and HIV/AIDS in particular since 2009. Mbozi district's experiences regarding primary health care interventions are not quite average but typical for many districts. Mbozi is far removed from the traditional centres of economic production, the cash-cropping regions of the north or the economic hub of Dar-es-Salaam, where the earliest health care facilities developed. Situated in the Southern Highlands at the borders of Malawi and Zambia, Mbozi is nonetheless quite fertile. Thus, the area has been better off than the most impoverished districts in the country's geographic centre. Today, the coffee economy in the area, mainly established after independence, makes the district one of the richest in the country. In this context and similar to other districts in the country, Mbozi has witnessed increased health facilities. Also typical, this increase was disrupted by the economic crisis and the Structural Adjustment Programmes (SAPs) from the 1980s onwards. The paper uses material from the Tanzania National Archives (TNA) at Dar es Salaam, Mbeya Zonal Archives (MBZA), and Mbozi District Administration to capture local developments and the national historical trajectory. The primary material also includes in-depth interviews with residents of the district to provide glimpses into recent local popular experiences (Sadock, 2012, 2013, 2015, 2016).

The paper is divided into four chronological sections. The second section provides a brief background on the establishment of medical services in Tanzania during the German colonial period, followed by the trajectory of primary health care policies and their implementation in British-controlled Tanganyika since the 1920s. Thereafter, the independence and *Ujamaa* period is analysed. The empirical section ends with the 1980s and early 1990s as a period of economic crises and health privatisation. The conclusion reflects on the international interactions of Tanzania as a trailblazer for primary health care.

2. The establishment of medical services in Tanzania

The history of western medicine[2] in Tanzania started with missionaries in 1877 (Nsekela & Nhonoli, 1976, p. 6; Sullivan, 2011, pp.72-73). Yet, the focus of this paper is not on missionary health interventions but on government health care. The German imperial government, which colonised the territory after 1885, began to establish a curative and preventive system in 1888. A few curative health facilities in urban areas catered to military personnel and civil servants. Except for the sisal, coffee and tea growing areas, curative services in rural areas were neglected (Msambichaka et al., 1997, p. 13). By 1914 the territory had only 26 hospitals, the largest being Tabora hospital with 75 beds. The German policy preferred hospitals in urban areas over small health units in rural areas (Msambichaka et al., 1997). Thus, primary health care for the general population during the German period was negligible. As for preventive medicine and except sleeping sickness control, vaccination against small

2 It is, however, important to note here that the pre-colonial Tanzanian societies were not tabula rasa in terms of prevention and treatment of diseases. Traditional medicine was central treating numerous diseases. Public health measures to prevent epidemics such as quarantine were also common. For a detailed discussion see Chief Mkwawa's measures against the spread of plague and small pox in pre-colonial Uhehe chiefdom in D. Clyde's (1962, pp. 13-14) *History of Medical Services in Tanganyika*.

pox and malaria control, preventive services were neglected (*ibid*; Bauche, 2017). Regarding medical training, Germans did not train African personnel to serve in medicine (Kilama et al., 1974, pp. 191-192; van Etten, 1976, p. 24).

Urban-based health service provision was racially biased both during the German period and the British period. Whites, Indians and a few African state employees received treatment in separate hospitals. Hospitals provided the racialised groups were with different amenities: while White patients received superior services, services for Indians were less generous, and Africans received the most inferior treatment. This approach reflected both the racialised worldview of colonialism and the imperial aim of the *mise-en-valeur* of the colony, thereby protecting key employees and labourers in the different colonial enterprises and projects. In addition, the colonial health regime aimed to contain epidemics and venereal diseases through campaigns, which posed a threat of not only spreading to the Whites but also decimating African labour (van Etten, 1976, p. 19; Beck, 1970, p. 200; Sadock, 2015, pp. 210-213).

3. Health care under British rule

The British colonial power inherited after the German defeat in the First World War a nascent structure of both curative and preventive medical facilities. Initially and in line with its German predecessor, the British administration aimed for curative services in urban areas. However, with the establishment of the dispensary system in the mid-1920s, medical services expanded to rural areas. This policy of mass access to medical services constituted the first element of a primary health care approach *avant la lettre*. The British administration attempted to counter three consequences of the First World War: the prevalence of epidemic diseases threatening the supply of healthy African labour for the colonial economic project; the need to newly establish effective colonial occupation and legitimate rule; and increasing African demands for health service, which were related to the discovery of effective medication for the treatment of some diseases.

During the First World War, Tanganyika had been a battlefield. Warfare between the imperialist powers (primarily Germany, Great Britain and Belgium) devastated, in particular, the southern parts of the country, which already had severely suffered from the suppression of the 1905-07 anti-colonial Maji-Maji uprising (Pesek, 2010). The hardships resulted in the prevalence of diseases such as yaws, plague, tuberculosis and sexually transmitted diseases, and a generally high mortality rate among the African population. Indeed, the diseases were considered the cause of the territory's low population density, which in turn hindered economic growth.

The so-called 'native labour question', which the German colonists had already struggled with, encumbered British post-war colonial development plans (Orde Browne, 1927, pp. 112-116; Iliffe, 1979, pp. 151-163). Economically, Tanganyika was divided. Cash-crop areas emerged mainly in the northern regions, where African commercial farming and European-owned plantations developed. These, as well as the few urban settlements, depended on "peripheral regions supplying migrant labour" as well as "intermediate regions supplying food and other services" (Iliffe, 1979, p. 274). When migrant labour supply from peripheral regions fell short, rural health also in these regions became an important administrative concern. The administration also began to consider maternal and infant welfare to contribute to demographic growth (van Etten, 1976, p. 27; Mihanjo, 2004, pp. 99-101).

Dispensaries, whose implementation began in 1926, may be considered the first element of an emerging primary health care system. A dispensary was a medical centre that provided first aid and simple medical

treatment of diseases and referred patients in need of more specialised skills to a health centre or hospital. The dispensary system added a rural layer to the existing structures of urban, racialised health care provision.

The establishment of a rural system of dispensaries also served to transmit colonial and western values and legitimise British colonial rule. During the interregnum of the First World War, many rural regions had effectively returned to self-rule. The establishment of public dispensaries indicated the re-establishment of colonial occupation. Also, it signalled the superiority of the British over German colonial occupation: where the Germans did not care about the health of their rural colonial subjects, the British did.

Clyde (1962, p. 119) points out that Dispensers and Tribal Dressers spread Western ideas of medicine and hygiene.[3] Dispensers underwent medical training for three years, but unlike Tribal Dressers, they were also trained in laboratory investigation and served in central government dispensaries (Sullivan, 2011, p. 79¬). Tribal Dressers mainly served in Native Authority dispensaries and could clinically diagnose and treat many diseases (TNA, 1934). As early health professionals, Dispensers and Tribal Dressers in particular and dispensaries, in general, served as intermediaries between colonial rulers and subjects. Underscoring the political role of dispensaries in colonial Tanganyika, Malloy notes that dispensaries were conduits through which imperial ideologies and cultural values moved to the far-flung rural areas of the territory (Malloy, 2003, pp. 237-239). The provision of health services was meant to produce legitimacy, showing the people that "the authorities cared" for them (Beck, 1970, p. 135).

Indeed, colonial subjects started to have a positive attitude toward western medicine and public health services. One reason for such newly arising positive regard for public health services was the discovery and local production of effective medication such as Bismuth salt. As Clyde (1962, p. 113) points out, the effective treatment of yaws, a bacterial disease, in the 1920s led to Africans demanding health services. In some cases, they initiated public health facilities themselves. In 1922 in Kilimanjaro, for example, the subjects of chief Shangali Ndesauru of Machame built a fifty-bed dispensary at their expenses. Similarly, at Negezi in Shinyanga, a hospital and dispensary were built using local materials, while the central administration provided windows, doors and a dispenser (Clyde, 1962, p. 115). Africans also called for the provision of health services in return for the taxes they paid. For example, in the 1920s and 1930s, peasants in Rungwe district demanded curative services (Masebo, 2010, p. 189). Reminiscing about this, a peasant, Jopho Kiboa, noted that:

You know, chiefs collected taxes with the promise that money would be used to provide treatment services in their communities. And people paid taxes because they knew they will benefit from them. As they continued paying taxes, they realised that there were no efforts to build hospitals here [Ileje]. When people or their children were sick, they continued traveling long distance to Tukuyu. People did not like this. They thought that their taxes were benefiting residents of Tukuyu town who could easily access the district hospital. They did not want to pay taxes which benefited other people. They refused to pay taxes in order to force their chiefs and the colonial government to listen and implement their demands. Withholding taxes began when they were demanding curative medical services. (Masebo, 2010, p. 191)

African demands, protests and tax boycotts against local authorities took place in many parts of the colony (Kilama et al., 1974, p. 193).

3 In the late colonial and post-independence period, the personnel's administrative denomination was changed to "Rural Medical Aides".

3.1 Decentralisation, adaptation and resistance

The dispensary system was institutionalised as part of the newly established Native Authorities,[4] a local government structure at the district level under an appointed chief who presided over a Native Council.[5] In the British indirect rule system, the central administration ruled colonial subjects through tribally defined chiefs. The 1926 Native Authority Ordinance empowered these local authorities, among other functions, to care for the sick in health facilities, prevent the spread of infectious diseases, and implement environmental and sanitary measures for the well-being of the citizens in their areas (Mihanjo, 2004, p. 100; van Etten, 1976, p. 20). Referring to decentralisation, medical and general functions of Native Authorities, a British Medical Officer in Iringa noted that:

[U]p to 1926 all medical work was carried directly by [central] Government, with possible help of few missions. In 1926, however, the newly instituted Native Authorities began to assume some of the responsibilities and charges of this work, and set aside funds which were to be used for the payment of dressers, the purchase of drugs and the erecting of small dispensaries (TNA, 1937).

Medical services under Native Authorities became popular among Africans. The popularity was manifested in local initiatives to build dispensaries. In the 1940s, in the Mbozi division of Mbeya district, the native local authority constructed five dispensaries (TNA, Mbozi District Book vol. II, 1929). Attendance also increased. In Iringa, medical authorities reported increasing patients in dispensaries from 8858 patients in 1933 to 18,076 in 1937 (TNA, 1937, p. 127). In the 1940s and 1950s in Mbeya district, the number of cases being treated in health facilities increased every year, leading to overcrowding (TNA, 1947, p. 11; TNA, 1958, p. 2).

The popularity of the services also spread to urban areas. Maternal welfare centres were popular as early as the 1920s and 1930s in Dar es Salaam, Tanga, Tabora, Kilimanjaro and Kahama. The centres, which the central government ran, offered education on child care, midwifery, hygiene and nutrition, and the vaccination of children. In Kahama, mothers received prizes for the best-fed and healthy babies during popular baby-shows (Clyde, 1962, pp. 127-129).

Tanganyika's population took an active part in introducing public medical services. However, some services' popularity should not be interpreted as uncritical consensus with the colonial health project as a whole. Indeed, Africans were selective about the medical services they wanted and protested against some of the services. They also adopted the services depending on specific conditions. Sanitary intervention, in particular, triggered African protests or attempts to adapt regulations to suit particular living circumstances. From 1926, the colonial government trained African District Sanitary Inspectors and tasked them with imparting hygiene in rural areas. The hygiene and sanitary measures consisted of information on constructing well-ventilated houses, deep-pit latrines, incinerators, and lessons on improving and protecting water supplies. Lectures on infectious diseases and how to prevent

4 In the colonial context, the term "native" referred to indigenous Africans as opposed to Europeans and Asians.

5 As a prelude to the introduction of rural health care facilities, the British colonial administration in 1920 instituted two reforms: splitting the Medical Department, as inherited from the Germans, into curative and sanitary departments; and passing Ordinance No. 3 of 1920, which aimed to prevent infectious diseases by requiring Africans to report to the government any outbreak of listed (notifiable) diseases (fevers known as enteric, typhus, typhoid, para-typhoid, relapsing and continuing; beriberi, cerebral spinal meningitis, chicken pox, mumps, measles, cholera, diphtheria, influenza, leprosy, plague, scarlet fever, smallpox, yaws, yellow fever and sleeping sickness) (Clyde, 1962, pp. 112-114; Mihanjo, 2004, p. 99).

them also figured in the programme. Tanganyika's villagers, however, regarded the government-paid sanitary inspectors with distrust, as the inspectors had the authority to enter into peoples' homes and ask intimate, private, culturally unacceptable questions. This situation caused villagers to ignore directives and other measures issued by the sanitary inspectors. Indeed, many people were quite satisfied with their own methods and saw no reason to change their habits to new hygienic practices (TNA, 1945a, p. 2).

In other cases, rural populations sought to adapt sanitary measures to suit their specific needs, as illustrated by negotiating plague-control interventions. In 1937, the government mounted campaigns to eradicate rats using media such as posters. One such poster read in Swahili: *Hatari ya Panya: Huyu Adui yetu Huleta Maradhi Huiba Chakula chetu Huharibu Mali; Mfukuze Nyumbani Mwenu kwa Kuminyma Chakula na Kuweka Nyumba Safi*. ("The Danger of Rats: They Bring Plague, Eat our Food, and Destroy our Property; Eradicate Rats by Denying them Food in the House and Keep Your House Clean"; Clyde 1962, p. 138, author's translation). As Clyde (1962, p. 112) reports, in Singida, peasants successfully negotiated with sanitary officers, convincing them to smoke out rats rather than burning entire homesteads (*tembe*). The method allowed the *tembes* to continue serving as the dwelling for both humans and cattle. Demolishing the *tembes* would have put cattle at risk of being attacked by wild animals or taken by thieves.

3.2 Budgetary constraints

While the policy tasked native authorities with covering the running cost of dispensaries from their own revenue, the central government financed the hospitals, most of which were located in district capitals and other towns. Both regulations followed the Colonial Office's policy, which asked British colonies to use domestic revenues to cover expenses, and furthermore discriminated against the African rural population with its focus on urban hospitals catering mainly for non-Africans:

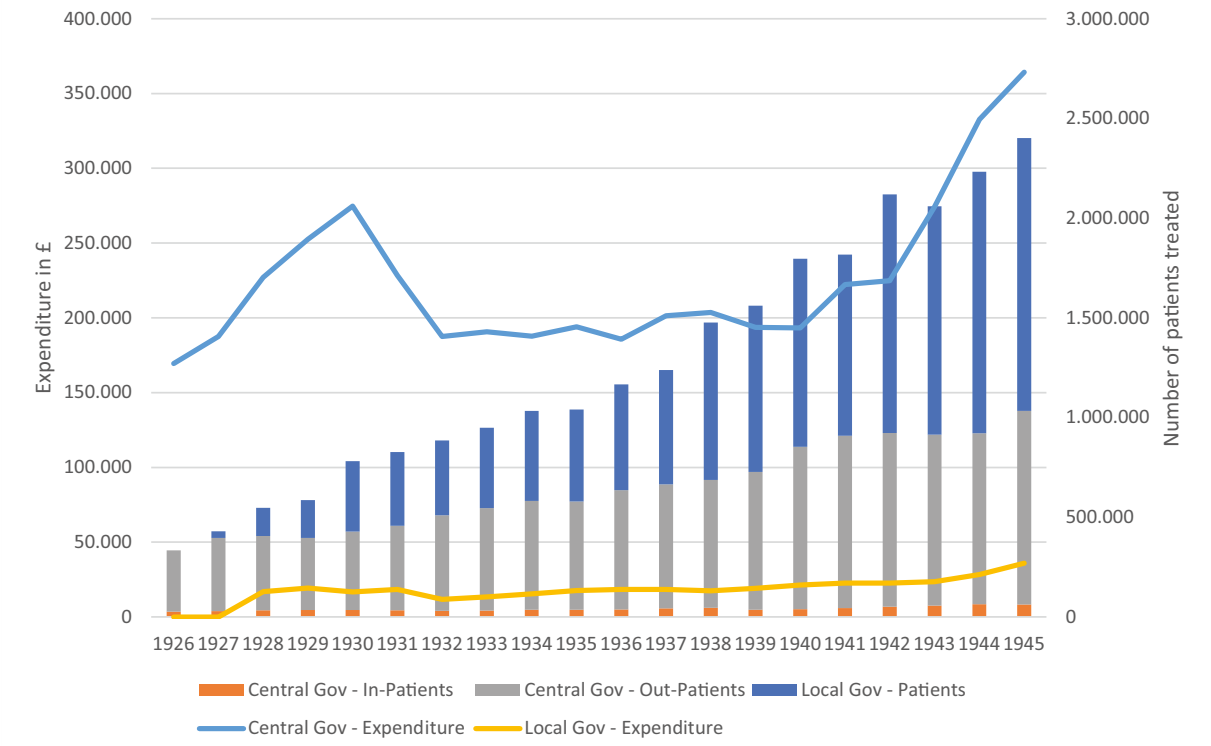
Fundamental to understanding the position of the rural health services in the period (…) was the lack of public finance, caused by the colonial government's policy of economic self-support for the territory on the one hand and its fiscal policy which was heavily geared towards supporting central government's activities with their urban bias on the other hand. (van Etten, 1976, p. 30)

London's policy changed slightly with the 1929 Colonial Development Act. The act listed "the promotion of public health" among a number of other aims and created a Colonial Development Fund, from which the colonial administration could finance special projects. Until after the Second World War, the Colonial Development Fund remained insignificant for the health sector. By 1940, it covered only 3 per cent of public health expenses in Tanganyika (van Etten, 1976, p. 30).

Funding for medical services in Tanganyika in that period was generally operating under severe budgetary constraints. While the number of patients attending medical services steadily increased, expenditures did not keep pace. As table 1 shows, the picture is most favourable regarding in-patients treatment in central government hospitals. While from 1926 to 1945, the number of patients doubled, expenditures increased roughly by the same factor. However, out-patient treatment, financed from the same spending, more than trebled during the period. The picture is much bleaker regarding local (native) government facilities, which treated about ten times the number of patients in 1945 compared to 1928. Expenditures in this period, however, only doubled.

Given such budgetary constraints, preventive as well as curative medical interventions

Figure 1.
Government Expenditures on Medical Services in Tanganyika, 1926-1945



Source: G. M. van Etten, 1976, p. 31.

faced several problems. One such problem was the lack of medical personnel across the territory. For example, in 1935, the whole of Mbeya district, with an estimated population of 84,591 people, had only fifteen Tribal Dressers (TNA, 1935). As the provincial commissioner noted, little could be done in terms of medical intervention "unless the number of dressers can be increased" (ibid.). Tribal Auxiliaries, who later became known as Rural Medical Aides (RMA) and received more profound training than Tribal Dressers, were even fewer. In 1941, the district had nine native medical facilities. Tribal Auxiliaries staffed only five of these few facilities.

The uneven distribution of medication also hindered effective treatment, for example of sexually transmitted diseases (STDs) such as syphilis. Before the Second World War, standard drugs against syphilis were Bismuth salts, mercury and arsenical compounds such as Salvarsan (TNA, 1928). While Bismuth became available in Dar es Salaam from 1924, it did not reach many rural health facilities. Salvarsan, the government claimed, was too expensive to treat all African patients (TNA, 1932). The shortage continued after introducing penicillin in the 1940s, which was not only considered too expensive. Rural dispensaries also lacked refrigerators for their storage (TNA, 1945b; TNA 1948b). Where available, the drug was given free of charge only to STD-infected pregnant mothers, infants and severe STD cases (TNA, 1945c). However, the meagre budget allocated to the health sector violated the government's free drug policy for African STD patients (Tanganyika Territory, 1944, p. 28). Overall, the health budgets did not correspond to the spread of health problems in the African population (Beck, 1970, p. 157; van Etten, 1976, p. 33).

Table 1.
Expenditure on medical services and number of patients treated by central and local government, 1926-1945

	Central Government			Local government	
Year	Expenditure in £	In-patients	Out-patients	Expenditure in £	Patients treated
1926	169.355	26.620	307.635	n.a.	n.a.
1927	187.600	28.808	367.762	n.a.	32.800
1928	227.018	32.794	372.764	16.830	141.300
1929	252.476	34.803	361.101	19.382	190.545
1930	274.715	34.810	393.783	16.702	352.423
1931	228.343	33.338	423.169	18.455	369.735
1932	187.493	30.751	479.517	11.830	374.614
1933	190.725	32.164	514.197	13.344	402.011
1934	187.777	35.803	546.445	15.388	451.520
1935	193.930	36.673	542.659	17.594	461.097
1936	185.735	38.021	598.016	18.428	529.954
1937	201.280	43.098	621.590	18.433	573.987
1938	203.609	45.526	641.193	17.399	789.915
1939	193.683	36.824	689.660	19.044	834.408
1940	193.321	38.791	814.036	21.399	943.743
1941	222.208	45.127	863.432	22.575	908.559
1942	224.792	51.852	870.838	22.578	1.195.890
1943	274.060	56.317	857.352	23.587	1.145.516
1944	332.705	63.152	857.953	28.279	1.311.316
1945	364.306	62.590	970.565	35.926	1.367.864

Source: G. M. van Etten, 1976, p. 31.

3.3 Post-war policies: top-heavy health development

Only after the Second World War, the Colonial Office in London provided a more significant chunk of development funding to the colonies, including Tanganyika. Although not sufficient, a part of these became available for the provision of health services. In the 1946 "Ten-Year Development and Welfare Plan for Tanganyika Territory", the colonial administration formulated a preference to expand curative medical services. The blueprint foresaw the expenditure of one million pounds over a decade, financed by the imperial 1945 Colonial Development and Welfare Act, to expand medical services. Similarly, the 1949 "Report on the Medical and Health Services of Tanganyika Territory", drafted by the Colonial Secretary's Office Chief Medical Officer, Eric Pridie, recommended a stronger emphasis on curative services and increasing the number of medical staff in hospitals as to react to growing African demand. Indeed, colonial reports of the time are replete with the Legislative Council's African members' requests for more medical services to Africans.[6]

The Ten-Year Plan and the Pridie Report, and the funding from London used for their implementation, shaped medical policy in Tanganyika until independence. The top-heavy plans steered the medial system towards a curative, hospital-focussed approach. In the early 1950s, the colonial government rehabilitated and built more hospitals, especially hospitals located at district headquarters (van Etten, 1976, p. 37). Between 1949 and 1956, the number of hospital beds increased by 45 % (Chudson & Hayes, 1958, p. 6). Both the Pridie Report and the Ten-Year Development Plan excluded the expansion of the dispensary system. Native Authorities continued to finance the dispensaries based on local taxation.

Why did the colonial authorities in London and Tanganyika seek to expand medical services to Africans after the Second World War? The reasons resemble the economic and political factors of the first expansion after the First World War: the colonial economy, severely affected by the 1930s economic depression and the following war, required reconstruction. For example, according to the colonial authorities, public health in Iringa in the mid-1930s "suffered severely from the financial stringent of the past economic slump period" (TNA, 1936). Similarly bemoaned was the severe shortage of funds, medical staff and equipment during the war (Tanganyika Territory, 1944, p. 1). The provision of health services, the authorities argued, would result in a healthy population working in productive agriculture and mining sectors. Both sectors were considered central to rebuilding Tanganyika's economy. Secondly, the colonial administration sought to satisfy African claims for more and better medical services, as African representatives called for in the Legislative Council. Thirdly, the British post-war Labour Party government (1945-51) came to power with a promise of improving the welfare in Britain and the Empire (Riley, 2017, pp. 49-53).

Despite the Pridie Report, the Ten-Year Plan, and funding from the Colonial Development and Welfare Act, colonial health provision continued to have severe budget shortcomings. In Mbeya, in 1948, local authorities still found themselves unable to provide an adequate supply of drugs for the treatment of STDs (TNA, 1948a). Ten years later, the Southern Highlands provincial commissioner observed that the services provided by Native Authority dispensaries varied considerably, depending on, among other

6 The Legislative Council, created in 1926, was a representative advisory institution at the central government level. African participation in the council began after the Second World War. During this period, it was made up of 15 colonial officials and 14 appointed "unofficial" members to debate about legislation and public issues. Between 1945 and 1948 the unofficial membership consisted of four Africans, three Asians and seven Europeans (Iliffe, 1979, pp. 474-75).

Table 2.
Summary of colonial policies on primary health care from 1926 to 1961

Year	Policy
1926-1961	**Ownership and Financing of Dispensaries** Newly established Native Authorities built, owned and funded dispensaries from local revenue. Hospitals and maternal centres held, financed and organised by the central government were located in urban areas.
	Training of Medical Personnel Native Authorities trained Tribal Auxiliaries (T.A.) to work in their dispensaries from 1926. The central government trained African Sanitary Inspectors who were tasked to impart education to villagers. From 1941, T.A. became Rural Medical Aids (RMA) and received three years of medical school training.
	Health Education African Sanitary Inspectors gave health education in rural areas in respect to sanitary and hygiene issues. The central government also provided instruction on maternal and child care in maternal centres located in towns.
	Drugs and their Availability Drugs such as Salvarsan and Penicillin were effective for treating many bacterial diseases but not available to all African patients. Specific social groups such as pregnant mothers and infants received them. Authorities considered the drugs too expensive to be made generally available.
1946-1961	**Development Plans** The 1946 Ten-Years Development and Welfare Plan and succeeding blueprints excluded dispensaries. Instead, the plans focused on the development of hospitals in urban areas

Source: own presentation.

factors, their ability to supply enough drugs (Tanganyika Provincial Commissioner, 1959, p. 136). A year after that, the provincial medical report documented that the "financial year started with a general lack of funds, which necessitated strict economic measures that affected every medical aspect" (TNA, 1959). The lack of drugs, however, should not only be attributed to funding shortages. Other problems also led to erratic and inadequate medical supplies, such as delays in the delivery from medical stores to health facilities (TNA, 1947).

Also, the number of medical facilities continued to fall short of needs across the colony. For instance, in Mbozi division in Mbeya district in 1947, there were only four Native Authority dispensaries, each serving an average of 14,356 people (TNA, 1944, 1947, 1948c; Mbeya District, African Population as at 23rd August 1948). Moreover, these few dispensaries lacked medical equipment. In the 1950s, in Mbeya district, only Mbeya Hospital housed a laboratory (TNA, 1958). The lack of drugs, staff and facilities were embedded in the bigger problem of a meagre government budget allocated to the health sector.

From table 2, three major issues come to the foreground. Firstly, the central government relieved itself from providing health care in dispensaries in rural areas. Secondly, curative services were emphasised when compared to preventive measures against diseases. Lastly, drugs were not freely given to all patients.

4. International trailblazer: The expansion of primary health care after independence

Immediately after Tanzania's independence in 1961, the new government initiated the first Three-Year Development Plan[7] (1961-1964). This plan, however, continued the colonial policy of providing curative health services mainly in urban areas, even if no longer on a racialised basis (Msambichaka et al., 1997, p. 14). Politically, the emphasis on economic rather than social development cast a shadow also over the health sector. However, starting with the first Five-Year Development Plan (1964-1969) onwards, the provision of health services became a major governmental priority ("New Development Plans Approved by the Cabinet", 1969). The plan set a target of having one hospital bed for every 1000 persons in districts and providing at least one hospital in each of the then 17 regions (Kilama et al., 1974, p. 195).

With the Arusha Declaration of 1967, the government of the Tanganyika African National Union (TANU, renamed in 1977 into *Chama cha Mapinduzi*, CCM, "Party of the Revolution", governing in a single-party system until 1990) declared a Tanzania version of socialism—*Ujamaa*—as the ruling party's guiding programme. With the advent of *Ujamaa*, the government modified health care provision. It began to reach out to "the masses" in the rural areas, which had been neglected by the previous colonial focus on cash-crop export growing and the urban regions. When the Tanzanian peasant became the centre of the country's development vision, the rural population's health became a more urgent concern. However, this also meant facing needs that ultimately overwhelmed existing means.

During this period, the government opted to couple the preference for rural health with a renewed emphasis on primary health care, away from a curative approach. The community-centred, educative and participatory ideals of *Ujamaa* and their translation into national health policies largely anticipated the Alma-Ata declaration's principles of social equality and social development, affordable cost, and the involvement of self-reliant communities through education and participation (WHO, 1978). Thus, the change of direction in the health sector preceded the 1978 WHO Alma-Ata Declaration on Primary Health Care, which is often hailed as the principal agenda-setting document of international public health developments in the period (Bech et al., 2013, p. 69; MOH, 1990, p. 7). In practice, the Tanzanian approach focused on several elements, including the provision of health education, food and nutrition, sanitation and supply of water, maternity and child health, vaccination against major infections, treatment of epidemic and endemic diseases, provision of essential drugs and equipment, and provision of mental, oral and eye health care (MOH, 1990, pp. 9-18).

In implementing these policies, the government faced the classic question about whether to pursue economic and social development in sequence or in parallel (Thuilliez & Berthélemy, 2014). It opted for the latter: economic development would finance expanding health services, while improved health provision would simultaneously foster economic development. At a dinner hosted by the Medical Association of Tanganyika in 1967, President Julius Nyerere argued that the provision of health services to citizens served as a means to economic development, quipping that "an unhealthy person cannot be expected to be fully productive" ("Plan for Vigorous Health Education Plan", 1967). Similarly, Prime Minister Rashid Kawawa, in a national radio broadcast in 1973 noted that "Tanzanians should understand that with poor health the country

7 Beginning in the late colonial period, these multi-year plans set economic and social targets and strategies to achieve them (Malima, 1979).

cannot develop because the people cannot promote agriculture which is the cornerstone of development" ("Mtu ni Afya Goes into Full Swing", 1973).

The second Five-Year Development Plan (1969-1974) initiated a further radical expansion and focus on preventive health in rural areas. The plan marked the turn away from the previous concentration on urban curative health services favouring preventive health services. The plan furthermore promised free-of-charge treatment and access to health care for all individuals (Msambichaka et al., 1997, p. 14; "Health Services in Villages", 1969; "Plans to Integrate Health Services", 1969; Salim, 1976; Kaigarula, 1979).

One motivation for the move towards free-of-charge treatment and expansion predominantly in rural regions was TANU's eagerness to please the rural masses, a core constituency since the struggle for independence in the late 1950s (Kilama et al., 1974, p. 195). In the Ujamaa ideology, most prominently spelled out in President Nyerere's various writings and speeches, rural peasants played a central role as the overwhelming majority of the national population. In 1962, Nyerere described his vision of communal production in newly established villages in his pamphlet "Ujamaa. The Basis of African Socialism" as a mechanism that would combine increased agricultural output with schools, hospitals and clean water, eventually allowing the establishment of industrial production (Nyerere 1962; Coulson, 2013, p. 87). Providing free care thus may have been driven by economic consideration, as an attempt of safeguarding the agricultural workforce's health. However, as in the education sector (Morrison, 1976), TANU officials also understood that the provision of health services bolstered the legitimacy of a young state.

In September 1971, a party conference resolution urged the government to give a high priority to the "soft-sector" development in rural areas, namely education, health and water supply (Msambichaka et al., 1997; "Mtu ni Afya Goes into Full Swing", 1973; "Health and Development", 1973). TANU's 1975 election manifesto promised to distribute health facilities as widely as possible, increase the training of health personnel, put a greater emphasis on preventive measures against diseases, and foster proper housing conditions ("Electing a Parliament for Party Consolidation", 1975).

To implement this vision, the government embarked on building health facilities and supplying them with personnel. According to the census carried out in 1979, Tanzania had 2,952 health facilities, whereas, at the time of independence, 1,095 facilities had existed ("Major Thrust on Preventive Care", 1980). In the rural areas, new health worker categories such as Rural Medical Aides, Medical Assistants and Village Helpers were introduced or re-assigned to increase the number of rural primary health care workers. Medical Assistants, who before had been assisting doctors in hospitals in towns, were posted in rural health centres. Rural Medical Aides, trained for two years in first aid and treatment of less complicated cases, ran dispensaries and carried out health and hygiene education in rural areas. Village Helpers, selected among villagers, were trained for between three and six months by district medical officers on first aid, health, hygiene and sanitary education. There was an increase in the number of trainees in each cadre. By the end of 1975, Rural Medical Aide schools existed in nearly all regions. The number of Rural Medical Aides stood at 500 in 1970 and was expected to increase to 2800 by 1980. Several schools teaching Medical Assistants were also newly opened. The number of Medical Assistants stood at 300 in 1970 and was projected to increase to 1200 by 1980 (van Etten, 1976, p. 99-100).

The expansion of free health care also included nationalising most private for-profit health care. These services had existed since the colonial period. In 1967, President Nyerere had promised the Medical Association that the government had no intention to na-

tionalise private practices: "We do not nationalise businesses which do not pay unless doctors are making millions", he quipped, "amid roars of laughter" at the Medical Association's annual dinner ("Plan for Vigorous Health Education Plan", 1967). A decade later, however, the government passed the 1977 Private Hospitals (Regulations) Act, which brought an estimated 73 private health facilities under state control. The government justified the move with cost-cutting measures and accused private health care facilities of exploiting health care workers and patients contrary to the country's socialist principles. The private facilities were taken over by either a parastatal or a CCM wing such as the women's league. Exceptions applied to voluntary agencies or religious groups, who were allowed to charge a nominal fee set by the government for their services. Although initiatives to end private practices started in the 1970s, the ban on private practices was implemented in 1980 only after a considerable delay. Doctors destined to lose a substantial amount of income resisted, even if eventually unsuccessfully (Kamya, 1976; "Sokoine Warns Private Doctors", 1977; "Individual Medical Practice to be Abolished", 1977; "Private Clinics Fold up in June", 1980; "End of Commercial Medicine in Tanzania", 1980). Hospitals that belonged to various religious groups also became district-designated hospitals offering free health services to all citizens ("Preventive Health Services Boosted", 1978).[8]

The increasing number of personnel and facilities and free medical care, and public awareness campaigns on hospital treatment's importance, made public facilities popular among patients. Public health care facilities treated a growing number of patients ("5.6 m Patients Treated in Government Hospitals", 1971). According to the Minister of Health, the average Tanzanian attended outpatient treatment in public health facilities six times per year ("Major Thrust on Preventive Care", 1980).

Internationally, Tanzania's turn to a rapid expansion of essential public health services garnered strong attention. From 1967 until the late 1970s, the country was a donor darling, especially of progressive NGOs and governments, who keenly invested in a state project promising a genuinely African form of egalitarian, participatory, socialist development (Jennings, 2002; Helleiner et al., 1995, p. 6). T. Kue Young, who volunteered in 1979 to train health workers, describes the international popularity of Tanzania's health approach:

During the 1970s and 1980s Tanzania received massive international aid. About 70% of the health capital budget in the late 1970s was from foreign governments, international organisations, church missions and overseas volunteer agencies. As a volunteer working in Tanzania, I was struck by the multiplicity of foreign nationals from both the East and West jostling for an opportunity to help. […] The positive accomplishments of Tanzania compared with other developing countries have made it almost a "most favored nation" in the eyes of many donor governments and agencies. (Young, 1986, p. 132).

Such attention produced a reciprocal effect. While Tanzania usually found itself at the receiving end of global policy prescriptions, the WHO's 1973 "Organizational Study on Methods of Promoting the Development of Basic Health Services" analysed its health practices, along with those of eight other countries, to identify successful formulas. The report, which "shaped WHO ideas on primary health care", presented Tanzania's primary health policy as an example of what could be achieved with minimal means (Cueto, 2004, p. 1866). A follow-up study in 1975 summarised that *the innovative*

8 A "designated hospital" was usually owned by a religious group such as a church. The state paid the running cost including salaries of health workers. In turn, the designated hospital was required to offer free medical services (see "Preventive Health Services Boosted", 1978).

Table 3.
Ministry of Health expenditure on health in selected years, 1970s-early 1990s

Year	Total Health Expenditure (Mill TSh[9])	Real Expenditure (Mill TSh)	Health as % of Total Govt. Expend.	Health Expenditure per Capita (TSh)	
				Nominal Real	Real
1970/71	152	152	6.2	11.5	11.5
1974/75	426	149	6.1	28.4	19.1
1978/79	688	274	5.3	40.4	16.1
1982/83	983	165	5.1	51.1	8.5
1984/85	1329	129	4.8	64	6.3
1987/88	3074	131	4	136	5.8
1988/89	5509	416	5	238	18
1989/90	6532	392.8*	4.6	272.2	17.3
1991/92	7316	392.8*	3.5	299.8	12.8
1992/93	9764	401.2	2.8	389	15.9

Notes: Real Values arrived at by deflating nominal values by the NCPI. 1970/71 = 100. *deflated by NCPI 1977 = 100.

characteristics of the [Tanzanian] approach could be adapted in tackling the pressing health problems of any developing country with similar health problems but with a different sociopolitical system. The approach is attractive in that it clearly demonstrates what can be done with minimum resources. What is needed is a strong national will, an objective examination of the health problems of the country, a clear definition of targets, programmes and priorities in planning, and close adherence to a definite policy in the allocation of resources and the implementation of measures. (Djukanovic et al., 1975, p. 62; see also Wald, 2008, p. 266)

5. Health provision under stress: Challenges of expansion

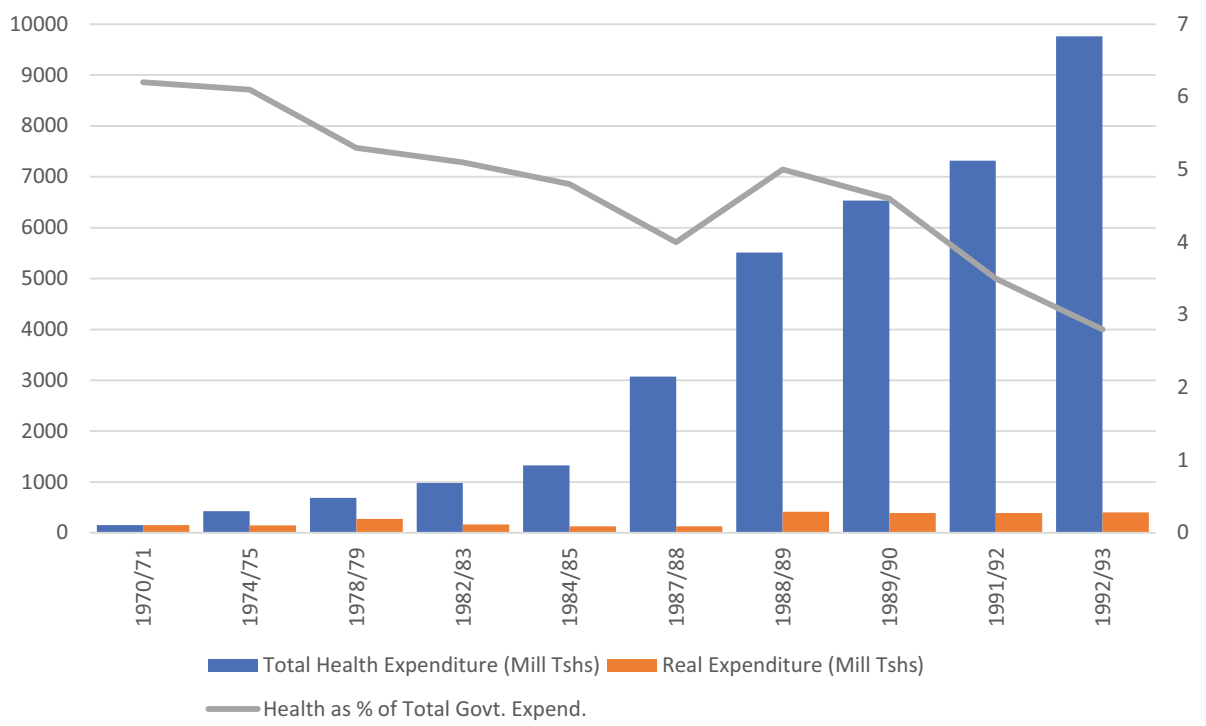
At first glance, it may seem that patients' treatment went well in public health facilities, but a closer look reveals many monetary challenges resulting in various shortcomings. Budgetary constraints constituted one of the major problems that hindered the provision of medical services. While the budget allocated to the health sector increased in the 1960s and early 1970s when it stood at 6% of total government expenditures, it dropped to 5% in the late 1970s (it further plunged to 4% and 2% in the 1980s and early 1990s, respectively) (Msambichaka et al., 1997, p. 21). Table 3 shows the downward trend.

Although table 3 shows an increase in the budget for health, its percentage compared to other sectors continued to decline over the years. Moreover, the table indicates a small budget allocation to health in the 1970s, 1980s and early 1990s.

The health budget problems resulted from a macroeconomic demise in the 1970s. In 1973 and 1974, Tanzania faced severe droughts, leading the government to use its foreign reserve to import food at the cost of $240 million. In 1974, the previous year's $71 million budget surplus turned into an $89

9 TSh = Tanzanian Shilling

Figure 3.
Summary of Ministry of Health Expenditure Trends: Selected Years



Source: Msambichaka et al., 1997, p. 21.

million deficit. The simultaneous increase in fuel prices and the decline in the export crops' value such as sisal, tea and cotton on world markets had a lasting negative impact on the national economy (Mwase, 1973; "The Food Situation in Tanzania", 1976). Nonetheless, the leadership pressed on with its program of "villagisation", during which millions of small farmers relocated from isolated homesteads into planned villages. While villagisation was supposed to increase agricultural output (and bring the people closer to village health facilities), the programme interrupted the production cycle (Tambila, 2008, pp. 229-230; Coulson, 2013, pp. 280-309). For the public health sector, meagre budget allocation resulted. As early as 1976, the District Medical officer of Mbozi district warned that "the money allocated to dispensaries and health centres for the purchase of drugs is too small. This is the reason for the lack of drugs and even food and other equipment in many dispensaries" (MBZA, 1976a). After an attack by neighbouring Uganda, a militarily successful but economically debilitating war in 1978/79 further hampered economic development (Umozurike, 1982). The multiple crises undermined the ruling party's developmental plan's full implementation, including preventive, expansive health policies.

Lack of money led to several negative microeconomic dynamics such as petty corruption, drug and equipment theft, absenteeism of workers, lack of staff and unequal access to health facilities and services. Budget misallocation also became a problem. In 1991, Philemon Sarungi, Minister of Health and Social Welfare, complained that Regional Development Directors and district councils diverted money allocated for health centres and dispensaries to travelling allowances, buying petrol and car maintenance ("Sarungi Shocked by Poor State of Rural Hospitals", 1991).

Besides budgetary constraints, another challenge that existed from the 1960s to the 1980s was some health workers' illegal practices and actions, including theft, ab-

senteeism, and corruption (Sadock, 2019, pp. 31-32). While theft and corruption were criminal offences, the offences partly reflected economic difficulties. The theft and illegal re-selling of drugs and equipment from public health facilities were common (see, e.g. "Ministry Acts on Malaria", 1983). Theft of drugs was also reported in Mbozi district in 1977:

Theft is happening in many dispensaries on a daily basis. The following dispensaries have been affected by burglary: Nyimbili, Isansa, Myunga, Iyula, Kapele Mission, Isandula and Ivuna. Medical Aides in cooperation with village chairpersons and the police are in hot pursuit of the burglars. Indeed, the police have arrested some of the culprits at Tunduma. (Mbeya Zonal Archives, MBZ/MB/21/3, 1977 (MBZA, 1977))

Health workers also directly sold government medicine, which was supposed to be free of charge, and pocketed the money. In some cases, only patients who bought drugs were attended to by doctors (Muluka, 1979; Bech et al., 2013, p. 90).

Absenteeism of health workers became a problem in many public health facilities. For example, in 1965, the Medical-in-Charge of rural Mbozi district documented the unexcused absence of a Medical Rural Aide in charge of Ivuna dispensary, who reportedly went fishing at Lake Rukwa under the pretext of treating patients there (MBZA, 1965). The problem was made worse by insufficient staff in the health facilities. In 1976, for example, out of 17 dispensaries in Mbozi district, seven dispensaries had no midwives. Some dispensaries had no staff at all (MBZA, 1976b). The problem of a lack of staff continued a decade later. In 1986, the Mbeya Regional Medical Office reported the scarcity of health staff in the region (MBZA, 1987).

Another obstacle was the lack of access to health facilities. Although, as noted earlier, the government increased the number of health facilities every year, the facilities did not grow with the pace of population increase. In addition, their distribution across all geographical areas remained uneven. In Mbozi district, some health facilities had been inaccessible to communities due to long distances to the facilities since independence (Mbozi District Council, 2001, p. 10). A similar problem of access to health facilities was reported in the 1970s in Kilolo district of Iringa Region (Ngonyani, 2018, p. 84).

The ban on private health services in 1977 also led to tacit protests, which further weakened the health sector. Rather than surrendering the facilities to the government or the political party, some owners turned the facilities into shops or bars or closed them down. According to newspapers, some facilities, which fell under the rubric of parastatals, did not adhere to the government mandates, as they charged high fees ("Private Clinics Fold up in June", 1980; "New Move on Private Hospitals", 1983).

5.1 Mtu ni Afya: Health education and vaccination

The turn to primary health care in the context of the 1967 Arusha declaration included a renewed commitment to health education and vaccination. The war against diseases should not solely depend on curative treatment but also entailed preventive campaigns. Resembling the colonial period, the post-independence government continued to disseminate health education through films, posters, and other media. The use of the national Radio Tanzania Dar es Salaam (RTD), however, became predominant. The radio broadcasted various programmes on diverse health issues. A good example was *Mtu ni Afya* ("Man is Health") (Sullivan, 2011, p. 94). In 1973, the programme, which involved the Ministries of Health and Education as well as the Prime Ministers' Office and was funded by the Sweden International Development Agency (SIDA), aimed to teach the

masses about preventing diseases, especially malaria, hookworms, dysentery, tuberculosis and bilharzia. The programme entailed a 30-minute radio broadcast to approximately 2 million study groups established throughout the country, whose members, after listening to the programme, took preventive actions such as digging latrines ("Mtu ni Afya Goes into Full Swing", 1973).

Besides the prevention of infectious diseases, the campaigns also educated on nutrition. In 1966, nutritional clinics opened in various parts of the country. The clinics examined and treated malnourished children, while mothers received information on the preparation of nutritious food for their children. *Mtu ni Afya*, the campaign on infectious diseases, in 1974 was followed by a campaign to improve nutrition called *Chakula ni Uhai* (Food is Life) that focussed on nutritiously balanced food and diets (Kahama et al., 1986, p. 166). This role was later taken up by the Maternal and Child Health (MCH) clinics. The campaigns continued in the 1980s and early 1990s.

As for vaccination, a few years after independence, the focus of immunisation was smallpox, prevalent in the southern regions and Lake Victoria. The WHO supported the vaccination and reported great success partly because of strong support from TANU cell leaders who mobilised the people in support of the campaign ("Smallpox Campaign", 1969). Indeed, by 1970 smallpox was reported to have been eradicated in Tanzania ("Tanzania Immunises 60% of Children", 1977). Donor and international organisations supported the government-initiated Expanded Programme on Immunisation (EPI) in the 1970s and Universal Child Immunisation (UCI) in the 1980s ("UNICEF earmarks 41m for Tanzania", 1976; Msambichaka et al., 1997, p. 50). The programmes focused on immunising against measles, polio, smallpox, tuberculosis, diphtheria, whooping cough and tetanus. The vaccination campaigns against the diseases showed tremendous success. For example, in 1972, 74,733 children under five years of age were vaccinated in Tanzania. The number increased to one million in 1976 ("Tanzania Immunises 60% of Children", 1977).

Despite the successes, vaccination campaigns encountered challenges. The most common challenge was that the campaigns and interventions were too dependent on external assistance, which typically covered a specific period such as two years; thus, the campaigns lacked sustainability. This situation was made worse because the country's internal resources were too meagre to sustain the programmes (Msambichaka et al., 1997, p. 50). Another challenge was that the economic crises of the 1970s and 1980s had adverse impacts on vaccination initiatives. These national challenges were manifested at a local level, such as Mbozi district.

In Mbozi district, the campaigns on communicable diseases were conducted in schools, villages, market places and health facilities (Mbozi District Annual Medical Report, 1981 (MBZA, 1981)). Most of these places were reached through a mobile clinic scheme that started in 1970, replicating a Chinese model, which consisted of a team of medical personnel from the district headquarters who visited villages to offer health education, vaccination as well as treating patients (Mbozi District Monthly Medical Report for November 1972 (MBZA, 1972)).

However, in Mbozi district, economic, political, and medical problems hampered the campaigns against communicable diseases. Although many health lectures were conducted in the district, lack of transport held back full coverage of the district (MBZA, 1974). In the 1970s and 1980s, the team had only one dilapidated car at its disposal, which was often out of service, which meant that very few places could be visited (MBZA, 1987). These problems continued during the liberalisation period of the 1980s and early 1990s

6. The challenges continue: Primary health care and economic liberalisation

After hesitating for several years, in 1985, Tanzania began cooperating with the World Bank on an "Economic Recovery Project", which served as a basis for a 1986 "Stand-by Agreement" with the International Monetary Fund (IMF). Cooperation with the international financial institutions provided new credit, but it also meant the end of the socialist Ujamaa development model. The newly adopted liberalisation approach notably included the devaluation of the Tanzanian currency, the removal of government subsidies and the cutting of state expenditures, the liberalisation of import and export trade regulations, and other measures to foster the growth of private investment and enterprises (Havnevik, 1993, pp. 290-291; Bech et al., 2013, pp. 69-71; Sadock, 2015, p. 83). Yet even before the 1986 agreement with the IMF, the health sector had suffered from an economic crisis. Per capita spending on health had declined by over a third between 1980 and 1986. The devaluation of the Tanzanian Shilling in 1986 led to a 300-400 per cent price increase, resulting in a severe scarcity of essential drugs and medical equipment (Lugalla, 1995, pp. 44-45).

Nonetheless, the government attempted to continue the previous approaches of rural primary health expansion. By 1990, for example, there were 3000 dispensaries compared to 825 at independence, 260 health centres compared to 22 at independence, and 154 hospitals compared to 98 hospitals at independence ("Mwinyi Launches Health Plan", 1990). However, the population-doctor ratio increased from 19,053 in 1981 to 24,880 in 1990, while the population-nurse ratio rose from 3,310 people in 1970 to 5,470 people in 1990 (Lugalla, 1995, p. 44).

The 1990 National Health Policy (MOH, 1990) served as the blueprint of structural adjustment for the health sector. One central aspect of the policy was the re-introduction of private for-profit health services. Amid intense lobbying from doctors and their associations, especially the Medical Association of Tanzania, the World Bank and the IMF, in 1991, the government re-introduced private for-profit health facilities where patients paid for the services.

In the 1988/1989 financial year, the government proposed a user fee of 20 Tanzania Shilling for citizens using public health facilities. The charges were introduced to increase the ability of the Ministry of Health and local governments to provide medical services ("Hospital to Charge 20/= Registration Fee", 1988). Introducing user charges was a sharp departure from the policy of free provision of health services to all citizens, which had existed since independence. However, this proposal was not implemented until July 1993. It was initially introduced only to patients attending referral, regional and district hospitals. In 1994, primary health centres and dispensaries continued to offer free medical services. Exemptions of fee payment were also provided to groups such as students and patients suffering from chronic and epidemic diseases ("Medical Cost Sharing Clarified", 1993).

Gradualism was the ruling party's strategy to avoid alienating its rural electoral constituency. Inside the party, the gradual approach also appeased the leftist CCM members. They continued to espouse the socialist ideology despite the party's 1991 Zanzibar Declaration, in which it formally turned away from socialism. Lastly, gradual measures gave room for the government to study the policy's feasibility.

The initial consequences of the various policies, however, did not show much positive impact. Indeed, several continuities could be observed. For example, the problem with drug theft persisted. In 1988, Minister of Health and Welfare Aoron Chiduo noted that since the government had allowed private individuals to deal in the pharmaceuti-

cal trade, many private shops emerged. Still, there was sufficient evidence to prove that some medicines in such pharmacies originated from government hospitals and institutions. The minister, during the parliament's annual budget debate, argued that a lack of foreign exchange had caused the shortage of medicine, equipment and transport facilities in health centres. Explicitly referring to drugs, he further remarked that even with the availability of the donor-supported "Essential Drugs Programme", only 16 per cent of the required budget could be covered ("Hospital to Charge 20/= Registration Fee", 1988).

Three years later, the following health minister, Philemon Sarungi, called for an "all-out war" against traders who sold government medicines, saying they were the source of the government hospitals' medicine shortage. Testifying the police forces' weak investigation capacities, he called upon the regions to use traditional militia, *Sungusungu*, to check on the shops and punish those found with government drugs ("Sarungi Shocked by Poor State of Rural Hospitals", 1991). Blaming traders, however, was a tried-and-true governmental tradition for making scapegoats. The underlying problem was the failure to provide a sufficient drug supply. The shortage of drugs then offered favourable conditions for the emergence of all sorts of illegal practices.

In the early 1990s, a "Presidential Commission against Corruption" identified several forces that engendered corruption, including the shortage of drugs and equipment, a misconception of the cost-sharing policy, inadequate supervision of employees of dispensaries and hospitals, as well as the policy of allowing health workers to establish private dispensaries, hospitals and pharmacies (Presidential Commission of Inquiry against Corruption, 1996, p. 440). The commission added that absenteeism continued to be widespread: "Doctors have been delivering services in their [private] hospitals during government working hours while they are required to be providing services in government hospitals" (Presidential Commission of Inquiry against Corruption, 1996, pp. 440-441). Heggenhougen & Lugalla (2005, pp. 293-294) blamed the low salaries of health workers as a prime reason for corruption in the sector.

Cost-sharing, as the introduction of fees has been called, limited the access of the majority of poor Tanzanians to both government and private health services (Heggenhougen & Lugalla, 2005, p. 295). Leakage occurred even in internationally funded programmes against HIV/AIDS, such as the disappearance of drugs supplied in collaboration with Germany's GTZ, the European Union and Tanzania's National AIDS Control Programme (NACP) to health centres in Mbeya in 1994 (MBZA, 1994). Consequently, fee exemptions were of little practical value for patients. An AIDS[10] patient in the early 1990s in Mbozi district noted that he, together with other AIDS patients, enjoyed exemption[11] from cost-sharing in government health facilities. However, he reported that drugs were unavailable in the facilities, making free prescriptions worthless (confidential interview, 2014).

As a result of the liberalisation policy, the number of private health facilities and privately owned pharmacies increased. Mbozi District in 1987 had thirty-one health facilities which, except for those owned by voluntary agencies (churches), belonged to the government (MBZA, 1987). Yet in 1996, facilities in the district increased to forty-three, of which thirty-eight were dispensaries: twenty-one owned by the government and seventeen by private individuals. The remaining five health facilities included two hospitals: one owned by the government

10 In Mbozi district, the first case of AIDS was reported in 1986. The cases continued to increase in the 1990s and early 2000s. For a detailed discussion of the diseases and its social consequence's see Sadock (2016).

11 As the AIDS pandemic continued to wreak havoc, exceptions were granted to other groups such as widows, orphans and the elderly.

while the Moravian Church owned the other. The church also held one health centre, while the government had two health centres (United Republic of Tanzania, 1997, p. 55). It is, however, essential to note that despite the increase of private health facilities, their access, as Wyss et al. (1996) aptly document for Dar es Salaam, was limited to few more affluent urban dwellers. The facilities hardly existed in rural areas where for-profit health facilities remained unfeasible. Also in Mbozi district the facilities were located solely in towns.

7. Conclusion: International dimensions of primary health care in Tanzania

This paper established the elements, motivations and challenges of state engagement and disengagement in providing primary health care in Tanzania from the colonial to the post-colonial period. The feeble engagement of the early British colonial state was founded on the philosophy that a colony should run by using its resources. The colonial state engagement increased after the 1930s depression and the Second World War. It had become clear that disregarding the health of the large majority undercut broader developmental aspirations. Tanganyika's status as a protectorate under the League of Nations and later the United Nations and local and nationalist demands for health services increased the pressure on the colonial government. After independence, especially during Ujamaa socialism, the government enormously expanded health services, especially in rural areas. Similar to the colonial period, the factors leading to this expansion included legitimacy—among the regime's rural supporters—but were also linked to the hope that they would trigger broad-based development based on higher agricultural production.

Health policies in colonial and post-colonial Tanzania have been shaped by domestic and international (including imperial) forces. We can differentiate among three dimensions of international interaction with health policy design, implementation and outcome: transnational economic exchange; imperial and international governmental institutions; and global governmentalities and ideologies. The first, economic exchange, shaped both the actual material capacity of Tanzania's emerging welfare state as well as the ideas of how this capacity might be enlarged through development. Tanzania's disadvantageous and deteriorating terms of trade, which were set by external forces and hardly influenced by any domestic actor group, severely limited and then nearly crashed public health provision during the period under investigation. The domestic economic structure, dominated by peasants often producing only a slight surplus beyond their own subsistence needs, also set limits to what individuals, families or communities could contribute to the financing of health services.

Imperial and international governmental institutions played a decisive role throughout nearly the entire period under investigation. After the Second World War, the British colonial administration reported to London and needed to answer to the U.N. Trusteeship Council. The claims and criticism of public health voiced by its colonial subjects were sometimes effective, but primarily as the colonial administration sought to avoid a loss of face on the imperial and international level. Only during the two decades following independence was Tanzania's government essentially sovereign in setting health policies and budgets under relatively beneficial economic and political circumstances. Donor-financed programmes and projects have been highly significant. Yet the government was largely successful in streamlining these flows of money and expertise according to its own conceptions. During the economic crisis and structural adjustment, this agency slipped to a large extent. International financial institu-

tions wielded enormous power over the fiscal policies of Tanzania, which in economic matters lost much of its hard-won sovereignty. Austere state budgets heavily damaged the public health sector. Even today, Tanzanians have better chances to shape the relationships with the multitude of smaller bilateral, multilateral and private donors than with the powerful international financial institutions.

The preservation of agency is closely connected to the third dimension of international interaction, namely global governmentalities. In this perspective, Tanzania, from independence until the end of its socialist experiment, acquired remarkable discursive influence on the international level. While the government under its charismatic leader Julius Nyerere developed ideas that proved appealing in both the eastern and western blocs as well as the global South. While often on the receiving side of international interactions, in the health field, Tanzania (in concert with a few other developing nations) remarkably acted as a trailblazer. The country set an example for the global Primary Health Approach. It showed how a young state focussed on the most pressing problems could deliver a basic health system in an extremely dire economic situation. Almost tragically, Tanzania's primary health care approach has been undermined by disadvantageous terms of trade and externally imposed fiscal austerity, at the very moment when many of its core ideas and elements became enshrined into the Declaration of Alma-Ata.

Why has Tanzania's primary health care approach proved so resilient despite its many challenges, surviving (if barely) even the ravages of economic and political calamities of the 1980s and 1990s? The approaches' first elements had already been introduced during the British colonial period. Preventive measures such as awareness and vaccination campaigns partnered with a decentralised system of locally governed and funded dispensaries and dressers promised some easing of the most pressing problems of colonial rule: the shortage of healthy labourers; a cost-efficient, reliable and robust institutional presence in the rural areas; and generally, political legitimacy for colonialism domestically and on the imperial and international level. Altogether, the state counted on the prospects of a cost-efficient health improvement leading to a more vital link between the colonial state and colonised society. Primary health care *avant la lettre* also served to satisfy contradictory metropolitan expectations of financial prudence and social progress.

After independence, expressed broadly similar motives for the radical expansion and modernisation of the inherited primary health care elements. In contrast to many of the independent government's economic policies, the approach did not face international opposition. Instead, it allowed the government to become part of an international group of states promoting similar health policies and attract additional donor funding. The colonial government's balance of curative and preventive services in urban areas shifted much more decisively to providing free primary health care services with strongly preventive elements in rural areas. The policy continued until the era of SAPs, when introducing user fees, the dysfunctionality of many public health care facilities, and the non-emergence of a functioning health care market due to a lack of solvent consumers in rural areas undercut primary health care. The expectation that private health service could replace the enfeebled public system proved futile, especially concerning primary health care for the rural poor. Nonetheless, until the time of writing, the original primary health care approach has remained a central pillar of Tanzania's overall public health policies.

References

5.6 m Patients Treated in Government Hospitals. (1971, May 5). *The Nationalist*.

Bauche, M. (2017). *Medizin und Herrschaft: Malariabekämpfung in Kamerun, Ostafrika und Ostfriesland* (1890–1919). Frankfurt: Campus.

Bech, M., Lawi, Y., Massay, D., & Rekdal, O. (2013). Changing Policies and their Influence on Government Health Workers in Tanzania 1967–2009: Perspectives from Rural Mbulu District. *International Journal of African Historical Studies, 46*(1), 61–103.

Beck, A. (1970). *A History of the British Medical Administration of East Africa, 1900–1950*. Massachusetts: Harvard University Press.

Bruchhausen, W. (2017). The Human Right to Health and Primary Health Care (PHC) Policies. In S. Klotz, H. Bielefeldt, M. Schmidhuber, & A. Frewer (Eds.), *Healthcare as a Human Rights Issue* (pp. 145–166). Bielefeld: Transcript.

Chudson, W., & Hayes, J. P. (1958). *The Economy of Tanganyika. Preliminary Memorandum for the IBRD Survey Mission*. Washington: International Bank for Reconstruction and Development.

Clyde, D. (1962). *History of Medical Service in Tanganyika*. Dar es Salaam: Government Press.

Colonial Development Act (CDA). (1929). Retrieved June 19, 2020, from http://www.legislation.gov.uk/ukpga/Geo5/20-21/5/enacted.

Coulson, A. (2013). T*anzania: A Political Economy* (2nd edition). Oxford: Oxford University Press.

Cueto, Marcos. (2004). The Origins of Primary Health Care and Selective Primary Health Care. *American Journal of Public Health, 94*(11):1864–1874.

Devereux, S. (2020). Policy pollination: A brief history in Africa. SOCIUM SFB 1342 *Working Papers 8/2020*. University of Bremen, Collaborative Research Center 1342.

Djukanovic, V., Mach, E. P., & World Health Organization. (1975). *Alternative approaches to meeting basic health needs in developing countries: A joint UNICEF/WHO study*. Geneva: World Health Organization.

Electing a Parliament for Party Consolidation: Election Manifesto. (1975, October 2). *Daily News*.

End of Commercial Medicine in Tanzania. (1980, June 26). *Daily News*.

Hamann, S. (2020). Not home-made: Historical and contemporary social policy dynamics in Cameroon. *Global Social Policy, 20*(3), 286–304. https://doi.org/10.1177/1468018120923235.

Hanerieder, T. (2019). How Do Professions Globalize? Lessons from the Global South in US Medical Education. *International Political Sociology 13*(3):296–314. https://doi.org/10.1093/ips/olz010

Havnevik, K. J. (1993). *Tanzania: The Limits to Development from Above*. Motola: Nordic Africa Institute.

Health and Development. (1973, May 14). *Daily News*.

Health Services in Villages. (1969, September 27). *The Nationalist*, p. 8.

Heggenhougen, K., & Lugalla, J. (2005). How should Tanzania Improve People's Health? In K. Heggenhougen, & J. Lugalla (Eds.), *Social Change and Health in Tanzania* (pp. 291–300). Dar es Salaam: Dar es Salaam University Press.

Helleiner, G. K., Killick, T., Lipumba, N., Ndulu, B. J., & Svendsen, K. E. (1995). *Report of the Group of Independent Advisers on Development Cooperation Issues Between Tanzania and Its Aid Donors*. Copenhagen: Royal Danish Ministry of Foreign Affairs.

Hospital to Charge 20/= Registration Fee. (1988, July 28). *Daily News*.

Illife, J. A. (1979). *A Modern History of Tanganyika*. London: Cambridge University Press.

Individual Medical Practice to be abolished. (1977, March 31). *Daily News*.

Jennings, M. (2002). Almost an Oxfam in Itself: Oxfam, Ujamaa and Development in Tanzania. *African Affairs, 101*(405), 509–530.

Kahama, G., Maliyamkono, T. L., & Wells, Stuart J. (1986). *The Challenges For Tanzania's Economy*. Dar es Salaam: Tanzania Publishing House.

Kaigarula, W. (1979, March 6). Taking Health Services to Where the People are – the Rural Areas is the Major Preoccupation of Tanzania. *Daily News*.

Kamya, J. (1976, August 19). Do not Abolish Private Hospitals. *Daily News*.

Kilama, W., Nhonoli, A., & Makene, W. (1974). Health Care Delivery in Tanzania. In G. Ruhumbika (Ed.), *Towards Ujamaa: Twenty Years of TANU Leadership* (pp. 191–217). Nairobi: East African Literature Bureau.

Kuhlmann, J., González de Reufels, D., Schlichte, K., & Nullmeier, F. (2020). How social policy travels: A refined model of diffu-

sion. *Global Social Policy, 20*(1), 80–96. https://doi.org/10.1177/1468018119888443.

Lugalla, Joe L. P. (1995). The Impact of Structural Adjustment Policies on Women's and Children's Health in Tanzania. *Review of African Political Economy, 22*(63), 43–53.

Major Thrust on Preventive Care. (1980, July 9). *Daily News*.

Malima, A. K. (1979). Planning for Self-Reliance: Tanzania's Third Five Year Development Plan. *African Development, 4*(1), 37–56.

Maliyamkono, T. L., & Mason, H. (2006). *The Promise*. Dar es Salaam: Tema Publishing Company.

Malloy, P. (2003). "*Holding [Tanganyika] by the Sindano": Networks of Medicine in Colonial Tanganyika* (PhD Dissertation). University of California, Los Angeles.

Masebo, O. (2010). *Society and Infant Welfare: Negotiating Medical Interventions in Colonial Tanzania, 1920–1950* (PhD Dissertation). University of Minnesota, Minneapolis.

Massoud, O. (2008). Governance and Primary Health Care Delivery in Nigeria. In M. Sama, & V. Nguyen (Eds.), *Governing Health Systems in Africa* (pp. 15–24). Dakar: CODESRIA.

MBZA [= Mbeya Zonal Archives, henceforth MBZA] (1965, July 26). *Health General, From Regional Medical Officer to the Executive Officer, District Council, Mbeya Re: Ivuna Dispensary* (Acc. 16 HE11/17 No. RMO /H.1/17).

MBZA. (1972). *Mbozi District Monthly Medical Report for November 1972* (Acc. 16 HE/11/42 No. R.1/8).

MBZA. (1974). *Mbozi District Monthly Medical Report for February 1974*.

MBZA. (1976a, February 6). *Mganga Mkuu wa Wilaya, Mbozi kwenda kwa Mkurungenzi wa Maendeleo wa Wilaya, Mbozi, Taarifa ya Mwaka 1975* (Acc. 16 HE11/105).

MBZA. (1976b, October 18). *Taarifa ya Mwezi Septemba, Wilaya ya Mbozi 1976* (Acc. 16 HE11/42 No. R1/8 Kumb. Na. VHO/ v1&2/25).

MBZA. (1977, April 23). *Mganga Mkuu wa Wilaya ya Mbozi kwenda kwa Mkurugenzi wa Maendeleo wa Wilaya, Mbozi, Taarifa ya Mwaka ya Mganga mkuu wa Wilaya ya Mbozi, Taarifa ya Mwezi Januari 1977* (Acc. 16 HE11/42 Kumb. Na. MBZ/MB/21/3).

MBZA. (1981). *Mbozi District Annual Medical Report* (Acc. 16 HE11/25/1 No. RMO/A1/II).

MBZA. (1987). *Taarifa ya Mganga Mkuu wa Wilaya ya Mbozi Januari-Desemba 1987* (Acc. 16 HE11/106 No.VH/T.18/61).

MBZA. (1994, December). *Regional Medical Office. Europäische Kommission: General Direktion Entwicklung*.

Mbozi District Council, District Medical Office. (2001). *Comprehensive Council Health Plan for the year 2001*. Mbozi District.

Medical Cost Sharing Clarified. (1993, June 30). *Daily News*.

Mihanjo, E. (2004). Colonial Policy on Sexually Transmitted Diseases and Other Infectious Diseases in Tanganyika 1900–1960. In Y. Lawi, & B. Mapunda (Eds.), *History of Diseases and Healing in Africa, Proceedings of a Workshop held at the University of Dar es Salaam, 20th December 2003* (pp. 90–107). GeGCA-NUFU and History Department Publication No. 7.

Ministry Acts on Malaria. (1983, June 24). *Daily News*.

MOH [= United Republic of Tanzania, Ministry of Health, henceforth MOH]. (1990, February). National Health Policy. Retrieved April 19, 2020, from www.tzonline.org.

MOH. (1995). *Planning and Management of Primary Health Care in Tanzania: A Manual for District Health Teams*. Dar es Salaam: Ministry of Health.

MOHSW [= United Republic of Tanzania, Ministry of Health and Social Welfare]. (2007). *Primary Health Services Development: MMAM 2007–2017*. Dar es Salaam: Ministry of Health and Social Welfare.

Morrison, D. R. (1976). *Education and politics in Africa: The Tanzanian case*. London: Hurst.

Msambichaka, L., Kilindo, A., Kiwara, A., & Mkusa, E. (1997). *Economic Adjustment Policies & Health Care in Tanzania*. Dar es Salaam: Economic Research Bureau, University of Dar es Salaam.

Mtu ni Afya Goes into Full Swing. (1973, May 14). *Daily News*.

Muluka, O. (1979, Oktober 5). "Hatupati Dawa Gombe". *Uhuru*.

Mwase, N. (1973, June 22). Towards the Third Five Year Development Plan. *Daily News*.

Mwinyi Launches Health Plan, says: Joint Efforts Necessary to Fight Diseases. (1990, June 17). *Daily News*.

New Development Plans Approved by the Cabinet. (1969, May 10). *The Nationalist*.

New Move on Private Hospitals. (1983, April 17). *Daily News*.

Ngonyani, S. (2018). *A History of National Health Care Provision Policies in Tanzania: A Case of Kilolo District, 1960s–1980s* (Master's Thesis). University of Dar es Salaam, Dar es Salaam.

Nsekela, A., & Nhonoli, A. (1976): *Health Services and Society in Mainland Tanzania: A Historical Overview – Tumetoka Mbali*. Dar es Salaam: East African Literature Bureau.

Nyerere, J. (1962). *Ujamaa: The Basis of African Socialism*. Dar es Salaam: Jihad Productions.

Orde Browne, G. (1927). Native Labour in Tanganyika. *Journal of the Royal African Society, 26*(102), 112–116.

Pesek, M. (2010). *Das Ende eines Kolonialreiches: Ostafrika im Ersten Weltkrieg*. Frankfurt: Campus.

Plan for Vigorous Health Education Plan. (1967, May 8). *The Nationalist*.

Plans to Integrate Health Services. (1969, October 29). *The Nationalist, p. 1*.

Presidential Commission of Inquiry against Corruption. (1996). *Report on the Commission on Corruption*: Volume 2. Dar es Salaam.

Preventive Health Services Boosted. (1978, August 25). *Daily News*.

Private Clinics Fold up in June. (1980, March 21). *Daily News*.

Riley, C. L. (2017). 'The Winds of Change Are Blowing Economically': The Labour Party and British Overseas Development, 1940s–1960s. In A. W. M. Smith, & C. Jeppesen (Eds.), *Britain, France and the Decolonisation of Africa* (pp. 43–61). London: UCL Press.

Sadock, M. (2012). 'Eating a Ripe Banana with its Skin on': Health Education Campaigns against STDs and HIV/AIDS in Mbozi District, Tanzania, 1980s–2010. *The African Anthropologist, 19*(1-2), 1–18.

Sadock, M. (2013). Government and the Control of Venereal Disease in Colonial Tanzania, 1920–1960. In S. Wieringa, & H. Sivori (Eds.), *The Sexual History of the Global South: Sexual Politics in Africa, Asia, and Latin America*. London: Zed Books.

Sadock, M. (2015). *History of Sexually Transmitted Diseases in Mbozi District, Tanzania, 1905–2005* (Unpublished PhD Thesis). University of Dar es Salaam, Dar es Salaam.

Sadock, M. (2016). HIV/AIDS and Social Exclusion in Mbozi District, Tanzania, 1980s–2014. *Tanzania Zamani, 8*(1), 1–26.

Sadock, M. (2019). Soma Ule (S. U.): The Political Economy of Corruption in Tanzania, 1960s–2010. *Tanzania Zamani, 11*(1), 30–70.

Salim, S. S. (1976, April 12). Peasants get health Priority. *Daily News*.

Sarungi Shocked by Poor State of Rural Hospitals. (1991, March 24). *Daily News*.

Smallpox Campaign. (1969, April 5). *The Nationalist*.

Sokoine Warns Private Doctors. (1977, April 29). *Daily News*.

Sullivan, N. (2011). *Negotiating Abundance and Scarcity: Health Sector Reform, Development Aid, and Biomedical Practice in a Tanzanian Hospital* (PhD Dissertation). University of Florida, Gainesville.

Tambila, K. (2008). The Impact of Economic Ups and Downs. In I. Kimambo, B. Mapunda, & Y. Lawi (Eds.), *In Search of Relevance: A History of the University of Dar es Salaam* (pp. 227–238). Dar es Salaam: Dar es Salaam University Press.

Tanganyika Provincial Commissioner. (1959). *Annual Report 1958*. Dar es Salaam: Government Printer.

Tanganyika Territory. (1944). *An outline of Post-War Development Proposals*. Dar es Salaam: Government Printer.

Tanzania Immunises 60% of Children. (1977, April 8). *Daily News*.

The Food Situation in Tanzania. (1976, March 15). *Daily News*.

Thuilliez, J. & Berthélemy, J. (2014). Health and Development: A Circular Causality. *Revue d'économie du développement,* HS01(22), 109–137. https://doi.org/10.3917/edd.hs01.0109.

TNA [= Tanzania National Archives]. (1928, December 4). Dr. A. J. *Boase Report on the use of Bismuth Salts for the Treatment of Yaws and Venereal Diseases. A circular from the Secretary of State for Colonies to the Governor, Tanganyika* (Acc. J 9 No.10024).

TNA. (1929). *Mbozi District Book vol. II*.

TNA. (1932). *Venereal Diseases and Yaws, Syphilis Treatment with Bismuth 1921–1931* (Acc. 450 No. 3).

TNA. (1934, June 8). *Extract from Memorandum on Tribal Dressers by the Director of Medical and Sanitary Services*.

TNA. (1935). *Secretariat No. 13571 Provincial Commissioner, Provincial Office Iringa, to Chief Secretary to the Government*, "Ref No 22/10/21 referring to your letter No. 13571/ 285 of 20th December 1934 regarding the DMSS Proposals for the Better Training of Tribal Dressers."

TNA. (1936). *Mbeya – Iringa and Southern Highlands Provinces – Provincial Book II*.

TNA. (1937). *Mbeya (Iringa and Southern Highlands) Provincial Book vol. 1*: B. A. Coghlan, Medical Officer, History of Government Medical Activities: Iringa and Njombe Districts till 1937.

TNA. (1944, October 20). "*Post War Medical Policy 1943–1945*". A letter from the Medical Officer, Government Hospital Mwanza, to the DMS, 20th October 1944 (Acc. 450 No. 3/1179).

TNA. (1945a). *Tanganyika Secretariat 25473 vol. II: Medical Auxiliaries, Note on the Extraction of Health Services in Rural Areas*.

TNA. (1945b, November 24). *Director of Medical Services to the Senior Medical Officer,* Dodoma, 20th October 1945 on "A Circular from the DMS to the Chief Secretary" (Acc. 450 No. 3/193).

TNA. (1945c, November 24). *Director of Medical Services*, Dar es Salaam, to the Chief Secretary. "Control and Prevention" (Acc. 450 No. 3/235).

TNA. (1947, May 19). *Annual Medical Report Southern Highlands Province* (Acc. 450 No. 3/ 1401/15).

TNA. (1948a, April 6). *W. Ellis-Jones to the Senior Medical Officer,* Southern Highlands Province, Mbeya (Acc. 450 No. 3).

TNA. (1948b, April 15). *Medical Officer, Sukumaland, to the Provincial Medical Officer*, Lake Province, Mwanza (Acc. 450 No. 3).

TNA. (1948c). *Mbeya District Book II. East African Population Census*.

TNA. (1958). *Annual Provincial Medical Report* (Acc. 450 No.3. 1623/9).

TNA. (1959). *Annual Provincial Medical Report* (Acc. 450 No HE 1636/10A).

Turshen, M. (1989). *The Politics of Public Health*. New Jersey: Rutgers University Press.

Umozurike, U. D. (1982). Tanzania's Intervention in Uganda. *Archiv des Völkerrechts, 20*(3), 301–313.

UNICEF Earmarks 41m for Tanzania. (1976, June 26). *Daily News*.

United Republic of Tanzania, The Planning Commission, Dar es Salaam, and Mbozi District Council. (1997). *Mbozi District Socio-economic Profile*.

Van Etten, G. (1976). *Rural Health Development in Tanzania: A Case-Study of Medical Sociology in a Developing Country*. Assen: van Gorcum.

Wald, P. (2008). *Contagious: Cultures, Carriers, and the Outbreak Narrative*. Durham/London: Duke University Press.

WHO. (1978). *Declaration of Alma-Ata*. International Conference on Primary Health Care. 6–12 September 1978. Alma-Ata, USSR.

WHO. (n. d.). Fact Sheets: Primary Health Care. Retrieved June 25, 2020, from https://www.who.int/news-room/fact-sheets/detail/primary-health-care.

Wyss, K., Whiting, D., Kilima, P., McLarty, D. G., Mtasiwa, D., Tanner, M., & Lorenz, N. (1996). Utilisation of government and Private Health Services in Dar es Salaam. *East Africa Medical Journal, 73*(6), 357–363.

Young, T. K. (1986). Socialist Development and Primary Health Care: The Case of Tanzania. *Human Organization, 45*(2), 128–134.