

# **Creating Health Futures**

## **Maternal Health Policy, Planning, and the Making of Postcolonial Tanzania, 1961–1980**

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to complete the Doctorate from the Faculty of Arts and Humanities  
of the University of Cologne  
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**by**

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## **Declaration**

This is my original work and has never been presented in any university anywhere for academic acclaim. It has not yet been published, except possibly in part, with the approval of the dean, the faculty of philosophy, and the supervising professor. This dissertation has benefited from other works, both literal and in spirit, as a source of inspiration, all of which were duly acknowledged and relevant permissions sought from the specific authors, especially for images used. Likewise, no part of the work should be reproduced, in whole or in part, by any means, except for brief excerpts used under fair dealing for research, private study, or critical scholarly review or discussion, and only with proper acknowledgement.

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I am not aware of any conflicts of interest.

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### **A note on language and translation**

Although this thesis is written in English, it draws on sources from various languages and historical periods. First, in Tanzania, most of the archival documents I accessed were written in Swahili, and nearly all interviews were conducted in Swahili. Secondly, I conducted archival work in Norway and Switzerland, where the materials gathered were primarily in German, French, or Norwegian. I have included some Swahili and German words and direct quotations in italics, where I considered it essential to retain their original meanings or usages. All translations, except where explicitly noted, are my own and reflect my interpretation of the original texts. Some historical terms—now outdated or considered derogatory—may appear in italics or quotation marks. These are used cautiously and accompanied by explanatory notes where necessary.

## Operational Definition of Terms

Colonialism and imperialism. In this study, colonialism refers to the political control and exploitation of one country by another, accompanied by effective settlement. In contrast, imperialism denotes control and exploitation without necessarily involving effective occupation. However, the two may be used interchangeably in this study.

Hybridisation refers to the blending or mixing of different medical systems to produce a new, hybrid form.

Maternal health relates to women's reproductive health during pregnancy, childbirth, and the postnatal period.

Postcolonial I use 'postcolonial' (without a hyphen) to refer to the historical period following the formal end of colonial rule, marked by a nation's political independence and efforts at self-governance. However, it also encompasses the ongoing social, economic, and institutional legacies of colonialism that continue to influence a country's development trajectory. In this study, postcolonial Tanzania is defined as the period from 1961, the year of independence. However, I argue that colonial structures and ideas persisted, shaping health policies and practices, particularly in health planning, throughout the subsequent decades.

Subaltern I use 'subaltern'<sup>1</sup> to refer to marginalised individuals and groups—particularly traditional midwives, herbalists, rural women, and local health actors—whose voices, knowledge systems, and experiences were historically excluded or subordinated in the formulation and implementation of national health policies. On a global scale, Tanzania may also be considered a subaltern state, occupying a peripheral position in international health policy planning, often framed primarily as a recipient of aid, expertise, and development agendas rather than as an active agent in policymaking.

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<sup>1</sup> Gayatri Chakravorty. Spivak, 'Can the Subaltern Speak?', in *Can the Subaltern Speak? Reflections on the History of an Idea* (Columbia University Press, 2010), <http://www.jstor.org/stable/10.7312/morr14384.5>.

Synchronisation refers to the parallel operation or coordinated coexistence of various medical systems without necessarily blending them.

‘Western’ and ‘traditional medicine’ I acknowledge the complexities associated with the terms ‘traditional medicine’ and ‘Western medicine’, encompassing issues related to their meanings, methods, and practices. Within the context of this study, ‘traditional medicine’ refers to therapeutic approaches aligned with African philosophy, legal frameworks, religious beliefs, and broader cultural practices. It also involves methods and theories of health and healing originating from the African continent, typically involving herbs, rituals, and the invocation of spirits. These ways of healing are also referred to as Popular, Indigenous, or African medicine. On the other hand, ‘Western medicine’ refers to medical ideas originating within the geographical scope of Europe or the Global North and is often used interchangeably with biomedicine/modern medicine in this context. It denotes therapeutic practices introduced to Africa as concepts originating in the Western world. Despite numerous scholarly explorations into the problematic nature of these terminologies, they persist as categories that shape identities and frame discussions about healthcare practices in the African context.<sup>2</sup>

Welfare refers to the overall well-being of individuals and communities, encompassing their social, economic, and health conditions. In the context of health policy, welfare encompasses government and institutional efforts to provide essential services and support,

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Steven Feierman, ‘Struggles for Control: The Social Roots of Health and Healing in Modern Africa’, *African Studies Review* 28, 2/3, no. 2/3 (1985): 73–147, [www.jstor.org/stable/524604](http://www.jstor.org/stable/524604); Steven Feierman and John Janzen, *The Social Basis of Health and Healing in Africa* (University of California Press, 1992); Balogun Oladele Abiodun, ‘Medicinal Practice in Western Science and African Traditional Thought: A Comparative Analysis’, *African Identities* 3, no. 2 (2005): 211–25; Samuel S. Antwi-Baffour et al., ‘The Place of Traditional Medicine on African Society’, *American Journal of Health Research* 2, no. 2 (2014); Michael Jennings, ‘Bridging the Local and the Global Faith-Based Organizations as Non-State Providers in Tanzania’, in *The Politics of Non-State Social Welfare*, ed. Melani Cammett and Lauren M. MacLean (Cornell University Press, 2014), <https://doi.org/10.7591/9780801470349-008>; Michael Jennings, ‘Cooperation and Competition: Missions, the Colonial State and Constructing a Healthy System in Colonial Tanganyika’, in *Beyond the State: The Colonial Medical Service in British Africa*. (Manchester University Press, 2016); Maurine R. Musie et al., ‘African Indigenous Beliefs and Practices during Pregnancy Birth and After Birth.’, in *Working with Indigenous Knowledge: Strategies for Health Professionals* (Aosis Books, 2022).

such as access to healthcare, nutrition, education, and social protection—aimed at improving the quality of life and reducing vulnerabilities, particularly among marginalised groups, including mothers and children.

## Abbreviations and Acronyms

AMO	Assistant Medical Officers
ASP	Afro-Shirazi Party
BNCU	Bukoba Native Cooperatives Union
CHAWATIATA	<i>Chama cha Waganga na Wakunga wa Tiba Asilia Tanzania</i> (The National Union of Traditional Healers and Midwives)
CCM	Chama cha Mapinduzi (Party of the Revolution)
CHF	<i>Confœderatio Helvetica Franc</i> , the national currency of Switzerland
CMT	Chinese Medical Teams
COSTECH	The Tanzania Commission for Science and Technology
CPC	Communist Party of China
DFG	Deutsche Forschungsgemeinschaft (German Research Foundation)
DC	District Commissioner
DMS	Dar es Salaam Medical School
DOA	Deutsch-Ostafrika (German East Africa)
DRC	Democratic Republic of Congo
EAC	East African Community
EU	European Union
FAO	Food and Agriculture Organisation
FRG	Federal Republic of Germany
GDR	German Democratic Republic
INGOs	International -Non-governmental Organisations
KNA	Kenya National Archives
KNUC	Kilimanjaro Native Cooperative Union
KSCL	Kilombero Sugar Company Limited
KV	Kilombero Valley
MATC	Medical Assistants Training Centre
MCH	Maternal and Child Health
MDA	Mahenge Diocesan Archives
MDGs	Millennium Development Goals
MITU	Mwanza Intervention Trials Unit
MMMT	Mang'ula Machine Mechanical Tools

MMR	Maternal Mortality Rate
MOH	Ministry of Health
MP	Member of Parliament
NAM	Non-Aligned Movement
NAN	National Archives of Norway ( <i>Arkivverket</i> )
NDC	National Development Corporation
NEC	National Executive Council
NIMRI	National Institute for Medical Research
NORAD	Norwegian Agency for Development Cooperation
NRC	National Records Centre
NUTA	National Union of Tanganyika Workers
PHN	Public Health Nurse
PRC	People’s Republic of China
RAC	Rural Aid Centre, Ifakara
RHC	Rural Health Centre
SAGCOT	Southern Agricultural Growth Corridor of Tanzania
SDGs	Sustainable Development Goals
SMI	Safe Motherhood initiative
SSA	Sub-Saharan Africa
StABS	Staatsarchiv Basel-Stadt
STI	Sexually Transmitted Infections
STFL	Swiss Tropical Field Laboratory
TAA	Tanganyika African Association
TAMISEMI	<i>Tawala za Mikoa na Serikali za Mitaa</i> (regional administration)
TANU	Tanganyika African National Union
TAZARA	Tanzania Zambia Railway Authority
TBA	Traditional Birth Attendants
TFL	Tanganyika Federation of Labour
TNA	The Tanzania National Archives
TNFHC	Tanganyika National Freedom from Hunger Committee
TTCSA	Tanganyika Territory Civil Service Association
TWICO	Tanzania Wood Industries Corporation
TYL	TANU Youth League
UDI	Unilateral Declaration of Independence
UFI	Ubungo Farm Implements Factory

UMATI	<i>Chama cha Uzazi na Malezi Bora Tanzania</i> (Tanzania Family Planning Association)
UNFPA	[formerly] United Nations Fund for Population Activities
UNICEF	United Nations International Children’s Emergency Fund
URT	United Republic of Tanzania
USSR	Union of Soviet Socialist Republics
UTP	United Party of Tanzania
UWATA	<i>Umoja wa Waganga wa Tanzania</i> (Union of Tanzanian healers)
UWT	<i>Umoja wa Wanawake wa Tanzania</i> (Union of Tanzanian Women)
VDC	Village District Committees
VEO	Village Executive Officers
VFCU	Victorian Federation of Cooperative Unions
VHM	Village Medical Helper
VSA	Village Settlement Agency
WHO	World Health Organisation

## Glossary of Swahili Terms

<i>Harambee</i>	A call for community self-help by combining and sharing resources
<i>Kujitegemea</i>	Self-reliance, independence or autonomy. It encompasses the idea of being able to take care of oneself and make one's own decisions without relying on others. <i>Kujitegemea</i> was key to <i>Ujamaa</i>
<i>Maendeleo</i>	Progress or development
<i>Mfumaki</i>	Name given to the <i>Ujamaa</i> communal land or projects. Acronym for <i>mfuko wa maendeleo ya Kijiji</i>
<i>Uhuru</i>	Freedom, independence or sovereignty
<i>Ujamaa</i>	means fraternity or familyhood. The term was ascribed to the socialist system of village cooperatives that was started in Tanzania in the 1960s
<i>Vijiji</i>	Villages, [Singular- <i>Kijiji</i> ]
<i>Vitumbua</i>	A kind of doughnut common in East Africa, made with coconut and cardamom

## Table of Contents

<b>Declaration</b> .....	<b>ii</b>
<b>Acknowledgements</b> .....	<b>iii</b>
<b>Conflict of Interest and Funding</b> .....	<b>v</b>
<b>A note on language and translation</b> .....	<b>vi</b>
<b>Operational Definition of Terms</b> .....	<b>vii</b>
<b>Abbreviations and Acronyms</b> .....	<b>x</b>
<b>Glossary of Swahili Terms</b> .....	<b>xiii</b>
<b>Table of Contents</b> .....	<b>xiv</b>
<b>List of Figures</b> .....	<b>xvii</b>
<b>List of Tables</b> .....	<b>xviii</b>
<b>Abstract</b> .....	<b>xix</b>
<b>Dedication</b> .....	<b>xx</b>
<b>CHAPTER ONE</b> .....	<b>1</b>
<b>INTRODUCTION</b> .....	<b>1</b>
1.1 Background of the Study .....	1
1.2 Thematic Review of Literature and Historiography .....	7
1.2.1 The Transition from Colonial to Postcolonial Welfare and Policy Planning	9
1.2.2 Health Policy Planning in the era of <i>Ujamaa</i> .....	13
1.2.3 Transnationalism in Health: Maternal Health Actors and the Missionary Factor and the Role of Experts. ....	16
1.3 Theoretical Considerations, Methodology and Sources. ....	20
1.3.1 Theoretical Considerations .....	20
1.3.2 Methods and Sources .....	28
1.4 Remarks on Periodisation and Scope .....	33
1.5 Outline of the Dissertation .....	35
<b>CHAPTER TWO</b> .....	<b>37</b>
<b>FROM TERRAIN TO TREATMENT: BACKGROUND TO THE TANZANIAN HEALTH SECTOR WITH A FOCUS ON KILOMBERO VALLEY</b> .....	<b>37</b>
2.1 Introduction. ....	37
2.2 Geographical setting of Tanzania and Kilombero District .....	37
2.3 The climate of Tanzania .....	40
2.4 The people: Tanzania and Kilombero Valley .....	43
2.5 Economic Organisation of Tanzania and Kilombero .....	46
2.6 Health and Healing in Tanzania: Prelude to Independence .....	49

2.7 Summary.....	63
<b>CHAPTER 3 .....</b>	<b>65</b>
<b>THE FIRST YEARS OF <i>UHURU*</i>: EARLY MEDICAL PLANS, MATERNAL HEALTH STRATEGIES AND CHALLENGES, 1961-1974 .....</b>	<b>65</b>
3.1 Introduction .....	65
3.2 State Building and Organisation of the Medical Sector after Independence: A Colonial Legacy.....	66
3.3 Health Policies, Planning, and TANU Politics.....	78
3.3.1 A Brief History of the Origin and Growth of TANU .....	79
3.3.2 TANU Politics: The Dual Impact on the Health Workers and Public Welfare.....	85
3.4 Health Planning within Development Plans.....	91
3.4.1 Training of Medical Workers.....	95
3.4.2 Practising as a Health Worker.....	101
3.5 Triumphs and Trials: Challenges of Planning in the first years of independence .....	104
3.6 The Implication of Health Plans on Maternal Health.....	109
3.6.1 Trained vs. Traditional Midwives: Issues in Maternal Health Workforce	110
3.6.2 Maternal Health Care and the Problem of Health Facilities .....	117
3.6.3 The role of TANU Women in Improving Maternal Health.....	124
3.7 Summary.....	127
<b>CHAPTER FOUR.....</b>	<b>129</b>
<b>THE ERA OF SELF-RELIANCE: <i>UJAMAA</i>, MATERNAL HEALTH AND MEDICAL PLANNING IN TANZANIA, 1967-1980s.....</b>	<b>129</b>
4.1 Introduction .....	129
4.2 Background to <i>Ujamaa</i> : Rethinking Post-independence Development .....	129
4.3 Introducing <i>Ujamaa</i> : A Brief Overview.....	131
4.4 National Health Policy Planning and <i>Ujamaa</i> .....	137
4.5 Rural Health and <i>Ujamaa</i> Planning in the Kilombero Valley.....	141
4.5.1 Rural Women, Agriculture and MCH.....	142
4.5.2 Villagisation and Health Development in the Kilombero Valley .....	153
4.5.3 Rural Maternal Health and Nutrition .....	158
4.6 The Era of Campaigns and Health Education Policies.....	164
4.6.1 Health Education Campaigns and the Question of Preventive or Curative Health Care .....	164
4.6.2 Obstacles Experienced in Health Education and Campaigns .....	172

4.7 <i>Ujamaa</i> and the Attempt to Revive African Traditional Medicine in Kilombero Valley.....	175
4.8 Challenges in the <i>Ujamaa</i> era and their Impacts on Health, Provision, and Planning .....	182
4.9 Summary.....	189
<b>CHAPTER FIVE.....</b>	<b>192</b>
<b>ENTANGLED FUTURES: TRANSNATIONAL ACTORS AND HEALTH</b>	
<b>POLICY PLANNING IN TANZANIA, 1961-1980s .....</b>	<b>192</b>
5.1 Introduction .....	192
5.2 A Background to Health Cooperation in Tanzania .....	194
5.3 Tanzania and International Health Support .....	197
5.3.1 Laying the Groundwork: The Swiss Capuchins and Baldegg Sisters.....	197
5.3.2 Sister Arnolda, St Francis Hospital, Ifakara and Swiss Development Aid .....	202
5.3.3 ‘Hilfe am Ort’ by Switzerland: The Rural Aid Centre, Medical Assistants Training Centre and Mlimba Health Centre .....	208
5.3.4 The Impact of Swiss Involvement in MCH in Kilombero.....	219
5.4 China-Tanzania Cooperation .....	221
5.4.1 Chinese Medical Aid to Tanzania.....	226
5.5 The Impact of the Chinese medical work on Maternal health in Kilombero ..	235
5.5.1 Change of Attitude Towards Traditional Medicine .....	240
5.5.2 Bringing Vaccination Production Closer to home .....	243
5.5.3 China's Family Planning Policies and the Indirect Impact on Tanzania...	243
5.5 Summary.....	253
<b>CHAPTER 6: .....</b>	<b>256</b>
<b>CONCLUSION: TOWARDS A HYBRID FUTURE OF HEALTH.....</b>	<b>256</b>
<b>REFERENCES .....</b>	<b>262</b>
<b>APPENDICES .....</b>	<b>291</b>
A. Research Permit .....	291

## List of Figures

Figure 1: Map showing Tanzania's Boundaries and surrounding countries..	41
Figure 2: Map showing the Morogoro region in Tanzania.	42
Figure 3: The Kilombero Valley and the surrounding areas.	42
Figure 4: A photo of Sewa Haji. Source	52
Figure 5: Sewa Haji Hospital.	52
Figure 6: Princess Margaret Hospital in 1955, later named Muhimbili Hospital..	53
Figure 7: 'New' ward in Muhimbili Hospital named after Sewa Haji	53
Figure 8: The organisation of the health sector	76
Figure 9: Mothers and children queuing to attend the clinic holding their growth and antenatal cards.....	116
Figure 10: Showing different experiences of pregnant women at the clinic.....	117
Figure 11: Women sleeping on the floor at Ocean Road in 1969. ....	120
Figure 12: A portrayal of the Land Cruiser used in mobile clinic services.....	122
Figure 13: Women listening to a Health Education session.....	125
Figure 14: A photo illustrating a mother breastfeeding her baby. ....	126
Figure 15: Relationship between Agriculture, Health and Labour. ....	144
Figure 16: Children in a daycare centre in the 1970s.....	148
Figure 17: The first dispensary at Msolwa Ujamaa, built by the Chinese in the 1970s. ....	156
Figure 18: The 1969 to 1970s immunisation cards showing the transformation and the emphasis on colour shades to show baby weight. ....	171
Figure 19: St Raphael's Archangel Tabora Parish. ....	199
Figure 20: A structure used as a dispensary during the German colonial era at Tabora Mahenge.....	200
Figure 21: On the Left is the first group of Capuchins to Tanzania. Right, the first group of Baldegg sisters in 1921.....	201
Figure 22: Sister Anorlda Kury, 'Mama Ifakara'.....	206
Figure 23: A local holding Mao's photo. ....	227
Figure 24: Africans showing reverence to Mao's portrait. ....	227
Figure 25: These figures show a doctor's degree and registration certificate of one of the doctors who came to Tanzania as part of CMT. ....	232
Figure 26: Chinese and local medical workers offering preventive health education to villagers on Bilharzia.....	236
Figure 27: The use of Contraceptives in the late 1980s in Morogoro, 2022-Present. ....	250

## List of Tables

Table 1: The recorded MCH statistics in Dar es Salaam.....	57
Table 2: A summary of the hierarchy of training for medical workers.....	74
Table 3: Budgetary allocation between Rural and Urban between 1970 and 1980.....	90
Table 4: Budgetary Allocation per Ministry.....	92
Table 5: Numbers in Full-time Basic Education (Public schools only).....	98
Table 6: Urban-rural distribution of senior medical workers.....	102
Table 7: Ocean Road Hospital maternity admissions.....	119
Table 8: Development of the Rural Health Care between 1961 and 1980.....	140
Table 9: The teachings organised by UWT in different regions in 1975.....	147
Table 10: The Distance between Villages and Health Facilities.....	158
Table 10: Health issues addressed in the Mtu ni Afya Campaign.....	165
Table 11: A song composed to popularise the health campaign.....	166
Table 12: Maternal and under-5 mortality from 1961 to 1996.....	171
Table 13: Budgetary allocation in Rural and Urban between 1970 and 1980.....	189
Table 14: The gradual expansion of St. Francis Hospital, Ifakara.....	207
Table 15: Syllabus at the RAC Ifakara and the facilitators.....	213
Table 16: The distribution of the money offered by different bodies for the construction of the MATC.....	216
Table 17: A CMT to Morogoro on 26th September 1972.....	240

## Abstract

This thesis examines the development of maternal health policy planning in Tanzania between 1961 and 1980 within the broader context of postcolonial nation-building. The period from 1961 to 1980 marked Tanzania's transition from colonial rule to self-governance. Future-making and planning dominated the making of the newly independent state of Tanzania under the leadership of President Julius Kambarage Nyerere and his party, the Tanganyika African National Union (TANU). After independence, Nyerere underscored the urgent need to combat ignorance, poverty, and disease. According to Nyerere, these three enemies were detrimental not just to the health of the people but also to Tanzania's national development and future. Yet, the legacy of colonialism continued to shape the health sector, where welfare and medical services had historically been marginal to colonial agendas and often delegated to Christian missionaries. The rural areas were conspicuously neglected in the national health plans and provisions. The new post-independence government faced the dual challenge of inheriting an underdeveloped colonial health infrastructure while seeking to fulfil the nationalist aspirations of equitable service provision. Focusing on maternal health, this study examines how the Tanzanian state envisioned, planned, and implemented health policies during the first two decades of independence. It explores the impact of *Ujamaa* and broader socio-economic strategies on healthcare delivery, as well as the roles of TANU members, experts, and missionaries. The study also focuses on the instrumental role of transnational actors, specifically Switzerland and China, in health-policy planning in Tanzania. The analysis is grounded in three theoretical frameworks: the travelling theory, which highlights the transnational movement and adaptation of ideas—in this case, concepts of health; political economy, which foregrounds the state's role in structuring health systems; and the postcolonial theory of hybridity, which critiques the imposition of external models without adequate integration of local knowledge and practices. Methodologically, the study draws on archival research, oral histories, and secondary sources. The collected data enabled an investigation into how national-level policies, primarily formulated in urban areas, were reflected in and implemented at the local level in the rural Kilombero Valley. Ultimately, the study revealed how health-policy planning in postcolonial Tanzania followed colonial patterns. The challenges faced by health workers and facilities necessitated the mobilisation of resources to build health structures through *Ujamaa*, as well as assistance from international cooperation. The study also shows the struggle of women in navigating maternal health concepts and national policies, as shown in aspects such as maternity leave and family planning. Despite the notable efforts that Tanzania demonstrated in improving health, this study shows how health plans often failed, worsened by problematic infrastructure, and an ambivalent rural-urban divide that influenced the health system, even during periods of relative economic success and gradual service expansion in the 1960s and early 1970s, and the ultimate decline in the 1980s.

**Dedication**

**To my lovely daughter**

*Deborah Praise Njeri*

# CHAPTER ONE

## INTRODUCTION

### 1.1 Background of the Study

Following independence in 1961, Tanzania embarked on an ambitious modernisation project under President Julius Nyerere and TANU. This era was characterised by the ‘hard work of future-making’,<sup>3</sup> a commitment to translating independence into tangible development. Development was framed as a means of achieving self-determination, equity, and freedom from imperialism. Central to this vision was the goal of improved healthcare, as Nyerere identified ignorance, poverty, and disease as the principal enemies of the people.<sup>4</sup> As in many newly independent African nations, Tanzania viewed health as a foundation for development.

The creation of a ‘healthy future’ in Tanzania involved not only the state but a range of actors, including bilateral, multilateral, and voluntary agencies, who emphasised biomedicine. While substantial medical aid, the rhetoric of *Ujamaa*, and the persistence of traditional medicine reflected a general recognition of healthcare as essential to development, the continued difficulties in achieving widespread biomedical provision—especially in rural areas—highlight the gap between acknowledgement and actual prioritisation in state planning and budgets. The vision for Tanzania’s future was inherently conflicted, as it sought to balance a nation that aspired to modernise and ‘catch up’ with the Global North, while simultaneously striving to remain free from imperialism and external domination during the Cold War period. These paradoxes lie at the centre of this dissertation, which examines maternal health policy and planning in post-independence Tanzania (1961–1980), as a window into the broader tensions of nation-building, development, and global health governance.

Maternal health emerged as a vital domain where the aspirations and contradictions of health planning would play out. It was the arena where tensions were negotiated: between ideals of modernisation and the limitations of resources, between national self-reliance and dependence on external aid. Central to this analysis is the concept of planning—a key mechanism through which the postcolonial state attempted to translate its ambitions into concrete outcomes. Planning is a multifaceted concept. Diana Conyers notes that the term ‘plan’ denotes different

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<sup>3</sup> Theo Aalders and Detlef Müller-Mahn, ‘The Hard Work of Future-Making: Alienated Futures, Invisible Labour and Liberation.’, *Territory, Politics, Governance*, 2025, 1–18, <https://doi.org/10.1080/21622671.2024.2438844>.

<sup>4</sup> Julius Nyerere, *Freedom and Development: A Selection of Writings and Speeches, 1963-1978*. (Dar es Salaam: Oxford University Press, 1973), 15, 32, 56.

things, and so does planning.<sup>5</sup> Planning, therefore, is broadly understood as the process of making deliberate choices to allocate limited resources toward specific objectives. Beenhakker defines planning as ‘the art of getting the future things done’.<sup>6</sup> People and governments alike are overly concerned with planning due to their concern for a better future. The need for planning is also primarily due to the realisation that needs will always outdo resources, and the latter must be used efficiently for progress to be achieved. This concept of planning was fundamental to the ambitions and constraints that shaped maternal health policy in the early postcolonial Tanzania.

Planning is often associated with policymaking. Although the two concepts are not synonymous, they are intricately connected and inherently interdependent. Plans serve as the means to execute established policies, while policies necessitate well-structured implementation plans, creating a mutual reliance between the two processes. Andrew Green shows that planning operates at both allocative and operational levels.<sup>7</sup> Within the context of this chapter and the broader thesis, the focus is directed towards government-led planning (allocative) and collaborative efforts with partners, particularly aimed at enhancing healthcare services. It is allocative planning that captures the strategic decisions about goals, resources, and timelines. Its analysis reveals the ambitions and constraints that shaped maternal health policy in the early postcolonial era. Thus, planning can be said to be about ‘choices and deciding about the best available resources to achieve a particular work or objective’<sup>8</sup>—what René Dumont calls the ‘classification of priorities’.<sup>9</sup> Hence, planning is complex, leading Green to consider it ‘difficult, mysterious, complex, confusing’, but inevitable.<sup>10</sup>

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<sup>5</sup> Diana Conyers, *An Introduction to Social Planning in the Third World*. (New York: John Wiley and Sons Ltd, 1982), 1.

<sup>6</sup> Beenhakker as quoted by Diana Conyers, 2.

<sup>7</sup> Andrew Green identifies two types of planning: allocative and activity planning. Allocative planning involves decision-making about what will be spent, when, and where, while activity planning entails having predetermined activities on a schedule that describes when they will be implemented. This study is primarily concerned with allocative planning, which includes aspects such as ‘where are we going? (objectives), with what? (resources), how? (efficiency/implementation), when? (future), degree of formalisation (explicitness, systematic, and method)’. See Andrew Green, *An Introduction to Health Planning for Developing Health Systems*, 3rd ed. (Oxford University Press, 2007), 2-3

<sup>8</sup> Conyers, 2.

<sup>9</sup> René Dumont, *False Starts in Africa*. Translated by Phylis Nants Ott (New York: Andre Deutsch, 1966), 99.

<sup>10</sup> Andrew Green, *An Introduction to Health Planning for Developing Health Systems*, 3rd ed. (Oxford University Press, 2007), 1; Conyers, *An Introduction to Social Planning in the Third World.*, 20.

It is within this broader understanding of planning, which encompasses both rational and uncertain processes, that the postcolonial state in Tanzania positioned itself as the principal architect of health policy and provider of health services, immediately after independence. However, soon after independence, it became evident that national efforts alone could not fully address the country's complex health challenges. As a result, Tanzania became increasingly engaged with voluntary agencies as well as the global health agenda, notably as issues such as maternal health gained international attention and cooperation initiatives increased. Between 1960 and 1980, both national and international bodies, through collaborative initiatives, made significant efforts to improve health outcomes not only for that particular period but also with plans projected into the future.

Maternal health, especially, was at the intersection of local and global action. Maternal health and aspects such as maternal mortality rates (MMRs) were recognised as sensitive indicators of both the robustness and fairness of national health systems.<sup>11</sup> Unlike many other health metrics, maternal death rates capture not only the presence of medical services but also the effectiveness of referral systems, the availability of emergency obstetric care, and broader structural determinants such as gender inequality, poverty, and geographic barriers. Since most maternal deaths are preventable, persistently high mortality rates are widely interpreted as evidence of shortcomings in health governance. Consequently, health discourses, both internationally and nationally, often use maternal health as a moral and political measure of development. In 1987, for instance, the Safe Motherhood Initiative (SMI) was launched by a coalition of international organisations, notably the World Health Organisation (WHO), the United Nations Population Fund (UNFPA), and the World Bank, in Nairobi, Kenya.<sup>12</sup> The ambitious goal of the SMI was to reduce maternal deaths by 50 per cent by the year 2000.<sup>13</sup> However, by the turn of the century, this target remained unmet, prompting its inclusion as goal number five in the Millennium Development Goals (MDGs), which again aimed to improve maternal health. Despite renewed commitment, this goal, like its predecessor, was not fully achieved.

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<sup>11</sup> Angela E. Shija et al., 'Maternal Health in Fifty Years of Tanzania Independence: Challenges and Opportunities of Reducing Maternal Mortality', *Tanzania Journal of Health Research* 13, no. suppl 1 (2011): 1–15; Veronica Kimani, 'Maternal Healthcare and Health Policy Planning in Tanzania, 1961-1970s', *Africa Development* XLIX, no. 2 (2024): 87–115, <https://doi.org/10.57054/ad.V49i2.5715>; 'Trends in Maternal Mortality Estimates 2000 to 2023 Estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division', World Health Organization, 2025.

<sup>12</sup> 'Safer Motherhood Initiative-Proposal for Actions. 30197619 WB IBRD/IDA WB-IBRD/DA', The World Bank Group Archives, <https://thedocs.worldbank.org/en/doc/269141666968791207-0560011987/original/WorldBankGroupArchivesFolder30197619.pdf>.

<sup>13</sup> Chibuike O. Chigbu, 'Maternal Mortality and Near Miss Events: The African Perspective', in *Maternal-Child Health: Interdisciplinary Aspects Within the Perspective of Global Health* (Universitätsverlag Göttingen, 2013), 3.

The MDGs were replaced by the Sustainable Development Goals (SDGs) in 2015, which are to be achieved by 2030. Unlike the MDGs, the SDGs do not have a specific goal for maternal healthcare; rather, they focus on general health and well-being, as stated in SDG 3.<sup>14</sup> Despite global efforts such as the Safe Motherhood Initiative (1987), MDGs (2000–2015), and SDGs (2015–2030), progress has been uneven.<sup>15</sup> This study argues that while global initiatives brought attention and resources, their overly ambitious targets often failed to translate into tangible improvements. In Tanzania, maternal mortality rates remain high, especially in rural regions, a stark contrast to the post-independence vision of equitable health for all. However, these global and national initiatives did not emerge or operate in a vacuum. Their limited success can only be fully understood through a deeper historical lens—one that traces the enduring political, economic, and institutional challenges that have shaped health outcomes. This is the central concern of the present study.

Post-independence health planning in Tanzania was deeply tied to the desire to construct a more inclusive and just society. Healthcare was not only a service but also a symbol of national unity and racial equity, reflecting efforts to reverse colonial hierarchies. This attempt was notable across various projects, some of which are beyond the scope of this study but worth mentioning. They ranged from the ‘free’ healthcare immediately after independence, which was fully funded by the state, to various campaigns, such as ‘Health for All by 2000’, which dominated the state-provided medical space from the late 1970s, following the Alma-Ata Declaration, to cost-sharing in the 1990s. Immediately after independence, the state-centred approach was opposed to the private provision of healthcare. However, systemic challenges in the state-centred approach persisted, leading to the embrace of private practice in the health sector.<sup>16</sup> (See Chapter 3)

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<sup>14</sup> Goal 3 Department of Economic and Social Affairs (un.org) (Accessed on 06.09.2022)

<sup>15</sup> In 2017, sub-Saharan Africa (SSA) recorded that one out of thirty-six women succumbed to maternity-related complications; in some areas in Tanzania, the numbers cited are as high as 546 per 100,000. Over the same period in the European Union (EU) region, maternal mortality was estimated to be 10 per 100,000, while in the USA it was 19 per 100,000. For these statistics and more see Doyle Shane, ‘Maternal Health, Epidemiology and Transition Theory in Africa’, in *Epidemiological Change and Chronic Disease in Sub-Saharan Africa* (UCL press, 2021), 106; Dismas Matovelo et al., ‘Why Don’t Illiterate Women in Rural, Northern Tanzania, Access Maternal Healthcare?’, *BMC Pregnancy Childbirth* 21, no. 452 (2021): 1, <https://doi.org/10.1186/s12884-021-03906-2>; A report by Make Mother Matter, ‘Maternal Health Care in the EU’, May 2021, 1; Maternal mortality country profiles (who.int) (Accessed on 06.09.2022).

<sup>16</sup> John Illife, *East African Doctors: A History of the Modern Profession* (Cambridge: Cambridge University Press, 1998); Musa Sadock and Alex Veit, ‘International Trailblazer: Primary Health Care in Tanzania, 1920s-1990s’, in *SOCIUM SFB1342 Working Papers, 19* (Bremen: SOCIUM, SFB1342, 2021), 27; Randall M. Packard, *A History of Global Health: Interventions into the lives of Other Peoples*. (Baltimore: John Hopkins University Press, 2016).

Therefore, healthcare provision by the Tanzanian government was presented as a key commitment; however, Tanzania's medical situation remained dire.<sup>17</sup> This posed a test of whether the state could fulfil its promise of improved healthcare and a better future for its citizens. Different 5-year and 10-year development plans were drawn up to address key areas of the economy.<sup>18</sup> In these plans, the primary goal for the government was to achieve *maendeleo* [economic progress], with healthcare being a key component, but not a priority in the Tanzanian government's plans at the time of independence.<sup>19</sup> Other scholars have contended that the development of a functioning healthcare system became one of the central political goals of the country's first three-year plan (1961-1963), its five-year plan (1964-1969), and other quinquennial plans, which were part of a 20-year plan which were planned to run from 1961 to 1980.<sup>20</sup> I argue that while the Tanzanian government recognised the importance of maternal health and health care in general, and integrated it into its development plans, its ability to implement and sustain these ambitions remained limited.

With low life expectancy and persistently high maternal and infant mortality rates at independence, improving maternal health was central to Tanzania's broader efforts towards better national health outcomes.<sup>21</sup> Reducing maternal and infant mortality was not only a pressing public health issue, but raising life expectancy from 35 to 50 years by 1980 was an explicitly stated goal in the first development plan.<sup>22</sup> Maternal health care was therefore positioned as a key priority in the government's strategy to strengthen the healthcare system.

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<sup>17</sup> Nancy Rose Hunt, "'Le Bebe en Brousse': European Women, African Birth Spacing and Colonial Intervention in Breast Feeding in the Belgian Congo", *The International Journal of African Historical Studies* 21, no. 3 (1988): 401–32. Illife, *East African Doctors: A History of the Modern Profession*.

<sup>18</sup> 'United Republic of Tanganyika and Zanzibar: First Five-Year Plan for Economic and Social Development, 1st July 1964 to 30th June 1969, Vol 1.', 1964; 'United Republic of Tanzania, Second Five-Year Plan for Economic and Social Development, 1st July 1969 to 30th June 1974 Vol 1', n.d.; 'The United Republic of Tanzania: First Year Progress Report on the Implementation of the Five-Year Development Plan (Public Sector). 1st July, 1964 to 30th June 1965', The Ministry of Economic Affairs and Development Planning, 1964.

<sup>19</sup> The argument was that of '*maendeleo*' (Swahili for progress) but, it would often translate to economic progress. Health was not openly stated in the plan such that it came second and as necessitated by other plans of *maendeleo*, see, Community Based Provision of Key Social Services: A Case Study of Tanzania. (The United Nations University WIDER: World Institute for Development Economics Research. Research for Action 41, 1997), also Emma Athanasio Minja, 'A History of Government Interventions in Rural Development: The Case of Ujamaa Policy in the Kilombero Valley, Ca. 1960 to the Present' (MA Dissertation, University of Dar es Salaam, 2020), 32; Marja Liisa Swantz, *Community Based Provision of Key Social Services: A Case Study of Tanzania*. (The United Nations University WIDER: World Institute for Development Economics Research. Research for Action 41, 1997), 10.

<sup>20</sup> Van etten, 'Towards Research on Health Development in Tanzania', *Social Science and Medicine*, 6 (1972): 339; Sadock and Veit, 'International Trailblazer: Primary Health Care in Tanzania, 1920s-1990s', 13; Andrew Coulson, *Tanzania: A Political Economy* (Clarendon Press, 1982), 121; Swantz, *Community Based Provision*, 9; Margunn M Bech et al., 'Changing Policies and Their Influence on Government Health Workers in Tanzania, 1967-2009: Perspectives from Rural Mbulu District', *The International Journal of African Historical Studies*, no. 46(1) (2013): 61–103.

<sup>21</sup> 'United Republic of Tanganyika and Zanzibar: First Five-Year Plan for Economic and Social Development, 1st July 1964 to 30th June 1969, Vol 1.', 1964;

<sup>22</sup> 'United Republic of Tanganyika and Zanzibar: First Five-Year Plan for Economic and Social Development, 1st July 1964 to 30th June 1969, Vol 1.' viii

Moreover, improving maternal health would ensure improved healthcare from childhood onwards and the general wellness in the country. This historical emphasis on maternal health provides a compelling rationale for this study's focus. By focusing on maternal health, this research directly addresses one of the most pressing and politically significant health concerns of the post-independence Tanzanian state. Beyond being a public health concern, maternal health symbolised the new state's commitment to social equity, development and overall global health agenda.

Social equity was also evident in the Tanzanian government's strong emphasis on developing rural areas. Within the context of the Cold War at the time, Nyerere noted that 'while some nations aim at the moon, we are aiming at the village'.<sup>23</sup> These notions were well articulated in the concept of *Ujamaa* (familyhood/socialism). To realise the vision of *Ujamaa*, six years after independence, the government initially created a programme that encouraged people to voluntarily create and join villages, but later resorted to force, as shown in Chapter Four.

To understand maternal health policy in post-independence Tanzania, it is necessary not only to analyse national plans, but also to consider how such plans were reshaped through interactions with local communities, missionary organisations, and international actors. Existing scholarship often focuses on the perspectives 'from above' that centre on doctors, midwives, politicians, experts, and policymakers, especially in colonial history. In the postcolonial era, health-policy planning has not been a vibrant academic field in the history of medicine in Tanzania. Additionally, the very recipients of many health policies, especially rural women, who were central to the implementation of these policies, remain marginalised. This study situates maternal health planning within the broader political and institutional landscape of the postcolonial Tanzanian state, foregrounding both national ambitions and global and local realities, guided by the following research questions;

1. How did the newly independent government of Tanzania plan for maternal health within its broader healthcare strategies, and what challenges shaped these efforts between 1961 and 1974?
2. In what ways did the policy of *Ujamaa* influence health planning and the implementation of maternal health policy in the Kilombero Valley from 1967 to 1980?
3. How did negotiations with transnational actors influence the planning and implementation of maternal health and health-policy planning in Tanzania between 1961 and 1980?

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As quoted by Hyden in Goran Hyden, *TANU Yajenga Nchi: Political Development in Rural Tanzania*. (Uniskol Bokforlaget och Skola, 1968), 1.

To address these questions, this study begins by analysing health policy and decision-making at the national level. This choice is informed by the fact that, during the period under study, Tanzania's planning and governance structures, led by TANU, largely followed a top-down model, in which policies were formulated centrally and implemented across the country. However, understanding policy formulation alone is insufficient; it is equally important to explore how these national policies were received, interpreted, and adapted at the local level. Unique to my approach is the combination of national policy analysis with a grounded investigation of local experiences and responses to maternal health policy in Kilombero Valley. Given the impossibility of conducting an in-depth study across all regions of Tanzania, I selected the Kilombero valley, which offers a valuable window into how health policies were locally negotiated, appropriated, and sometimes contested, allowing for a more nuanced understanding of the gap between planning and implementation of national health policy.

The Kilombero Valley has been renowned for its agricultural potential and rich biodiversity since colonial times, and it was thus often referred to as a 'food basket'.<sup>24</sup> Due to the region's blend of rural populations, missionary presence, and later, state and donor-supported health interventions, the Kilombero Valley hosted a diverse array of healthcare providers, including government services, voluntary agencies, and traditional midwives. This made it an ideal site for analysis, which is provided in subsequent chapters.<sup>25</sup>

## 1.2 Thematic Review of Literature and Historiography

While existing scholarship has richly examined colonial-era medicine and missionary healthcare in Africa, a striking gap remains in historical analyses of maternal health policy in the post-independence period. Regarding the history of Tanzania, scholars have examined missionary medicine, development planning, and donor involvement.<sup>26</sup> However, maternal health is often treated as part of broader issues, such as population control, development and economic needs or health reforms, rather than as a subject in its own right. By contrast, the colonial-era maternal and child health (MCH) systems, as addressed by Nancy Hunt, Ulrike Lindner, and Walter Bruchhausen, are conspicuously present historiographical topics.<sup>27</sup> The

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<sup>24</sup> By 2010, the region was part of the Southern Agricultural Growth Corridor of Tanzania (SAGCOT), a public-private initiative spanning from 2010 to 2030 aimed at promoting agricultural transformation in the southern Highlands of Tanzania.

<sup>25</sup> A detailed description of the Kilombero Valley is provided in chapter two.

<sup>26</sup> Michael Jennings, *Surrogates of the State: NGOs, Development, and Ujamaa in Tanzania* (Kumarian Press, 2008); Ruth Prince and Rebecca Marsland, *Making and Unmaking Public Health in Africa: Ethnographic and Historical Perspectives* (Ohio University Press, 2014); Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Stanford University Press, 1991); Packard, *A History of Global Health*.

<sup>27</sup> Vaughan, *Curing Their Ills*; Illife, *East African Doctors: A History of the Modern Profession*; Maryinez Lyons, *The Colonial Disease: A Social History of Sleeping Sickness in Northern Zaire, 1900–1940*, (Cambridge

lacuna in postcolonial health-policy analysis is especially evident in relation to the politics of state-building, international cooperation, and the implementation of health policies at the local level. It is this gap that my study aims to address.

Building on the work of scholars such as James Midgley, I agree with his assertion that health planning cannot be addressed from a single angle. Considering aspects such as the Second World War, the formation of the WHO and problems of urbanisation, including overcrowding, crime, the development of shanties, poor sanitation, the outbreak of diseases, and vagrancy, Midgley shows how such issues produced disorder and lawlessness, which in turn led the government to reconsider its approach to social welfare.<sup>28</sup> My study examines how various changes introduced by the state or other actors influence the social welfare and health debate in post-independence Tanzania. It engages with debates surrounding state capacity, international health governance, and the roles of traditional healers and midwives within health-policy frameworks, as well as their implications for maternal health. It contributes to the historiography of medicine by analysing national-level health planning in relation to the response and lived experiences of people, as well as implementation at the local level. In doing so, the study draws on insights from political economy, postcolonial theory, and the concept of travelling ideas to analyse how maternal health policies were negotiated, adapted, and hybridised within specific historical and spatial contexts.

The positioning of this study at the intersection of several fields—history of medicine, development studies, political economy, and global health—provides both a challenge and an advantage. The challenge lies in navigating the breadth and complexity of these intersecting disciplines. Nevertheless, the advantage lies in the innovative approach, which helps to understand the complex interplay of factors that led to maternal health in Tanzania emerging as a multifaceted concern, encompassing both political, economic, technical, and social aspects. In doing so, I bridge several conversations, ranging from the colonial-to-postcolonial transition in health systems to the impact of *Ujamaa*-era development planning, and to the influence of transnational actors such as the WHO, United Nations International Children’s Emergency Fund (UNICEF), and Swiss and Chinese medical cooperation in shaping maternal health provision under the following three themes.

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University Press, 1992); Hunt, ‘Le Bebe en Brousse’; Bruchhausen Walter, ‘Practising Hygiene and Fighting the Natives’ Diseases». Public and Child Health in German East Africa and Tanganyika Territory, 1900-1960’, *DYNAMIS*. 23 (2003): 85–113; Ulrike Lindner, ‘The Transfer of European Social Policy Concepts to Tropical Africa, 1900–50: The Example of Maternal and Child Welfare’, *Journal of Global History* 9, no. 2 (2014): 208–31, <https://doi.org/doi:10.1017/S1740022814000047>.

James Midgley, ‘Imperialism, Colonialism and Social Welfare.’, in *Colonialism and Welfare: Social Policy and the British Imperial Legacy* (Edward Elgar Publishing, 2011), 46.

### 1.2.1 The Transition from Colonial to Postcolonial Welfare and Policy Planning

The colonial state and its various agencies introduced biomedicine to Africa. Medicine was seen as one of the ‘tools of the empire’, following Daniel Headrick, who argues that European imperialism in the 19th century was not merely a product of ambition but, on an operational level, was made possible through a range of technological innovations.<sup>29</sup> In the East African context, particularly in Tanzania, such technologies, ranging from quinine and steamboats to railroads and medical equipment, played a pivotal role in penetrating and administering vast rural regions.<sup>30</sup> These ‘tools of empire’ also laid the foundation for colonial health infrastructures, which prioritised control and labour productivity over equitable care.<sup>31</sup> Health systems are, therefore, political entities. Interrogating the interrelationship between health, state formation, and political power, John Iliffe, Maghan Keita, Steven Feierman, and John Janzen, for example have examined how health systems are not only technical or administrative domains but also arenas where state authority, legitimacy, and social contracts are negotiated and contested.<sup>32</sup>

In the context of Tanzania, studies in the 1960s and 1970s by David Clyde, van Etten, Aloysius Nhololi, and Aimon Sekela document the gradual transformation of the health sector across historical epochs, tracing continuities and ruptures from colonial administration to post-independence reforms.<sup>33</sup> Peter Kallaway and Harald Barre further contend that postcolonial welfare-policy planning and administrative structures often mirrored those of the colonial state, with religious institutions playing a significant, sometimes ambivalent, role in shaping health policy and service delivery.<sup>34</sup> Despite this rich body of work, there remains a need for more

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<sup>29</sup> Daniel R Headrick, *The Tools of Empire: Technology and European Imperialism in the Nineteenth Century* (Oxford University Press, 1981).

<sup>30</sup> Robert Koch, ‘Die Bekämpfung der Malaria’, *Zeitschrift Für Hygiene Und Infektionskrankheiten* 43, no. 1 (1903): 1–4, <https://doi.org/10.1007/BF02217532>; Daniel R Headrick, *Power over Peoples: Technology, Environments, and Western Imperialism, 1400 to the Present* (Princeton University Press, 2010); Stefanie Gänger, *A Singular Remedy: Cinchona Across the Atlantic World, 1751–1820* (Cambridge University Press, 2021).

<sup>31</sup> For further reading on how health was and continues to be used to serve specific interests both in colonial and post-colonial era in Africa and beyond see Vaughan, *Curing Their Ills*; Lyons, *The Colonial Disease: A Social History of Sleeping Sickness in Northern Zaire, 1900–1940*; David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India* (University of California Press, 1993); Warwick Anderson, *Colonial Pathologies: American Tropical Medicine, Race, and Hygiene in the Philippines* (Duke University Press, 2006); Packard, *A History of Global Health*.

<sup>32</sup> Feierman, ‘Struggles for Control’; Feierman and Janzen, *The Social Basis of Health and Healing in Africa*; Iliffe, *East African Doctors: A History of the Modern Profession*; Keita Maghan, *A Political Economy of Health Care in Senegal*, African Social Studies Series Vol 10 (Brill, 2007).

<sup>33</sup> David F. Clyde, *History of Medical Services in Tanganyika* (Government Press, 1962); G.M Van Etten, *Rural Health Development in Tanzania* (Van Gorcum & Comp. B.V, 1976); Aloysius M. Nhololi and Aimon J. Nsekela, *Health Services and Society in Mainland Tanzania: A Historical Overview ‘Tumetoka Mbali’* (EALB, 1976).

<sup>34</sup> Peter Kallaway, ‘Education, Health and Social Welfare in the Late Colonial Context: The International Context, Missionary Council and Educational Transition in the Interwar Years with Special Reference to Colonial Africa.’, *History of Education* 38, no. 2 (2009): 217–46; Peter Kallaway, ‘Welfare and Education in British Colonial Africa 1918-1945’, in *Education and Development in Colonial and Postcolonial Africa: Policies, Paradigms, and*

integrated analyses that foreground the political economy of health, examining how power, resources, and global actors interact with local institutions and ideologies to produce specific health outcomes at a micro-local level, which is the aim of this study.

Understanding these political and economic foundations requires a closer look at the origins of state health governance in East Africa. While pre-colonial societies relied on healers, diviners, spiritualists, and herbalists, the twentieth-century European conquest imposed a new, state-controlled health system—Western medicine—which became a central pillar of the colonial agenda.<sup>35</sup> Western medicine was a significant plank in the European ‘civilising’ mission aimed at ridding the ‘dark’ continent of Africa from its ‘sickness’.<sup>36</sup> As Ann Beck, Bruchhausen, Ruth Odinga, Anna Crozier, and Andreas Eckert demonstrate, colonial health structures were initially designed to serve European colonial officials, settlers and, later, African labourers, reflecting the priorities and hierarchies of the colonial state.<sup>37</sup> This selective approach to health governance not only marginalised African health needs but also established patterns of inequality and state control. Arlinde Vrooman, Veronica Kimani, Jutta Bolt, and Jeanne Cilliers have shown that such marginalisation persisted into the postcolonial era.<sup>38</sup>

Several reasons contributed to the extension of health provision beyond the ranks of colonial officials. According to Lindner, Hunt, and Vögele, the need for labour became a pressing issue. However, policymakers were faced with a plummeting birth rate and a declining population not just in Europe but also in the colonies at the beginning of the twentieth century. The population

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*Entanglements 1890-1980s*. (Palgrave Macmillan, 2020); Harald Barre, *Traditions Can Be Changed: Tanzanian Nationalist Debates around Decolonising ‘Race’ and Gender, 1960-1970s* (transcript Verlag, 2022).

<sup>35</sup> Z Goldsmith, “Health, Healing and Medicine”. The Use of Divergent Creative Resorts in Sierra Leone’, paper presented at “a paper presented at the 22nd Annual meeting of the African studies Association Los Angeles California, 31 November 1979.

<sup>36</sup> Helen Tilley, *Africa as a Living Laboratory: Empire, Development, and the Problem of Scientific Knowledge, 1870-1950* (University of Chicago Press, 2011). Oswald Masebo, ‘Society, State, and Infant Welfare: Negotiating Medical Interventions in Colonial Tanzania, 1920-1950’ (Ph.D. Dissertation, University of Minnesota, 2010), 6. Debby Gaitskell, “‘Getting Close to the Hearts of Mothers’: Medical Missionaries among African Women and Children in Johannesburg between the Wars’, in *Women and Children First: International Maternity and Infant Welfare 1870-1945*. (Routledge, 1992), 178.

<sup>37</sup> Ann Beck, *Medicine, Tradition and Development in Kenya and Tanzania, 1920-1970*. (Waltham: Crossword Press, 1981); Odinga, A. (1990). *A History of Health Science in Nairobi 1899-1963*. M.A Thesis Kenyatta University; Andreas Eckert. “Regulating the Social: Social Security, Social Welfare and the state in the Late colonial Tanzania” *Journal of African History*, Vol. 45, No.3 (2004), JSTOR. Walter Bruchhausen, “Practising hygiene and fighting the Natives diseases”, Public and child health in German East Africa and Tanganyika territory, 1900-1960. *Dynamis*, 23. Granada, Spain (February, 2003), 87. Ulrike Lindner, “Transfer of European social policy concepts to Tropical Africa, 1900-1950: the example of maternal and child welfare”. *Journal of Global History*, 9 (May, 2014), 211 doi:10.1017/ S1740022814000047. Anna Crozier, *Practising Colonial Medicine: The Colonial Medical Service in British East Africa* (Bloomsbury Publishing Plc, 2007).

<sup>38</sup> Arlinde C.E. Vrooman, ‘The Development of Colonial Health Care Provision in Ghana and Côte d’Ivoire: Ca. 1900–55’, *Economic History of Developing Regions* 38, no. 3 (2023): 215–55, <https://doi.org/10.1080/20780389.2023.2209284>; Kimani, ‘Maternal Healthcare and Health Policy Planning in Tanzania, 1961-1970s’; Jutta Bolt and Jeanne Cilliers, ‘The Expansion of Colonial State Healthcare in Twentieth-Century British Africa’, *Medical History* 69, no. 1 (2025): 119–65, <https://doi.org/10.1017/mdh.2024.45>.

decline heightened fears of labour shortages in the colonies.<sup>39</sup> This decline in the colonies was attributed to diseases, famine, and wars of conquest.<sup>40</sup> To increase population growth and reduce preventable deaths (and ultimately increase the workforce), colonial policy makers decided to address the issue via maternal health, by supporting maternity and infant welfare programs.<sup>41</sup> The same problems, such as the relationship between the workforce and healthcare, are found in post-independence health plans in Tanzania. An interesting aspect that I address in this study is the change from the fear of a declining population to the calls for birth control and family-planning campaigns.

Overall, the role of medicine as a political tool is a crucial issue for both colonial and postcolonial governments. As Crozier notes, colonial medicine was viewed as a means of achieving political objectives.<sup>42</sup> Helen Tilley adds that '[medical] sciences were used as tools of the empire'<sup>43</sup> For Marcel Dreier, the welfare of the locals became a significant theme of colonial policies and a topic of rural governmentality.<sup>44</sup> These scholars confirm that the centrality of government in providing healthcare during the colonial period cannot be disputed. In the field of maternal health, the same technological and administrative systems that enabled colonial expansion often neglected or marginalised local birthing knowledge, particularly the roles of traditional midwives and herbalists. The legacies of these imbalances, where Western medicine was institutionalised and African healing systems were delegitimised, persisted into the postcolonial period, in which the government delineated what was legitimate and what was not, often propagating colonial administrative and epistemic authority. This study captures these traces by examining the infrastructures of postcolonial government, such as roads and railways, which were primarily developed for extractive and political purposes, incidentally affecting access to maternal care in the rural Kilombero Valley. However, healthcare provision was rarely a central concern. As I will show, this postcolonial policy plan was a replica of the colonial state's view of healthcare.

The Tanzanian government controlled the health-policy planning immediately after independence through the ruling party and other government avenues. By examining the roles

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<sup>39</sup> Hunt, 'Le Bebe en Brousse'; Jörg Vögele, 'Has All That Has Been Done Lately for Infants Failed?' 1911, *Infant Mortality and Infant Welfare in Early Twentieth-Century Germany*, *Annales de Démographie Historique*, no. 2 (January 2010): 131–46; Lindner, 'The Transfer of European Social Policy', 208.

<sup>40</sup> Goran Hyden, *Beyond Ujamaa in Tanzania: Underdevelopment and an Uncaptured Peasantry* (Heinemann, 1980), 40.

<sup>41</sup> Hunt, 'Le Bebe en Brousse'; Ann Beck, *A History of the British Medical Administration of East Africa, 1900-1950* (Harvard University Press, 1970); Crozier, *Practising Colonial Medicine*. Lindner, 'The Transfer of European Social Policy', 214; Walter, 'Practising Hygiene and Fighting the Natives' Diseases»'.

<sup>42</sup> Crozier, *Practising Colonial Medicine*, 3.

<sup>43</sup> Tilley, *Africa as a Living Laboratory*, 15.

<sup>44</sup> Marcel Dreier, 34

of TANU, UWT, and other government agencies in health policy planning, particularly in maternity care, this study demonstrates that, despite being politically and economically marginalised, women played a central role in policy implementation. The women of Tanzania formed various groups that supported TANU wholeheartedly. Important instruments used by TANU to propagate the party's policies were songs. Notable choir groups, such as Lele Mama, Bomba Kusema, British Empire, Warumba, Ratusadan, and Safina Submarine, as well as word of mouth and street marches, played a significant role. Susan Geiger notes that this became a ritualistic practice, with some women, such as Salima Ferouz, having to sell vitumbua to buy their TANU membership cards.<sup>45</sup> It was TANU women, Geiger adds, that took nationalism and other ideologies to the hinterlands of Tanzania. Although Geiger has studied women's efforts in TANU, most of her work focused on the personal stories and experiences of these women as members of TANU.<sup>46</sup>

Another group that popularised party policies was the Youth League. This comprised young Tanzanian men and women. Andrew Ivaska and Emily Calacci describe how urban centres, especially Dar es Salaam, became sites of intense social struggle after independence.<sup>47</sup> It was a period during which women navigated employment and motherhood in a gendered society distinct from the pre-colonial and colonial periods. My analysis of the role of youth and women in my research examines how they contributed to the propagation of health policies, expanding beyond Ivaska and Calacci urban areas in the rural Kilombero Valley.

An equally critical dimension in understanding health policy in Tanzania's rural areas lies in the role of traditional medicine. This debate reflects on an ongoing contestation of biomedicine and traditional health systems. While the postcolonial state, much like its colonial predecessor, promoted biomedicine as the dominant model, it failed to eradicate traditional medicine, which remained deeply ingrained in local practices and beliefs. Numerous scholars have documented these contestations across the continent.<sup>48</sup> In the case of maternal health, Kotni El Mounia demonstrates the struggle to modernise traditional midwifery from a broader context by analysing the masculinisation of reproductive knowledge in 18<sup>th</sup>- and 19<sup>th</sup>-century Europe, and how these ideas were disseminated in the colonies.<sup>49</sup> Similarly, Tabitha Kanogo reflects on the

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<sup>45</sup> Susan Geiger, *TANU Women: Gender and Culture in the Making of Tanganyikan Nationalism, 1955-1965* (Heinemann, 1997), 1, 58, 79.

<sup>46</sup> Geiger, *TANU Women*, 12.

<sup>47</sup> Andrew Ivaska, *Cultured States: Youth, Gender and Modern Style in 1960s Dar Es Salaam*. (Duke University Press, 2011), 2; Emily Callaci, *Street Archives and City Life: Popular Intellectuals in Postcolonial Tanzania (Radical Perspectives)* (Duke University Press, 2017).

<sup>48</sup> Abiodun, 'Medicinal Practice in Western Science and African Traditional Thought: A Comparative Analysis'; Antwi-Baffour et al., 'The Place of Traditional Medicine on African Society.'

<sup>49</sup> Mounia El Kotni, 'Midwifery in Cross-Cultural Perspectives', in *The Routledge Handbook of Anthropology and Reproduction*, 1st edn (UNFPA, 2014).

medicalisation of midwifery in colonial Kenya and the resulting confrontations between the people, the local government and the colonial state.<sup>50</sup> Robbie Davis further highlights how political forces shaped the mainstreaming of midwifery.<sup>51</sup> In the Tanzanian context, medical anthropological studies by Rebecca Marsland reveal the ongoing struggle to create a hybrid system that accommodates both traditional and biomedical practices.<sup>52</sup> Susanna Hausmann Muela et al. further demonstrate that achieving this balance remains challenging due to factors such as affordability and cultural preferences.<sup>53</sup> These findings underscore that complex and dynamic negotiations between competing medical paradigms and social realities have shaped health-policy planning in postcolonial Tanzania. Drawing on maternal health and the dynamics in the Kilombero Valley, this study examines how the post-independence state negotiated this space.

### 1.2.2 Health-Policy Planning in the Era of *Ujamaa*

*Ujamaa* conspicuously put Tanzania on the world map; therefore, the literature is awash with various subjects relating to *Ujamaa*.<sup>54</sup> Despite the centrality of health to *Ujamaa* and to the broader vision of self-sufficiency, it remains an underexplored area in scholarly research. This study addresses this gap. It examines *Ujamaa*-era policies and the interplay between the overall agricultural goals and the tension between food production and healthcare needs. I show how broader socialist policies influenced maternal health through changes in family planning, maternity leave, and the balance between preventive and curative care. Although health was central to African socialist ideology, its practical implementation, particularly its effects on

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<sup>50</sup> Tabitha Kanogo, 'The Medicalization of Maternity in Colonial Kenya', in *African Historians and African Voices: Essays Presented to Professor Bethwell Allan Ogot on His Seventieth Birthday*. (Schlettwein, 2001).

<sup>51</sup> Robbie Davis Floyd, 'Daughter of Time: The Postmodern Midwife 1', n.d., accessed 26 May 2025, [efaidnbmnnnibpcajpcglclefindmkaj/http://www.davis-floyd.com/wp-content/uploads/2016/11/Daughter-of-Time-MIDIRS2.pdf](http://www.davis-floyd.com/wp-content/uploads/2016/11/Daughter-of-Time-MIDIRS2.pdf).

<sup>52</sup> Rebecca Marsland, 'The Modern Traditional Healer: Locating "Hybridity" in Modern Traditional Medicine, Southern Tanzania', *Journal of Southern African Studies* 33, no. 4 (2007): 751–65.

<sup>53</sup> Susanna Hausmann Muela, Adiel K. Mushi, and Joan Muela Ribera, "The Paradox of the Cost and Affordability of Traditional and Government Health Services in Tanzania," *Health Policy and Planning* 15, no. 3 (September 2000): 296–303

<sup>54</sup> Lal Priya, 'Militants, Mothers and the National Family: Ujamaa , Gender and Rural Development in Postcolonial Tanzania', *The Journal of African History* 51, no. 1 (2010): 20; Hyden, *Beyond Ujamaa in Tanzania: Underdevelopment and an Uncaptured Peasantry*; Minja, 'Government Interventions'; Gussai Sheikheldin, 'Ujamaa: Planning and Managing Development Schemes in Africa, Tanzania as a Case Study.', *The Journal of Pan African Studies* 8, no. 1 (2015): 78–96; Barre, *Traditions Can Be Changed*; Illife, *East African Doctors: A History of the Modern Profession*; Musa Sadock, 'History of Sexually Transmitted Diseases in Mbozi District, Tanzania, 1905-2005' (Ph.D. Dissertation, University of Dar es Salaam, 2015); Kaduma Luoneko, 'Rural to Rural Migration and Local Economies: A Case Study of Kilombero District, Tanzania, 1960-2000' (MA (History) Dissertation, University of Dar es Salaam, 2019); Coulson, *Tanzania: A Political Economy*; Jennings, *Surrogates of the State: NGOs, Development, and Ujamaa in Tanzania*; Evaristi Magoti Cornelli, 'A Critical Analysis of Nyerere's Ujamaa: An Investigation of Its Foundations and Values' (Ph.D Thesis, the University of Birmingham, 2012); Donatus Komba, 'Contribution to Rural Development: Ujamaa and Villagisation', in *Mwalimu: The Influence of Nyerere*. (London: James Currey Ltd, 1995); Emma Athanasio Minja and Julius Maximillan Chuhila, 'Ujamaa in the Kilombero Valley: Msolwa and Signali Villages as a National Project ca 1967-1990', *Tanzania Zamani* xiv, no. 1 (2022).

maternal health in rural areas, remains unexamined in existing scholarship. To my knowledge, no prior historical study has specifically analysed how socialist development policies shaped maternal health at the local level in postcolonial Tanzania, or explored the intersections of national expectations, *Ujamaa*-era reforms, and everyday maternal health outcomes in a rural context such as the Kilombero Valley. By addressing this gap, my research offers the first focused historical analysis of these dynamics, providing new insights into the local impacts of socialist policy on maternal health in postcolonial Tanzania. In doing so, this research contributes to a deeper understanding of how socialist development policies shaped maternal health at the local level in postcolonial Tanzania.

While *Ujamaa* was rooted in Tanzania's specific historical and cultural context, it was also part of a broader wave of African socialism that swept the continent in the post-independence era. Leaders such as Kwame Nkrumah in Ghana and Léopold Sédar Senghor in Senegal articulated their visions of socialism, each drawing on local traditions and responding to colonial legacies in distinct ways.<sup>55</sup> These leaders called for a social, political, and economic shift that affected not only the administrative but also the medical systems. Examining these parallels and contrasts situates *Ujamaa* within a broader transnational discourse, illustrating how historical events can drive significant societal changes, especially in the health sector. For instance, Alisa Klaus, Rima D. Apple, and Deborah Dwork have demonstrated how periods of upheaval in other parts of the world have led to significant transformations in child and maternal health policies.<sup>56</sup> Klaus examines the evolution of child healthcare and motherhood in the United States and France, with a focus on the development of child-welfare policies. Similarly, Rima Apple analyses the emergence of the ideal of 'perfect motherhood' in the USA during times of social change, noting how shifts in women's roles and labour patterns influenced caregiving practices. Dwork's study, 'War is Good for Babies', demonstrates how major events such as conflicts and wars catalysed changes in attitudes toward child-rearing and policy-making.

Jane Lewis, writing about England, shows the role of government and other institutions in trying to improve maternal health.<sup>57</sup> However, according to Lewis, the government's aims and

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<sup>55</sup> Kwame Nkrumah, *Consciencism: Philosophy and Ideology for Decolonization and Development with Particular Reference to the African Revolution* (Heinemann, 1964); Léopold Sédar Senghor, *Freedom I: Négritude and Humanism*. Translated and Introduction by Wendell A. Jeanpierre. (Présence Africaine, 1974); Reiland Rabaka, *The Négritude Movement: W. E. B. Du Bois, Leon Damas, Aimé Césaire, Leopold Senghor, Frantz Fanon, and the Evolution of an Insurgent Idea*. (Lexington Books, 2015).

<sup>56</sup> Alisa Klaus, *Every Child a Lion: The Origins of Maternal and Infant Health Policy in the US and France, 1890-1920* (Cornell University Press, 1993); Rima D. Apple, *Perfect Motherhood: Science and Childrearing in America* (Rutger University Press, 2006); Deborah Dwork, *War Is Good for Babies and Other Young Children: A History of the Infant and Child Welfare Movement in England 1898–1918* (Tavistock Publication, 1987).

<sup>57</sup> Jane Lewis, *The Politics of Motherhood: Child and Maternal Welfare in England, 1900-1939* (Croom Helm, 1980).

expectations did not always align with the wishes of the majority, especially mothers, a notable feature of Tanzania's *Ujamaa* era. The importance of Klaus, Lewis and Dwork to this study is that, by drawing on these global examples, we see that Tanzania's experience under *Ujamaa* was part of a larger pattern which forms a basis of this study: moments of political and social transformation often serve as catalysts for reimagining health systems and redefining the relationship between the state, society, and medical care.

Most studies on *Ujamaa* have focused on agricultural production and rural development.<sup>58</sup> These writers explain *Ujamaa* as the basis for individual, communal, and state progress through agricultural development. It was in organised settlements that people would produce what was needed for subsistence and sale. However, writers such as Goran Hyden, Maxmillan Chuhila, Andrew Coulson, and Freyhold have depicted *Ujamaa* as a failure that led to disruption instead of improving rural lives.<sup>59</sup> Michaela portrays *Ujamaa* as a social experiment that achieved only a small portion of its intended goals.<sup>60</sup> These writers paved the way for those who analysed *Ujamaa* as a 'failure'. Scott, for instance, argues that *Ujamaa* was a grand state project conceived under the influence of high modernism and extreme state authoritarianism.<sup>61</sup> Janiki Boessen et al., arguing in the same vein, noted that *Ujamaa* was 'socialism from above'.<sup>62</sup> These studies provide a basis for analysing *Ujamaa* in relation to health provision.

Scholars have also addressed the concept of *kujitegemea* (self-reliance), which was popularised through *Ujamaa*. According to Nyerere, Tanzania aimed to develop homegrown solutions that linked *Ujamaa* to industrialisation, infrastructure development, and commerce.<sup>63</sup> Few studies have connected the concept of self-reliance to health in Tanzania; yet, Feierman aptly notes that '...health cannot be separated from the broader story of social change'.<sup>64</sup> Thus, health is a product of social, political, and economic factors. While the *Ujamaa* promise was that villagisation would enable the provision of social services, few studies have been conducted on

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<sup>58</sup> Michaela Von Freyhold, *Ujamaa Villages: Analysis of a Social Experiment* (Heinemann, 1979); Hyden, *Beyond Ujamaa in Tanzania: Underdevelopment and an Uncaptured Peasantry*; Komba, 'Contribution to Rural Development: Ujamaa and Villagisation'; Paul Bjerck, *Building a Peaceful Nation: Julius Nyerere and the Sovereignty of Tanzania, 1960-1964*. (University of Rochester Press, 2015); Barre, *Traditions Can Be Changed*; C.K Omari, *Villagisation and the Potential of the Peasant Reorganisation in Tanzania*, Tanzania: Political Party, Rural Development, Nationalism and International Environment. First Preliminary Report of African Studies (Social Science 1) (1986).

<sup>59</sup> Hyden, *Beyond Ujamaa in Tanzania: Underdevelopment and an Uncaptured Peasantry*; Coulson, *Tanzania: A Political Economy*; Freyhold, *Ujamaa Villages: Analysis of a Social Experiment*; James C Scott, *Seeing Like a State: How Certain Schemes to Improve the Human Condition Have Failed* (Yale University Press, 1998).

<sup>60</sup> Freyhold, *Ujamaa Villages: Analysis of a Social Experiment*, 110.

<sup>61</sup> Scott, *Seeing Like a State: How Certain Schemes to Improve the Human Condition Have Failed*, 3.

<sup>62</sup> Jannik Boesen et al., *Ujamaa–Socialism from Above* (Scandinavian Institute of African Studies, 1977).

<sup>63</sup> Janiki Boessen, Brigit Storgard Madsen, and Tony Moody, *Ujamaa–Socialism from Above* (Uppsala: Scandinavian Institute of African Studies, 1977); Resnik N Idrian, *The Long Transition: Building Socialism in Tanzania* (London: Monthly Review Press, 1981).

<sup>64</sup> Feierman, 'Struggles for Control', 73.

this topic—notably those by Theodore Ku Young, William Mayer, and Meinrad Haule Lembuka.<sup>65</sup> From a historical perspective, Musa Sadock has connected health issues to *Ujamaa* in his study on smallpox and sexually Transmitted Infections (STIs) in Mbozi.<sup>66</sup> Notably, none of these connections linked *Ujamaa* to maternal health, a gap that this study aims to address.

### **1.2.3 Transnationalism in Health: Maternal Health Actors, the Missionary factor and the Role of Experts.**

Scholars of medicine and imperialism have shown the role played by transnational actors in Africa.<sup>67</sup> Tilley notes that as early as 1929, when the British and South African Associations for the advancement of science met for the first on African soil in South Africa, it was made clear by Jan Hofmeyr, the president of the South African association, that Africa was a natural laboratory, where animals and humans could be examined in their natural milieu.<sup>68</sup> In the meeting, Hofmeyr asked, ‘What can Africa give to science or what can science give to Africa?’<sup>69</sup> This question, often posed rhetorically, highlights a persistent gap in scholarship regarding Africa’s active role in shaping scientific and medical knowledge.<sup>70</sup> However, it provides a glaring confirmation that Africa has indeed had a significant impact on science.

The role of Africa in science was reduced to that of a recipient; therefore, science had more to offer Africa than Africa had to offer science. Scholars have demonstrated how Africa became a hub for the transfer of modernity. Lindner explains the transfer of social policies from Europe between 1900 and 1950.<sup>71</sup> Hunt and Bruchhausen also discuss the introduction of health policies

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<sup>65</sup> William P. Mayer, ‘Implementation and Control Under Decentralisation: Tanzanians Rural Health Centre Programme’ (M.A, University of Dar es Salaam, 1974); Meinrad Haule Lembuka, ‘The Influence of Ujamaa Policy in Realization of Developmental Social Work in Tanzania – Ubuntu Perspective’, *People Centred – The Journal of Development Administration (JDA)*, 8, no. 3 (2023): 83–90; Theodore Kue Young, ‘Socialist Development and Primary Health Care: The Case of Tanzania’, *Human Organization* 45, no. 2 (1986): 128–34.

<sup>66</sup> Sadock, ‘Sexually Transmitted Diseases’; Sadock and Veit, ‘International Trailblazer: Primary Health Care in Tanzania, 1920s-1990s’; Musa Sadock, ‘Prevention Is Better Than Cure’: Smallpox Vaccination in Postcolonial Tanzania, 1961-1980.’, *Zamani: A Journal of African Historical Studies*. 1, no. 1 (2024), <https://doi.org/10.56279/ZJAHS1116>.

<sup>67</sup> Gaitskell, “‘Getting Close to the Hearts of Mothers’”: Medical Missionaries among African Women and Children in Johannesburg between the Wars’; Walter, ‘Practising Hygiene and Fighting the Natives’ Diseases’; Tabitha Kanogo, *African Womanhood in Colonial Kenya 1900-50* (Oxford: James Currey Ltd, 2005); Marcel Dreier, ‘Health, Welfare and Development in Rural Africa: Catholic Medical Mission and Configuration of Development in Ulanga, Tanzania, 1920-1970.’ (Ph.D. Dissertation, University of Basel, 2015).

<sup>68</sup> Tilley, *Africa as a Living Laboratory*, 1.

<sup>69</sup> Tilley, *Africa as a Living Laboratory*.

<sup>70</sup> I argue that Jan Hofmeyr’s characterization of Africa as a ‘natural laboratory’, where both animals and humans could be studied ‘in their natural milieu’ reflects a deeply problematic and colonial mindset. This view reduces African lives and environments to mere objects of scientific experimentation, perpetuating a legacy in which Africa was treated as a site for invasive research without adequate consent or regard for ethical considerations. Such attitudes underscore the longstanding racialised hierarchy in global science, where Africa has too often been positioned not as an equal partner but as a source of raw materials, a testing ground, or merely a consumer of external scientific products. In chapters 4 and 5, I show how these entrenched power dynamics continue to shape the relationship between Africa and global science, reinforcing inequities despite the rhetoric of globalisation.

<sup>71</sup> Lindner, ‘The Transfer of European Social Policy’.

by colonial masters in Belgium, the Congo, and Tanzania, respectively. The role of transnational actors in the Tanzanian health system, therefore, is a result of a long interaction with foreigners since the colonial era. The continuities of the involvement of transnational actors in Tanzania's health system have been captured by scholars such as Michael Jennings, Lukas Meier, and Dreier.<sup>72</sup> Jennings has extensively shown the continuities of missionary work in Tanzania. He argues that missionaries played a significant role in the colonial and postcolonial health sector.<sup>73</sup>

Meier focuses on Swiss development aid in the Ivory Coast and Tanzania, arguing that science was transferred to Africa packaged in two contrasting narratives: one of emancipation and the other of colonial dominance. Dreier, still focusing on Swiss aid and Catholic developmentalism, notes that Ifakara Health Institute 'is at the heart of Switzerland, and to Tanzania it brought with it a package that included holy water, crucifix, icon, images, syringes, hammocks, missionary dress, tents, dispensaries, and religion'.<sup>74</sup> These studies suggest that the transmission of health and religious practices by missionaries was not in a cultural vacuum; rather, it was deeply intertwined with European culture and ways of thinking.

Some missionaries saw their calling not just as a 'moral duty' but a 'holy duty'. Thus, such a duty would not be abridged by worldly political events, such as the end of colonialism, and so they remained in Tanzania after independence. The missionaries not only came to preach the gospel but also to spread the 'ideas of progress' through institutions such as schools and hospitals.<sup>75</sup> Indeed, the idea of Western medicine was introduced in many parts of rural Africa by the missionaries. Even though there was evidence of discord between the missionaries and the colonial government, Ideas such as improving health for the common goal of subduing Africans for each European group to achieve its mandate led the two parties to agree.<sup>76</sup> Indeed, 'mission and government hospitals became centres of cross-cultural contacts'.<sup>77</sup>

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<sup>72</sup> Jennings, *Surrogates of the State: NGOs, Development, and Ujamaa in Tanzania*; Lukas Meier, 'Striving for Excellence at the Margins: Science, Decolonisation and the History of the Swiss Tropical and Public Health Institute (Swiss TPH) in (Post-) Colonial Africa 1943-2000' (Basel, 2012); Dreier, 'Health, Welfare and Development in Rural Africa'.

<sup>73</sup> Jennings, *Surrogates of the State: NGOs, Development, and Ujamaa in Tanzania*; Jennings, 'Cooperation and Competition'; European missionaries, including those without a medical background or training, such as Paul Gröschel, began practising due to the existing need. In many places in Africa, any European was seen as a physician, see James Leonard Giblin and Jamie Monson, eds, *Maji Maji: Lifting the Fog of War*, African Social Studies Series, v. 20 (Brill, 2010), 270.

<sup>74</sup> Dreier, 'Health, Welfare and Development in Rural Africa', 27.

<sup>75</sup> Marcel Dreier, 3

<sup>76</sup> For a description of different groups of Europeans and their goals in Africa during the era of conquest See John Anderson, *The Struggle for the School*, and also, Midgley, 'Imperialism, Colonialism and Social Welfare', 44.

<sup>77</sup> Kanogo, *African Womanhood in Colonial Kenya 1900-50*, 165.

The missionaries' field of expertise lay in the institutions they built that Africans frequented: mission stations, schools, churches, and health centres. Of these, medicine became the key tool for gaining Africans' confidence, as it addressed their most immediate need: well-being. The interactions between missionaries and Africans were not without conflict. Dreier and Kanogo have shown the cultural expectations and clash between ideas that travelled from Europe to East Africa. Dreier shows how Catholic nuns struggled to position themselves in Ifakara, an area where a childless woman was not welcomed to practice midwifery.<sup>78</sup> Similar contestations are recorded by Kanogo in Kenya, where the use of male midwives was culturally unacceptable.<sup>79</sup> Lindner and Bruchhausen argue that the use of traditional midwives was also criticised by missionaries, who, for example, labelled them as 'the last fortress of satan' because they kept 'harmful customs'.<sup>80</sup> While these studies have captured the interplay of the 'new' ideas with African traditions during the colonial era, my study examines the propagation of the colonial legacy by the post-independence state of Tanzania.

After independence, Tanzania became a hub for health actors from different countries and international non-governmental organisations (INGOs). Although Nyerere declared that the government would adopt *Ujamaa*, which was closely associated with socialism, he never claimed that the country was socialist or that he was cutting off capitalism.<sup>81</sup> Indeed, Nyerere noted that *Ujamaa* should be rooted in the people, empowering them to make their own decisions in pursuit of a better life. Additionally, he emphasised that the striving for self-reliance (*kujitegemea*) did not mean closing the country off to collaboration with like-minded nations.<sup>82</sup> The opening of Tanzania to donor funding, whether from the East or the West, led to an influx of numerous transnational actors into the country, as shown in the subsequent chapters. This is also evident in the fact that, as Coulson notes, Nyerere benefited from Western capital.<sup>83</sup>

With the Arusha Declaration in 1967, Tanzania's transnational relations underwent a significant shift. The Arusha Declaration positioned Tanzania as leaning towards socialism and Nyerere's orientation towards the East. Regarding medical history, Sino-Tanzanian relations have

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<sup>78</sup> Dreier, 'Health, Welfare and Development in Rural Africa', 112.

<sup>79</sup> Male midwives were ostracised because they were seen as outcasts see Kanogo, *African Womanhood in Colonial Kenya 1900-50*, 171.

<sup>80</sup> Bruchhausen Walter, 'Practising Hygiene and Fighting the Natives' Diseases'. Public and Child Health in German East Africa and Tanganyika Territory, 1900-1960', *DYNAMIS*. 23 (n.d.): 105; Lindner, 'The Transfer of European Social Policy', 412.

<sup>81</sup> Coulson, *Tanzania: A Political Economy*, 2.

<sup>82</sup> Nyerere, *Freedom and Development*.

<sup>83</sup> Coulson, *Tanzania: A Political Economy*, 2.

attracted considerable attention.<sup>84</sup> George Yu provides a compelling history of China's policy toward Africa, analysing how China presented itself as a neutral, anti-colonial player to postcolonial African states. However, this position was later criticised by Alicia Altefon-Ong and Martin Bailey, who argue that the relationship between Tanzania and China was that of 'unequal partners'.<sup>85</sup> Allen Dobson and Zhou Xun have demonstrated how China sought to enhance healthcare under Mao Zedong, which was also aligned with China's position in world politics, as shown in chapter five.<sup>86</sup> Andrea Kifyasi's study focuses on Chinese medical assistance to Tanzania, highlighting its role in fostering socialist solidarity.<sup>87</sup> John Illife also shows the influence of Chinese medicine on the medical profession in Tanzania after 1967.<sup>88</sup> These studies have proven vital in my conceptualisation of Chinese medical assistance and its impact on maternal health in Kilombero.

As illustrated by Tanzania's colonial history, the history of the travelling of ideas and knowledge is long. Rebecca Lee examines the transfer of medical ideas from the transatlantic trade to the colonial era.<sup>89</sup> This exchange is still ongoing, as Johanna Kuhlmann et al. have shown their explanation of the three stages of the diffusion of ideas.<sup>90</sup> Rosina Foli adds to this debate by examining the role of transnational actors and policy-making in Ghana.<sup>91</sup> David Dolowitz and David Marsh demonstrated that there was some exchange where some countries 'learn from abroad'.<sup>92</sup> My study aims to contribute to this debate by analysing transnationalism from a historical and postcolonial perspective at the micro level.

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<sup>84</sup> Martin Bailey, 'China and Tanzania: A Friendship between Most Unequal Equals', *Millennium: Journal of International Studies*, 1973; Bruce D. Larkin, *China and Africa 1949-1970: The Foreign Policy of the People's Republic of China*. (Berkeley: University of California Press, 1971); Allen Dobson, 'Health Care in China After Mao', *Health Care Finance Review* 2, no. 3 (1981): 41–53; Elizabeth Hsu, 'Medicine as Business: Chinese Medicine in Tanzania', in *China Returns to Africa: A Rising Power and a Continental Embrace*. (New York: Columbia University Press, 2008), 221–36; Zhou Xun, *The People's Health: Health Interventions and Delivery in Mao's China, 1949-1983*. (Montreal & Kingston: McGill-Queen's University Press, 2020); Andrea Kifyasi, 'Neither a Saviour nor Exploiter: A Historical Study of China's Medical Assistance in Post-Colonial Tanzania' (Basel, University of Basel, 2021); George T. Yu, *China's African Policy: A Study of Tanzania* (New York: Praeger publishers, 1975).

<sup>85</sup> Alicia Altofer-Ong, 'They Came as Brothers, Not Masters: Chinese Experts in Tanzania in the 1960s and 1970s', *Journal Für Entwicklungspolitik* XXVI 3, no. 3 (2010): 73–94; Bailey, 'China and Tanzania: A Friendship between Most Unequal Equals'.

<sup>86</sup> Dobson, 'Health Care in China After Mao'; Xun, *The People's Health: Health Interventions and Delivery in Mao's China, 1949-1983*.

<sup>87</sup> Kifyasi, 'Neither a Saviour nor Exploiter: A Historical Study of China's Medical Assistance in Post-Colonial Tanzania'.

<sup>88</sup> Illife, *East African Doctors: A History of the Modern Profession*.

<sup>89</sup> Rebekah Lee, *Health, Healing and Illness in African History*, 2021.

<sup>90</sup> Johanna Kuhlmann et al., 'How Social Policy Travels: A Refined Model of Diffusion', *Global Social Policy* 20, no. 1 (2019): 80–96, <https://journals.sagepub.com/home/gsp>.

<sup>91</sup> Rosina Foli, 'Transnational Actors and Policymaking in Ghana: The Case of the Livelihood Empowerment Against Poverty', *Global Social Policy* 16, no. 3 (2016): 268–86, <https://doi.org/DOI:10.1177/1468018115615643>.

<sup>92</sup> David P. Dolowitz, and David Marsh, 'Learning from Abroad: The Role of Policy Transfer in Contemporary Policy-Making', *Governance* 13, no. 1 (2002): 5–23.

In sum, the discussed literature on health-policy planning in Tanzania reflects a growing body of work that engages with themes of state-building, national development, and international cooperation. While these studies offer a rich foundation, my research seeks to contribute to this expanding field by analysing health planning through the intersecting lenses of political economy, postcolonial theory, and travelling theory. This approach enables a more nuanced understanding of how global health ideas were negotiated, adapted, and integrated within Tanzania's postcolonial context.

### **1.3 Theoretical Considerations, Methodology and Sources.**

#### **1.3.1 Theoretical Considerations**

Many theories have been used to explain development in Africa. Some of these theories, developed at the advent of colonialism in Africa in the mid-19th century, coincided with, but were also integral to, colonial narratives about African institutions and societies. With these narratives, European culture was assigned the superior position. Mary Louise Pratt notes that such writings made it easy for the Europeans to produce 'the rest of the world',<sup>93</sup> different from them. This co-production created a kind of binary situation that Edward Said called 'othering',<sup>94</sup> in contrast with the 'ideal' West. Most colonial anthropologists and historians depicted Africans as inferior, living a barbaric life, 'full of wild beasts and diseases'.<sup>95</sup> They viewed Africa as a continent with no history, and therefore Africans as a people without a history.<sup>96</sup> They also emphasised the inability of Africans to make their own history, and believed African institutions were too oppressive and tradition-bound.<sup>97</sup> Their arguments primarily relied on written sources from proxies of colonial agents, such as traders, missionaries, and explorers, who were also integral to the colonial scheme. This theorisation ignored other sources of history, including oral tradition, upon which African history is anchored.<sup>98</sup>

Based on this idea of Africa as a continent lacking history and civilisation, the colonisation of Africans was justified with the narrative of a 'colonising mission'. In this, the colonisation of Africans was aimed at bringing Africans to a level where they could enjoy life and be 'civilised'

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<sup>93</sup> Mary Louise Pratt, *Imperial Eyes: Travel Writing and Transculturation* (Routledge, 2008), 3.

<sup>94</sup> Edward W. Said, *Orientalism* (Vintage, 1978).

<sup>95</sup> Achille Mbembe, *On the Postcolony* (University of California Press, 2001), 178.

<sup>96</sup> Bethwell A. Ogot, *African Historiography: From Colonial historiography in general*, in *General History of Africa*, (California: University of California Press, 1992), 71.

<sup>97</sup> Arnold Temu and Bonaventure Swai, *Historians and Africanist History: A Critique*: (London: Zed Press, 1981), 18

<sup>98</sup> Amadou Hampate Ba, 'Tongues That Span the Centuries: The Faithful Guardians of Africa's Oral Tradition', *UNESCO Courier: A Window Open to the World* XXXII, no. 8/9 (1979): 16–23; Jan Vansina, *Oral Tradition as History*. Madison: University of Wisconsin Press. (University of Wisconsin Press, 1985); Stephen Belcher, 'Oral Traditions as Sources', in *Oxford Research Encyclopedia of African History* (Oxford University Press, 2018), <https://doi.org/10.1093/acrefore/9780190277734.013.363>.

by a ‘superior race’.<sup>99</sup> Thus, ideas such as evolutionary theory and modernisation theory were used to justify Africa's urgent need for this ‘help’. These theories became fertile ground for the perpetuation of narratives about the limitations of Africans. However, even within the colonial setup, some Europeans acknowledged and praised the intelligence of Africans, particularly in their efforts to mitigate disease and conserve the natural environment.<sup>100</sup> European culture, they noted, was not the only known answer to questions about life and existence. This category of thinkers was the seed from which Africanists emerged. Africanists were Europeans who believed in and wrote in support of the agency of the African people.

Over time, the progression of colonialism prompted increased criticism of how knowledge about Africa and Africans was produced and disseminated. Evolutionary theory was challenged for its racial biases, while modernisation theory, which encouraged colonies to emulate the industrialised nations, especially their colonial rulers, was criticised for perpetuating underdevelopment and dependency. In response, a range of theories have since been applied to explain development in Africa.

To illustrate the complexities and multi-layered nature of health-policy planning after independence, my study draws on three complementary theoretical frameworks: travelling models, postcolonial theory, and political economy. The use of these theories provides a layered analysis of health-policy planning, as the idea of travelling models helps trace how health concepts and models are transferred across international and local borders, in this case from China, Switzerland, and Tanzania, and how they were adapted and reinterpreted within the Kilombero Valley. Postcolonial theory enables a critical analysis of how health ideas were embedded within and shaped by histories, national aspirations, and the hybridisation or synchronisation of different forms of medicine.<sup>101</sup> At the same time, political economy connects the analysis to state-building and resources, as well as to legitimacy and authority, especially in the era of President Nyerere. In what follows, I will elaborate on each of these theories and explain how they enrich my analysis.

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<sup>99</sup> Mbembe, *On the Postcolony*, 1.

<sup>100</sup> Tilley, *Africa as a Living Laboratory*; ‘Der Schweizer Kapuziner in Africa’, *Missionsbote*, no. 5 (September - October 28 Jahrgang): 76; Louise Jilek-Aall, *Call Mama Doctor: African Notes of a Young Woman Doctor* (George Allen and Unwin LTD, 1980).

<sup>101</sup> In Chapter 6, I conclude by showing how a hybrid or a synchronised health future depicts the Tanzania health-policy planning in the first two decades of independence. In this work I define hybridisation as blending or mixing of different medical systems to produce a new, hybrid form while synchronisation refers to the parallel operation or coordinated coexistence of various medical systems without necessarily blending them.

The travelling model idea explains how concepts move from one place to another.<sup>102</sup> Edward Said, one of the proponents of this aspect, explained how ideas—just like human beings — travel. He described this movement in four key stages: the point of origin, the distance traversed, the set of conditions, and accommodation.<sup>103</sup> The origin of the concept is assumed to be superior to the intended destination, and the travelling concept is treated as a catalyst for change in the new location, often seen as a symbol of modernity.<sup>104</sup> It is this notion that popularised the need for European health concepts in Africa from the colonial period onward. An example of this is how these ideas are met with a set of conditions at the final destination, which could include resistance or acceptance, determining the final stage of accommodation or incorporation in the new place. I demonstrate this concept by discussing China’s and Switzerland’s medical assistance to Tanzania.

The assumption is that the travelling concept is diffusionist, in that ideas travel from a high to a low level of concentration. Thus, European ideas of Western (biomedical) medicine were introduced to Africa during colonialism as a travelling concept, in which biomedical ideas, experts and notions of technological advancement were circulated. Throughout the colonial experience, as per the ‘civilising mission’, it was the prerogative of the ‘white’ man to modernise the ‘black’ man and his space.<sup>105</sup> Therefore, Africa was taken as a laboratory for scientific research, development experiments, and transnational methods.<sup>106</sup> Health-related matters such as maternity were ‘modernised’ not only through Western medicine but also through other transplanted ideas, including Western education. In the gendered colonial education, which sought to propagate 19th-century Victorian ideals,<sup>107</sup> men were taught the 3Rs (Reading, Writing, and Arithmetic), while women were taught the 3Bs (Baby, Birth, and Broom),<sup>108</sup> which aimed to promote hygiene and nutrition. While African health and healing knowledge was transmitted from the old to the young, the missionaries and colonial agents believed that any imported concept from Europe was far more effective than the ‘intergenerational transfer of wisdom from old women and [men]’.<sup>109</sup> Thus, progress could only

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<sup>102</sup> Andrea Behrends, Sung-Joon Park, and Richard Rottenburg, *Traveling Models in African Conflict Management: Translating Technologies of Social Ordering*, vol. 13 (Leiden: Brill, 2014), 1.

<sup>103</sup> Edward W. Said, *The World, the Text, and the Critic* (Harvard University Press, 1983), 226.

<sup>104</sup> Behrends, Park, and Rottenburg, *Traveling Models in African Conflict Management*, 13:9.

<sup>105</sup> Rostow W.W, *The Stage of Economic Growth* (Cambridge University Press, 1960); Gunnar Myrdal, *Asian Drama: An Inquiry into the Poverty of Nations* (Penguin Books, 1968).

<sup>106</sup> Tilley, *Africa as a Living Laboratory*, 27.

<sup>107</sup> Felicia Appel, ‘Victorian Ideals: The Influence of Society’s Ideals on Victorian Relationships’, *Mckendree University*, no. 18 (2012): 1, <https://www.mckendree.edu/academics/scholars/issue18/appell.htm>; Charles Petrie, ‘Victorian Women Expected to Be Idle and Ignorant’, in *Victorian England* (San Diego: Greenhaven Press, Inc, 2000), 184.

<sup>108</sup> Robert Tignor, *Colonial Transformation of Kenya: The Kamba, Kikuyu, and Maasai from 1900-1939* (New Jersey: Princeton University Press, 1976), 206.

<sup>109</sup> Elke Seefried, ‘Globalized Science: The 1970 Futures Field’, *Centaurus* 59 (2018): 1.

be achieved through the lenses of Western modernity, science, and rationalism. Following this colonial logic, ideas had to be transferred from the metropole (Europe) to the periphery (Africa), which was, among other policy areas, applied to social welfare and health policies during the colonial period, as Lindner has shown.<sup>110</sup>

After independence, the propagation of health as a travelling model continued in the activities of international bodies such as the WHO, UNICEF, and International Non-governmental Organisations (INGOs). Additionally, bilateral ties played a crucial role in enhancing Tanzania's health infrastructure, particularly through Chinese government assistance in constructing the TAZARA railway and Swiss medical aid.

The travelling model idea, however, is criticised for its close connection to the modernisation paradigm. Modernisation meant that Africa was envisioned as undergoing a process of reorganisation to mirror the West, resulting in numerous development projects and ideas initiated during the colonial period and continued after independence. A few years after independence, it became increasingly clear that the modernisation paradigm was not yielding results. Some scholars have argued that it overlooked African realities and achievements.<sup>111</sup> Indeed, modernisationist thinking did not help to alleviate poverty, inequality, disease, hunger, prejudice and ignorance.<sup>112</sup> In the end, it was concluded that the very modernisation that was to bring progress was the primary cause of underdevelopment and dependency in African states.<sup>113</sup> The travelling model is also criticised for ignoring the role of the less dominant region or group. In other words, the framework gives less consideration to what Pratt popularised as 'contact zones', defined as 'social spaces where disparate cultures meet, clash, and grapple with each other'.<sup>114</sup> According to Pratt, 'while the subjugated people cannot readily control what the dominant culture imposes upon them, they do determine to varying extents what they absorb into their own, how they use it, and what they make it mean'.<sup>115</sup> Therefore, the 'African condition' could only be described as a crisis.<sup>116</sup> These shortcomings, however, are understood in that Africans could negotiate their space in the transplanted idea. But could the 'subaltern

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<sup>110</sup> Lindner, 'The Transfer of European Social Policy', 208.

<sup>111</sup> Julius E. Nyang'oro, *The State and Capitalist Development in Africa: Declining Political Economies* (California: ABC-CLIO, 1989); Edward Kisiang'ani, 'Rethinking Frantz Fanon in the Context of the Kenyan Decolonization Experience, 1895-1992' (Kenyatta University, 2003), 35

<sup>112</sup> Rochona Mamjumdar, 'Postcolonial Theory', in *The Routledge Companion to Historical Theory* (London: Routledge, 2022), 164.

<sup>113</sup> Collins Leys, *The Rise and Fall of Development Theory* (EAEP, 1996); Walter Rodney, *How Europe Underdeveloped Africa* (Bogle-Louverture, 1976).

<sup>114</sup> Pratt, *Imperial Eyes*, 7.

<sup>115</sup> Pratt, *Imperial Eyes*, 7.

<sup>116</sup> Nyang'oro, *Declining Political Economies*.

speak?’<sup>117</sup> These limitations prompted me to use postcolonial theory to analyse how medical ideas were appropriated in the local context.

Although the Non-Aligned Movement (NAM) was formally established in 1961 at the Belgrade Conference in Belgrade, Yugoslavia, its ideological roots can be traced to the 1955 Bandung Conference in Indonesia, where newly independent nations articulated a shared vision of postcolonial sovereignty and resistance to Cold War alignments.<sup>118</sup> In this conference, twenty-nine independent nations of Asia and Africa, represented by 600 delegates, met from April 1955 to ‘mark their commitment to a post-imperial world’.<sup>119</sup> The formation of NAM enabled postcolonial nations to assert independence, resist imposed global binaries, and collectively articulate their distinct political identities—thus embodying the key postcolonial concepts of self-definition and otherness.

The concept of otherness is very instrumental to the development of postcolonial thinking. This thinking emerged as a response to the cultural, political, and epistemological legacies of colonialism, imperialism, and later neo-colonialism. However, it was not until the 1980s that postcolonial theory emerged in the Anglo-American Academy.<sup>120</sup> Postcolonialism critiques how enduring colonial structures continue to shape knowledge, identity, history, and global inequalities. Borrowing from anti-colonial thinkers such as Frantz Fanon, Mahatma Gandhi, and Kwame Nkrumah,<sup>121</sup> proponents of postcolonial thinking critique neo-colonial and imperialistic structures and knowledge production. Ngugi wa Thiong’o, in his call for ‘decolonising the mind’, advocates for the use of vernacular languages.<sup>122</sup> Edward Said, Homi Bhabha, Leela Gandhi, Dipesh Chakrabarty, Ania Loomba, Mary Louise Pratt, and Gayatri Spivak further question the colonial domination and marginalisation of the Global South.<sup>123</sup> This discourse is further explored by African writers such as Isaria Kimambo, Arnold Temu,

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<sup>117</sup> Spivak, ‘Can the Subaltern Speak?’

<sup>118</sup> Jürgen Dinkel, ‘The Cold War and the Postcolonial Moment – Prehistory, Aims and Achievements of the Non-Aligned Movement 50 Years after Belgrade’, n.d, 1, Retrieved from <https://meinclio.clio-online.de/open/pdf/conferencereport/fdkn-122348/>

<sup>119</sup> Majumdar, ‘Postcolonial Theory’, 164.

<sup>120</sup> Majumdar, ‘Postcolonial Theory’, 163.

<sup>121</sup> Frantz Fanon, *The Wretched of the Earth* (New York: Grove Press, 1961); Kwame Nkrumah, *Consciencism: Philosophy and Ideology for Decolonization and Development with Particular Reference to the African Revolution* (London: Heinemann, 1964); Frantz Fanon, *Black Skin, White Masks* (London: Pluto Press, 1986); Bikhu Parekh, *Colonialism, Tradition, and Reform: An Examination of Gandhi’s Political Discourse* (New Delhi: SAGE Publications, 1989); Kisiang’ani, ‘Rethinking Frantz Fanon in the Context of the Kenyan Decolonization Experience, 1895-1992’.

<sup>122</sup> Ngugi wa Thiong’o, *Decolonising the Mind: The Politics of Language in African Literature* (London: James Currey Ltd, 1992).

<sup>123</sup> Said, *Orientalism*; Dipesh Chakrabarty, ‘Postcoloniality and the Artifice of History: Who Speaks for “Indian” Pasts?’, *Representations* 37, no. No. 37, Special Issue: Imperial Fantasies and Postcolonial Histories (1992): 1–26; Homi Bhabha, *The Location of Culture* (Routledge, 1994); Pratt, *Imperial Eyes*; Spivak, ‘Can the Subaltern Speak?’; Leela Gandhi, *Postcolonial Theory: A Critical Introduction*, second edition (Columbia University Press, 2019).

Wamba Dia Wamba, Achille Mbembe, and, more recently, Ndlovu Gatsheni in his exegesis of decolonial thought.<sup>124</sup>

The notion of the ‘post-colonies’ refers to a specific historical trajectory in which societies emerging from colonialism did not have to revert to traditional pre-colonial life and were not purely Westernised. It was then crucial that the ex-colonies establish their own space. I use this paradigm to examine Tanzania’s health-policy planning after independence by analysing how Tanzania positioned itself in health-policy planning and implementation. From colonialism, Tanzania adopted *Ujamaa*. According to Nyerere, *Ujamaa* was neither socialism nor capitalism but an avenue where Tanzania was ‘moving towards greater equality of treatment for all its people’.<sup>125</sup> The notion of post-coloniality was that the subaltern could speak not by ‘locating her separateness from dominant culture but by highlighting the extent to which she moulded even those processes and cultures that subjugated her’.<sup>126</sup> Therefore, contrary to the discourse that capitalised on the European vs. African dichotomy, postcolonial theory focuses on how the two interact in one space, leading not to a kind of assimilation or resistance, but to an ‘entanglement’.<sup>127</sup> This is what Pratt describes as ‘contact zones’ or ‘transculturation’, referring to the interplay between the periphery and the metropole.<sup>128</sup> Thus, the continuing, now post-colonial, relationship between the former colonial masters and the newly independent states and other transnational actors is ‘characterised as an illicit cohabitation, a relationship made fraught by the very fact of the colonial (neo-colonial) authority and its “subject” having to share the same living space’.<sup>129</sup>

This study, therefore, adopts the postcolonial theory of hybridity. According to Majumdar, hybridity is the idea that culture and people are continually constituted by practices and acts of ‘translation’, rather than existing as authentic and essentialised totalities.<sup>130</sup> Loomba, on the other hand, defines hybridity in the postcolonial context as the integration and mingling of cultural signs and practices between the coloniser and the colonised.<sup>131</sup> In this study, I demonstrate the various forms of hybridity that emerged as a result of transnationalism, expert

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<sup>124</sup> Isaria N. Kimambo, *Three Decades of Production of Historical Knowledge at Dar Es Salaam* (1993); Arnold Temu and Bonaventure Swai, *Historians and Africanist History: A Critique: Post-Colonial Historiography Examined* (Zed Pr., 1981); Mbembe, *On the Postcolony*; Ndlovu-Gatsheni Sabelo, *Empire, Global Coloniality and African Subjectivity* (Bergahn, 2013); Ndlovu-Gatsheni Sabelo, ‘Decoloniality as the Future of Africa’, *History Compass* 13, no. 10 (2015): 485–96, <https://doi.org/10.1111/hic3.12264>; Ndlovu-Gatsheni Sabelo et al., *Coloniality of Power in Postcolonial Africa – Myths of Decolonization* (CODESRIA, 2022).

<sup>125</sup> Coulson, *Tanzania: A Political Economy*, 2.

<sup>126</sup> Ania Loomba, *Colonialism/Postcolonialism* (Routledge, 2005), 231.

<sup>127</sup> Mbembe, *On the Postcolony*, 14.

<sup>128</sup> Pratt, *Imperial Eyes*, 7.

<sup>129</sup> Gordon Omenya, ‘The Relations between the African and Asian Communities of Kenya’s Nyanza Region, 1901-2002’ (MA (History) Dissertation, Kenyatta University, 2010), 40.

<sup>130</sup> Majumdar, ‘Postcolonial Theory’, 171.

<sup>131</sup> Loomba, *Colonialism/Postcolonialism*, 163.

ideas, and local actors in shaping the future of maternal healthcare in Tanzania during the first two decades of independence, even after some of these ideas were introduced to Africa as travelling concepts. The acceptance that African knowledge was not as ‘primitive’ gives room to this kind of conceptualisation.<sup>132</sup> This understanding is further emphasised by Ian Hacking, who notes that ‘there is not one science but many...’ while John Janzen notes that ‘neither African nor European medicine is very effective’.<sup>133</sup> In the context of health and disease control, the hybridity between indigenous knowledge and Western medicine was always inevitable, as many governments, both colonial and post-colonial, have been unable to provide sufficient services to warrant the eradication of the former. Indeed, Feierman introduces his chapter on ‘Patterns of control’<sup>134</sup> by noting that:

No colonial power and no independent African state has ever intervened decisively to destroy popular healing. Governments have been either unable or unwilling to provide biomedical care to their entire populations, and have therefore been forced to tolerate the survival of African healing. This fortunate outcome is also a consequence of the determination and cunning exercised by popular healers over generations. Healers have long cultivated secretiveness as a survival strategy.

A postcolonial perspective provides a critical framework for analysing health planning in Tanzania, highlighting how colonial legacies continue to shape policy priorities, institutional structures, and maternal health practices. In this context, the concept of hybridity sheds light on how global health initiatives, missionary activities, and state policies intersect with local knowledge, cultural beliefs, and traditional care systems, resulting in complex and sometimes conflicting forms of maternal health provision in the Kilombero Valley. While postcolonial theory and the idea of travelling models illuminate these layered legacies and hybrid practices, it is also essential to consider the impact of material factors such as funding, institutional authority, and global economic relations. Therefore, I also employed a political economy approach to situate maternal health within the broader context of resource allocation, development planning, and the influence of the state, its agencies, and external actors on health policy in Tanzania.

Political economy, as a theoretical approach, explores the interdependent relationship between political structures and economic systems. The intellectual roots of political economy lie in the 17<sup>th</sup> century, with the works of classical economists and political theorists such as Adam Smith,

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<sup>132</sup> Tilley, *Africa as a Living Laboratory*, 15.

<sup>133</sup> Both Ian and John are quoted by Helen Tilley “Africa as a living laboratory, pp. 15 and 16

<sup>134</sup> Feierman, ‘Struggles for Control’, 74.

David Ricardo, and Thomas Malthus.<sup>135</sup> Their central argument was that politics and economics are inextricably linked; political decisions shape economic outcomes, and vice versa.

In health studies, the political economy of health offers a powerful critique of health inequalities by drawing attention to structural determinants of health. It interrogates the distribution of resources, the role of the state, and the economic interests that influence health systems. The foundational works of Karl Marx and Friedrich Engels were instrumental in linking poor health outcomes to the capitalist system. They argued that the rise of capitalist industrialisation led to exploitative labour conditions, inadequate housing, malnutrition, and widespread disease.<sup>136</sup> Anti-capitalist critiques further emphasised that class inequality, working conditions, and profit-oriented production systems were central causes of ill-health and early mortality.<sup>137</sup>

Socialist systems, while offering alternatives to capitalist frameworks, were not immune to criticism. Scholars such as Mihajlo Jakovljevic et al. note that many socialist states, including the Union of Soviet Socialist Republics (USSR) and the People's Republic of China (PRC), relied heavily on large-scale industrial manufacturing.<sup>138</sup> These development models often required mass mobilisation of labour, including women, creating health burdens despite the promise of universal care. Ironically, they reproduced features of the very capitalist systems they sought to critique. Economic goals in both systems had a direct influence on health outcomes, policy priorities, and access to services.

In the Global South, and particularly in postcolonial contexts like Tanzania, political and economic systems were often inherited from colonial structures but reconfigured through development ideologies.<sup>139</sup> After independence, the Tanzanian state became the principal actor in health provision, assuming both the roles of provider and regulator. It was 'the political process of health that determined who got what and how'.<sup>140</sup> Political elites framed health policy

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<sup>135</sup> Michael Harvey, 'The Political Economy of Health: Revisiting Marxian Origins to Address 21st Century Health Inequalities.', *AMJPH Public Health*, no. 111 (2021): 293.

<sup>136</sup> Marx Karl and Friederich Engels, *Manifesto of the Communist Party by Karl Marx and Frederick Engels* (1848), <https://www.marxists.org/archive/marx/works/download/pdf/Manifesto.pdf>; Marx Karl, *Capital A Critique of Political Economy Volume I Book One: The Process of Production of Capital* (2015), <https://www.marxists.org/archive/marx/works/download/pdf/Capital-Volume-I.pdf>; Raju J Das, 'Capital, Capitalism and Health', *Critical Sociology* 49, no. 3 (2023): 395–414.

<sup>137</sup> Nyang'oro, *Declining Political Economies*; Gøsta Espin-Andersen, *The Three Worlds of Welfare Capitalism* (Polity Press, 1990).

<sup>138</sup> Mihajlo Jakovljevic et al., 'Global South Political Economy of Health Financing and Spending Landscape, History and Presence', *Journal of Medical Economics* 24, no. sup 1 (2021): 30.

<sup>139</sup> Mhazo T Alison and Mapunga C. Charles, 'The Political Economy of Health Financing Reforming on Zimbabwe: A Scoping Review', *International Journal for Equity in Health* 21, no. 42 (2022): 61; Jakovljevic et al., 'Global South Political Economy of Health Financing and Spending Landscape, History and Presence', 30; Harvey. M Brenner, 'Political Economy and Health', in *Society and Health* (Oxford University Press, 1995), 211.

<sup>140</sup> Alison and Charles, 'The Political Economy of Health Financing Reforming on Zimbabwe: A Scoping Review', 1.

through the lens of state legitimacy, public service, and national development. Julius Nyerere's *Ujamaa* socialism placed the state at the centre of planning, including maternal and child-health services.

This study posits that the post-independence political economy of Tanzania is crucial to understanding the evolution of health policy planning in Tanzania. The Tanzanian government's efforts to build a welfare-oriented system were shaped by its political ideology, economic constraints, and global health partnerships. Therefore, policy-making and implementation were not merely technical acts but were infused with political priorities and financial capabilities. According to Brenner,

The political economy, in interaction with government policies, influences a nation's health through the mechanisms of production, distribution, and consumption. The primary links between the economy and healthcare are economic growth and instability. Its key elements ...are nutrition, housing, sanitary engineering, primary education (of the mother) and primary health care, all of which require societal investment and thus sufficient material wealth.<sup>141</sup>

Thus, the political economy lens sheds light on the material and institutional contexts in which health policies were crafted, implemented, and contested in Tanzania. It foregrounds the role of the state, the impact of economic ideologies, and the structural challenges of postcolonial governance, offering a critical entry point for the historical analysis that follows. In summary, I reiterate that no single framework sufficiently captures the complexity of this study. While political economy provides structural insight, it is limited in addressing questions of cultural translation and historical legacy. By combining it with postcolonial theory and the travelling model concept, this study accounts for external influence, local agency, and the adaptation of global health ideas in postcolonial Tanzania.

### **1.3.2 Methodology and Sources**

This study employed a qualitative and historical approach to examine the development, transformation and implementation of maternal health policies in Tanzania from 1961 to the 1980s. As noted above, the study is grounded in the political economy of health, postcolonial theory and the travelling model frameworks. A wide variety of primary and secondary sources was utilised. These materials were sourced from various libraries and archives across East Africa, Germany, Switzerland, and Norway.

I collected a vast variety of secondary sources, primarily books, journal articles and dissertations, from the *Universitäts- und Stadtbibliothek Köln* (USB) and the subsidiary libraries in the departments, such as the History Institute, Ethnology Institute, and the African

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<sup>141</sup> Brenner, 211, 224.

Studies Institute, at the University of Cologne. The German National Library of Medicine (ZB MED) in Cologne and the Kenyatta University Post Modern Library's Africana section in Nairobi were also invaluable. Corroborating these materials with primary sources aided in contextualising the findings within broader regional and global trends. These sources were also instrumental in identifying historiographical debates and framing my theoretical approach. They provided essential background on Tanzanian political history, the development of health systems in Africa, gendered perspectives on care, and the global discourse on maternal health.

I conducted fieldwork and archival and library research in Tanzania after obtaining clearance from the Tanzania Commission for Science and Technology (COSTECH) (see Appendix 1). Clearance from COSTECH was later followed by a relatively lengthy bureaucratic and hierarchical process at the Ministry of Regional Administration and Local Government (TAMISEMI).<sup>142</sup> The letter from TAMISEMI introduced me to the Provincial authorities in Morogoro, who then facilitated my access to the local level through the District Commissioner (DC), ultimately allowing me to reach the *Mtendaji wa Kijiji* (village level).

At the local level, I conducted oral interviews in the Kilombero Valley in separate periods between February 2023 and February 2025. This fieldwork was conducted for two reasons. First, while the study is centred on policy-making at the national level, the fieldwork enabled access to how the policies were implemented and appropriated at the local level. Second, cognisant of the silences and marginalisation that are often perpetuated through written records,<sup>143</sup> oral interviews offered the much-needed gendered and rural perspectives. I visited Ifakara, Kidatu, and Mang'ula, where I visited locations such as Viwanja Sitini, Posta, Uwanja wa Ndege, Lipangalala, Kidatu A and B, Magula A and B, Msolwa *Ujamaa* in Sanje, and Mahenge. Mahenge was the first area of operation for the medical work of German colonial officers and German missionaries, whose mission work was later assumed by Swiss Capuchin missionaries after World War I (see Chapter Five). The Swiss missionaries expanded their medical and evangelical work across the valley. Ifakara was the centre of operations for the Swiss Missionaries from the 1920s, and their presence is captured in the many landmarks they left on site, mainly hospitals and training institutes.

With the help of research assistants, I gathered oral narratives through interviews with retired health workers, including nurses, AMOs, MCHAs, and former staff members at the Ifakara Health Institute, as well as Catholic Church priests and nuns, traditional health practitioners,

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<sup>142</sup> TAMISEMI is Swahili, acronym for Tawala za Mikoa na Serikali za Mitaa

<sup>143</sup> Jacques Depelchin, *Silences in African History. Between the Syndromes of Discovery and Abolition* (Mkuki na Nyota, 2005); Peter R. Schmidt and Jonathan R. Walz, 'Silences and Mentions in History Making', *Historical Archaeology* 41, no. 4 (2007): 129–46, <https://doi.org/10.1007/BF03377299>.

midwives, and members of the general public around the Kilombero Valley. These interviewees were identified through purposive and snowball sampling, based on their knowledge of events related to Tanzania's history in general or their involvement in the health sector. Luckily, it was a heterogeneous group that shared information very generously, as they recalled the era of Nyerere, TANU, and *Ujamaa*, as well as the Chinese and Swiss in the Kilombero Valley. The majority of my interviewees consented to my research requests; two refused to be interviewed. One had fears about who exactly we were, while the other was unavailable for the two interview appointments we had agreed on. This was perhaps because he did not want to refuse the interview openly, but he also did not want to be interviewed at all.

The interviews were conducted in Swahili, recorded, and transcribed immediately to preserve the authenticity of the data. I also took notes during the interview on observations from fieldwork. Considering the limitations of oral information, the gathered information was corroborated with existing literature on health matters to verify its validity. The notes taken and transcribed interview notes were grouped thematically to fit the study's objectives, which helped develop the narrative. In this study, oral sources proved essential in supplementing unrecorded aspects of the past, as people's memories and lived experiences often preserve crucial historical knowledge.

Traditionally, oral storytelling was used to pass down cultural aspects from one generation to the next. It remains an essential tool for the recollection of pre-colonial, colonial, and post-independence histories. This study benefited immensely from the oral histories of individuals who experienced the *Ujamaa* policy first-hand, as well as from TANU politics and the maternity services provided by both local and visiting doctors from China during the post-independence period. These oral accounts were invaluable in offering gendered and rural perspectives often marginalised in written records. This supports the conclusions of Jan Vansina, Amadou Hampate Ba, and Stephen Belcher, who emphasised the vital role of oral traditions in understanding African history.<sup>144</sup>

I also amassed a wide range of archival materials. For archival materials in Tanzania, a separate permit was required after obtaining the COSTECH permit, regardless of whether the archive was state-controlled or NGO-based. Between December 2022 and February 2025, I intermittently visited the Tanzania National Archives (TNA) in Dar es Salaam and the National Records Centre (NRC) in Dodoma, where I accessed both colonial and postcolonial state documents, missionary records, printed materials, annual reports, maps, and technical

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<sup>144</sup> Vansina, *Oral Tradition as History*. Madison: University of Wisconsin Press.; Ba, 'Tongues That Span the Centuries'; Belcher, 'Oral Traditions as Sources'.

assistance files on medical cooperation between Tanzania and other countries, *Ujamaa* politics, and health campaigns. Beyond state-controlled archives, I consulted records from religious, missionary, personal and international non-governmental organisations (INGOs), located in local church archives and health facilities. These materials supplemented my other sources and helped to trace the long history of the role of faith-based actors in health provision, especially regarding maternal health in Tanzania. With the permission of the Bishop of the Mahenge Diocese, for example, I also accessed the Mahenge Diocesan Archive (MDA), which documents a rich history, especially regarding the arrival of German and Swiss missionaries as early as the turn of the 20<sup>th</sup> century. Father Abdon Mkope kindly granted me access to documents and items he had personally preserved, such as old magazines and maps. Additional sources included development reports by multilateral institutions, newspaper articles, and missionary newsletters.

Engaging with these sources also required critical reflection on the nature of archives themselves. Ann Laura Stoler has observed that archives are not merely repositories for retrieving knowledge; they are active sites of knowledge production, intricately shaped by dynamics of secrecy, legal frameworks, and power.<sup>145</sup> Meier adds that archives are ‘expressions of state power, closely related to the logic of governance’.<sup>146</sup> Building on this, I suggest that archives can also reflect institutional authority more broadly. For example, during my research in Tanzania, the role of institutional gatekeeping that extends beyond the state itself was illustrated by the fact that access to the MDA in Mahenge depended on the bishop’s clearance.

Outside Tanzania, I visited the Staatsarchiv Basel-Stadt in Basel and the Swiss Bundesarchiv in Bern. These two archives were essential to my research, as Switzerland was one of the most important partners in Tanzanian transnational medical efforts, especially in Ifakara. The Swiss archival material provided insights into the correspondence of the Basel Foundation, a key donor to health projects in Ifakara, the involvement of various pharmaceutical industry leaders, and the Swiss Government’s development aid activities in Tanzania.

In Basel, I also visited the Swiss Tropical and Public Health Institute, where I accessed several secondary materials written on health planning and health research in Tanzania. The chapter on transnationalism also inspired my visit to the Norwegian National Archive (NAN) in Oslo, where I accessed materials on health cooperation that Tanzania maintained not only through the Norwegian Agency for Development Cooperation (NORAD) but also with other actors

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<sup>145</sup> Ann Laura Stoler, ‘Colonial Archives and the Arts of Governance’, *Archival Science* 2, nos 1–2 (2002): 87, <https://doi.org/10.1007/BF02435632>.

<sup>146</sup> Lukas Meier, ‘Striving for Excellence at the Margins: Science, Decolonisation and the History of the Swiss Tropical and Public Health Institute (Swiss TPH) in (Post-) Colonial Africa 1943-2000’ (Basel, 2012), 22.

between 1960 and the 1980s. At the time of this research, the WHO Library in Geneva was undergoing renovations; however, the archive graciously provided me with access to an extensive collection of WHO documents on Tanzania and the entire East African region. While archival research is never easy, working in archives in Switzerland and Norway made the work bearable because one could book before and plan on the time to be used in the archive, depending on the amount of materials found, unlike in Tanzania, where I had to arrive physically to write on a piece of paper what needed to be searched for physically by the archivist. My experience of the accessibility of the archives outside Tanzania resonates with Meier's assertion that

written testimonies on postcolonial Africa are not necessarily to be found in Abidjan, Dar es Salaam or Kinshasa but instead stored in well-organised archives in France, Britain or Belgium, [Switzerland or Norway, VK]. It is here where the power of the post-colonial becomes most palpable.<sup>147</sup>

Within Tanzania, I also sourced materials from different libraries. These include the University of Dar es Salaam's main library, particularly the East Africana Section, which was particularly valuable, especially for newspapers and government reports. As Barre notes, newspapers played a crucial role in understanding Tanzania's political landscape in the 1960s and 1970s, primarily because they were the primary avenues for disseminating opinions and ideas.<sup>148</sup> Additionally, newspapers in Tanzania served as the arena for struggles over identity, nationhood, and criticism.<sup>149</sup> Some of the newspapers, periodicals, and magazines I accessed were *The Standard*, *Ngurumo*, *Uhuru*, *Mwafrika*, and *The Nationalist*,<sup>150</sup> as well as *Cheche* and *Lishe*. These papers enabled me to explore party politics on various development topics and their impact on health planning. Indeed, these papers captured the daily struggles of citizens in accessing health facilities.

The Chama Cha Mapinduzi (CCM) library in Dodoma provided me with access to a variety of records and reports (medical, annual, regional, and socioeconomic development), newspapers, personal diaries, and TANU and later CCM publications, which supplemented both the oral and archival sources used. Finally, several materials were accessed online through various search engines and online archival platforms, primarily archives of the British Parliament, online newspapers, scholarly papers, and other digitised materials, as listed in the reference section. Combining all these materials helped in building the narrative of this study.

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<sup>147</sup> Meier, 'Striving for Excellence at the Margins: Science, Decolonisation and the History of the Swiss Tropical and Public Health Institute (Swiss TPH) in (Post-) Colonial Africa 1943-2000', 23.

<sup>148</sup> Barre, *Traditions Can Be Changed*.

<sup>149</sup> Barre, *Traditions Can Be Changed*.

<sup>150</sup> The *Nationalist* was launched in April 1964 as the newspaper of TANU and was later replaced by the *Daily News*.

Despite the numerous successful and positive encounters during this study, some challenges arose. First, gathering secondary, archival and oral data requires patience and time. In some cases, this requirement was exacerbated by long waits and a bureaucratic system for research approval, as noted above. Secondly, some archival materials could not be accessed because files were either missing or misplaced. Additionally, apart from English, the archival documents collected were in Swahili, German, French, and Norwegian. My command of Swahili was instrumental in conducting interviews and navigating local archives. It enabled direct communication with participants, especially older interviewees in the Kilombero Valley, without relying on translators, which fostered trust and allowed for a richer, more nuanced data collection. This linguistic fluency strengthened the research's cultural sensitivity and helped to bridge the gap between national policy narratives and community-level experiences. For all the other languages necessary for this study, digital translation tools were employed to engage with the materials, effectively enabling a diverse transnational perspective that enriched the study's analysis of global-local linkages in health-policy making.

Thirdly, the Kilombero Valley is a well-researched area, and respondents are generally accustomed to interacting with researchers. While this can usually be an advantage, it can also be a hindrance in many ways. The residents are used to the same kind of questions and sometimes harbour unmet expectations from previous researchers. Therefore, some participants were still hesitant, particularly regarding the use of audio recorders. To uphold high ethical standards and ensure complete transparency, we recorded interviews only with participants' consent. Additionally, all individuals who did not wish to be identified remain anonymous. In this vein, it was crucial to create an atmosphere of trust, which I achieved by prioritising ethics, honesty, and transparency in my fieldwork. An additional advantage in the widely researched Kilombero was that historical research on health policy remains relatively rare, which several interviewees remarked upon with interest. Many shared that they had encountered a few researchers focused specifically on the history of health, particularly maternal health. This uniqueness often elicited enthusiasm and curiosity, helping to build rapport and facilitating access to information during interviews.

#### **1.4 Remarks on Periodisation and Scope**

Chronology and periodisation are two key factors in any historical study. This study is centred around the period from 1961 to the 1980s. This encompasses the period from Tanzania's independence on December 9, 1961 to approximately 20 years later, during which the nation focused on intensive future planning, coinciding with a time of both hope and struggle. First, this period includes the 'decade of Africa' (the 1960s), when most of the African countries

gained formal independence and embarked on the process towards building, ordering and organising their futures. On the one hand, this season in itself was crucial for these countries in that it generated not only the desire for self-determination but also the yearning to reap the ‘fruits’ that came with it. On the other hand, it was a period of political and economic struggle for many of these former colonies, including Tanzania. This study, therefore, presents the first two decades of Tanzania's independence, with a focus on health-policy planning.

The period after 1980 is just as crucial as the period before 1961. Therefore, although it is beyond the scope of this study, I regularly engage with colonial debates, which I deem necessary to understand postcolonial Tanzania. For instance, one theme that cuts across this study is that colonial legacies are evident in Tanzania’s health sector as colonial policies continue to inform postcolonial plans. I focus on maternal health planning because it is a key health indicator, and because it also resonates with the struggles that many African women in the Global South still face today, many decades after independence. Through the national health-policy plans drawn up and implemented by the central government, I demonstrate how they were reflected in maternal health in a rural setting in the Kilombero Valley.

Regarding transnational actors, I focus on China and Switzerland, among the many partners that have played a role in the Tanzanian health sector, including multilateral and international bodies. Although I briefly mention the role of UNICEF in Chapter Three, the choice of the two nations may seem arbitrary, as many others could have been considered. However, the decision is essentially a matter of time, space, and sources. Thus, I opted for bilateral partnerships, which were quite common during the period under study. Coinciding with the Cold War, geopolitical considerations were critical. As noted above, Tanzania, as a newly independent state, needed to safeguard its sovereignty. Switzerland and China were often seen as two essential partners; the former was considered ‘neutral’ and concerned with humanitarianism, while the latter, considered as a fellow ‘brother’ from the Global South, was perceived as less exploitative than those from the West. The choice of these two countries enables a discussion of the types of medical assistance that originated from the Global North and South and how they were appropriated in Tanzania. I must emphasise, however, that my primary goal is not to provide a comparative analysis of the two, but rather to demonstrate that health-policy planning in Tanzania was profoundly shaped by external actors, and cannot be fully understood without including them. I therefore hope to contribute to a more nuanced understanding of postcolonial state formation and global health cooperation, particularly as shaped by political economy, travelling ideas, and postcolonial concepts such as hybridity and the synchronisation of diverse governance logics, where international norms, local practices, and inherited colonial structures were negotiated and aligned.

## 1.5 Outline of the Dissertation

This dissertation is divided into six chapters. Although I consider periodisation a key factor in addressing the events that influenced health planning, the dissertation is organised thematically rather than strictly chronologically. This chapter introduces the study, outlining the literature review, methodology and the theoretical framework that underpin the dissertation.

Chapter two establishes the political, social, and economic context of Tanzania, with a particular focus on the Kilombero region. This context situates the study within the broader evolution of the health system from its colonial origins and provides a foundation for the subsequent chapters. Chapter three examines health provision in the immediate post-independence period, exploring the enduring legacies of colonialism and the challenges Tanzania faced at independence. It discusses how health was planned in the initial Development Plans and analyses key health documents, such as the Titmuss Report. The chapter argues that while President Nyerere and the ruling party, TANU, were central to policy-making, TANU-affiliated bodies, such as the TANU Youth League (TYL) and the TANU Women's Wing, played instrumental roles in promoting health policies, addressing colonial legacies, and tackling economic challenges and human resource scarcity, which significantly affected the future of health planning in post-independence Tanzania.

Chapter Four explores the concept of *Ujamaa* as a guiding policy for health planning. The chapter assesses both the successes and failures of *Ujamaa* in advancing health, arguing that agriculture, the backbone of the economy, was intended to improve health through better nutrition and improved living standards. However, the emphasis on a cash-crop economy also posed challenges. On the positive side, the construction of health units and dispensaries in some villages brought services closer to the people, thereby improving MCH. Living close together in villages was both catastrophic and beneficial. *Ujamaa* facilitated health campaigns, such as '*Mtu ni Afya*', but the move to villages, some of which lacked water, contributed to disease. The chapter thus concludes that the impact of *Ujamaa* on health planning and maternal health was uneven; while some villages, such as Msolwa, prioritised health, others did not.

Chapter Five addresses the negotiations and influence of experts and external actors in Tanzania's health sector. The chapter uses the cases of China and Switzerland to illustrate Tanzania's long-standing history of international cooperation. It argues that foreign donors and partners have played a significant role in Tanzania's medical landscape by financing, developing infrastructure, and training medical personnel. Chinese support, rooted in shared

socialist ideals after 1967, is examined. The chapter concludes that China's medical teams had only a limited, short-term impact, as their presence in Tanzania was brief. Their overall stay in Tanzania typically lasted only two years for any doctor in the Chinese Medical Teams (CMT). During these two years, doctors were sent on short-term stays to their respective villages, as the Ministry of Health (MOH) attempted to balance the high demand for CMT across vast regions of Tanzania. In contrast, Switzerland, through the Capuchins, the Basel Foundation, and pharmaceutical companies, established a training centre in Ifakara, which helped to increase the number of health workers. The chapter also notes that these 'friendly' nations pursued their interests and revealed how any medical help was often driven by a hidden agenda rather than purely humanitarian grounds. China sought to increase its influence at the United Nations, while Switzerland aimed to export medical science and technology and to experiment with new medical knowledge. Chapter six provides the overall summary and conclusion to this dissertation.

## CHAPTER TWO

### FROM TERRAIN TO TREATMENT: BACKGROUND TO THE TANZANIAN HEALTH SECTOR WITH A FOCUS ON KILOMBERO VALLEY

#### 2.1 Introduction.

This chapter lays the foundation for the subsequent chapters of this study. While its primary aim is locating the inception and development of Western medicine in Tanzania and Kilombero in particular, it also discusses the locale of the study, providing the geographical, social, economic, and political setting, which is vital in defining how the health system, policies, and services were organised, administered and delivered to the people. Understanding the setting also helps to position the government's decision on the various policies and plans that were implemented. Tanzania has for many years attracted internal migrations and external visitors, including missionaries and colonialists, who left a lasting impact on the practice of medicine. Despite the transnational approach to medicine from various players, primarily missionaries, the chapter also emphasises that communities in the Kilombero region had traditional knowledge of medicine. This approach lays the groundwork for understanding the health sector in general and maternal health in particular.

#### 2.2 Geographical setting of Tanzania and Kilombero District

Tanzania is located in East Africa. It has a total area of 945,087 square kilometres (364,900 square miles), making it the biggest country in East Africa. Tanzania lies south of the equator and has a coastline of approximately 800 km (500 miles).<sup>151</sup> The Great Rift Valley also passes through Tanzania. It is part of Africa's Great Lakes region, which includes lakes such as Tanganyika, Edward, Victoria, Albert, and Malawi. The latitude of Tanzania is 6.3690° South and the longitude is 34.8888° East.<sup>152</sup> Tanzania's geographical location rendered it particularly susceptible to tropical diseases. At the same time, the vastness of the nation remained a challenge in providing health care, not just to the colonial government but also to the postcolonial government.

Before Germany colonised Tanzania, the East African coast had interacted with visitors from other parts of the world, long before 1500. For instance, interaction with the Chinese in the postcolonial period was seen as a renewal of the relationship that had been built as early as the

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<sup>151</sup> Francis Julius and Ian Bryceson, 'Tanzanian Coastal and Marine Resources: Some Examples Illustrating Questions of Sustainable Use', in *Marine Protected Areas in Relation to Fisheries Management*. (NORAD, 2014), 1; John Lance Geoghegan, 'The Movement for Independence in Tanganyika' (M.A, University of Pennsylvania, 1965), 1.

<sup>152</sup> Consolata Kapinga and Ibrahim Hussein, 'United Republic of Tanzania Ministry of Natural Resource and Tourism: Country Report on Implementation of Review of Significant Trade (Rst) Recommendations for Prunus Africana' (Naivasha, 2008), 2.

T'ang dynasty (618-907).<sup>153</sup> Persians from the Shirazi empire were also present on the islands of Mafia and Kilwa. However, the first interaction that Tanzania had with Europeans was with the Portuguese during an expedition led by Pedro Álvares Cabral, who conquered the city of Kilwa in 1500.<sup>154</sup> Although the Portuguese conquered East Africa, their dominance was halted by the Omani Arabs led by Seyyid Said. This was followed by the relocation of Seyyid Said's Capital from Muscat to Zanzibar.<sup>155</sup>

After the death of Said, his son Majid took over. In 1862, Seyyid Majid established a town on the mainland opposite Zanzibar, naming it Dar es Salaam (Haven of Peace).<sup>156</sup> The last 30 years of the 19<sup>th</sup> Century saw an influx of European missionaries, which the Scramble for Africa later followed. In this scramble, European countries competed for areas of strategic importance in Africa. This competition almost sparked a war, which led to the convening of the Berlin Conference to resolve the question of colonies in an amicable manner. By this time, Dr Karl Peters, acting on behalf of the German Colonial Society, had visited Tanganyika and signed treaties with many local chiefs. Hence, after the Berlin Conference, Tanganyika, as part of German East Africa, became a German Sphere of influence.<sup>157</sup>

The influx of Europeans did not amuse the sultan of Zanzibar. Perhaps without fully understanding the concept of colonialism, the then-ruler of Zanzibar, Seyyid Bargash, protested against the German incursion. Kaiser, the German Chancellor, instead responded by sending five German warships to Zanzibar, leaving Bargash with no alternative but to give in.<sup>158</sup> However, Germany, Britain and France went ahead and formed a joint committee to investigate Seyyid Bargash's claims over the territory.<sup>159</sup> Following the committee's findings that the Sultans had only a 16 km coastal strip claim, they proceeded to occupy the interior and the land immediately adjacent to the Sultan's zone in Kenya, which was claimed by the British, and in Tanganyika by the Germans. In 1885, Germany declared Tanganyika a sphere of influence under the auspices of the German East Africa Company.<sup>160</sup> This was followed by the agreements of 1886 and 1890 between Germany and Britain, which defined the East African boundaries between Uganda, Kenya, and Tanganyika.

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<sup>153</sup> Yu, *China's African Policy*, 14; Sherrif Abdul, *Dhow Culture of the Indian Ocean: Cosmopolitanism, Commerce and Islam* (Columbia University Press, 2010).

<sup>154</sup> Geoghegan, 'The Movement for Independence in Tanganyika'.

<sup>155</sup> Thomas Methuselah Msaky, 'Tanganyika The Road to Independence' (University of Rhode Island, 1964), 7, <https://digitalcommons.uri.edu/theses/1788>.

<sup>156</sup> Geoghegan, 'The Movement for Independence in Tanganyika', 4.

<sup>157</sup> Msaky, 'Tanganyika The Road to Independence', 8.; German East Africa comprised of Mainland Tanzania, Rwanda and Burundi.

<sup>158</sup> Geoghegan, 'The Movement for Independence in Tanganyika', 4.

<sup>159</sup> Msaky, 'Tanganyika The Road to Independence', 9.

<sup>160</sup> John Illife, *Tanganyika Under German Rule* (Cambridge: Cambridge University Press, 1969), 32.

Following the defeat of the Central Powers in World War I, which resulted in the loss of German colonies, Tanganyika became a mandated territory under the supervision of the League of Nations. Britain administered it on behalf of the League from 1919, although real occupation did not occur until 1920. This mandate, however, did not define the time frame during which the British were to remain in Tanganyika or whether the local people would have a plebiscite at some point. Hence, Tanzania was colonised by Germany, and later became a British territory as Tanganyika.

The current borders of Tanzania, like those of the rest of the colonies, were therefore drawn according to the Berlin Act. Hence today, mainland Tanzania, which is the core interest of this study, borders Kenya, Lake Victoria and Uganda to the North, the Indian Ocean to the East, Malawi, Lake Nyasa, and Mozambique to the South, Zambia to the southwest, and Rwanda, Burundi and Lake Tanganyika in the West (see Figure 1 below).

On 9<sup>th</sup> December 1961, after nearly eight decades of colonialism, Tanzania was freed from the yoke of colonialism under the leadership of President Julius Nyerere of the Tanganyika African National Union (TANU). However, it is worth noting that today, Tanzania, as it is commonly known, adopted its name after its merger with the People's Republic of Zanzibar on April 26, 1964,<sup>161</sup> which also included the Islands of Mafia and Zanzibar (Pemba and Unguja). After the merger, the official name became Jamhuri ya Muungano wa Tanzania (The United Republic of Tanzania) or simply Tanzania. Colonisation, however, left an indelible mark on the country, such that almost all of the main sectors of its political, economic and social life have a colonial legacy. The health sector is no exception, as this dissertation repeatedly shows.

At independence, Tanzania was subdivided into fifteen regions. They include Arusha, Central, Coast, Kigoma, Kilimanjaro, Mara, Morogoro, Mtwara, Mwanza, Ruvuma, Shinyanga, Southern Highlands, Tabora, Tanga, and West Lake. Today, Tanzania is divided into 31 administrative regions: 26 on the mainland and 5 in Zanzibar. The Kilombero Valley, located in Morogoro, is of key interest to this study. At independence, the Kilombero area was part of the Mahenge district; later, it became part of Ulanga. Today, Kilombero is a district in its own right, comprising five divisions: Ifakara, Mang'ula, Kidatu, Mngeta, and Mlimba.

The Kilombero Valley is part of the larger Rufiji Basin, the Selous Game Reserve, the Udzungwa Mountains, and the Miombo woodland.<sup>162</sup> It is also home to the Kilombero Valley

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<sup>161</sup> Theo Wilhelmus Johannes Schulpen, *Integration of Church and Government Medical Services in Tanzania: Effects at District Level*. (African Medical and Research Foundation, 1975), 27.

<sup>162</sup> Jamie Monson, 'Agricultural Transformation in the Inner Kilombero Valley of Tanzania 1840-1940' (Ph.D. Dissertation, University of California, 1991), 14.

Food Plain (KVFP). This forms part of the Southern Agricultural Growth Corridor of Tanzania (SAGCOT), which is commonly referred to as a food basket. The region has many permanent rivers, including the Kilombero, Great Ruaha, Ruhudji, and Kihansi, which are part of the Rufiji Basin. There are also swamps, such as the Kibasira. The River Kilombero, which is of interest in this study, is fed by the Ruhunje, Mnyera, Mpanga, Kihansi, and other smaller streams, including Rumena, Msola, Idete, and Ruipa.<sup>163</sup> Apart from fishing and agriculture, these water bodies contribute to the production of hydroelectric power, such as the Kidatu-Kihansi Hydro Power and large irrigation schemes. The production of food has led to a continued population increase as people migrate to Kilombero, which is one of the factors influencing the state of health, as shown later.

### 2.3 The Climate of Tanzania

The climate of Tanzania is relatively hot and dry with seasonal rainfall. However, it can be divided into four climatic regions: the highlands of the North East and South West, the coastal lowlands, which are hot and humid, the Central Plateau, which is hot and arid, and the high inland mountain and lake region of the Northern border, which includes Mt. Kilimanjaro.<sup>164</sup> Although the country faces the global challenge of climate change, it continues to experience a one-season rainfall pattern from December to May, characterised by alternating long and short rains.<sup>165</sup> Specifically, Morogoro experiences a range of temperatures, from 18°C to 32°C. It also has two seasons of rainfall: short and long. Short rains occur between October and December, while the long rains take place between March and May, with a dry season in between.<sup>166</sup> The climatic conditions became a defining factor of the health situation in Morogoro. During the rainy seasons, the incidence of some diseases increased, and it was also during the same seasons when most of the roads and rivers were impassable, making it difficult to access health facilities. Such factors, as shown in this dissertation, have led the people of the Kilombero Valley to continue to rely on traditional healers and traditional birth attendants.

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<sup>163</sup> Alexander M. Telford, *Report on the Development of the Rufiji and the Kilombero Valleys* (London, 1929), 49.

<sup>164</sup> <https://www.britannica.com/place/Tanzania>

<sup>165</sup> Schulpen, *Integration of Church and Government Medical Services in Tanzania*, 4.

<sup>166</sup> Bagaile Majubu Misana, 'A History of Tourism and Its Socio-Economic Effects on Surrounding Communities in Kilombero District: A Case Study of Selous Game Reserve (1920s-2010s)' (MA (History) Dissertation, University of Dar es Salaam, 2020), 25.



Figure 1: Map showing Tanzania's Boundaries and surrounding countries. Adopted from Encyclopaedia Britannica, 2008.<sup>167</sup>

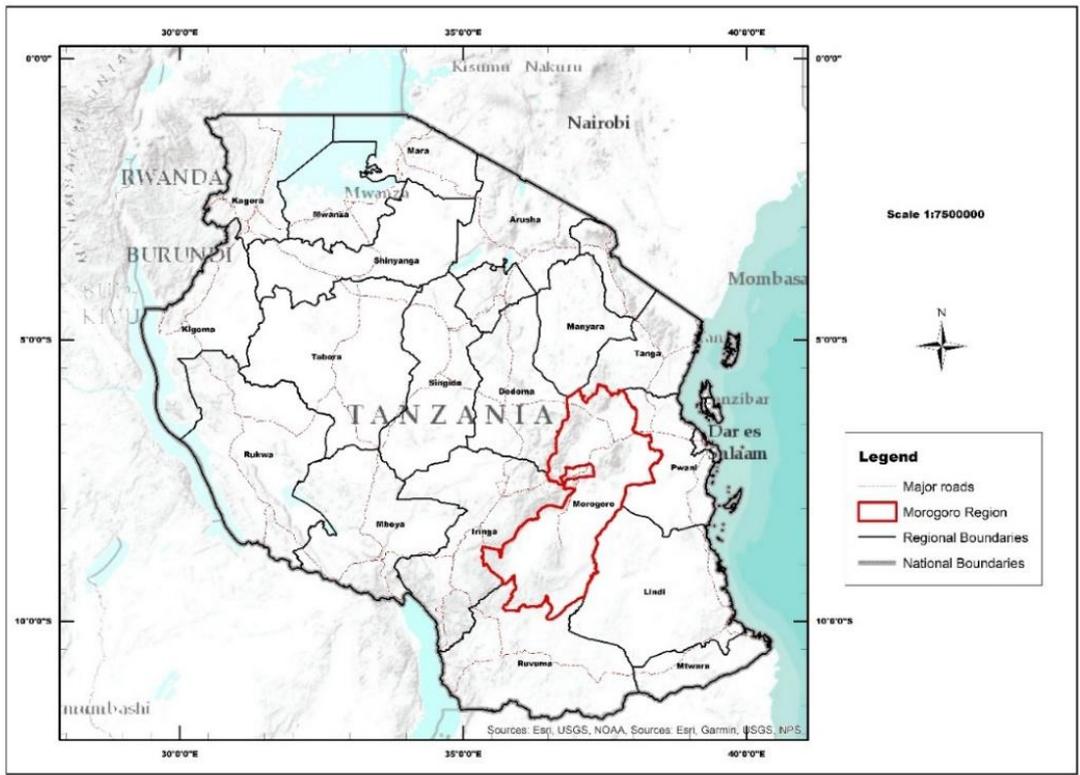


Figure 2: Map showing the Morogoro region in Tanzania. Source: OpenStreetMap contributors, and the GIS user community.

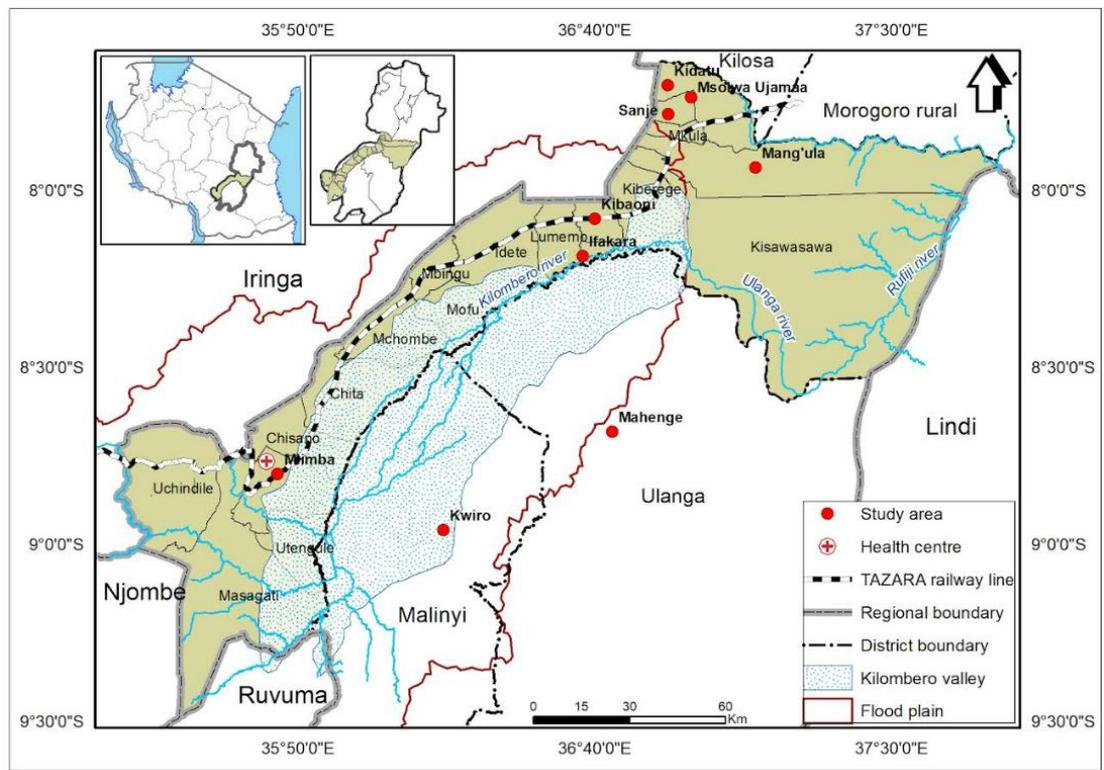


Figure 3: The Kilombero Valley and the surrounding regions. Source: University of Dar es Salaam Cartographer.

## 2.4 The People: Tanzania and Kilombero Valley

Archaeologists have identified Tanzania as a potential cradle of humankind since the discovery of a man's remains in Olduvai Gorge.<sup>168</sup> There are also remnants of the early inhabitants associated with hunter-gatherer lifestyles. These include the Tindiga and the Sandawe, whose languages share characteristics with the clicking sounds of the Khoi Khoi.<sup>169</sup> However, in modern history, Tanzania is home to over 120 indigenous ethnic groups. Despite this large number of different groups, Tanzania is known for ethnic and racial tolerance compared to its neighbours, where tribalism occasionally led to clashes.

The ethnic groups of Tanzania are categorised into the larger language clusters of Bantu, Nilotes and indigenous hunter-gatherers.<sup>170</sup> The Bantu are the majority, comprising communities such as the Sukuma, Zaramo, Nyamwezi, Hehe, Haya, Chagga, and Wandamba. The Nilotes include the Maasai, Arusha, Samburu, and Baragunyu. The pro-Bantu are believed to have migrated from the North and Horn of Africa and were survived by the Zaramo and the Mbungu.<sup>171</sup> The pro-Hamites originated from Asia and intermarried with the proto-Bantu populations, producing the Nyamwezi, Hehe, Bena, Makonde, Kinga, and others.<sup>172</sup> The Swahili Coast Bantu were integrated into Arabic blood and culture, and the majority became Muslims.<sup>173</sup> There is also an ethnic minority of Asian and European descent, some of whom came to Tanzania after independence as expatriates on projects initiated or funded by foreign countries.

The multiplicity in Tanzania's ethnic composition is also reflected in its religious diversity, which comprises mainly Christianity, Islam, and African Traditional Religion. Locals associate this with Nyerere's efforts against any form of discrimination.<sup>174</sup> Nyerere also encouraged people to migrate and settle where there was arable land that could be utilised profitably, as shown in Chapter Four. This also led to interactions among different communities, reducing conflict.

There is evidence of both rural-urban and rural-to-rural migration during the pre-colonial, colonial and post-independence eras.<sup>175</sup> The movement led to the mixing of people of different

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<sup>168</sup> Schulpen, *Integration of Church and Government Medical Services in Tanzania*, 6.

<sup>169</sup> Msaky, 'Tanganyika-The Road to Independence', 5.

<sup>170</sup> Geoghegan, 'The Movement for Independence in Tanganyika', 2.

<sup>171</sup> Frank T. Grimer, 'The Rufiji Basin Tanganyika: Report to the Government on the Preliminary Reconnaissance Survey of the Rufiji Basin 1955-1960 Sec 2, Paper 6: Land Tenure, Population, Education and Communication', *The Rufiji Basin Tanganyika*, 1960, 4.

<sup>172</sup> Grimer, *The Rufiji Basin Tanganyika: Report to the Government on the Preliminary Reconnaissance Survey of the Rufiji Basin 1955-1960 Sec 2, Paper 6: Land Tenure, Population, Education and Communication*, 4.

<sup>173</sup> George Peter Murdock, *Africa: Its People and Their Culture History* (Mc Graw-Hill Book Co., 1959), 360. Geoghegan, 'The Movement for Independence in Tanganyika', 2.

<sup>174</sup> Mpanzi Patrick: Oral Interview at Coco Beach, Dar es Salaam, on 15.1.2023

<sup>175</sup> Luoneko, 'Rural to Rural'.

backgrounds.<sup>176</sup> This interaction led to the borrowing of different ideas about health and healing, such that, in addition to the European Western medicine introduced through colonialism, there was also a period of inter-community transfer of indigenous knowledge.

Tanzanian ethnic diversity is also reflected in art and music. Different genres of music exist in Tanzania. Each community had a wide range of traditional folk songs, folktales, riddles, proverbs, and sayings.<sup>177</sup> After independence, Ivaska notes that even in big cities like Dar es Salaam, popular culture continued to encourage traditional songs and culture.<sup>178</sup> In the 1960s, Congolese music, blending African and Cuban rhythms, gained popularity in Tanzania following the migration of over 200 Congolese musicians from the DRC to Dar es Salaam.<sup>179</sup> In addition, the *Taarabu* genre was popular among coastal women. Music was not only social but also political, especially to the ruling Party, TANU.

Music and dance became one of the most important tools for spreading not only health education and campaigns but also TANU's agenda. TANU women were known for various music bands, such as Warumba, Lelemama, and the British Empire.<sup>180</sup> It was through TANU activities and popularisation that most government policies were popularised and implemented. The TANU Women and Youth League utilised music and art to disseminate party policies. In the process, health information was passed on. Tanzanian art is also reflected in wood and stone carvings. Communities like Wabena are known for their skilled craftsmanship in creating sculptures. During my archival search, I noted that the visiting Chinese doctors were gifted with Tanzanian sculptures at the end of their contracts.<sup>181</sup>

The Kilombero valley is home to different communities from Tanzania and beyond. The inhabitation of Kilombero has a long history, spanning from the 1800s to the post-independence era, and the area has always attracted people.<sup>182</sup> The second half of the 19<sup>th</sup> century saw the migration of communities, such as the Ndendeule from the south, who were fleeing the Zulu wars.<sup>183</sup> However, those who are argued to have inhabited Kilombero early enough and hence

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<sup>176</sup> Luoneko, 'Rural to Rural'.

<sup>177</sup> Ba, 'Tongues That Span the Centuries'; Vansina, *Oral Tradition as History*. Madison: University of Wisconsin Press.

<sup>178</sup> Ivaska, *Cultured States*.

<sup>179</sup> Alex Perullo, 'Rumba in the City of Peace: Migration and the Cultural Commodity of Congolese Music in Dar Es Salaam, 1968-1985', *Ethnomusicology* 52, no. 2 (Spring/Summer 2008): 296.

<sup>180</sup> Geiger, *TANU Women*.

<sup>181</sup> 'TNA/HEA/90/5/493 Technical Health Assistance China, Vinyago Kama Zawadi', unpublished manuscript, Tanzania National Archives, 1976.

<sup>182</sup> Ralph Jätzold and Eckhard Baum, *The Kilombero Valley: Characteristic Feature of the Economic Geography of a Semi-Humid East Africa Flood Plain and Its Margins*, Afrika-Studien 28 (Weltforum Verlag, 1968), 35.

<sup>183</sup> Jätzold and Baum, *The Kilombero Valley*, 35.

qualify to be termed as indigenous to the area are the Wangindo, Wandamba, and Wambunga.<sup>184</sup> There are also smaller communities, such as the Wapogoro, Wahehe, Wabena, and Wamatumbi. The majority of these communities belong to the Bantu linguistic cluster, as noted above. As mentioned in chapter one, being an area of high biodiversity, agriculture and development projects, Kilombero continued to attract people internally, including the pastoralists such as the Maasai, Sukuma, and Wadatogo in search of pasture for their animals,<sup>185</sup> and externally, including people from Malawi, Zambia, Mozambique and the DRC.<sup>186</sup>

Thus, people around the Kilombero have a long history of interactions and the sharing of resources, ideas, and knowledge through intermarriage, trade, and war. According to Jamie Monson, intermarriages boosted interconnectedness and allowed access to various production zones.<sup>187</sup> Monson adds that it is through such relationships that maximum production and security within the communities were enhanced. Different communities occupied different ecological zones, thereby enabling access to diverse food sources and social security. It is argued that the Bena of the rivers, for instance, would hide their cattle with their relatives, the Bena of the highlands.<sup>188</sup> These interactions also involved the exchange of ideas, including medicinal knowledge and motherhood techniques. Due to these interactions, the concepts of medicine and motherhood in Kilombero, as well as the transformations that came with government policies after independence, are fascinating.

The Kilombero Valley, therefore, attracted people from rural and urban areas, who later established permanent settlements there.<sup>189</sup> Several major government initiatives impacted the Kilombero Valley, most notably the construction of the Tanzania-Zambia Railway (TAZARA), the establishment of the Kilombero Sugar Company Limited (KSCL), and the promotion of rice farming. Changes brought about by these projects, such as land-use alterations and infrastructure development, had several impacts on healthcare, particularly maternal health, throughout the region. As Steven Feierman has aptly put it, ‘changes in transport, production technique, marketing, education, profoundly affect the shape of the local society and therefore healing’.<sup>190</sup>

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<sup>184</sup> United Republic of Tanzania, *Prime Ministers Office Regional Administration and Local Government Authorities. Kilombero District Council Strategic Plan, 2013/2014 to 2017/2018* (Morogoro, 2019), 14.

<sup>185</sup> Misana, ‘A History of Tourism and Its Socio-Economic Effects on Surrounding Communities in Kilombero District’, 33; Luoneko, ‘Rural to Rural’.

<sup>186</sup> Perullo, ‘Rumba in the City of Peace: Migration and the Cultural Commodity of Congolese Music in Dar Es Salaam, 1968-1985’

<sup>187</sup> Monson, ‘Agricultural Transformation in the Inner Kilombero Valley of Tanzania 1840-1940’, 3.

<sup>188</sup> Monson, ‘Agricultural Transformation in the Inner Kilombero Valley of Tanzania 1840-1940’, 10.

<sup>189</sup> Luoneko, ‘Rural to Rural’, 65; Minja, ‘Government Interventions’.

<sup>190</sup> Feierman, ‘Struggles for Control’, 83.

## 2.5 Economic Organisation of Tanzania and Kilombero

Agriculture has been the backbone of the Tanzanian economy. Even after independence, the president called on the people of Tanzania to embrace agriculture as a means to fight poverty. Agriculture in Tanzania spans a range from small-scale to large-scale operations. It is also divided into either commercial or subsistence. Coffee, tea, cotton, sisal, tobacco, and cashew nuts are grown on a large scale, mainly for export. Sugar and rice are also produced in large quantities, especially in the Kilombero Valley. Other crops grown in Tanzania include maize, sorghum, millet, bananas, cassava, sweet potatoes, barley, wheat, and potatoes. Knowledge of the beliefs and taboos surrounding nutrition is a fundamental factor in understanding a people's health. The quality and quantity of food remain key, especially for mothers and children. Indeed, nutrition is a theme that spans several chapters of this study.

Crops grown in a region directly impact people's health. This is because they influence not only the diet but also the economic capacity, purchasing power, lifestyle, and, eventually, the political voice of the people. Kilombero Valley, for instance, is also an agricultural hub. Since the early days of colonialism, the valley has been known for its farming potential. According to the report by Telford in 1929, Kilombero was the most promising area for development,<sup>191</sup> with rice identified as the most crucial crop since the pre-colonial period. Simansky et al. also reiterated that the land around the Rufiji basin was suitable for rice growing.<sup>192</sup> It is believed that rice was introduced to the Middle Ages by the Persians, and some rice varieties were considered indigenous to Kilombero. The Pogoro argued that it is the power of God that taught them to grow rice.<sup>193</sup>

The region is renowned for its fertile soils and the abundance of water from the numerous rivers, as noted above. Even with its diverse ecological zones, the most significant part of the district is arable land. Many writers have noted that the region's productivity has long attracted visitors, dating back to the pre-colonial and colonial periods, particularly from Indians and Germans. For the Germans, the area was important for political reasons, which were twofold. Initially, it was seen as capable of producing enough rice, thereby reducing or ending the German reliance on British Indian rice. Secondly, rice grown for commercial purposes was seen as a means of helping Africans to generate an income, thereby enabling them to pay taxes to the government.<sup>194</sup> Although this was viewed as a positive aspect of the capitalistic nature of the

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<sup>191</sup> Telford, *Report on the Development of the Rufiji and the Kilombero Valleys*, 52.

<sup>192</sup> Simansky et al., *The Rufiji Basin Tanganyika: FAO Report to the Government of Tanganyika on the Preliminary Reconnaissance Survey of the Rufiji Basin. Expanded Technical Assistance Programme. Vol 1*, no. 1269, The Rufiji Basin Tanganyika (Rome, 1961), 1.

<sup>193</sup> Jatzold and Baum, *The Kilombero Valley*, 41, 46.

<sup>194</sup> Monson, 'Agricultural Transformation in the Inner Kilombero Valley of Tanzania 1840-1940.', 20.

colonial enterprise, it also affected production. The people concentrated more on growing rice as a commercial crop, leading to a decrease in the production of other grains, such as millet and sorghum, which were more nutritious, especially for pregnant and young children, but were less profitable.<sup>195</sup> Jamie Monson argues that production changed from being geared towards ‘local production needs, to meet[ing] those of regional chiefs and their provincial agents’.<sup>196</sup> She adds that this kind of production strengthened regional chiefs and Kingdoms, which put politics at the centre of economic organisation. This trend continued with the post-independence government.

As time passed, profit-oriented agriculture was adopted, with rice and sugar plantations dominating the better part of the Kilombero Valley, reaching its climax after the introduction of capitalist colonialism. Simsim, sunflower, and cocoa were later also grown for commercial purposes. Additionally, animals such as goats, sheep, chickens, and dogs were kept, but the presence of tsetse flies did not favour the keeping of cattle in large numbers.<sup>197</sup> However, it is argued that communities around Kilombero Valley had learnt strategies to curb animal pests, diseases, poisonous plants, and natural predators such as lions and leopards.<sup>198</sup> Such statements portray the contestation between traditional and Western approaches towards medicine.

The Kilombero Valley is also renowned for its forestry, fishing, and trading activities. As noted above, a large part of the district is covered by forest. Activities such as timber harvesting, honey production, wax collection, pulp and paper manufacturing are frequently carried out in forested areas.<sup>199</sup> Fishing was also undertaken in the Kilombero River and other water bodies.<sup>200</sup> As mentioned above, due to the many rivers available in the region, fishing was done in almost every village by both men and women.<sup>201</sup> However, professional fishermen fished on a large scale. Indeed, Rice and dried fish were some of the products exported from the Kilombero Valley to the neighbouring districts of Njombe and Iringa, using canoes, as far as Bagamoyo through the Ifakara and Kisasi routes.<sup>202</sup>

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<sup>195</sup> Turshen Meredith, ‘The Impact of Colonialism on Health and Health Services in Tanzania’, *International Journal of Health Services* 7, no. 1 (1977): 8–30.

<sup>196</sup> Monson, ‘Agricultural Transformation in the Inner Kilombero Valley of Tanzania 1840-1940’, 18.

<sup>197</sup> James Giblin, ‘The Precolonial Politics of Disease Control in the Lowlands of Northeastern Tanzania’, in *Custodians of the Land: Ecology & Culture in the History of Tanzania* (James Currey Ltd, 1996), 130.

<sup>198</sup> Monson, ‘Agricultural Transformation in the Inner Kilombero Valley of Tanzania 1840-1940’, 92.

<sup>199</sup> H.S Perry and A.A McDonald, *The Rufiji Basin Tanganyika: Report to the Government on the Preliminary Reconnaissance Survey of the Rufiji Basin 1955-1960 Sec 3, Paper 5: Forestry*, The Rufiji Basin Tanganyika (1960), 1–11.

<sup>200</sup> Jätzold and Baum, *The Kilombero Valley*, 24.

<sup>201</sup> Monson, ‘Agricultural Transformation in the Inner Kilombero Valley of Tanzania 1840-1940’, 66.

<sup>202</sup> Monson, ‘Agricultural Transformation in the Inner Kilombero Valley of Tanzania 1840-1940’, 16.

Trade between local communities has existed from time immemorial. Local trade later developed into long-distance trade involving the Arabs and the Swahili. After independence, commercial production continued, with farmers selling their sugarcane and rice produce to agro-based factories, such as the Kilombero Sugar Company Limited (KSCL). Although the division of labour was often gendered, women did most of the household and farm work. Jamie Monson describes how weeding paddy was an extremely tedious task done during the rainy seasons, with feet immersed in water up to ankle or knee depth, which had a profound impact on the health of women and their children.

Rubber was also an essential resource in Kilombero, which attracted both Germans and Indians to the area. By 1870, the Indians are recorded to be travelling as far as Ifakara to buy latex.<sup>203</sup> Thus, rice and rubber were sufficient reasons for the Germans to consider establishing a settler community in southern Tanzania, although the outbreak of the First World War thwarted these plans. However, the biodiversity attracted early traders who opened up the region to more visitors and the penetration of ideas, exposing the Kilombero Valley to visitors early on.

In 1961, Tanzania adopted a development agenda, which by then was a modernisation strategy under Julius Kambarage Nyerere's leadership. The agricultural sector remained the backbone of the economy, and the government gave farmers supplements such as fertilisers and seeds.<sup>204</sup> There was also a massive campaign to mechanise agriculture to increase yields. Nyerere's vision was to transform agriculture from its domestic, small-scale nature to a large-scale, commercial one, particularly for crops such as sisal, coffee, and cotton for export.<sup>205</sup> He wanted Tanzania to be competitive in foreign markets and to secure a guaranteed minimum price for the aforementioned export crops. In 1961, Tanzania's population was 10,346,695, up from 10,052,151 in 1960.<sup>206</sup> Through increased food production, the much-desired population growth and improved life expectancy would be achieved.

From 1961 to 1967, the country adopted a free-enterprise economy with the state at the centre. Even though Ujamaa was formally established in 1967, a pilot programme for village settlements was initiated immediately after independence, following the World Bank's advice to enhance agricultural production—the project aimed to encourage the modernisation of agriculture among the rural population.<sup>207</sup> Although Goran Hyden describes the problems of the

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<sup>203</sup> Monson, 'Agricultural Transformation in the Inner Kilombero Valley of Tanzania 1840-1940', 20.

<sup>204</sup> Hyden, *Beyond Ujamaa in Tanzania: Underdevelopment and an Uncaptured Peasantry*.

<sup>205</sup> *Tanzania: World Bank and Tanzania Relations 1961-1987*, no. 8329, Vol. 1 (1990), 1.

<sup>206</sup> <https://www.worlddata.info/africa/tanzania/populationgrowth.php> accessed on 04.04.2023

<sup>207</sup> *Tanzania: World Bank and Tanzania Relations 1961-1987*, 1.

Village Settlement Scheme,<sup>208</sup> a similar repetition was experienced in the implementation of the Ujamaa policy after 1967.

These political, economic, social, and climatic factors provide a basic understanding of Tanzania, specifically the Kilombero Valley, and of how this background influences health-policy planning and implementation. To further expand on the background, I now shift my attention to the historical context of healthcare in Tanzania before independence, providing a context for the postcolonial plans discussed in the subsequent chapters.

## **2.6 Health and Healing in Tanzania: Prelude to Independence**

Western medicine in Tanzania was introduced by Europeans either through colonialism or evangelisation. It is argued that the first hospital to be established in what was then Tanganyika was by the Church Missionary Society (CMS) in Mamboya, near Mpwapwa, in 1877.<sup>209</sup> Mamboya is located in the Kilosa District in Morogoro. CMS was followed by other mission societies, mainly from Britain and Germany. Initially, health provision to Africans was not part of the colonial government's agenda.<sup>210</sup> In rural areas, especially, the role of medical provision was left to the Christian missionaries.

Missionaries viewed the provision of medical services as a means of protecting their interests from both the colonial government and the local population.<sup>211</sup> Both the Africans and the colonial government benefited from the missionaries, and medicine became a unifying common cause. Indeed, despite the wars of conquest between the colonial government and Africans, medicine became a unifying factor, especially during epidemics. The arrival of Europeans in many parts of Africa coincided with a period of widespread outbreaks of human and animal diseases that were previously unknown to Africans. As such, Africans had to seek medical attention from the missionaries on how to treat the new ailments.

The main goal for the missionaries was proselytisation. However, due to the high demand, medical missions became extremely popular. As shown in Chapter Five, the Kilombero Valley was influenced by both German colonial medical officers and medical missions as early as 1911, a trend that was later continued by Swiss missionaries. Nevertheless, the missionaries have also been seen as part of the larger colonial enterprise. As Muriuki noted, the cross was followed by the flag.<sup>212</sup> This statement is interpreted to mean that colonialism followed

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<sup>208</sup> Hyden, *Beyond Ujamaa in Tanzania: Underdevelopment and an Uncaptured Peasantry*, 80.

<sup>209</sup> Richard M. Titmuss et al., 'The Health Services of Tanganyika: A Report to the Government' (London: Pitman Medical Publishing Co. Ltd, 1964), 1.

<sup>210</sup> Mario J. Azevedo, *Historical Perspectives on the State of Health and Health Systems in Africa, Volume I: The Pre-Colonial and Colonial Eras (African Histories and Modernities)* (Palgrave Macmillan, 2017), 183.

<sup>211</sup> Jennings, 'Cooperation and Competition', 153.

<sup>212</sup> Geoffrey Muriuki, *A History of the Kikuyu, 1500-1900* (Oxford University Press, 1974).

Christianity, or rather, that the missionaries paved the way for the colonialists. Indeed, European interests had to be ‘protected politically and medically’.<sup>213</sup> Even in the case of Tanganyika, the missionaries were quickly followed by German colonial officials in 1899.

The medical missionaries were not the only health providers; the colonial government also played a role. The first group of German colonial officials to Tanganyika included five fully qualified medical doctors,<sup>214</sup> and fifteen orderlies.<sup>215</sup> At the time, Africa was often described as a diseased continent, largely because of the prevalence of tropical diseases. In the Kilombero Valley, diseases such as malaria, sleeping sickness, bilharzia, hookworms, and onchocerciasis were common.<sup>216</sup> As a result, every European group that sailed to Africa included medical practitioners. This was the case for the German colonisers and missionaries in Tanganyika. Since it was not a legal requirement for the Germans to return to Germany, the majority settled in Tanganyika, where the doctors provided medical services to the local population.<sup>217</sup> After all, for a curious scientist, Africa served as a valuable laboratory for studying humans and animals in their natural habitats.<sup>218</sup>

In 1890, Tanganyika became a German colony, with its capital initially in Bagamoyo, later relocated to Dar es Salaam. The first medical department was established on April 1, 1891; however, the medical services it provided were hierarchical. Priority was given to military personnel, followed by German merchants, and then African troops.<sup>219</sup> At this juncture, the typical African was not a consideration in the government's deliberations. This gap, as noted above, was primarily filled by the missionaries, a role they were to hold for a long time afterwards. Although there were military hospitals in Dar es Salaam, Lindi, Kilwa, Pangani, Moa, Mikindani, and Mtwara, among other towns, the services were primarily stratified based on race, as described above. Maternity was left principally to the missionary sisters and was not a concern of the government until the population question came to the fore, as shown in Chapter Five.<sup>220</sup>

In 1894, the German parliament voted to construct the Ocean Road hospital to serve patients of grade 1 (i.e., the European population). The implementation occurred in 1897, when a 25-bed

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<sup>213</sup> Nhonoli and Nsekela, *Health Services and Society in Mainland Tanzania*, 7.

<sup>214</sup> Nhonoli and Nsekela, *Health Services and Society in Mainland Tanzania*, 8.

<sup>215</sup> Titmuss et al., *The Health Services of Tanganyika*, 2.

<sup>216</sup> MOH, *The Rufiji Basin Tanganyika: Report to the Government on the Preliminary Reconnaissance Survey of the Rufiji Basin 1955-1960 Sec 3, Paper 4: Medical Appraisal*, The Rufiji Basin Tanganyika (1960), 3.

<sup>217</sup> Illife, *East African Doctors: A History of the Modern Profession*.

<sup>218</sup> Tilley, *Africa as a Living Laboratory*.

<sup>219</sup> Nhonoli and Nsekela, *Health Services and Society in Mainland Tanzania*, 8.

<sup>220</sup> Lindner, ‘The Transfer of European Social Policy’, 215.

hospital was built, which remained a European hospital until independence.<sup>221</sup> The German colonial government, however, did not commit to constructing a hospital for the African population, citing a lack of funds. It was the German colonial chief medical officer, Becker, who approached Sewa Haji Paroo (see Figure 4), a wealthy Indian philanthropist, to donate towards an African hospital.<sup>222</sup> Nhonoli and Sekela note that on 15<sup>th</sup> April 1892, Sewa Haji donated 12,400 rupees with the condition that the hospital should be named after him. This hospital was established in 1897 and remained operational for over 60 years, closing after the opening of Princess Margaret Hospital in 1960. To honour Sewa Haji, two wards in Princess Margaret Hospital (later renamed Muhimbili Hospital (see figure 6)) were named Sewa Haji (see Figure 6). By the end of their 26-year rule, the Germans had built 12 general hospitals, a sanatorium in Usambara and a lunatic asylum at Lutindi.<sup>223</sup> Germans are thus credited with starting the fight against smallpox, malaria and plague. The Germans also began manufacturing the smallpox vaccine locally.<sup>224</sup> In a nutshell, it was the Germans who laid the foundation for the Western medicine and hospital system in Tanzania.<sup>225</sup>

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<sup>221</sup> Tanganyika, Ministry of Health and Labour. *The Annual Report of the Health Division, 1960, Vol. 1, Prepared by the Chief Medical Officer* (1960), 1.

<sup>222</sup> Tanganyika, Ministry of Health and Labour. *The Annual Report of the Health Division, 1960, Vol. 1, Prepared by the Chief Medical Officer*, 1.

<sup>223</sup> Titmuss et al., *The Health Services of Tanganyika*, 2.

<sup>224</sup> Nhonoli and Nsekela, *Health Services and Society in Mainland Tanzania*, 9.

<sup>225</sup> Titmuss et al., *The Health Services of Tanganyika*, 2.



*Figure 4: A photo of Sewa Haji. Source: Adopted from David Clyde, 'History of medical services in Tanganyika', 1962, 14*



*Figure 5: Sewa Haji Hospital: Source: Annual Medical Report 1955.*



*Figure 6: Princess Margaret Hospital in 1955, later named Muhimbili Hospital. Source: Annual Report: Medical Department 1955.*



*Figure 7: One of the 'new' wards in Muhimbili Hospital named after Sewa Haji to honour him. Source: taken by the author on 25th January 2023.*

The outbreak of World War I led most doctors to redirect their efforts towards the war, which significantly impacted the public health sector. In the case of Tanganyika, the situation was even worse because the defeat of the Germans left a gap and a period of uncertainty in the region's administration.

After World War I, Germany was forced by the terms of the Treaty of Versailles to renounce its claims to Tanganyika. The British took over the administration of Tanganyika, and under the leadership of the British Governor, Sir Horace Byatt, all Germans, including missionaries, were required to leave the territory. Their land was then allocated to new immigrants and Africans. The repercussion in the health sector was that in the years between 1919 and 1929, civilian medicine was in 'a neglected state'.<sup>226</sup> Initially, just as in the German era, the medical sector was taken over by the British army. It was not until 1923 that British civil medical

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Titmuss et al., *The Health Services of Tanganyika*, 4.

research took over.<sup>227</sup> However, one of the positive impacts of the First World War was that the world became more aware of health issues. The Africans became more aware of hygiene and Western medicine, which raised their consciousness; however, medical services in the colonies were not available to sustain the demand, and most European colonial masters were struggling with the aftermath of the war and were unable to make a significant investment in health provision in the colonies.

The health situation worsened after the war due to the political uncertainties in Tanganyika.<sup>228</sup> In 1923, there were only 10 medical officers in the vast region of Tanzania. Most doctors were located in urban areas. This meant that some rural areas had not come into contact with any Western medicine. To solve this problem, the British, after taking over the trust territory of Tanganyika and realising that it was impossible to fill this void, they introduced African medical assistants to manage the population. This led to the training of the African dressers.<sup>229</sup>

However, the nature of colonialism was largely capitalistic, and the development of health facilities primarily occurred in urban areas, such as Dar es Salaam and other major towns, which were resource- and labour-rich or fertile regions. As early as 1928, it was noted that a third of the sanitation budget was spent on Dar es Salaam. Nevertheless, the situation in Dar es Salaam was still unfavourable, and it was worse in rural areas. As narrated from her medical experience in the Kilombero Valley in the 1960s, Louise Jilek-Aall illustrates the challenges of being a doctor in the 'bush'.<sup>230</sup> In addition to poor government policies, socio-cultural issues were at play, which affected health, especially maternal and child welfare. For instance, mothers in an African set-up did not believe in delivering their babies in isolation, while lying down, alone in a medical ward. Home deliveries entailed being surrounded by the closest female kin and resting on all four limbs.<sup>231</sup>

In an attempt to address the situation, the British, through the native authorities, established dispensaries in rural areas in 1929. These facilities were to be staffed with health workers, which necessitated the training of auxiliary staff, as those from Britain were insufficient. Three levels of training occurred: 1. African District Sanitary Inspectors, who were responsible for general public health; 2. dispensers who acted as hospital assistants and later became medical assistants;

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<sup>227</sup> Beck, *A History of the British Medical Administration of East Africa, 1900-1950*.

<sup>228</sup> Msaky, 'Tanganyika-The Road to Independence', 35.

<sup>229</sup> *Tanganyika, Ministry of Health and Labour. The Annual Report of the Health Division, 1960, Vol. 1, Prepared by the Chief Medical Officer*, 2.

<sup>230</sup> Jilek-Aall, *Call Mama Doctor: African Notes of a Young Woman Doctor*, 20.

<sup>231</sup> Shane, 'Maternal Health, Epidemiology and Transition Theory in Africa', 111. Lindner, 'The Transfer of European Social Policy', 218.

and 3. tribal dressers, selected by local chiefs, who later became rural medical aids.<sup>232</sup> This training also allowed locals to handle medical issues, which was considered more ‘effective’ than using expatriates.<sup>233</sup> However, the use of local people and medical workers was far from ideal.

Mother and Child Health (MCH) largely depended on voluntary agencies, especially missionaries and traditional midwives, even though the government was also involved, mainly in urban areas. The first government-based MCH clinic in Dar es Salaam was opened in 1925.<sup>234</sup> A maternity section had been opened in 1924, but it was not until 1929 that fully trained maternal and child-welfare officers were employed. In 1929, the British Parliament discussed the funding allocated to train midwives in East Africa.<sup>235</sup> Maternity sections in both urban and rural areas gained popularity. Others were soon established in other major towns, such as Tanga, Tabora, Kahama, and Machame.<sup>236</sup> In 1929, 43,000 mothers and children visited government clinics, while 25,000 were seen in mission clinics.<sup>237</sup> Most of these visits were to immunise children against infectious diseases, such as smallpox, but not the actual delivery. It was here that surveys were conducted, establishing health indicators and vital statistics such as deaths, births and nutritional status.<sup>238</sup> However, this was skewed because most people lived in rural areas, where their social, economic, and cultural lifestyles differed significantly from those of the people who lived near and sought medical help from such centres. It is worth emphasising here that living close to a health facility did not mean that women sought medical help there. As I show in Chapter Five, women residing near St Francis Hospital, Ifakara, would also seek help from traditional midwives.

Throughout the 1930s, the situation was challenging due to the global economic recession’s impact. The health budget was reduced, which affected both the services offered and the staff. By 1936, the health budget had been cut by a third, and the number of doctors had fallen from 59 in 1929 to 47 in 1938. Health inspectors were reduced from 218 in 1929 to 140 in 1931, and the hiring of new staff was stopped until 1958. This had a profound impact on health provision, particularly in maternity care. The set goal of turning the dispensaries into health centres by 1938 was not met until the 1950s. Nevertheless, Western medicine grew, and maternity services

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<sup>232</sup> Titmuss et al., *The Health Services of Tanganyika*, 6.

<sup>233</sup> Titmuss et al., *The Health Services of Tanganyika*, 6.

<sup>234</sup> Staatsarchiv Basel-Stadt, ‘PA 940 HI (1) I Tanzania Maternal and Child Health Programme’, 1976, 4.

<sup>235</sup> ‘Hansard, UK Parliament (House of Commons), December 12, 1929.

[\(https://Hansard.Parliament.Uk/Commons/1929-12-12/Debates/Aad51566-Eee2-40e6-976a-9e2ff2dfdab2/EastAfrica \(Midwives, Training\) \(Accessed September 23, 2024\)](https://Hansard.Parliament.Uk/Commons/1929-12-12/Debates/Aad51566-Eee2-40e6-976a-9e2ff2dfdab2/EastAfrica%20(Midwives,%20Training)), 1929.

<sup>236</sup> Staatsarchiv Basel-Stadt, ‘PA 940 HI (1) I Tanzania Maternal and Child Health Programme’.

<sup>237</sup> Titmuss et al., *The Health Services of Tanganyika*, 8.

<sup>238</sup> Staatsarchiv Basel-Stadt, ‘PA 940 HI (1) I Tanzania Maternal and Child Health Programme’.

gained popularity in Tanzania, such that by 1940 in Dar es Salaam, over 100 mothers attended the routine Monday morning inspection.<sup>239</sup>

Before the 1940s, the medical missions were the most active in the maternity section. According to Michael Jennings, ‘the government only became active [in the maternity section] from the 1940s’, especially in the rural areas. Jennings adds that the ‘government could only pretend that it was the primary health deliverer’. Nonetheless, the involvement of the government in maternity care led to an increase in medical facilities and more mothers seeking maternal care as a result. In some cases, the government and mission facilities complemented each other. A case in point, as noted by Jennings, is that of Mpwapwa, where the CMS hospital provided care for women and children, while men received care at the government facility.<sup>240</sup> Therefore, it seemed as if the government had effectively ‘conceded MCH services’ to the missions.<sup>241</sup>

According to the Dar es Salaam Maternity and Child Welfare archives, Mondays were used for the Antenatal clinic, where about 10 to 20 women attended weekly. Tuesdays were welfare tea days, where children up to 2 years were brought, especially those who had not attained the required weight. It is recorded that between 60 and 70 infants were brought, an increase from the 1930s (see Table 1). Wednesdays were used to handle Tuesday's overflow.<sup>242</sup> This shows that maternity and child-welfare clinics gained popularity by the day. However, the popularity of these services is debatable, given the recorded attendance relative to the population of African women. However, it would be challenging to provide such a critique because home deliveries were not recorded. Nevertheless, Chapter 5 attempts to capture this in a narrower local sense in the Kilombero area. Additionally, I demonstrate how Tanzania continued with such colonial plans and timetables, such as daily schedules for various tasks at the clinic, which were impractical in the era of *Ujamaa* when women were also expected to work and ‘build the nation’, and had to be revised by 1975.

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<sup>239</sup> TNA/450/108, Dar es Salaam Maternity and Child welfare clinic, 19.4.1940.

<sup>240</sup> Jennings, ‘Cooperation and Competition’, 157.

<sup>241</sup> Jennings, ‘Cooperation and Competition’, 160.

<sup>242</sup> TNA/450/108, Dar es Salaam Maternity and Child welfare clinic, 19.4.1940; MOH, *Medical Appraisal*, 3.

Data/Year	1939	1938	1937
Birth in Clinic	124	100	74
Those who attended the welfare clinic	91	56	57
Those not seen again	33	44	17
Those still attending clinics at one year	71	35	44
Dead but born in the clinic	7	4	5

*Table 1: The recorded MCH statistics in Dar es Salaam. Compiled from data sourced from TNA/450/108, 19.04.1940.*

Medical staff scarcity remained a problem. By 1943, the medical officer in Dar es Salaam was already seeking assistance due to the increased number of patients.<sup>243</sup> The facilities, including both the buildings and equipment, were also in poor condition. In 1943, for instance, the medical officer's assessment report found the maternity location in Dar es Salaam unsuitable, noting that the passage in front of the wards was noisy and that patients therefore had no privacy. He also recommended closing the pavilion to reduce dust and heat. The servery was also to be redesigned to have shelves instead of serving from the ground. In addition, he recommended that the babies' ward be designed in a way that was closer to the postnatal women's ward so that the women would see their babies even if the mother would not touch them. The separate ward for babies may have been designed in this way to enhance hygiene. However, according to the medical officer, hygiene, though important, separating the babies from their mothers would "keep off African women"<sup>244</sup> This brings up the question of the intersection between Western medicine and African medicine and beliefs, as explored later.

By 1944, there were plans to expand the mother and child welfare section. However, due to the demand, the counter-effect of a lack of resources, and inflation, the expansion was to be implemented in temporary buildings, allowing the plan to be implemented almost immediately.<sup>245</sup> The staffing problem was also experienced during the construction of standard

<sup>243</sup> TNA/450/108, Dar es Salaam Maternity and Child welfare clinic, 19.4.1940.

<sup>244</sup> TNA/ACC450/108, Dar es Salaam Maternity and Child welfare clinic, March 1, 1943.

<sup>245</sup> TNA/ACC450/108, Dar es Salaam Maternity and Child welfare clinic, March 5, 1944.

maternity structures. The period during World War II worsened the already existing health challenges. The majority of the British medical staff had joined the war. In 1942, there were only 39 government doctors in Tanzania.<sup>246</sup> The missionaries had only 17 doctors in their network. Nevertheless, there were a few positive changes. The health department was divided into four units. These were the administrative division, the medical and dental division, the laboratory and research division, and the Public Health Division (PHD). The PHD included maternal and child welfare, school health, the health of the labour force, educational programmes, and communicable disease control.<sup>247</sup> The provision of maternal services continued despite the challenges. Collaboration between the Europeans and Africans was sought. For instance, in 1945, the Women's Service League requested training for African Ayahs, but the request was rejected.<sup>248</sup>

Almost 60 years after the end of colonialism, Tanzania was still battling the challenge of diseases. The reasons were three-fold. Firstly, in essence, new diseases emerged as a result of the disruption of social life and culture, such that issues like sexually transmitted diseases (STDs) became common.<sup>249</sup> Secondly, the mechanisms that Africans had developed for fighting diseases had been destroyed or condemned as inferior or satanic. Thirdly, the disruption of the economy, which was primarily agricultural, led to a shift in the types of nutritious crops grown, resulting in a diet dominated by less healthy foods, such as maize and cassava. Cassava was 'nutritionally worthless but effortless' in terms of labour inputs when compared to millet and sorghum, which were cumbersome to prepare.<sup>250</sup> The introduction of 'new' crops and the capitalist economy had a negative impact on people's health. Women and children were the most affected. Indeed, malnutrition and anaemia persisted even after independence. The colonial government, for instance, would not link high rainfall potential to malnutrition.<sup>251</sup> However, malnutrition is not only related to insufficient food, but also to poor feeding, often resulting from ignorance, poverty, and social status.<sup>252</sup>

In Kilombero, these problems were exacerbated by cultural practices and taboos on some foods. According to the Rufiji Basin report of 1960, people consumed goat or chicken on special occasions, and these animals were mainly kept for sale.<sup>253</sup> Additionally, the people of this region were also not fond of eating eggs or drinking milk. Furthermore, vegetables such as green leaves

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<sup>246</sup> Titmuss et al., *The Health Services of Tanganyika*, 13.

<sup>247</sup> Titmuss et al., *The Health Services of Tanganyika*, 13.

<sup>248</sup> TNA/ACC450/108, Dar es Salaam Maternity and Child welfare clinic, August, 17, 1945.

<sup>249</sup> Sadock, 'Sexually Transmitted Diseases'

<sup>250</sup> Meredith, 'The Impact of Colonialialism on Health and Health Services in Tanzania', 23.

<sup>251</sup> Meredith, 'The Impact of Colonialialism on Health and Health Services in Tanzania', 24.

<sup>252</sup> *Tanganyika, Ministry of Health, 1957. Annual Report: Medical Department.* (1957), 10.

<sup>253</sup> MOH, *Medical Appraisal*, 3.

or pumpkins were not popular, while fruits, mostly mangoes or oranges, were only eaten in season.<sup>254</sup> Regarding maternal health, the impact of nutrition on mothers and their babies has been noted. Mothers did not have enough milk to breastfeed their babies, thus resulting in the practice of feeding the child with porridge on the second day after birth.<sup>255</sup> Hence, according to the report, “health education was necessary”. However, this was not a new phenomenon, as such problems had been addressed by missionaries in the early years of colonisation, as noted in Chapter One. The question that I attempt to answer is why such issues persisted even after independence.

By 1950, the maternity section, though operational, especially in urban areas, had a myriad of problems. There were infrastructural problems, as noted above; however, some of the buildings had to be converted to accommodate European nurses and others, such as Mrs Shah, who wanted to work voluntarily to gain experience in infant-welfare work.<sup>256</sup> In some areas, there was no separation between the regular patient wards and maternity wards.<sup>257</sup> In addition, the problem of staffing was worsened by the fact that the majority of the students training in medical courses were men, and as per the African culture, the role of midwifery was a preserve of women.<sup>258</sup> According to Zuhra Newspaper, African women refused to attend clinics and decided to give birth at home, ‘whether dangerous or not’, so long as a man operated the maternity section. The newspaper read ‘*Wanawake hawataki kupekuliwa na wanamme*’<sup>259</sup> (Women do not want to be inspected by men).

By the mid-1950s, the health department’s policy was therefore to train more midwives to assist in domiciliary maternity services in rural areas. The aim was for these midwives to assist women in delivering at home, but they were to be in close connection with a rural health centre (RHC).<sup>260</sup> These centres were to be established throughout the country.<sup>261</sup> The services were provided by the government, native authorities, missions, the Red Cross, and the Tanganyika Council of Women, but there was no overall policy to coordinate these bodies.<sup>262</sup> However, unlike in the early years of colonialism when Africans saw it as taboo to have a man on maternity as described above, this time, women in Dar es Salaam did not have a problem being

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<sup>254</sup> MOH, *Medical Appraisal*, 12.

<sup>255</sup> MOH, *Medical Appraisal*, 12.

<sup>256</sup> TNA/ACC450/108, Dar es Salaam Maternity and Child welfare clinic, 1949.

<sup>257</sup> TNA/ACC450/108, Dar es Salaam Maternity and Child welfare clinic, March 1, 1943.

<sup>258</sup> Kanogo, ‘The Medicalization of Maternity in Colonial Kenya’; Kanogo, *African Womanhood in Colonial Kenya 1900-50*, 171.

<sup>259</sup> R Machado, ‘Hatutakumbali Wanaume Clinic’, *ZUHRA Newspaper*, 23 September 1950.

<sup>260</sup> *Tanganyika, Ministry of Health, 1955 Annual Report: Medical Department* (1956), 14.

<sup>261</sup> *Tanganyika, Ministry of Health, 1955 Annual Report: Medical Department*, 14.

<sup>262</sup> *Tanganyika, Ministry of Health, 1955 Annual Report: Medical Department*, 15.

inspected by a European-qualified officer. The argument was that African medical male assistants would talk about African women who had attended the clinic when they were off duty.<sup>263</sup> Whether this was considered to indicate a lack of professionalism, or that the husbands of the African women were just insecure, or that the women were subscribing to cultural expectations is not clear.

The problem of staffing persisted from colonial times to the post-independence era. Initially, the fact that there were few medical training centres in the country was a problem. In 1959, the government policy was to expand training facilities; however, many were concentrated in Dar es Salaam.<sup>264</sup> Interestingly, after the opening of Muhimbili Hospital, some training facilities, such as Kongwa, were closed to utilise the training facilities at the new hospital in the capital. Midwives' training at Tanga was also closed to expand the facilities in the capital.<sup>265</sup> While this appeared to be a good strategy for centralising training in the capital, the ripple effects were numerous and extended even after independence. For instance, rural areas ended up being neglected because not many trained staff members were willing to work in these areas, as shown in the next chapter.

The school curriculum was also problematic. The curriculum for Africans was the most basic and was originally intended to teach arithmetic, writing, and reading (3Rs).<sup>266</sup> According to Turshen, the education system was designed to address the colony's problems, and therefore Africans needed 'practical skills'.<sup>267</sup> Even in the late years of colonialism, the education curriculum for Africans did not improve to a level that would enable them to pursue higher education or technical courses required in fields such as medicine. The argument was that the 'black' man was not intellectually able to handle some subjects and that the curriculum was designed to help Africans prepare for problems in their country, hence 'applied skills' were essential.<sup>268</sup>

The Europeans, however, were accused of fearing competition from the Africans. Indeed, education in many colonies was not only gendered but racialised. Just one year before independence in Ifakara, there were only two schools in the region: an Asian primary school

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<sup>263</sup> R Machado, 'Hatutakumbali Wanaume Clinic'.

<sup>264</sup> *Tanganyika, Ministry of Health. Annual Report: Report on Health Services 1959, Prepared by the Principal Secretary Ministry of Health.* (1959), 3.

<sup>265</sup> *Tanganyika, Ministry of Health. Annual Report: Report on Health Services 1959, Prepared by the Principal Secretary Ministry of Health.*, 5.

<sup>266</sup> Anderson, *The Struggle for the School.*

<sup>267</sup> Meredith, 'The Impact of Colonialism on Health and Health Services in Tanzania', 27.

<sup>268</sup> Meredith, 'The Impact of Colonialialism on Health and Health Services in Tanzania', 27.

and an African middle primary school.<sup>269</sup> At the time, one can argue that education was still not prioritised by many, as school records show that attendance declined during the peak of agricultural activities. This meant that students would rather assist in agricultural work than attend school. The ripple effect was that few Africans took up courses that required a certain educational level. Medical courses were severely disadvantaged, to the point that even the training of village midwives was problematic. As such, maternity services were in high demand; however, even the domiciliary services were discontinued in 1959 due to a lack of trained staff. During the independent era, this issue persisted, and the government had to implement strategies to provide opportunities for individuals to receive training in various medical fields.

Lack of finances and inflation meant that the British colonial government did not invest in hospitals in the colonies. Thus, 10 years before independence, Tanzanian maternity section operations were problematic: in some areas, there was no power, electricity, or water; in others, a shortage of medical staff; and, worse still, in some places, a combination of all these and other problems. Thus, by the end of the 1950s, the health sector in Tanganyika remained disorganised, as various actors lacked a coordinating policy.<sup>270</sup> At this time, the British shifted the medical policy from preventive to curative, a change that persisted even after independence. Only diseases such as ‘malaria, sleeping sickness, nutrition and port health were administered centrally’, perhaps because of their significant impact on the economy, ‘...the rest were not, even maternal health, left without a centralised policy of operation’.<sup>271</sup>

By 1955, MCH services were under the jurisdiction of district hospitals, where a health visitor was stationed. The role of the health visitor was to visit different clinics and supervise satellite centres.<sup>272</sup> By 1956, these district hospitals had a limited number of maternity beds and antenatal and infant-wellness centres.<sup>273</sup> In 1958, institutionalised maternity was so popular that the ‘government could not meet the demand’.<sup>274</sup> Perhaps it was not a priority of the government at the time. This was also due to the government’s unfavourable financial situation. This notion is complex because maternity was always recorded as a busy section, yet it was not given the attention it deserved. This mistake was repeated in the independent government, where the number of beds allocated to MCH was so few in district hospitals, as shown in Chapter Three.

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<sup>269</sup> Grimer, ‘The Rufiji Basin Tanganyika: Report to the Government on the Preliminary Reconnaissance Survey of the Rufiji Basin 1955-1960 Sec 2, Paper 6: Land Tenure, Population, Education and Communication’, 2.

<sup>270</sup> *Tanganyika, Ministry of Health, 1955 Annual Report: Medical Department*, 15.

<sup>271</sup> Meredith, ‘The Impact of Colonialialism on Health and Health Services in Tanzania’, 26.

<sup>272</sup> *Tanganyika, Ministry of Health, Annual Report: Medical Department*, (1955), 15.

<sup>273</sup> *Tanganyika, Ministry of Health, Annual Report: Medical Department* (1955), 15.

<sup>274</sup> *Tanganyika, Ministry of Health, Annual Report: Medical Department* (1958), 15.

The 1957 approval by Legco for the ‘plan for the development of medical services in Tanganyika’ was contingent upon ‘such funds becoming available’. Indeed, in 1958, the hiring of staff was suspended due to a lack of funds.<sup>275</sup> Yet, in 1959, the Principal Secretary’s report to the Ministry of Health shows that the demand for health services had ‘reached embarrassing proportions’.<sup>276</sup>

Poor policy planning was evident, as the construction of hospitals continued; some, such as Muhimbili, were capital-intensive. Ultimately, the number of facilities, although insufficient to meet existing needs, was unable to match the number of required personnel.<sup>277</sup> The same problem of expansionist strategy is witnessed in the early years of independence, as explained in Chapter Three.

By the end of the colonial period, the health sector could be termed as a ‘public-private partnership’<sup>278</sup> and a separation between private and public, similar to the one that was in Britain, ‘put together but not integrated’<sup>279</sup> In brief, the changes introduced by Europeans in maternal health were both a blessing and a curse. On the one hand, the disruption of social, economic, and political organisation, and the introduction of policies such as capitalism, land alienation, and labour migration, led to the disruption of African ways of motherhood. On the other hand, the introduction of Western medicine, modern facilities, and vaccines against certain diseases had proven essential to the process of bringing a child into the world. In addition, condemning harmful African practices has proven crucial in fostering more positive perceptions of maternal health. Breastfeeding, for instance, was avoided by some communities who believed that the mother’s milk was poisonous and that cow milk or maize porridge was to be used in feeding the babies instead.<sup>280</sup> The concern of the medical department in 1958 was that mothers would immediately return to their ‘old bad habits’.<sup>281</sup> It was proposed to continue hygiene education and ‘mothercraft classes and demonstrations’.<sup>282</sup>

Increased nationalist activities characterised the 1950s in Tanzania. Nation-building was the new preoccupation not only of the elites and politicians, but also, according to Nyerere, for every Tanzanian. Nyerere spoke the language of unity for every Tanzanian, regardless of ethnicity, religion, or race. The use of the Swahili language played a significant role in uniting

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<sup>275</sup> *Tanganyika, Ministry of Health, Annual Report: Medical Department*, (1958), 1.

<sup>276</sup> *Tanganyika, Ministry of Health. Annual Report: Report on Health Services 1959, Prepared by the Principal Secretary Ministry of Health*, 1.

<sup>277</sup> *Tanganyika, Ministry of Health, Annual Report: Medical Department*, (1958), 4.

<sup>278</sup> Jennings, ‘Cooperation and Competition’, 153.

<sup>279</sup> Meredith, ‘The Impact of Colonialialism on Health and Health Services in Tanzania’, 27.

<sup>280</sup> *Tanganyika, Ministry of Health, Annual Report: Medical Department*, (1958),15.

<sup>281</sup> *Tanganyika, Ministry of Health, Annual Report: Medical Department*, (1958),17.

<sup>282</sup> *Tanganyika, Ministry of Health, Annual Report: Medical Department*, (1958),17.

people across the country. The idea of unity was also promoted by the fact that Tanzania's journey to independence was relatively peaceful, with no bloodshed. Apart from the early days of colonial conquest, which included wars such as the Hehe and Maji Maji rebellions, the struggle for independence in Tanzania after World War II did not involve violence.

Several factors contributed to the growth of nationalism. Due to the exploitative nature of colonialism, Africans were relegated to the production of agricultural goods as low-wage labourers. Colonial policies in the farm sector were oppressive to the Africans. For instance, in Uluguru, Morogoro, 1955, African farmers were forced to terrace the land ostensibly to prevent soil erosion, whereas this was not the case in European farms.<sup>283</sup> In addition to labour and education inequalities, land alienation was a significant problem in Tanzania. The European farmers wanted more land at the expense of the Africans. It was such grievances that led to the formation of cooperative unions, trade unions, and political parties, all of which contributed to the growth of nationalism and ultimately led to the granting of independence. Following independence, President Nyerere championed Africanisation and a decisive break from colonial structures. It was within this political and ideological context that the post-independence era began in Tanzania. The new government sought not only political sovereignty but also a reimagining of national institutions, including the health sector. However, this ambition raised a critical question: to what extent could the postcolonial state truly overcome the deep-rooted legacies of colonialism in healthcare provision and policy?

## 2.7 Summary

This chapter provides a background setting for this study. The geography of Tanzania and Kilombero, as well as the economic peculiarities, population, and health provision, before independence. It was clear that the economic, social, and colonial background of Tanzania and Kilombero, in particular, impacted the introduction, provision, and organisation of Western medical services. The shift from food-crop production to commercial agriculture, for instance, affected health, particularly maternal health, in Kilombero due to dietary changes. As early as the colonial period, proposals were made to include health education in the curriculum to emphasise optimal dietary requirements, hygiene, and sanitation.<sup>284</sup> The chapter has also traced the introduction of Western medicine from German colonialism through the British era, highlighting the numerous challenges to health provision in Tanzania, which led to cooperation,

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<sup>283</sup> George Kahama et al., *The Challenge for Tanzania's Economy*. (James Currey Ltd, 1986), 19.

<sup>284</sup> Grimer, 'The Rufiji Basin Tanganyika: Report to the Government on the Preliminary Reconnaissance Survey of the Rufiji Basin 1955-1960 Sec 2, Paper 6: Land Tenure, Population, Education and Communication', 40.

albeit not always harmonious, between the government and missionaries. The history presented in this chapter reveals that the health sector in Tanzania at the time of independence was in an embryonic stage, and significant improvements were needed. Yet even after independence, Tanzania struggled in its quest to eradicate diseases, improve healthcare, and, more importantly, maternal health, which was marred by challenges and was significantly shaped by what was left by the colonialists, which is the concern of the next chapter.

## CHAPTER 3

### THE FIRST YEARS OF *UHURU*\*: EARLY MEDICAL PLANS, MATERNAL HEALTH STRATEGIES AND CHALLENGES, 1961-1974

‘Planning is a systematic approach to attaining explicit objectives for the future through the efficient and appropriate use of resources, available now and in the future.’<sup>285</sup>

#### 3.1 Introduction

The previous chapter examined the political and socioeconomic context and introduced the geographical setting of the region under study. It also traced the establishment and organisation of Western medical services in Tanzania through the interventions of Christian missionaries, as well as German and British colonial administrations. Building on this foundation, the present chapter focuses on the state of the health sector in the immediate post-independence period. It explores how, in the spirit of self-determination, the Tanzanian government integrated health into its broader development agenda. Using political economy as a guiding analytical lens, the chapter demonstrates how health provision became central to national planning, as reflected in development plans, parliamentary proceedings, legislative acts, speeches by TANU leaders, and various policy directives.

This chapter further explores how the Tanzanian government established the foundation for organising its health sector, highlighting that significant progress was made through training health workers and building more health facilities. Despite the rhetoric reflected in government records and political speeches, the political economy of the time sidelined health in practice. As a result, achieving the goal of universal healthcare, particularly for the rural population, proved challenging. In numerous cases, policies reminiscent of the colonial era were embraced. The chapter demonstrates how local politics and power dynamics between the government and voluntary agencies impacted health planning and policy-making. The choice between the many needs of the day in a resource-strained period, across the ministries and within the health sector, characterised this period. In this chapter, I use maternal and child health (MCH) as a model for illustrating health planning within a particular department. While colonial legacies remained key in the postcolonial era, I argue that the uniqueness of Tanzania’s historical, political ideology, and social and economic makeup influenced the country’s path in planning health.

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\* *Uhuru* is Swahili for independence.

295 Andrew Green, *An Introduction to Health Planning for Developing Health Systems*, 3rd edn (Oxford University Press, 2007), 3.

### 3.2 State Building and Organisation of the Medical Sector after Independence: A Colonial Legacy<sup>286</sup>

The achievement of independence for Tanzania, like that of other African nations that had endured colonial subjugation, marked a significant period in the country's history. In most of these former colonies, Independence Day is honoured as a holiday for reflection, remembrance and celebration. For Tanzania, the day was December 9, 1961. This day was filled with festivities brimming with fireworks, bonfires, flag ceremonies, games, and military displays accompanied by grand parades, and the newspapers were inundated with messages of congratulations from various companies and industries to Nyerere and TANU.<sup>287</sup>

The overall argument<sup>286</sup> by the African political leaders in TANU was that colonialism was the reason behind the many problems of the African continent and Tanzania in particular. These leaders and the citizens interpreted independence as an opportunity to enjoy what had been denied to them by the colonial government. It was a period to 'modernise' Tanzania. During this period, modernisation was understood as the independent state's ability to achieve a lifestyle comparable to that previously associated with the minority European population. After independence, there was an intense fight against racial discrimination, especially in Dar es Salaam. The aim was to achieve the equalisation of services that had previously been segregated along racial lines, and to extend development beyond urban areas to rural areas.

After independence, the rural-urban divide emerged as a significant challenge for Tanzania. This divide was to persist as a long-term issue. In many urban areas, the colonial socio-political economy was the dominant force. The newly independent government of Tanzania embarked on shaping the country's future, focusing more on rural areas, which for a long time had been 'neglected' by colonial masters. As a result, immediately after independence, Nyerere's and TANU's policies were geared toward redressing the country's years of colonial injustices. At the time, the government posed as a 'state for all' institution.<sup>288</sup> Modernisation, therefore, emphasised agricultural intensification, the primary economic activity, especially for the rural populace. The adoption of tools, such as tractors and ploughs, was seen as a marker of agricultural modernisation.<sup>289</sup>

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<sup>286</sup> Some parts and arguments of this chapter were published in Veronica Kimani (2024) "Maternal Healthcare and Health Policy Planning in Tanzania, 1960-1970s" *Africa Development*, vol 49, 2. accessed on <https://doi.org/10.57054/ad.v49i2.5715>.

<sup>287</sup> Jonathan M. Jackson, 'Past Futures: Histories of Development in the Kilombero Valley, Tanzania' (University of Cologne, 2021), 246.

<sup>288</sup> Kjell Havnevik and Aida C. Isinika, *Tanzania in Transition: From Nyerere to Mkapa*. (Dar es Saalam: Mkuki na Nyota, 2010), 20.

<sup>289</sup> Goran Hyden, *Beyond Ujamaa in Tanzania: Underdevelopment and an Uncaptured Peasantry* (London:

At independence, key decisions were made regarding the nation's development and building. Policies and laws, institutions and available resources reflected an interplay between politics and the economy, which in turn affected the organisation of social welfare in the country. The President noted poverty, ignorance and diseases<sup>290</sup> as the 'enemies' of progress in Tanzania and causes of indignity. The primary objective of Nyerere was to restore dignity to the people of Tanzania by ensuring they had access to basic social services, including healthcare. However, grave medical and structural problems identified by Dr Eric Pridie in 1949, including a shortage of staff, particularly midwives, and the debate between curative and preventive, lingered.<sup>291</sup> With such a background, the transformation as envisioned by the president was not going to be a quantum jump.

The fight against poverty, ignorance and disease was uncertain and problematic. To begin with, the ambition to eliminate the three enemies was not exclusive to Nyerere, prompting speculation that the frequent usage of the term might have led to it being viewed as cliché. The phrase *poverty, ignorance and disease* traces back to the 1940 British documentary 'Men of Africa', and was also echoed in John F. Kennedy's 1963 speech addressing the Cuban Missile Crisis.<sup>292</sup> In Kenya, the first president similarly invoked the idea in his 1963 independence speech. He urged Kenyans to unite in the fight against *poverty, ignorance and disease*, emphasising that their true enemies were not the Europeans but these societal issues, which could be overcome through the spirit of *harambee*.<sup>293</sup> The societal issues present at independence in East Africa were not rhetorical, as the analysis of speeches might suggest. In Tanzania, one would find several epidemics and endemic infections such as malaria, leprosy, smallpox, tuberculosis, cholera, typhoid, dysentery, hookworms, measles and sleeping sickness, as well as compromised rural and urban hygiene, high maternal and infant mortality and poor sanitation.<sup>294</sup>

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Heinemann, 1980).

<sup>290</sup> Nyerere, *Freedom and Development*.

<sup>291</sup> Legislative council of Tanganyika: A review of Medical Policy in Tanganyika, 1949

<sup>292</sup> Jackson, 'Past Futures: Histories of Development in the Kilombero Valley, Tanzania', 250.

<sup>293</sup> Eddah Mutua and Alberto González, 'Ideographs of Suppression: Jomo Kenyatta's Independence Day Speech', *African Yearbook of Rhetoric* 4, no. 1 (2013): 14.

<sup>294</sup> President's Office, 'Regional Administration and Local Government: Rural Development Policy' (Government Printer, 2003), 19; Ralph Jätzold and Eckhard Baum, *The Kilombero Valley: Characteristic Feature of the Economic Geography of a Semi-Humid East Africa Flood Plain and Its Margins*, Afrika-Studien 28 (München: Weltforum Verlag, 1968), 118. Rudolf Geigy, 'ED-REG 1 (2) 190-2-8 Rural Medical Training at Ifakara: Swiss Help to Tanzania', 26 June 1965, 2, Staatsarchiv Basel-Stadt; *Tanganyika, Ministry of Health and Labour, 1961, Annual Report of the Health Division 1961, Vol 1. Prepared by the Chief Medical Officer*. (Dar es Salaam: Government Printer., 1961), 3.

These diseases, combined with the poverty and ignorance of the majority, as observed by Nyerere, exacerbated the problems of the young nation. The assertion that the colonial socio-economic system predisposed people to ill health is what motivated the newly independent government of Tanzania to take a zealous approach towards improving the situation. However, the political leaders and the policymakers continued to rely on, build on, and expand the very systems established during the colonial period, with an immediate improvement on the question of racial discrimination. Social welfare systems and structures, such as hospitals and educational facilities, were reorganised to address medical and educational needs, at least without racial bias.<sup>295</sup> Racial bias, however, was just one of the many issues that needed to be addressed.

Health provision was a priority for the government, as a healthy nation was also a productive one. Emphasis was to be particularly put on the rural areas. As early as 1962, Nyerere advocated for rural health development, starting at the village level, where village health posts, dispensaries, and health centres were planned for construction to supplement the existing ones, catering to both preventive and curative services.<sup>296</sup> Indeed, 'building the nation was not the task to entrust to chronically sick people'.<sup>297</sup> In 1964, the government policy, as stated by the Minister of Health in parliament, was to place greater emphasis on preventive medicine and health education.<sup>298</sup> In the parliamentary proceedings held on 18<sup>th</sup> June 1964, the minister emphasised the need for preventive health and added that:

Keeping the healthy people healthy, does not mean we will stop trying to cure the sick, that cannot happen!! But, we have a situation where today, people demand curative services, we want to create a situation where people demand preventive medicine to assist them in staying healthy and to enable them to put into effect the various development plans which we have and which we are putting to them to put into effect.<sup>299</sup>

Eleven days later, in the parliamentary proceeding on 29<sup>th</sup> June 1964, the minister of health emphasised that the 'MOH was not the ministry of medicine, ministry of hospitals or the ministry of patients'.<sup>300</sup> By making this statement, the minister stressed the importance of

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<sup>295</sup> Julius Nyerere, 'TANU National Conference: 10 Years After Independence.', unpublished manuscript, Dar es Saalam, September 1971, 2.

<sup>296</sup> Nyerere, *Freedom and Development*.

<sup>297</sup> 'Hansard. The Parliament of the United Republic of Tanganyika and Zanzibar. The Hansard: Proceedings of the National Assembly, 13th Meeting, 1964', 29 June 1964, 738.

<sup>298</sup> 'Hansard. The Parliament of the United Republic of Tanganyika and Zanzibar. The Hansard: Proceedings of the National Assembly, 13th Meeting, 1964'.

<sup>299</sup> 'Hansard. The Parliament of the United Republic of Tanganyika and Zanzibar. The Hansard: Proceedings of the National Assembly, 13th Meeting, 1964', 152.

<sup>300</sup> 'Hansard. The Parliament of the United Republic of Tanganyika and Zanzibar. The Hansard: Proceedings of

preventive medicine, not just curative medicine. However, the government continued to expand Western medicine by building more health facilities in rural areas. The reasons for the expansion were multifaceted. Politically, it was the duty of the state to provide social services to the people, through which political legitimacy and relevance were acquired. Economically, health was noted to be related to the much-needed productivity and growth, and socially, healthy people were seen as a free and dignified lot. Moreover, since the days of colonial medical campaigns, Africans have been led to believe in the ‘efficacy’ of Western medicine, especially during times of epidemics.<sup>301</sup>

The popularity of Western medicine continued to rise after independence. In 1961, Tanzania’s population was approximately 10,346,695.<sup>302</sup> Those who sought medical services in all health facilities in Tanzania, came to a total of 10,774,668, including both inpatients and outpatients.<sup>303</sup> It was reported that Africans who visited health facilities seeking treatment often demanded injections.<sup>304</sup> Even though scarification<sup>305</sup> was used in African traditional medicine, injections were not part of the treatment method.<sup>306</sup> This desire to be injected was a total contrast to the early days of colonialism, when some Africans were hesitant and apathetic towards Western medicine.<sup>307</sup> It was argued that even where a diet change was the most appropriate thing to do, patients believed in and demanded injections.<sup>308</sup> Injections seemed modern, Western, and practical. This, as we shall see later in this chapter and the next, had a significant impact on the development of curative services versus preventive services.

The Tanzanian government aimed to establish consistency in health services across rural and urban areas. This initiative was envisioned to address challenges related to the accessibility of health centres, alleviate the issue of overcrowding in hospitals and clinics, and increase the

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the National Assembly, 13th Meeting. 1964’.

<sup>301</sup> Ann Beck, *A History of the British Medical Administration of East Africa, 1900-1950* (Massachusetts: Harvard University Press, 1970); Helen Tilley, *Africa as a Living Laboratory: Empire, Development, and the Problem of Scientific Knowledge, 1870-1950* (Chicago: University of Chicago Press, 2011).

<sup>302</sup> <https://nbs.go.tz/index.php.sw/> accessed on 09.01.2023

<sup>303</sup> Nhonoli and Nsekela, *Health Services and Society in Mainland Tanzania*, 1.

<sup>304</sup> TNA, ‘C.5/47/43 Letters of Regional Development Committee: Ofisi Ya Waziri Mkuu Na Makamu Wa Pili Wa Rais.’, November 2, 1973, 5.

<sup>305</sup> Scarification here means scratching, etching, burning/branding, or superficially cutting to apply medicine or for ritual healing.

<sup>306</sup> Roland Garve et al., ‘Scarification in Sub-Saharan Africa: Social Skin, Remedy and Medical Import’, *Tropical Medicine & International Health* 22, no. 6 (2017): 708–15.

<sup>307</sup> Ann Beck, ‘Medical Administration and Medical Research in Developing Countries: Remarks on Their History in Colonial East Africa’, *Bulletin of the History of Medicine* 46, no. 4 (1972): 353; Jilek-Aall, *Call Mama Doctor: African Notes of a Young Woman Doctor*.

<sup>308</sup> Titmuss et al., *The Health Services of Tanganyika*, 68; ‘Hansard. Majadiliano Ya Mbunge. Mkutano Wa Nne, Sehemu Ya Pili. Tarehe 1-Julai 1966’, 1966, 2281.

number of health workers.<sup>309</sup> This approach aimed to bring services closer to the people, encouraging them to stay in rural areas and addressing the perception that certain services were exclusively available in urban centres. The planning efforts were evident in the restructuring of the health sector, the development of training programmes, and the construction of facilities. To achieve this, the government implemented changes that encompassed the entire medical care sector. However, the government's administrative structure affected the organisation of the health sector.

The system of administration was organised at two levels: the central (national) level, with devolved functions at the local (regional) level. As early as 1963, a demarcation existed between the national and local governments, based on the size of the region and the roles each was to play in providing medical services. These roles were dependent on the category or level of the hospital, specifically whether it was national or regional. The central government was responsible for running national or consultant hospitals, while hospitals at the regional level were under the responsibility of the local government. However, all policies were established by the central government and then implemented at the local level. Campaigns and control of common diseases, such as malaria and bilharzia, as well as general health inspections, were left to the local government. This arrangement was considered beneficial, as the argument was that each region could then prioritise the most crucial needs through effective planning.<sup>310</sup> In addition, it was also the role of the local authorities to manage ambulances while the central government was to concentrate on making policies, training medical personnel, and fulfilling supervisory and advisory roles. Nevertheless, overlaps and sometimes conflicts were not lacking, as shown in section 3.5.

The medical department was based on a '3-tiered administrative pattern'.<sup>311</sup> The Ministry of Health (MOH, referred to as AFYA) was the primary authority responsible for all matters related to health in Tanzania.<sup>312</sup> The ministry, as the overall body at the top, was responsible for 'bring[ing] about a healthy society'.<sup>313</sup> Below the ministry level was the regional level, followed by the local level (encompassing districts and below). A region was comprised of between five and six districts (See maps in Chapter 2). The plan was to have a hospital in each

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<sup>309</sup> *Tanganyika, Ministry of Health. Annual Report of the Health Division 1962 Vol 1. Prepared by the Chief Medical Officer. (1962), 3.*

<sup>310</sup> *Tanganyika, Ministry of Health and Labour, 1961, Annual Report of the Health Division 1961, Vol 1. Prepared by the Chief Medical Officer.*

<sup>311</sup> Titmuss et al., *The Health Services of Tanganyika*, 34.

<sup>312</sup> Afya is Swahili and loosely translate as 'good health'.

<sup>313</sup> 'Hansard. The Parliament of the United Republic of Tanganyika and Zanzibar. The Hansard: Proceedings of the National Assembly, 13th Meeting 1964', 736.

district. This hierarchy went down to the village level. At the top of the hierarchy was the Minister of Health, followed by the Chief Medical Officer, Deputy Chief Medical Officer, three Principal Medical Officers, the Principal Matron and the Chief Health Inspector in that order.<sup>314</sup> These offices comprised the top leadership in the ministry and were all based in Dar es Salaam. The holders of these offices were responsible for decision-making. This order reflects the hierarchical structure which was very similar to the British health system of administration. The system continued to be problematic, especially in providing health services to rural areas, as illustrated below. It also heightened disparities, including the rural-urban divide, which is a central theme in this dissertation.

At the regional level was the Regional Medical Officer (RMO), who acted on behalf of the Chief Medical Officer. Under the RMO were the District Medical Officers (DMOs) representing each of the districts.<sup>315</sup> Behind this hierarchy was a network of medical workers who served as the execution arm for the decisions made. These medical practitioners were divided into four groups: university graduate medical doctors, Assistant Medical Officers (AMOs), Medical Assistants (MAs), and Rural Health Workers (RHW). For university graduates, the entry requirement was a complete thirteen years of basic education (primary and secondary levels). The basic level was followed by a 5-year university course, after which a one-year pre-registration for medical employment was taken.<sup>316</sup> This category consisted of physicians, pharmacists, and dentists, whose number at independence was minimal. The situation was not only so for Tanzania, but for the whole continent, except for Algeria and Tunisia, which by 1960 had surpassed the WHO doctor-to-population ratio requirement of 1:10,000. The average ratio for the rest of the African countries was 1:20,002.<sup>317</sup> Specifically, in Tanzania, the ratio was 1:22000.<sup>318</sup> Therefore, training, not only graduate doctors but also other cadres of health workers, was an urgent obligation for Tanzania.

Different scholars have cited the number of available doctors in Tanzania at independence. According to Nsekela and Nhololi, the government inherited 400 graduate doctors from the colonial government, of whom only eighteen were Tanzanians. John Ilife puts the number of

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<sup>314</sup> *Tanganyika, Ministry of Health and Labour, 1961, Annual Report of the Health Division 1961, Vol 1. Prepared by the Chief Medical Officer.*, 1; Douglas Heath, 'Health Pyramid and the Private Practitioner', *Tanganyika Standard*, 4 January 1962.

<sup>315</sup> Titmuss et al., *The Health Services of Tanganyika*, 34.

<sup>316</sup> Staatsarchiv Basel-Stadt, Klaus E Gyr, 'PA 940d F2 (1) Ifakara Reiseberichte, Jahresberichte, Kursunterlagen 1960-1977: Swiss Joint Evaluation of Swiss Cooperation to Tanzania Health Projects' (1977).

<sup>317</sup> Keita Maghan, *A Political Economy of Health Care in Senegal*, African Social Studies Series Vol 10 (Brill, 2007), 45.

<sup>318</sup> 'Upcoming Private Practitioner', *Tanganyika Standard*, 29 January 1962.

registered medical doctors at independence at 403, and only 12 were African. Oscar Gish notes that there were 400 graduate doctors in 1961, of whom only 35 per cent worked for the government, 25 per cent for voluntary agencies, and 45 per cent in private practice. Like Illife, Gish noted that only twelve of these doctors were Africans.<sup>319</sup> The disparity in the number of African doctors may have stemmed from inadequate record-keeping, as acknowledged repeatedly in the medical department's annual reports.<sup>320</sup> However, the bottom line was that the number of African doctors was so small that the concept of self-reliance and the Africanisation of the health sector remained far-fetched, necessitating help from voluntary agencies and donors.

The problem of staffing was an inherited problem. As early as the 1940s, Dr Eric Pridie, the Chief Medical Officer to the Colonial Office, identified inadequate staff as a serious problem in Tanzania. Pridie's observations are documented in the 1946 ten-year welfare plan for Tanganyika, which identified the issues of the medical department.<sup>321</sup> The report was immediately followed by the ambitious Post-Second World War plan, which proposed having 2,000 medical doctors and 40,000 in twenty years.<sup>322</sup> These two documents achieved little at the implementation stage, a problem that persisted into the post-independent era.

Below the medical doctors were the Assistant Medical Officers (AMOs). They had eleven years of basic schooling.<sup>323</sup> They added three years of medical training. However, in many cases, the AMO did the work of a graduate doctor. Gish argues that 'AMO was the only known 'doctor' to the people in the rural areas'.<sup>324</sup> At independence, there were only twenty-two AMOs. Most of these AMOs were still urban-based, and the sector was dominated by expatriates who, in most cases, had higher qualifications. Below the AMOs were the medical assistants (MAs). At independence, there were 200 MA, and they were expected to increase to 1200 by 1980. The

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<sup>319</sup> Oscar Gish, 'The Way Forward: World Health Organisation', *Journal of World Health*, April 1975, 6; Nhonoli and Nsekela, *Health Services and Society in Mainland Tanzania*, 1; Illife, *East African Doctors: A History of the Modern Profession*; Oscar Gish, *Planning the Health Sector: The Tanzanian Experience.*, 2nd edn (Croom Helm, 1975).

<sup>320</sup> *Tanganyika, Ministry of Health. Annual Report of the Health Division 1962 Vol 1. Prepared by the Chief Medical Officer.*, 1.

<sup>321</sup> Dr Eric Pridie, 'A Ten-Year Development and Welfare Plan for Tanganyika Territory.' (Dar es Salaam, 1946).

<sup>322</sup> 'Post War Development-Medical Department, Dar es Salaam.', 1947.

<sup>323</sup> Basic Schooling involved 7-years of primary education, 4 years and secondary level(O-level), and 2 years of Advanced level (A-level), under the 7-4-2 system.

<sup>324</sup> Gish, 'The Way Forward: World Health Organisation', 13.

AMOs, MAs, Health Education Officers (HEOs), dental assistants, technicians, radiographers, A-nurses,<sup>325</sup> lab technicians and secretaries formed the intermediate level of training.<sup>326</sup>

The intermediate level was followed by the auxiliary level (see Table 2). The auxiliary level included Rural Medical Aides (RMAs), B-nurses, village midwives (later known as Maternal and Child Health Aides (MCHA)), and lab auxiliaries, all of whom needed seven years of primary schooling to qualify for the training.<sup>327</sup> However, in 1964, the requirement was raised to a secondary school certificate.<sup>328</sup> The struggle here was between raising the standards and overcoming the scarcity of qualified personnel for training. The RMA numbered 380 at independence, and, considering wastage, the government expected a total of 2,800 by 1980. It is worth noting that, despite the three different five-year development plans analysed in this chapter, which ran from 1961 to 1974, the government's overall achievement of its long-term planning strategy was set to 1980.<sup>329</sup>

With the change in policy at independence to focus more on rural health, the government targeted training more low-cadre health officers, who could fit well into the rural setting. This explains why the number of AMO and RMA rose exponentially by 1980. In the villages, the village medical helpers (VMH) were selected by fellow villagers. The criterion was that one had to complete primary school education. Having completed primary school education, the person chosen would receive three to six months of training at a District hospital, equipping them to deal with minor ailments, provide first aid, and prevent common illnesses. The village helpers were affiliated and supervised by the nearby Rural Health Centre (RHC).<sup>330</sup> The other category of auxiliary medical personnel was the MCHA, who, after being stationed at dispensaries and rural health centres, organised maternal and child health welfare, which included antenatal, delivery, post-natal, and family-planning services.

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<sup>325</sup> The difference between Nurse A and B was the level of entry and qualification where the former enrolled for nursing after O-levels while the latter enrolled after grade 7.

<sup>326</sup> Staatsarchiv Basel-Stadt Gyr, 'PA 940d F2 (1) Ifakara Reiseberichte, Jahresberichte, Kursunterlagen 1960-1977: Swiss Joint Evaluation of Swiss Cooperation to Tanzania Health Projects', 17.

<sup>327</sup> Staatsarchiv Basel-Stadt Gyr, 'PA 940d F2 (1) Ifakara Reiseberichte, Jahresberichte, Kursunterlagen 1960-1977: Swiss Joint Evaluation of Swiss Cooperation to Tanzania Health Projects'.

<sup>328</sup> *Tanganyika Ministry of Health and Labour, Annual Report of the Health Division 1961 Vol 1. Prepared by the Chief Medical Officer, Annual Report (Dar es Salaam, 1963), 26.*

<sup>329</sup> 'CCM Library, Jamhuri Ya Muungano a Tanzania, Mpango Wa Muda Mrefu 1981-2000', Government Printer, Dar es Salaam, 1980, 1.

<sup>330</sup> Gish, 'The Way Forward: World Health Organisation', 12.

Level of training	Categories and cadres of medical workers
National Level	Graduate doctors
Intermediate level	AMO, MA, HEO, DA, Technician, Lab technician, secretaries, A-nurse
Auxiliary level of training	RMA, B-nurses, village midwives/MCHA, lab auxiliary

Table 2: A summary of the hierarchy of training for medical workers

From this hierarchy, the organisation and structure of the health department saw little change after independence. Medical services were still organised on a provincial or regional basis. The only change in policy in 1961 was to assign provincial medical officers (PMOs) or regional medical officers (RMOs) additional duties beyond their administrative roles.<sup>331</sup> The aim was to address the problem of inadequate staff and perhaps keep the PMOs in charge of the real medical issues that their regions were facing. For instance, the RMO for Tanga was responsible for TB offices, while the RMO for the western region was responsible for sleeping sickness matters. Most of the RMOs were also in charge of the regional hospitals.<sup>332</sup>

All these categories of health workers were to be assigned to central and local government-run facilities, depending on the ranking of the hospital, although this was not always the case. For instance, medical officers and Assistant Medical Officers were to be in charge of hospitals, mostly at the district, regional, or zonal level. In contrast, medical assistants, RMA, and other aides were to serve in rural health centres and dispensaries under the local governments. However, in most cases, the demarcation was not a straightforward process because those meant to work in rural areas were also recruited to hospitals in urban areas, and the expertise of highly skilled doctors was also needed at the local level.<sup>333</sup>

In brief, the health-system hierarchy in Tanzania at independence can be described as a pyramid. At the bottom were the dispensaries, followed by the health centres, the district level, the regional level, and the zonal level, and at the apex was the MOH.<sup>334</sup> The MOH was the overall supervisory and policy-making body (see Figure 8). It prepared the budget yearly by assessing the needs of the state and the regions. The amount of funding, however, was dictated

<sup>331</sup> *Tanganyika, Ministry of Health and Labour, 1961, Annual Report of the Health Division 1961, Vol 1. Prepared by the Chief Medical Officer, 1.*

<sup>332</sup> 'Tanganyika, Ministry of Health and Labour, 1961, Annual Report of the Health Division 1961, Vol 1. Prepared by the Chief Medical Officer', 1.

<sup>333</sup> Kris Heggenhougen et al., *Community Health Workers: Tanzanian Experience* (Oxford University Press, 1987), 25.

<sup>334</sup> Heath, 'Health Pyramid and the Private Practitioner'.

by the Ministry of Finance, which was responsible for managing and allocating the available funds.<sup>335</sup> This was followed by parliamentary approval and later implementation at the national or regional level.<sup>336</sup> The national budgets were funded directly, but the needs of the region were addressed according to the regional budgets submitted by the Regional Development Director (RDD). This organisation was followed until 1972, when the Decentralisation Act was enacted to make the local government more responsive to local needs.<sup>337</sup> However, decentralisation faced several challenges, as discussed in the next chapter.

In the rural areas, a group of dispensaries were grouped under the umbrella of a health centre. The health centre was to have at least three beds for the rural dispensary under its supervision.<sup>338</sup> The health centre, manned by the AMO, clinical assistants, health visitors, and senior health inspectors, was located under a district hospital. The RHC and dispensaries were financed by the local government and assisted by the central government.<sup>339</sup> At the district level, hospitals were staffed by district medical officers, clinicians, nursing sisters, nurses, senior health visitors, and health inspectors. A group of district hospitals were put under a regional hospital, and this trend continued to the top of the pyramid. Conversely, budgetary allocation would signify an inverted pyramid because the majority of the people lived at the bottom of the pyramid. At the same time, the bulk of the health budget was used at the top. The same can be said about skills, expertise and experience. Complaints by some MPs may have been seen as trivial, but they were indicative of the situation on the ground. A case in point was that patients in Muhimbili National Hospital had better patient gowns, while those worn by patients in some districts were laughable.<sup>340</sup> This explains the rural-urban duality that the Tanzanian government wanted to address as early as 1961, but proved insurmountable.

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<sup>335</sup> Staatsarchiv Basel-Stadt Gyr, 'PA 940d F2 (1) Ifakara Reiseberichte, Jahresberichte, Kursunterlagen 1960-1977: Swiss Joint Evaluation of Swiss Cooperation to Tanzania Health Projects.'

<sup>336</sup> 'The Parliament of the United Republic of Tanganyika and Zanzibar. The Hansard: Proceedings of the National Assembly, 13th Meeting', 1964, 152.

<sup>337</sup> Wizara ya Afya, 'Hotuba ya Mheshimiwa Waziri Ali Mwinyi Katika Mbunge Julai 1973: Siasa na Makadirio ya Matumizi ya Fedha kwa Mwaka 1973/74', 1973, 2.

<sup>338</sup> Heath, 'Health Pyramid and the Private Practitioner'.

<sup>339</sup> 'Government Paper No. 1, 1963: Organisation of Services to be Administered by the Local Authorities in Tanganyika and the Consequential Financial Arrangements', 1963, 10.

<sup>340</sup> 'Hansard. Majadiliano ya Mbunge. Mkutano wa Nne, Sehemu ya Pili. Julai 1, 1966', 2276.

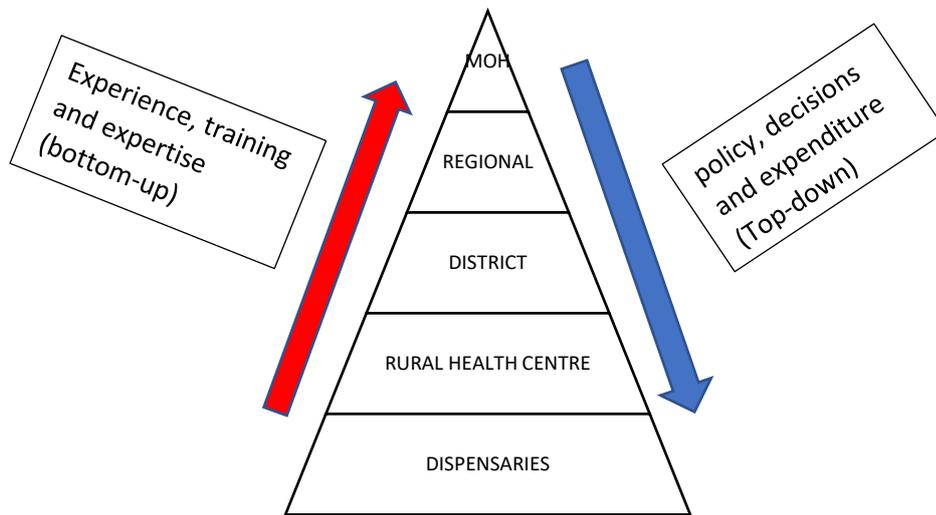


Figure 8: The organisation of the health sector

From the figure above, the flow of information, budgetary allocations, policy and instructions was top-down, while the referral process and the high level of expertise followed a bottom-up approach. In this hierarchy, the position and role of health workers in the sector were such that the majority of doctors worked in referral hospitals, while the rest, lower down the ladder, were tasked with concentrating on rural health. This hierarchical arrangement, however, was:

Politically expedient, amoral to the perfectionist...10,000 people in the bush do not make much noise in pressing for medical care, they got used to being ill and dying quietly without it, but 10,000 people in an urban area such as Dar es Salaam make a great deal of noise. They have become familiar with hospital care and the clamour is increased by the employers of labour.<sup>341</sup>

According to the plan, a health-centre hospital was to be situated in a place where it could provide coverage for 50,000 people and supervise five dispensaries. It was also to be in a place where referral of patients to a district. Other factors to be considered were proximity to schools, water supply, availability of staff housing, and the availability of self-help for construction. However, political considerations often took precedence over the rest.<sup>342</sup> This illustrates the fact that the provision of healthcare was also a political tool, and there was a need to make it accessible to the ‘politically aware’ group, as this would enhance the political legitimacy and survival of the political class. Therefore, even when the policy was intended to focus on rural areas, the need for political relevance and acceptability led to a greater emphasis on urban areas, where people were more politically conscious. The same position was held by the Minister of

<sup>341</sup> Heath, ‘Health Pyramid and the Private Practitioner’ 1962.

<sup>342</sup> Mayer, ‘Implementation and Control Under Decentralisation: Tanzanians Rural Health Centre Programme’, 11.

Health in 1964, when he explained why it was easier to cut the preventive health budget compared to the curative health budget. He noted that,

... if you close down a hospital, shut down a ward, withdraw a doctor, cut down on the nursing staff, then immediately these things are seen and felt by the public. The Government comes in for severe criticism. But, if you cut down on health inspection, vaccination campaigns, teaching hygiene and sanitation, then very little or no direct effect is felt. When a sick man goes to a hospital and finds it overcrowded, he blames the Ministry of Health for not providing enough beds or doctors... but he does not blame the Ministry for having failed to institute a vaccination campaign to prevent that particular illness...<sup>343</sup>

From the tenets of political economy, it is clear that the allocation of resources was dependent not only on availability but also on the decision-makers and their interests, particularly in achieving a political end, which played a significant part.

The focus on the urban areas meant that the reality of planning was far from the picture that TANU had painted. It also solidified the notion that colonial plans and policies largely predetermined Tanzania's development trajectory. In reality, the postcolonial state was in a far worse situation due to the high expectations of the people and the fact that there was very little money to meet all their needs. This situation is an example of what Robert Rhodes describes as planning 'within a set of constraints involving the limits imposed by economic ties with the developed world and the political realities which developed out of the colonial experience'.<sup>344</sup>

New challenges also emerged, especially that of coverage. At independence, the health system was still in its embryonic stages of development, with limited growth and expansion, resulting in many parts of rural Tanzania lacking access to health services. The available mission hospitals could also not be expanded using government money, as that was against the policy. As we shall see later, in 1966, the Minister of Health made it clear that the only collaboration was through government grants, enabling voluntary services to offer services but not to expand their facilities.<sup>345</sup> This does not mean that urban areas were well-equipped with state-of-the-art medical infrastructure. Most of the available medical services were largely curative, described by Oscar Gish as 'scattered, partial and uncoordinated'.<sup>346</sup>

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<sup>343</sup> 'The Hansard. Proceedings of the National Assembly in the Parliament of URT and Zanzibar. Proceedings from 16th June to 3rd July 1964', June 29, 1964, 737.

<sup>344</sup> Robert Rhodes, *Imperialism and Underdevelopment: A Reader* (New York: Monthly Review Press, 1970), 1.

<sup>345</sup> 'Maswali Katika Mbunge', *Ngurumo*, Juni 26, 1966.

<sup>346</sup> Gish, 'The Way Forward: World Health Organisation', 8.

The administrative divisions established during the colonial era, primarily between the central and local governments, continued after independence. According to Titmuss, the difference between the central and the local government was very thin, ‘geographical rather than in functionality’.<sup>347</sup> This hierarchy influenced the way the health sector was organised. However, the relationship and demarcation between the two levels were not as comprehensive, leading to gaps and overlaps. It also proved challenging to determine where to locate the voluntary agencies, the majority of which provided health services in rural areas. The two levels of government also affected the training and posting of health workers. The central government was responsible for training and deploying health workers, while the local government was responsible for maintaining the health centres, dispensaries, and posts within their jurisdiction. However, it was challenging for many local governments to raise revenues for specific projects or even maintain existing ones. These challenges, as described in Chapter Four, became even more conspicuous in the era of *Ujamaa* and after decentralisation in 1972, when the local government, with less revenue, had more duties to perform. Only the wealthier municipalities and larger towns, for instance, were able to maintain a full-time emergency ambulance service.<sup>348</sup> The entire administrative system was structured around the political framework, with the ruling party, TANU, playing a central role in policy formulation, proposal development, and implementation. In the next section, I will provide a brief introduction to TANU, its organisation, and its impact on health planning. As the only political party, policymaking was deeply rooted in the party’s directives during an era when party loyalty was highly prioritised.

### **3.3 Health Policies, Planning, and TANU Politics**

To fully grasp the evolution of healthcare policies in post-independence Tanzania, it is essential to analyse the political context, which was profoundly influenced by Julius Nyerere and his ruling party, TANU. Therefore, understanding TANU’s role and influence is key to appreciating the policymaking and planning processes, where the government acted not only as a healthcare provider but also as the primary planner and implementer of policies.

TANU was commonly referred to as *chama* (party). It was at the centre of all government planning. In a speech at the Uganda People’s Congress meeting in 1968, Nyerere underscored the pivotal role of a political party as a conduit connecting the government and its citizens. He emphasised:

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<sup>347</sup> Titmuss et al., *The Health Services of Tanganyika*, 68.

<sup>348</sup> ‘Background to the Budget: An Economic Survey 1968-69, Prepared Jointly by the Ministry of Economic Affairs, Development Planning and the Ministry of Finance’, 1968, 10.

...for the truth is that it is not the party which is the instrument of the government, it is the government which is the instrument through which the party tries to implement the wishes of the people and serves their interests. And the party has therefore to determine the basic principles on which the government should act; It has to determine the policies its government will follow... only such a party can ensure that the government and the people work together for the people's purposes.<sup>349</sup>

TANU was therefore so powerful that, according to Nyerere, the most important event in a country's political calendar was the party conference, and that a political party was the basis of a democratic government, with a party worker being the most significant person.<sup>350</sup> In the following section, I briefly provide the origin of TANU and thereafter its involvement in popularising and executing health policies, and the contributions of TANU party agents, women, and the Youth League in ensuring the government's policies were effectively implemented.

### 3.3.1 A Brief History of the Origin and Growth of TANU

The history of TANU has been thoroughly recorded. However, I will provide an overview of TANU's history to provide context for my argument. Following the German conquest and the suppression of recalcitrant groups such as the *Maji-Maji* and Hehe rebellion in Tanganyika, full-scale colonialism was instituted. This era was marked by the exploitation of both human and natural resources. Consequently, the British takeover after the First World War did not significantly differ from the German administration, as the primary objective of colonialism remained unchanged. Given the capitalist and exploitative nature of colonial rule, Africans established labour unions to voice their grievances against the discriminatory practices of the colonial state in the production of coffee and other cash crops. Kimambo et al. point out that as early as 1925, the Kilimanjaro Native Planters Association was established to address these concerns.<sup>351</sup> Apart from the farmers, colonial government employees who were of African descent had many issues, such as discrimination based on race and poor remuneration.<sup>352</sup>

In 1922, the Tanganyika Territory Civil Service Association (TTCSA) was formed, and in 1929, a branch of TTCSA was opened in Dar es Salaam.<sup>353</sup> This became the basis of the Tanganyika

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<sup>349</sup> Nyerere, *Freedom and Development*, 33.

<sup>350</sup> Nyerere, *Freedom and Development*, 33, 34

<sup>351</sup> Isaria N. Kimambo et al., *A New History of Tanzania* (Mkuki na Nyota, 2017), 171.

<sup>352</sup> Mohamed Said, *The Life and Times of Abdulwahid Sykes (1924–1968): The Untold Story of the Muslim Struggle against British Colonialism in Tanganyika* (London: Minerva Press, 1998).

<sup>353</sup> Kimambo et al., *A New History of Tanzania*, 154.

African Association (TAA). TAA was founded in 1929 by civil servants, urban dwellers and leaders. By 1933, the Muslims, led by Kleist, had formed the *Al Jamiatul Islamiyya* (Muslim Association of Tanganyika).<sup>354</sup> However independence was not the priority of many of these political associations in Africa at that time. Their primary concern was achieving a level of equilibrium in the operations of the colonial state. They wanted Africans to be accommodated in the colonial set-up, and an end to discrimination, especially against workers.

The global political landscape underwent significant shifts after the Second World War. Colonialism was quickly losing ground. The call for self-determination for the colonised people was amplified. This ignited the fire of nationalistic bodies all over Africa. At this juncture, the colonial state increased its efforts to develop the colonies.<sup>355</sup>

In the 1950s, the demand for self-rule in Africa gained momentum, particularly in the aftermath of India's and Pakistan's independence in 1947. In Tanganyika, the TAA emerged as the leading nationalist organisation, spearheading the charge for self-determination. However, a significant challenge arose, as many TAA leaders were employed by the colonial government, making it difficult for them to challenge the authorities from within. As civil servants, and concerned about repercussions from their employer, most TAA leaders and members were reluctant to openly criticise and oppose the government. Some critics argue that the TAA functioned more as a socialisation hub for black individuals within the British colonial government. The colonial administration explicitly warned of punishments for those involved in nationalist movements, further complicating the landscape.<sup>356</sup> One of the punishments was to be fired. Consequently, senior figures resigned from the party leadership to evade attention.

During the height of the independence movement in 1953, Nyerere returned from Edinburgh, where he had gone for his studies. At the time, Nyerere was a teacher in a missionary school and therefore faced less risk from the threats issued by the colonial government, or so he thought. However, as I argued in the previous chapter, whether missionary or government, the colonial system operated as a unified entity, which is reflected in the events that followed between Nyerere and the Mission school administration, which was assumed to be neutral. The Father in charge of the school where Nyerere was teaching called him, warning him to choose between his teaching career and politics. According to his resignation letter, he decided to

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<sup>354</sup> Said, *The Life and Times of Abdulwahid Sykes (1924–1968): The Untold Story of the Muslim Struggle against British Colonialism in Tanganyika*, 44.

<sup>355</sup> Tiyambe Zeleza, *Manufacturing African Studies and Crises* (CODESRIA, 1997), 218.

<sup>356</sup> Geiger, *TANU Women*, 53.

pursue a career in politics.<sup>357</sup> Favoured by his level of education and youth, he assumed the presidency of TAA from Abdul Wahid Sykes who seemingly relinquished the position, perhaps because of his job as a market master at *Kariakoo* under the colonial civil service.<sup>358</sup>

After assuming the party leadership, Nyerere renamed the organisation from TAA to TANU in 1954.<sup>359</sup> Unlike TAA, which predominantly comprised civil servants, TANU appealed to a diverse demographic, including teachers, farmers, peasants, professionals from both rural and urban areas, village residents, and individuals of varying educational backgrounds. This category of people joined TANU as a protest due to frustrations arising from the dominance of the economic and social space by the Europeans and the Asians.<sup>360</sup> However, Nyerere skilfully fostered harmony among people, transcending differences in religion, region, and ethnicity.<sup>361</sup> This harmony was sought by all means. Dissent was viewed as irresponsible, and troublemakers were dealt with firmly.<sup>362</sup>

In Dar es Salaam, Muslims formed the majority due to historical reasons related to the slave trade, where being a Muslim provided some protection against enslavement. It followed then that the originators of political activities in Tanganyika were mainly Muslims who were the majority in Dar es Salaam, and up to the 1950s and 1960s they formed the majority in political associations. It is important to note that in the 1960s and 1970s, TANU, led predominantly by Christians, faced scepticism from the Muslim community.<sup>363</sup> However, Nyerere, since the late 1950s, had successfully reassured people of TANU's inclusivity. This strategy enabled TANU to adopt a national perspective, giving it an edge over its competitors, namely the United Tanganyika Party (UTP), which was pro-British, and the African National Congress (ANC), led by Zuberi Mtemvu.<sup>364</sup>

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<sup>357</sup> TNA (letter posted at the entrance of the Archive), Julius Nyerere, 'Letter from Julius Nyerere to Father Lynch, the Headmaster St Francis College Pugu.', 22 March 1955.

<sup>358</sup> Geoghegan, 31. Geiger, *TANU Women*, 53. 'Mwalimu in 1950s Dar', *The East African*, 12 October 2008; Said, *The Life and Times of Abdulwahid Sykes (1924–1968): The Untold Story of the Muslim Struggle against British Colonialism in Tanganyika*.

<sup>359</sup> John Lance Geoghegan, 'The Movement for Independence in Tanganyika' (M.A, University of Pennsylvania, 1965), 3.

<sup>360</sup> Globalsecurity.org, 'The Emergence of TANU', n.d., accessed 14 February 2024, <https://www.globalsecurity.org/military/world/tanzania/history-independence-04.htm>.

<sup>361</sup> Kimambo et al., *A New History of Tanzania*, 156.

<sup>362</sup> Geoghegan, 'The Movement for Independence in Tanganyika', 42.

<sup>363</sup> Said, *The Life and Times of Abdulwahid Sykes (1924–1968): The Untold Story of the Muslim Struggle against British Colonialism in Tanganyika*.

<sup>364</sup> The two parties were later dissolved to allow TANU to operate as the only political part as from 1965

TANU members, led by Nyerere, travelled across the country persuading people to join the party. Colin Leys interprets this effort as a strategy to gain legitimacy while fostering public obedience and cooperation with the government.<sup>365</sup> The transformation of the party slogan is too telling of the efforts to retain relevance and legitimacy. From 1959, the TANU slogan evolved from ‘*Uhuru*’ (Freedom) to ‘*Uhuru na Kazi*’ (Freedom and Work) and later to ‘*Uhuru na Umoja*’ (Freedom and Unity). While this mobilisation was easy between 1954 and 1961, it became difficult after independence.<sup>366</sup> Before independence, the masses were united against a common ‘white’ enemy, *mzungu*. However, after independence, a powerful cause was needed to retain TANU as the dominant and relevant party. This was not easy for TANU, as it was a popularly nationalistic movement whose aim was to achieve independence; thus, the reason for its existence after independence was put on trial. It is noted that immediately after independence, there was low registration and attendance at meetings.<sup>367</sup> Tordoff argues that the active mobilisation by TANU during the colonial era needed to be kept alive and active, and so TANU became the main rallying point for the government in the post-independence era.<sup>368</sup>

As a result, Nyerere had to refashion the party. He redefined his role as a national leader. He championed the idea of a one-party state in which dissenting voices were deemed adversaries. He emphasised the imperative for every individual to engage in politics, considering it an inseparable aspect of life—‘*Siasa ni Maisha*’ (Politics is life).<sup>369</sup> His writings underscored the necessity of unity and cautioned against the polarisation of the nation through political differences and the existence of multiple political parties.<sup>370</sup> During the initial years of independence, Nyerere advocated that the nation was too fledgling to embrace multi-party democracy, deeming it unsustainable. He proposed adopting a single-party system for at least fifteen years, asserting that this period was crucial for establishing political, civic, economic, and social traditions unique to Tanganyika. The aim was to ingrain the traditions that were to be considered typically ‘Tanganyikan’, to the point that they become so ingrained that perhaps no leader would veer away from that tradition.<sup>371</sup>

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<sup>365</sup> Collins Leys, ‘The Political Climate of Economic Development African Affairs’, *African Affairs* 65, no. 258 (1966): 55.

<sup>366</sup> Collins Leys, ‘The Political Climate of Economic Development African Affairs’, 56.

<sup>367</sup> Geoghegan, ‘The Movement for Independence in Tanganyika’, 75.

<sup>368</sup> William Tordoff, *Government and Politics in Tanzania: A Collection of Essays Covering the Period Sept 1960 to July 1966* (East Africa Publishing House, 1967). xiv

<sup>369</sup> Nyerere, *Freedom and Development*.

<sup>370</sup> Julius Nyerere, *Freedom and Unity: Uhuru Na Umoja. A Selection from Writings and Speeches 1952-65* (London: Oxford University Press, 1967).

<sup>371</sup> Paul Bjerck, *Building a Peaceful Nation: Julius Nyerere and the Sovereignty of Tanzania, 1960-1964*. (New York: University of Rochester Press, 2015), 97.

Trade unions under the umbrella of the Tanganyika Federation of Labour (TFL) and cooperatives such as the Bukoba Native Cooperatives Union (BNCU), Kilimanjaro Native Cooperative Union (KNUC) and the Victorian Federation of Cooperative Unions (VFCU), which had worked jointly with TANU to advance their anti-colonialism agenda, were changed after independence.<sup>372</sup> After independence, Nyerere did not view trade unions as complementary to TANU, but instead saw them as competitors. Therefore, to consolidate TANU's monopoly, he banned TFL and replaced it with the National Union of Tanganyika Workers (NUTA), and every civil servant was required to be a member of TANU.<sup>373</sup>

The party's activities were to start at the grassroots level. For instance, the construction of the TANU main building was done by the combined efforts of all citizens. Nevertheless, the credibility of TANU's popularity and loyalty is debatable. The contributions towards the construction of the TANU main building were mandatory. The rallying call was that Tanzania '*itajengwa na watanzania wenyewe*' (Tanzanians will build Tanzania), prompting a compulsory deduction of three per cent from individuals' salaries for one month in 1971.<sup>374</sup> There were also complaints from workers about double deductions or deductions exceeding the amounts they had signed off on in their wages.<sup>375</sup> Abdi Mohammed from Morogoro, along with many others, complained of continued deductions for several months afterwards.<sup>376</sup> Such complaints indicate dissatisfaction among members.

Complaints, however, were to be directed to and handled through TANU. The fact that people complained about TANU and yet still aired their grievances through it can be seen as ironic, but there was no alternative. There were also complaints that non-members of TANU were denied jobs. Although this was openly discussed at the Musoma TANU branch, and the chairmen were advised not to deny people jobs on that basis,<sup>377</sup> it shows that being a member of TANU was expected for everybody. One respondent in Ifakara also recalled missing a job opportunity simply because he was not a member of TANU. 'I was told to attach a membership card to my application, but I did not have one. Although this was not publicly stated as the

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<sup>372</sup> Kahama et al., *The Challenge for Tanzanian's Economy.*, 22.

<sup>373</sup> From the Ag Permanent Secretary to Provincial TANU Branches, 'TNA, MMT/K.50.19 Vol 3/56 Taarifa ya Ujumbe wa Kamati Kuu ya Chama ya Mikoa ya Lindi Na Mtwara', October 20, 1973.

<sup>374</sup> TNA, HE/150/2, 'Mchango wa Jengo La TANU' (1973, n.d.).

<sup>375</sup> TNA Ref No. No. WP/32/6/29 'Makato ya SHS. 5/- Kwa Ajili ya Jengo la makao Makuu ya TANU.', July 10, 1972; Supplies Officer, 'TNA Ref CMS/ s/80/3/690 Refund of TANU Contributions Recovered Twice in Error', 1975.

<sup>376</sup> TNA, HE/150/2 'Mchango wa Jengo la TANU'.

<sup>377</sup> TNA, HE 150/150/2 TANU 'Azimio Kuhusu Kuajiri Wafanyikazi Walio Wanachama wa TANU au Afro-Shirazi' (1973).

reason, I believe it was the reason I did not get the job. In my next application, I had the card already, and I got the job'.<sup>378</sup>

In the villages and urban areas, different self-help groups were used to popularise the party's agenda. This included mobilising the community to participate in constructing dispensaries. In the training facilities, health workers were to be trained in politics because '*siasa ndio uti wa mgongo wa Tanzania*'<sup>379</sup> (politics is the backbone of Tanzania). Both students and teachers were mandated to become members, and non-membership was viewed with disapproval or met with surprise. An illustrative incident involved the application of a teacher, Mr Gregory Mhamela's application to join TANU. The query raised was how he could teach politics in a nursing school in Mirembe, Dodoma, without being a member of TANU, leading to the matter being escalated to the minister for further clarification. Despite the absence of regulations on whether one should be a member of either TANU or Afro-Shirazi by March 19, 1973,<sup>380</sup> membership held significant importance.

TANU adopted a transformative approach aimed at transforming Tanzania from a colony into a sovereign state. As early as 1962, Nyerere had advocated for Africanisation and promoting rural life in the villages. He advocated for pooling resources to build schools and hospitals, increase agricultural production, and provide access to clean water and sanitation.<sup>381</sup> The transformative approach was later followed by the modernisation approach, intended to improve existing amenities. As Harald Barre argues, independence came with both hopes and expectations, and also fears.<sup>382</sup> Nyerere always reminded people that they did not have economic and social freedom, but rather political independence.<sup>383</sup> No wonder TANU popularised the slogan *Uhuru na Kazi* (freedom and work).<sup>384</sup> Being free from disease was seen as a form of freedom.<sup>385</sup> At various TANU conferences, Nyerere emphasised that every citizen should have access to basic medical services.<sup>386</sup> What then was the interplay between TANU politics and health-policy planning?

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<sup>378</sup> Oral Interview at Vijana sitini Ifakara, September, 19, 2023. The respondent is anonymous  
<sup>379</sup> TNA, MMT/K.50.19 Vol 3/56 'Taarifa ya Ujumbe wa Kamati Kuu ya Chama ya Mikoja ya Lindi na Mtwara',  
From the Ag Permanent Secretary to Provincial TANU Branches, October 20, 1973.

<sup>380</sup> TNA, MMT/K.50.19 Vol 3/56 'From the Ag Permanent Secretary to Provincial TANU Branches; TANU and  
Afro-Shirazi later joined to form Chama Cha Mapinduzi (CCM).

<sup>381</sup> Kahama et al., *The Challenge for Tanzanian's Economy.*, 30.

<sup>382</sup> Barre, *Traditions Can Be Changed*, 11.

<sup>383</sup> Nyerere, *Freedom and Development*, 262.

<sup>384</sup> Coulson, *Tanzania: A Political Economy*, 268.

<sup>385</sup> Julius Nyerere, *Freedom and Development*, 58.

<sup>386</sup> Oscar Gish, 'The Way Forward: World Health Organisation', 13.

### 3.3.2 TANU Politics: The Dual Impact on the Health Workers and Public Welfare

As noted earlier, TANU was the sole political party directing all policy and planning operations. The medical sector was no exception. Health issues intersected with all levels of governance, from parliament and the executive to the general public, and the party served as the conduit through which these bodies interacted. Despite the volatile political climate of the Cold War and decolonisation struggles in other African nations, Tanzania made significant efforts to improve its health sector and beyond. It was through TANU that medical aid was provided to freedom fighters in different countries through the ‘Liberation of Africa’ drive, in which Tanzania played a leading role. For instance, the Hindu Mandal in Tanga donated, through the secretary of TANU Tanga Branch, drugs worth 1,500 shillings to be used by the FRELIMO freedom fighters.<sup>387</sup>

Within TANU, different groups took the role of popularising government policies. The Party was deeply ingrained, with slogans such as *‘Kidumu chama tawala, zidumu milele fikra za mweyekiti wa TANU’* (Long live the Party, long live the ideas of the chairman of TANU).<sup>388</sup> Groups, such as the TANU men and the TANU Youth League (TYL), were critical in popularising policies related to health. However, as shown below, TANU women and UWT are particularly important to this study, as their contributions to maternal health were notable.

TYL was particularly important in popularising party policies. It was comprised of young men and women who played a significant role in the popularisation and implementation of policies. Andrew Ivaska describes the role of the youth in independent Tanzania. He argues that the early 1960s was a period of intense social ferment, which was full of social struggles.<sup>389</sup> There was confusion and fear, especially in urban areas, about young people not adhering to their cultural traditions. After independence, however, there were deliberate efforts to have the youth embrace African culture. Embracing foreign culture, such as dressing in unacceptable attire and hairstyles, was condemned. TYL was one avenue where the ideals of being a youth in Tanganyika were made and actualised. TYL branches were established in all schools, colleges, military camps, homes, villages, and towns, allowing individuals between the ages of six and thirty-five to become members.<sup>390</sup> TYL was divided as follows:

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<sup>387</sup> TNA, HE TANU F/7/236 ‘Madawa wa Wapigianaia Uhuru FRELIMO’, April 27, 1974.

<sup>388</sup> TNA, A6/1/UT/ST/MW/2/1 ‘Ofisi ya Waziri Mkuu na Makamu wa Pili wa Rais. 1974 Celebration of TANU (20 Years)’, 1974.

<sup>389</sup> Andrew Ivaska, *Cultured States: Youth, Gender and Modern Style in 1960s Dar Es Saalam*. (Durham: Duke University Press, 2011), 2.

<sup>390</sup> CCM Library, ‘Sera ya Malezi ya Taifa kwa Watoto na Vijana Tanzania’ (CCM, 1987), 41.

1. TYL *Chipukizi* (Young Pioneers), for children between six and fifteen years old. Members of this group were in primary and secondary schools. They were taught about the party's protocols.
2. TYL *vijana* (Youth), between sixteen and thirty-five years old. It was the most diverse group found in universities, offices, villages, industries and secondary schools. These groups were tasked with implementing the party's policies, providing security, and advancing the economy and traditions.<sup>391</sup>
3. TYL *Makamo* (over 35 years).

TYL members were involved in sports, clubs, *ufundi* (craft), *ukombozi wa Afrika* (the liberation of Africa), discussing development with people and listening to their grievances, participating in the *mwenge* (national torch) celebrations, and promoting better *afya* (health).<sup>392</sup> General topics on wealth creation, discipline, tolerance, courage, nation-building, entertainment, and the propagation of national policies were addressed by TYL. Concerning health, young pioneers were taught about health issues in school and were expected to practise them at home as well.

The *Makamo* group, aged between 35 and 40, was active in providing labour for the construction of dispensaries.<sup>393</sup> Different youth camps came together to offer labour in constructing dispensaries in villages. The female youth volunteered in child care facilities to take care of the children (young ones) when their mothers were working.<sup>394</sup> Such became avenues for the transfer of knowledge about child-rearing to the young girls. These day care centres and their role in health policy implementation are discussed in the next chapter. Health messages were passed through the TYL traditional songs and dances, especially during various TANU celebrations. It is worth noting however, that most performances during national celebrations were controlled, such that a letter from the TANU national office to provincial commissioners and grassroots leaders would dictate what different TYLs would perform in TANU celebrations, most of which seemed to praise the executive and the party.<sup>395</sup> This gave the party legitimacy and the loyalty of members, so policies made through the party were readily accepted and implemented.

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<sup>391</sup> NRC, A6/63/A.6/7/100 'TANU Youth League', n.d.

<sup>392</sup> NRC, A6/63/A.6/7/100 'TANU Youth League'.

<sup>393</sup> TNA, c.10/2/Vol.2/31 'Baraza Kuu La Vijana', 1974.

<sup>394</sup> TNA, TYL, A6/63 'Ustawi wa Jamii'.

<sup>395</sup> NRC Ref MMF/2/8 'Letter to the District Education Officers., 'Kuzuia Magonjwa kwa Njia ya Nyimbo Mashindano Mkoa wa Mwanza', Februari 6, 1967.

The youth were connected to nation-building and patriotism. The Vice President, Rashid Kawawa, urged the educated youth to be good ambassadors in the villages by spreading modern ideas, especially in agriculture.<sup>396</sup> In better agricultural practices, malnutrition caused by lack of food was to be overcome. The fact that the youth had gained knowledge through schooling, youth camps, national youth service and interacting with various groups of people also spread ideas about food consumption and a balanced diet, hence overcoming malnutrition occasioned by ignorance.<sup>397</sup> TYL were also active in popularising policies on the prevention of diseases through songs.<sup>398</sup> The TANU youth later joined the working force. This meant that loyalty to TANU had been ingrained in them since the age of *chipukizi*. One of the main agendas of TANU was unity.

Through TANU, a sense of unity and oneness was created among the health workers. Within TANU, government workers were organised according to the department. For instance, health workers and those working in the health sector had their TANU branch, which was based in the health facilities or hospitals. The Muhimbili Hospital branch provides a good example. One of the biggest drives that TANU had was the nationwide contribution towards the construction of TANU headquarters in Dar es Salaam. Policemen, women, farmers, *Ujamaa* Villages (*vijiji vya Ujamaa*), judges, and the business community contributed.<sup>399</sup> Nurses and doctors were not left behind. Both the students and health workers were deeply entrenched in TANU politics. In 1971, for example, a group of RMAs wrote a letter thanking the president for allowing them, through the Ministry of Health, to take a refresher course at the Ifakara Medical School. To further demonstrate their appreciation, they contributed 146.50 shillings towards the construction of the TANU main building.<sup>400</sup> It is difficult to determine whether this act was a result of patriotism or free will, or whether there was indirect coercion that made these workers feel obliged to appear grateful to the existing political establishment. Would it also have been more profitable if such fund drives were towards the construction of health facilities?

Every state department had a branch of TANU. It was a way of bringing discipline to the working stations, where issues such as lateness, unprofessional attire, and intoxication were condemned. It was also through TANU branches that matters relating to local licenses to

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<sup>396</sup> 'Tunaelimisha Vijana Kupambana na Ujinga' Kawawa', *Uhuru*, Februari 4, 1966.

<sup>397</sup> 'Kadi ya Yusi Ligi Tayari', *Uhuru*, 18 February 1966, 1.

<sup>398</sup> NRC Ref MMF/2/8 Letter to the District Education Officers., 'Kuzuia Magonjwa kwa Njia ya Nyimbo Mashindano Mkoa wa Mwanza', Februari 6, 1967.

<sup>399</sup> 'Police and Citizens Contributed towards the Construction of TANU Offices—Mtwara Province', *Ngurumo*, Januari 8, 1970.

<sup>400</sup> TNA A/150/2 'Risala Toka kwa Mabwana Afya Wasaidizi Waliohudhuria Masomo ya Mwezi Moja (Novemba) Ifakara', Novemba 29, 1971.

practise traditional medical practices, such as circumcision, were decided.<sup>401</sup> Discipline matters in nursing schools were also addressed through the TANU branch chair, who acted as the mediator between the disagreeing parties. Through the departmental branches, members of the public could raise their grievances. For instance, through TANU, members of the public complained that patients were not being attended to promptly in hospitals and that they had to visit multiple dispensaries in search of medicine.<sup>402</sup> Additionally, there were complaints of theft of medicine at Muhimbili Hospital, prompting TANU to launch an investigation.<sup>403</sup> It is through TANU that health workers complained of poor pay and lack of motivation. These grievances proved difficult to address, given that TANU, as the ruling party, was also responsible for some of the very failures being contested.

The centrality of TANU, however, was detrimental in many ways. The primary concern was national unity, and the party boasted of inclusivity of all, mostly the peasants and the lowly; however, the main power was in the hands of individuals such as the president, ministers, and regional and area commissioners.<sup>404</sup> Tordoff adds that the ‘party became the mobilising agent for the government where the government was the senior partner’.<sup>405</sup> Thus, the stated inclusivity did not always mean that dissenting voices were lacking. For instance, in party activities, ‘money was painfully solicited and there was the guilt of extremism and intimidation’.<sup>406</sup> Thus, TANU was not always solving problems in the health sector; in some instances, it was a source of friction among its members. For example, disputes frequently arose between TANU leaders and doctors. A doctor would receive orders from a TANU branch chairman to travel to the village to help the sick, and at the same time, be ordered to participate in party *maandamano* (demonstrations).<sup>407</sup> This annoyed the doctors, who accused the TANU leaders of being impromptu and behaving as if they were above the law.<sup>408</sup> In Kilimanjaro, for instance, the medical doctors wanted the party branch to be disbanded. This necessitated the intervention of the Chairman of the National Union of Tanganyika Workers (NUTA), Mr Mponda, who organised a workers’ seminar. To solve the crisis, Mr Mponda made it clear that disbanding the TANU branch was not an option because it is the party that brought *uhuru* to the country, and disbanding any TANU branch is the same as burying the tools of

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<sup>401</sup> TNA HET/120/15 ‘Tawi la TANU’, September 8, 1975.

<sup>402</sup> TNA, HEA/150/2/411 ‘Malalamishi ya Baraza la Wazee wa TANU kwa Mheshimiwa Waziri Mkuu’, 1974.

<sup>403</sup> TNA HEA GR/G.19/20 ‘Utekelezaji wa Mkutano Mkuu wa TANU wa 15/16.’, April 30, 1975.

<sup>404</sup> William Tordoff, *Government and Politics in Tanzania*. xiv

<sup>405</sup> William Tordoff xiv.

<sup>406</sup> John Lance Geoghegan, ‘The Movement for Independence in Tanganyika’, 26.

<sup>407</sup> Kimani, ‘Maternal Healthcare and Health Policy Planning in Tanzania, 1961-1970s’.

<sup>408</sup> TNA, HE A/150/2 MMT U.U.25/ Vol 17 ‘Barua Kwa TANU Branch Kilimanjaro Toka Kwa Mganga Mkuu Mshauri.’, unpublished manuscript, May 5, 1975.

independence.<sup>409</sup> His intervention was to notify the doctors early enough in case they would be needed to participate in the party demonstrations. According to TANU leaders, such conflicts were to be solved amicably and they were not to be exposed to the media.<sup>410</sup> It is apparent that the NUTA chairman was pro-TANU, and the doctors had to align with the party's guidelines. Such challenges were cited in many TANU branches.<sup>411</sup>

In the first decades of independence, TANU's efforts in trying to achieve progress in healthcare were notable. Health problems, nonetheless, were still evident. It had dawned on the government that ensuring the health of a nation went beyond training medical staff and constructing medical facilities, but also involved other essential factors, such as nutrition and the environment. Most of the policies, such as the rapid expansion and construction of health facilities, were poorly planned, driven mainly by the desire to maintain self-independence, governance, and national-building activities.

The organisation within TANU, however, was problematic. There was a lack of proper planning and consultation within TANU and various government departments. For instance, local authority dispensaries increased from 61 to 776 between 1961 and 1963, and 978 in 1967.<sup>412</sup> This increase came with ripple effects on Tanzania's socio-political and economic landscape. First, there was no commensurate increase in staff. Secondly, financially, the economy was weakening, yet the medical obligations of the national and local governments were to be met. To put it into perspective, there were 51 MA and 484 RMA, a number too small to manage the mushrooming rural health facilities. At the same time, there was a 28 per cent increase in the number of patients, from 11,839,717 in 1966 to 15,258,858 in 1968. These figures show that several people sought medical services repeatedly. It is such records that the government used to justify the need for hospitals, not only for the increased number of people but also for a future projection, where the number of patients was expected to continue increasing, hence the need for expansion. The government, for instance, concentrated on big hospitals in urban areas. In 1969 alone, six regional and district hospitals, as well as nine dispensaries, were projected to be completed.<sup>413</sup> However, the government's policy was to concentrate on rural areas, but this

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<sup>409</sup> TNA, HE A/150/2 MMT U.U.25/ Vol 17 'Barua Kwa TANU Branch Kilimanjaro Toka Kwa Mganga Mkuu Mshauri'

<sup>410</sup> TNA, TYLA6/63 'Ustawi wa Jamii'.

<sup>411</sup> Oral Interview with interviewee A at Viwanja sitini, Ifakara, September 20, 2023.

<sup>412</sup> 'United Republic of Tanzania. Annual Report of the Health Division, 1967, Vol 1', 1967, 2.

<sup>413</sup> 'Background to the Budget: An Economic Survey 1968-69, Prepared Jointly by the Ministry of Economic Affairs, Development Planning and the Ministry of Finance', 35.

was not reflected in the budgetary allocation (see Table 3). These aspects highlight the challenges of future-making.<sup>414</sup>

Region/Year	Rural	Urban
1970/71	20%	80%
1974/75	37%	63%
1976/77	41%	59%
1979/80	42%	58%

Table 3: Budgetary allocation between Rural and Urban between 1970 and 1980.

Source: Andrea Kifyasi, 2021.

The allocation indicates that the TANU administration was pro-urban development, as most of the political elite and international actors had interests in this area. As shown in the next chapter, the budgetary allocation had long-term impacts, such that even by 1980, the medical situation in rural areas had not surpassed that in urban areas, in terms of facilities, equipment, or personnel. In addition to the question of availability, there was also concern about quality and the problems of maintaining the existing facilities. The populace in areas without facilities would lament their need for a clinic because that was the trend in the so-called ‘developed’ areas.<sup>415</sup>

In summary, TANU was at the centre of planning. The continued construction of facilities that did not operate optimally can be interpreted as a way for TANU to cement its relevance. In medical courses offered in schools such as Ifakara and Mbeya, politics was integrated into the curriculum. TANU was at the core of the Ifakara and Mbeya Medical School, where *siasa* (political studies) was taught as a course. Such courses were offered from primary school onwards. *Siasa* was later changed to *uraia* (civics).<sup>416</sup> The act reflects the centrality of TANU and Nyerere in planning and policy-making. It is against such a backdrop that one can understand the overall planning agenda within the development plans.

<sup>414</sup> Jackson, ‘Past Futures: Histories of Development in the Kilombero Valley, Tanzania’; Detlef Müller-Mahn et al., ‘Megaprojects—Mega Failures? The Politics of Aspiration and the Transformation of Rural Kenya’, *The European Journal of Development Research* 33: (2021): 1069–90, <https://doi.org/10.1057/s41287-021-00397-x>; Ulrike Lindner, ‘Introduction: Failed Futures? (Post)-Colonial Planning and Future-Making in Tanzania’, *Zamani: A Journal of African Historical Studies*. 1, no. 1 (2024), <https://doi.org/10.56279/ZJAHS1112>; Aalders and Müller-Mahn, ‘The Hard Work of Future-Making: Alienated Futures, Invisible Labour and Liberation’.

<sup>415</sup> ‘Wataka Kliniki’, *Ngurumo*, Septemba 6, 1972.

<sup>416</sup> Oral Interview with interviewee D, a residence at Ifakara (anonymous), September 25, 2023.

### 3.4 Health Planning within Development Plans

In Tanzania, the period between 1961 and 1974 witnessed a series of plans. For the first three years of independence, the Development Plan of 1961-1964 served as the blueprint that prepared Tanzania for its take-off after independence. Hence, the plan was prepared in the final days of colonial rule, using World Bank surveys.<sup>417</sup>

According to the 1961/64 plan, Tanzania was to lay greater emphasis on agriculture, which was identified as the backbone of the economy. Health needs, just as in the colonial days, were intertwined with the significant aspects of the economy. The argument put forward by planners was that advancement in health was connected to better agricultural practices. A healthy man was productive in both his work and his ability to reproduce. One's productivity is linked to their health. Therefore, the provision of health services was not solely due to the intrinsic importance of health in itself, but was rather perceived in terms of the economic value it yielded. Moreover, improved agricultural output would guarantee a sufficient food supply, a crucial element for nutrition and, consequently, enhanced health (Chapter 4). These were key concepts in the agricultural equation because human labour was a significant requirement from colonial days. Accordingly, as Nyerere argued, the rural areas were expected to benefit more from this arrangement because agriculture was practised mainly in these areas.<sup>418</sup> However, this was not always the case, and in most instances, the rural-urban divide persisted, with more resources being allocated to urban areas. Moreover, rurality was not the only consideration; the question was what the area could produce. In most cases, productivity was measured in terms of agricultural potential. This meant that the less productive regions were to face the same verdict as in the colonial era, therefore perpetuating the colonial order of benefiting productive areas and leaving out 'unproductive' areas.<sup>419</sup> These areas were agriculturally unproductive due to poor soils and climate, a categorisation that began in colonial times.

Agriculture remained a central focus of the government under Nyerere, who dedicated substantial efforts to advancing the sector. To modernise traditional farming methods and increase productivity, farmers were encouraged to adopt the use of tractors. The push for African unity in 1962 also facilitated the establishment of numerous cooperatives within which the improvement of agriculture could be pursued. For example, in 1965, the Ulanga District Cooperative Union obtained tractors from the government through a loan, reflecting the broader emphasis on agricultural modernisation.<sup>420</sup>

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<sup>417</sup> 'Tanganyika: Development Plan for Tanganyika 1961/62-1963/64', Dar es Salaam: Government Printer, 1961.

<sup>418</sup> Julius Nyerere, *Socialism and Rural Development* (Government Printer, 1967), 118.

<sup>419</sup> Diana Conyers, *An Introduction to Social Planning in the Third World*. (John Wiley and Sons Ltd, 1982), 27.

<sup>420</sup> Goran Hyden, *Beyond Ujamaa in Tanzania: Underdevelopment and an Uncaptured Peasantry*.

The 1961/64 plan was estimated to be worth twenty-four million pounds sterling. The budget allocation to the Health and Labour Ministry during the 1961/64 plan in comparison to other sectors is evident from the table below (Table 4). The allocation of funds across various needs during this period reflects the government's priorities, suggesting that matters of welfare were not a high priority, yet, even the certainty of fund availability was questionable, given Tanzania's heavy reliance on external assistance. The repercussions of low allocation to health became apparent in the subsequent years, during which the health budget was supported mainly through aid from friendly nations and voluntary agencies (see Chapter 5). Nonetheless, the independent government adopted the 1961/63 plan with a focus on prioritising development in rural areas. As a result, the government of Tanzania embarked on the construction of rural health centres, dispensaries and hospitals where the majority of the people lived.<sup>421</sup> The primary reason for this focus was to promote productivity on rural farms, but combating diseases and improving health were secondary considerations. This is evident in the approach taken to handle outbreaks as emergencies, relying on frequent short-term health campaigns rather than implementing enduring solutions, as elaborated in the next chapter.

No.	Ministry	£'000	Per cent
1	Prime minister	1,252	5.2
2	Agriculture	5,737	24
3	Communication, power and work	6,900	28.8
4	Education	3,270	13.7
5	Commerce and Industry	1,075	4.6
6	Local Government	1,244	5.2
7	Home Affairs	2,180	9.1
8	Health and Labour	954	4
9	Land Surveys	1,298	5.4
	<b>Total</b>	<b>23,930</b>	<b>100</b>

*Table 4: Budgetary Allocation per Ministry.*

*Source: Adopted from the 'Tanganyika: Development Plan for Tanganyika 1961/62-1963/64', 13.*

From the table, it is clear that health and labour,<sup>422</sup> received the least funding, as the country's primary focus was agriculture, seen as the cornerstone of rapid economic growth. Surprisingly,

<sup>421</sup> President's Office, '1-20', 19. Meredith, 'The Impact of Colonialialism on Health and Health Services in Tanzania.', 24.

<sup>422</sup> During his presidential speech on 10<sup>th</sup> December 1962, Nyerere announced that he had separated the Ministry of health and Labour into two ministries.

despite the clear link between health and productivity, it was not prioritised as a key factor in Tanzania's rapid development agenda. The little budget for health was strongly criticised by MPs, particularly Dr Stirling (MP, Mbeya), Maswanya (MP, Kahama), Kundyia (MP, Singinda), L.B Bennet (MP, Moshi) and Lady Chesham (MP, Iringa). With such a budget, Dr Stirling did not see the commitment from the independent government to improving health. Referring to poverty, ignorance and disease as the 'triple alliance' Stirling decried the notion of sovereignty in Tanzania by saying that 'we have been crying "*uhuru*" and now we cry *uhuru and magonjwa*' (independence and diseases).<sup>423</sup> While the plan did acknowledge that "investment in economic assets must be accompanied by investment in social services,"<sup>424</sup> economic development took precedence. Lady Chesham complained that:

'So little money has been allocated to health, was the gift of health to be withheld for the short-term policy of economic gains? I say short term because surely no one is so blind to think that a long-term policy can be founded on weak and diseased people.'<sup>425</sup>

Within the sphere of social services, education seemed to take priority, as it was closely tied to the acquisition of skills essential for economic advancement. Furthermore, given Nyerere's background as a teacher, it is unsurprising that education held significant importance to him. Nonetheless, one might have anticipated health to be prioritised, as it is fundamental to basic survival; without it, other needs become inconsequential.

After the 1961/64 plan came the first development plan of 1964-69. It was proudly referred to as the first development plan because the government took pride in developing the first 'homegrown' strategy, as opposed to the 1961-63 plan, which was designed through external influence. The quinquennium plan, 1964-1969, set out three primary objectives: first, to increase the annual per capita income from 19 to 45 pounds; second, to be fully self-sufficient in trained manpower needs; and third, to raise the life expectancy from 35 to 50 years.<sup>426</sup> The plan, with a total budget of £246,000,000, maintained a strong emphasis on agricultural development, similar to the 1961/63 initiative. Modern methods of farming were encouraged and agricultural education was integrated into the primary school curriculum.<sup>427</sup>

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<sup>423</sup> 'Health Grant Attacked', *Tanganyika Standard*, 20 May 1961.

<sup>424</sup> 'Tanganyika: Development Plan for Tanganyika 1961/62-1963/64', 8.

<sup>425</sup> *Tanganyika Standard*, 'Health Grant Attacked'; 'Health to Get the Lowest Sum', *Tanganyika Standard*, 23 May 1961.

<sup>426</sup> 'United Republic of Tanganyika and Zanzibar: First Five-Year Plan for Economic and Social Development, 1st July 1964 to 30th June 1969, Vol 1', 1964, viii.

<sup>427</sup> Geoghegan, 'The Movement for Independence in Tanganyika', 92; 'Wakulima Waungane', *Ngurumo*, January 17, 1970.

The second and third objectives were key to the health sector. Self-sufficiency in manpower meant training health workers, while raising life expectancy was heavily dependent on the health sector. In this plan, the health budget was increased by 20 per cent more than in the previous plan.<sup>428</sup> To achieve the main objectives of the plan, the health of the nation was to be prioritised, as only healthy people would be self-sufficient and trainable in schools, from the lower levels to the highest.

The preparation of the 1964-1969 Development Plan coincided with the submission of the Titmuss et al report in 1963. This report was the result of a task force established in July 1961 to examine the health sector. The role of this task force was to ‘examine the present organisation of the medical services in Tanganyika, bearing in mind the desirability of close integration of government and the voluntary services’.<sup>429</sup> The team comprised Richard M. Titmuss, Brian-Abel Smith, George Macdonald, Arthur W. Williams, and Christopher H. Wood.<sup>430</sup> After three years, the team produced the report, ‘The Health Services of Tanganyika’, commonly known as the Titmuss Report.<sup>431</sup> Titmuss and the team aligned with the Labour Party in Britain, which was an anti-colonialist party. The Labour Party’s principles and Titmuss’s commitment to and belief in social justice contributed to the establishment of the National Health Service (NHS) in Britain in 1948. As a result, in the immediate postcolonial period, Titmuss and his team were regarded as an ideal group to undertake the task of re-evaluating Tanzania’s health system.

The Titmuss Report served as the foundation for how the government and various stakeholders understood the health sector in Tanzania. The document was termed the most ‘valuable document’ in the health department.<sup>432</sup> The 249-page report extensively analysed the significant aspects of health in twelve different subsections. Its findings and recommendations were in line with the recommendations of both Dr Shircore (1924) and Dr Pridie (1949), who had proposed the need to improve rural health during the colonial period.<sup>433</sup> The government accepted the Titmuss report, but its execution was closely aligned with governmental priorities, specifically centred around economic production. This meant that the implementation of the report’s proposals was gradual, contingent on the availability of funds, primarily from the government, well-wishers or community efforts.

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<sup>428</sup> ‘United Republic of Tanganyika and Zanzibar: First Five-Year Plan for Economic and Social Development, 1st July 1964 to 30th June 1969, Vol 1’, 68.

<sup>429</sup> Titmuss et al., *The Health Services of Tanganyika*., vii

<sup>430</sup> These were British experts from the London School of Economics and London School of Tropical Medicine.

<sup>431</sup> Titmuss et al., *The Health Services of Tanganyika*.

<sup>432</sup> *Annual Report (Health) 1961*, 1.

<sup>433</sup> Pridie, *A Ten-Year Development and Welfare Plan for Tanganyika Territory*.

The 1964 Development Plan and the Titmuss Report emphasised the need for public health and the control of communicable diseases. The assumption was that if the two were addressed, life expectancy would be raised at a time when forty per cent of the population died before reaching adulthood.<sup>434</sup> The Development Plan of 1964-69 set the standard for curative services at one hospital per 100,000 inhabitants, one RHC per 50,000, and one dispensary for every 10,000.<sup>435</sup>

In the 1964-69 plan, as well as the Titmuss report, rural health was identified as an area for improvement. Health concerns became a collective responsibility. Even before the era of *Ujamaa*, communities mobilised to construct dispensaries. The criteria for establishing a dispensary were based on the accessibility of existing facilities and the dispensary-to-population ratio. However, in practice, this criterion appeared to be largely theoretical, as evidence shows that certain areas had better access to more healthcare facilities than others. These were areas that had medical missionary penetration early enough and were agriculture-based (largely cash-crop) regions. The political economy of Tanzania prioritised such areas. Additionally, the issue of inadequate infrastructure was worsened by a shortage of skilled labour, necessitating reliance on foreign assistance. Nyerere emphasised that this assistance would only come from those who respected the country's sovereignty.<sup>436</sup> Indeed, the first-year progress report on the implementation of the 1964 development plan and the evaluation of the development reports revealed significant challenges in finances and manpower, not only in the health sector but across all sectors.<sup>437</sup> This called for augmented training of manpower.

### 3.4.1 Training of Medical Workers

A careful analysis of all the medical department's plans and reports in the early years of independence reveals that the scarcity of facilities and personnel remained a pressing challenge.<sup>438</sup> Even in instances where the government mobilised communities to construct basic health facilities, these centres required health workers.

The lack of medical personnel forced Tanzania to rely on expatriates, most of them being the remnants of British colonialism. As early as 1961, the British were encouraged by Nyerere to

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<sup>434</sup> Staatsarchiv Basel-Stadt Gyr, 'PA 940d F2 (1) Ifakara Reiseberichte, Jahresberichte, Kursunterlegen 1960-1977: Swiss Joint Evaluation of Swiss Cooperation to Tanzania Health Projects', 1.

<sup>435</sup> Staatsarchiv Basel-Stadt Gyr, 'PA 940d F2 (1) Ifakara Reiseberichte, Jahresberichte, Kursunterlegen 1960-1977: Swiss Joint Evaluation of Swiss Cooperation to Tanzania Health Projects', 12.

<sup>436</sup> John Lance Geoghegan, 'The Movement for Independence in Tanganyika', 94. 'Hotuba ya Rais Mwalimu Julius K. Nyerere Katika Mbunge', June 8, 1965, 23.

<sup>437</sup> 'The United Republic of Tanzania: First Year Progress Report on the Implementation of the Five-Year Development Plan (Public Sector). 1st July, 1964 to 30th June 1965'.

<sup>438</sup> 'Annual Report (Health) 1961'; 'Annual Report of the Health Division 1962 Vol 1. Prepared by the Chief Medical Officer.', 1962; 'Annual Report of the Health Division, 1967, Vol 1', 1967.

remain in Tanganyika because the country so much needed their expertise. While some stayed, many expatriates chose to resign or retire. Retirement took away the most experienced staff, while others resigned to return to their home countries, particularly through the British compensation scheme.<sup>439</sup> It was observed that during the period between November 1961 and late 1962, all the liners travelling back to England, humorously dubbed ‘*Uhuru* boats’, were consistently fully booked.<sup>440</sup> In 1963, for instance, one matron, sixteen expatriate nurses, and a charge nurse left Tanzania for Britain, either due to retirement or because of the compensation scheme that Britain offered its former colonial officials.

Between 1962 and 1968, the relationship between Tanzania and Britain deteriorated, particularly over Britain’s response to the Unilateral Declaration of Independence (UDI) in Zimbabwe. Most British expatriates left Tanzania. While these positions were filled by locally trained staff, the gap was noticeable because the latter entrants were less experienced. In some instances, the government had to lower entry requirements for specific courses. While viewed by some as a means to address the shortage and embrace Africanisation, concerns were raised by the public, asserting that educational and work standards had declined.<sup>441</sup> Thus, the question of Africanisation, which aimed to instil confidence in the people and demonstrate that being African did not equate to being subordinate,<sup>442</sup> versus the question of maintaining quality, became problematic.

Addressing this challenge necessitated the training of more medical workers. From the numbers cited above, it was evident that there were few qualified Africans to take up the many opportunities after independence. The shortage of healthcare workers could not be resolved without addressing the issues in the education sector. The government realised that the shortage of health workers extended beyond medical training; it stemmed from the deficiencies in basic education.

The colonial education system had marginalised Africans to the lowest tier and prepared them for low-level positions. The system was designed to cultivate individuals for just basic education, perhaps to keep them submissive to authority. The rationale was that excessive

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<sup>439</sup> *Tanganyika, Ministry of Health and Labour, 1961, Annual Report of the Health Division 1961, Vol 1. Prepared by the Chief Medical Officer, 1.*

<sup>440</sup> Erberie as quoted by Jackson, ‘Past Futures: Histories of Development in the Kilombero Valley, Tanzania’, 251.

<sup>441</sup> ‘C.5/47/43 Letters of Regional Development Committee: Ofisi Ya Waziri Mkuu Na Makamu Wa Pili Wa Rais.’

<sup>442</sup> Nyerere, ‘TANU National Conference: 10 Years After Independence’, 7.

education might prompt Africans to question their role in the colonial structure.<sup>443</sup> Thus, the colonial education system was such that there were schools for Asians, Europeans and Africans.<sup>444</sup> It was not only racial but organised into many levels. Kahama et al. note that education for Africans was stratified into four years of primary school, four years in middle school, two years in junior secondary school, and then two years in senior secondary school, while the Europeans and Asians had six years in primary school and six years in secondary school.<sup>445</sup> What these many levels of stratification meant was that Africans had few opportunities to further their education, which had a profound impact on the future of Tanzania as an independent country. The scenario was explicitly reflected in the job market, where the division of labour was based on race. As a result, the post-independence government of Tanzania inherited this problem in the education system, both in terms of quality and quantity.

Nyerere invested heavily in basic education (See Table 5). Through education, poverty and ignorance were easier to handle.<sup>446</sup> One of the visions of TANU was to transform primary school education from the colonial curriculum to one that was more relevant to the needs of the day. These challenges of basic education trickled down to the already challenged medical sector. Nyerere believed that school was the starting point for a transformed society.<sup>447</sup> As noted earlier, basic education was also a qualification for medical training. Needless to say, poverty, ignorance and disease were interlinked and Tanzania could not address one and leave the other.

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<sup>443</sup> Majorie J Mbilinyi, 'African Education during the British Colonial Period 1919-61', in *Tanzania Under Colonial Rule* (London: Longman, 1979), 238.

<sup>444</sup> Mbilinyi, 'African Education during the British Colonial Period 1919-61', 236.

<sup>445</sup> Kahama et al., *The Challenge for Tanzanian's Economy.*, 22.

<sup>446</sup> 'Ujinga Huzaa Magonjwa', *Ngurumo*, December 21, 1964.

<sup>447</sup> René Dumont, *False Starts in Africa. Translated by Phylis Nants Ott* (Andre Deutsch, 1966), 139.

Type of Education	1962	1963	1964	1965	1966	1967	1968	1969
A.Primary Education.								
1. Entrants to primary school	125,521	136,496	140,340	149,314	154,512	157,196	163,480	170,000
2. Total enrollment	518,663	592,104	633,678	710,200	740,991	753,114	772,645	803,500
3. Number of Teachers (All grades)	10,273	11,100	12,044	13,576	14,809	15,271	16,580	16,900
4. Primary School leavers (VII and VII)	13,730	17,042	20,348	46,647	52,574	60,070	51,500	55,600
B.Secondary Education.								
1. Entrants to Sec. school	4,810	4,972	5,302	5,942	6,377	6,635	7,000	7,000
2. Total enrolment	14,175	17,176	19,897	21,915	23,836	25,551	28,000	28,900
3. Number of Teachers (All grades)	789	817	858	1,064	1,151	1,306	1,360	1,400
4. Output Form IV	1,950	2,839	3,630	4,558	4,723	5,004	5,800	6,400
5. Form V entrants	286	297	604	780	828	895	1,270	1,400
6. Form VI Output.	199	275	463	606	768	808	890	1,265

Table 5: Numbers in Full-time Basic Education (Public schools only).

Source: MOE Adopted and Modified from the Background to the Budget: An Economic Survey 1968/69.

The table above indicates a progressive increase in the number of students over time. However, this posed a challenge in the realm of planning and policy implementation, impacting not only the education sector but also extending to other areas, notably the health sector.

In terms of medical training, the government invested in building and expanding training centres, while still maintaining the option of sending medical workers for studies abroad. Training locally was not easy either, because the need exceeded the meagre resources. In 1961, there were only four schools for rural health workers, which trained only 74 health workers annually, and 14 nursing schools trained 235 nurses annually. There was a total of 1,343 health facilities, including hospitals and dispensaries, under the central government, local government, and voluntary agencies, among others.<sup>448</sup> These included 98 hospitals, 22 rural health centres, and 975 rural health dispensaries. Due to the lack of staff, supervision of these facilities was hardly possible, resulting in poor services. The staff supervision was done by the medical officer through visits at the rural dispensaries in their region ‘as often as desirable’.<sup>449</sup> According to

<sup>448</sup> Nhonoli and Nsekela, *Health Services and Society in Mainland Tanzania*, 1.  
<sup>449</sup> ‘Tanganyika, Ministry of Health, Annual Report of the Health Division, 1963, Vol 1.’, 1963, 32.

the 1963 report by the medical department, many health facilities, especially the MCH, lacked senior staff who could perform supervisory duties as needed.<sup>450</sup> Due to the staff shortage, supervision was not conducted in a manner that ensured adherence to the set standards. The reference to ‘standards’ appears overly idealistic, considering the dilapidated infrastructure, persistent staff shortages, and chronic supply deficits within the medical sector. Such a scenario was a replica of the colonial times.<sup>451</sup>

There was an urgent need to transform the medical training. This transformation was interpreted as part of educational transformation. At the time, university education was provided via the University of East Africa, notably Makerere College in Uganda.<sup>452</sup> Makerere College was established in 1922, but it was not until 1949 that it was granted university status to serve British East Africa. To curb over-reliance on Makerere and overseas scholarships, the government of Tanzania opened the Dar es Salaam Medical School (DMS) with the aid of the Rockefeller Foundation in 1963. The Rockefeller Foundation donated books, medical equipment and provided medical staff. The DMS operations started in existing buildings even before the official opening, highlighting the sense of urgency at the time. In addition to reducing the dependency on schools outside the country, particularly Makerere, localised training would also ensure that the health workers were conversant with local needs and resources.<sup>453</sup> It was observed that trainees from abroad struggled to adapt to local situations where equipment and facilities were scarce. This scenario resonated with the situation in Senegal, where one doctor noted, ‘All we can do is what we have been taught’.<sup>454</sup> This was concerning the fact that many were trained abroad, where conditions were different from what they found back home. Perhaps a close resemblance was found in the urban areas, which explains why many doctors preferred to work in the cities. This went against the government’s policy, which was aimed at improving rural health.

Rural health continued to be the concern of voluntary agencies. While this is discussed at length in Chapter Five, it is worthwhile to mention that Tanzania has benefited from medical aid from various countries and organisations. The Swiss Capuchins, for instance, established the Ifakara Rural Aid Centre in Kilombero, which later evolved into a training centre for medical

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<sup>450</sup> ‘Tanganyika, Ministry of Health, Annual Report of the Health Division, 1963, Vol 1’, 32.

<sup>451</sup> WHO archives, Geneva, ‘Health H/8/6 PP/CDW/E.2/4 Letter from C. Davies (District Medical Officer) to Dr Cecily Williams (Director of Medical Services) Village Midwives’. (27 February 1956).

<sup>452</sup> Kithinji M.W, ‘An Imperial Enterprise: The Making and Breaking of the University of East Africa, 1949–1969’, *Canadian Journal of African Studies / Revue Canadienne Des Études Africaines*, Vol. 46, no. 2 (2012): 195–214.

<sup>453</sup> ‘Wizara Ya Afya: Hotuba Ya Ndugu L. Stirling Waziri Wa Afya Katika Bunge’, 1976, 27.

<sup>454</sup> Cited by Maghan, *A Political Economy of Health Care in Senegal*, 133.

auxiliaries with support from Switzerland.<sup>455</sup> These voluntary agencies aligned with the government's efforts to develop rural areas. In their training centres, emphasis was placed on training low-cadre health workers who would then fill the many vacancies at the auxiliary level of medical care in the RHCs and dispensaries. The government intervened by lowering the entry requirements for some courses, allowing for an upgrade afterwards.<sup>456</sup> While this was seen as a good way of getting people enrolled in the medical centres, it was also problematic because not many would complete the course. In 1963, for instance, out of the 91 enrolled in the health-nurse course, only 54 completed it successfully. In Bukoba, of the first fifteen entrants, only ten finished the course.<sup>457</sup>

The problems found in medical training were related to issues emanating from basic schooling. To address the issue, the government introduced bridging courses in biology and chemistry to equip students with the foundational knowledge needed for medical-related studies.<sup>458</sup> These courses proved effective, as most trainees completed their programmes, with only a few exceptions, as shown by the Medical Assistant Training Centre (MATC) records, Ifakara.<sup>459</sup>

Beyond the challenge of the medical students was the shortage of tutors. In 1963, for example, several health-nurse educators from WHO left the country, and efforts to recruit sister tutors from various parts of the world were unsuccessful. Consequently, the idea of training nurse tutors locally emerged, highlighting the persistent dependency that remained until no other options were left. Many centres were opened for the training of tutors, both by the government and voluntary agencies, but the priority remained on the health auxiliaries.<sup>460</sup>

The shortage in MCH was particularly pressing. The section had a shortage of both senior and junior staff, particularly the midwives. As a result, women in Ifakara continued to rely on missionaries and traditional midwives.<sup>461</sup> Moreover, gender dynamics rooted in African culture further complicated the situation. Traditionally, midwifery roles in Africa were predominantly performed by elderly women who were socially acknowledged for their expertise. However, as

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<sup>455</sup> Staatsarchiv Basel-Stadt, Geigy, 'ED-REG 1 (2) 190-2-8 Rural Medical Training at Ifakara: Swiss Help to Tanzania'; Lukas Meier, 'Striving for Excellence at the Margins: Science, Decolonisation and the History of the Swiss Tropical and Public Health Institute (Swiss TPH) in (Post-) Colonial Africa 1943-2000' (Basel, 2012); Marcel Dreier, 'Health, Welfare and Development in Rural Africa: Catholic Medical Mission and Configuration of Development in Ulanga, Tanzania, 1920-1970.' (Ph.D. Dissertation, University of Basel, 2015).

<sup>456</sup> *Annual Report (Health) 1961*, 1.

<sup>457</sup> 'Tanganyika, Ministry of Health, Annual Report of the Health Division, 1963, Vol 1', 26.

<sup>458</sup> 'Tanganyika, Ministry of Health and Labour, 1961, Annual Report of the Health Division 1961, Vol 1. Prepared by the Chief Medical Officer', 2, 26

<sup>459</sup> Geigy, 'ED-REG 1 (2) 190-2-8 Rural Medical Training at Ifakara: Swiss Help to Tanzania'.

<sup>460</sup> Staatsarchiv Basel-Stadt, 'Bericht Ueber Die Reise Dr Herren Arthur Wilhelm, CIBA Und Prof. Rudolf Geigy, Schweizerisches Tropeninstitut, Zum Studium Der in OstAfrika Bestehenden Moeglichkartn Fuer Schweizerische Entwicklungshilfe-Zu Handen Des Basler Iniativ-Komitees', 1960; *Tanganyika, Ministry of Health, Annual Report of the Health Division, 1963, Vol 1*, 32.

<sup>461</sup> Women in Ifakara, 'Focus Group Discussion at Lipangalala', September 21, 2023.

mentioned earlier in the chapter, Tanzania's independence agenda was pro-modernisation, aimed at mirroring the industrialised countries of the Global North, so the use of traditional midwives was discouraged but not forbidden. Training of midwives was preferred because socio-politically, it was a sign of 'progress'. Nonetheless, the pace of training was not as rapid as the demand. Just as in the colonial period, the question of who to train remained. Young girls were not preferred to conduct deliveries in line with cultural needs.<sup>462</sup> To appear to be in line with cultural needs, the government temporarily hired married women in 1963 to aid in maternity services in Dar es Salaam.<sup>463</sup> Despite lacking midwifery training, married women were more socially accepted in maternity roles compared to young girls. If the government needed to employ such mitigation strategies in Dar es Salaam, one can only imagine the situation in the rural areas. The reality was that traditional midwives were widely consulted in rural areas (See section 3.6.1).

### 3.4.2 Practising as a Health Worker

Both the government and voluntary agencies provided training for medical workers. However, the government, through the MOH, coordinated the training process. Upon completion of the medical courses, the next stage was deployment. As per government policy, rural areas were to be prioritised. However, staffing in the rural areas remained a problem. The shortage of health workers was widespread, not just in rural areas but also in urban areas. Therefore, as already noted, even though the policy was pro-rural, the political and economic needs proved otherwise. Moreover, most health workers were attracted to urban areas because remuneration and social amenities were better, and facilities there were similar to or even better than those they had seen during training in developed countries or well-equipped facilities.<sup>464</sup> As a result, most senior and highly qualified health officers were found in urban areas, where a majority offered their services privately, and the urban well-to-do population could afford to pay for these services. These were the same places where the political elite lived, and therefore, they were the beneficiaries of the urban-based health system. This was illustrative of a system that continued to perpetuate distance between doctors and rural areas, from training to the deployment of doctors.<sup>465</sup>

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<sup>462</sup> W.H.O Archives Geneva, Health/8/6. 'Letter from C. Davies (District Medical Officer to Dr Cecily D Williams (Director of Medical Services, Dar es Salaam). Health Training', February 27, 1956.

<sup>463</sup> *Tanganyika, Ministry of Health and Labour, 1961, Annual Report of the Health Division 1961, Vol 1. Prepared by the Chief Medical Officer, 32.*

<sup>464</sup> Keita Maghan, *A Political Economy of Health Care in Senegal*, 44.

<sup>465</sup> Keita Maghan, *A Political Economy of Health Care in Senegal*, 44.

In many African countries, medical professionals often resisted being assigned to rural areas. The situation prompted the Tanzanian government to formulate various policies. First, as early as 1961, a policy existed that allowed medical assistants and assistant health inspectors to upgrade to nursing training.<sup>466</sup> An upgrade to nursing was perhaps meant to broaden the skills necessary for use at the auxiliary level. Additionally, a proposal was made to post medical officers to rural areas on a rotational basis, aiming to encourage them to leave urban areas. Moreover, there was a suggestion that doctors should serve in the government for some years before going private.<sup>467</sup> The Tanzanian government's efforts to address the resistance of medical workers towards rural placements did not yield the desired results. Many rural areas continued to experience a shortage of doctors, with a higher concentration of auxiliary health workers. At the same time, senior medical officers and specialists remained predominantly in urban areas (see Table 6). This disparity raises crucial questions about the willingness of the political to enforce these policies effectively.

Year/Cadre/Location	1972	1976	1978	1980
<b>Doctors</b>				
Urban	418	487	513	598
Rural	216	399	479	547
<b>Nurses</b>				
Urban	2,606	2,760	2,868	3,570
Rural	1,653	2,060	3,322	4,705

Table 6: Urban-rural distribution of senior medical workers.  
Source Heggenhougen, *Health Services: Official and Unofficial*, 310, cited by Kifyasi, 95

To address the rural-urban divide, various policies have been proposed. For instance, between 1961 and 1962, a proposal was made that private doctors would have to pay licensing fees and a tax of £100.<sup>468</sup> The argument behind this taxation was twofold: first, it was seen as a way for doctors to contribute to the income tax, which could then be used to help the government provide better rural health services and second, it was a way of discouraging private services, allowing doctors to concentrate on government employment. This tax, however, was contested. Some people saw it as a fine. Still, the main reason for the contestation was that some private doctors were offering services in areas where there was no other alternative, and therefore banning their practice in such areas would likely lead to chaos. The plan was thus to utilise the quota system for private doctors who had facilities where there were no government facilities,

<sup>466</sup> *Tanganyika, Ministry of Health and Labour, 1961, Annual Report of the Health Division 1961, Vol 1. Prepared by the Chief Medical Officer, 2.*

<sup>467</sup> Richard Titmuss et al., *The Health Services of Tanganyika*, 71.

<sup>468</sup> Richard Titmuss et al., *The Health Services of Tanganyika*, 17.

and if the quota was full, the tax was to be made operative on the surplus doctors.<sup>469</sup> It was not clear which criterion was to be used to define the size of the quota. Other methods of controlling private practice included offering government buildings at a nominal rent, providing car allowances, reducing railway fees, offering incentives such as purchasing drugs through medical stores, and, when necessary, restricting licenses to operate only in specific areas.<sup>470</sup>

The extreme move was the proposal to ban private practice, as it was argued to amount to ‘extortionism, leading to abuse of public services, economic waste, neglect of rural areas’, and advocated for a curative rather than preventive approach to medicine. The problem was, however, perpetual, for as early as immediately after independence, the Minister of Health and Labour described the concentration of health needs in the urban areas as a ‘luxury of extreme...’.<sup>471</sup> As early as 1962, government-employed doctors were discouraged from engaging in private practice.<sup>472</sup> Although a warning had been issued in the Minister of Health’s speech in parliament in June 1976, the actual ban on private practice did not occur until 1977, and it had adverse effects on the medical sector.<sup>473</sup> The changes between 1962 and 1967 were the result of the Arusha Declaration, which is addressed in the next chapter. But in short, the Party argued that health was not an appropriate sector for profit-making and that private medicine was inhuman, as making money from those who were suffering was wrong,<sup>474</sup> and against the collective spirit of *Ujamaa* as shown in the next chapter.

Most of the above proposals were implemented as policies. However, they proved to be more detrimental to the health sector. For instance, there was a mass exodus of doctors from Tanzania.<sup>475</sup> It was also worrying to the international community and expatriates living in Tanzania.<sup>476</sup> The taxation and ban on private practice did not bring about the expected change in revenue. This is because the tax did not contribute to either government revenue or national

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<sup>469</sup> Douglas Heath, ‘Health Pyramid and the Private Practitioner’, *Tanganyika Standard*, January 4, 1962.

<sup>470</sup> Douglas Heath, ‘Health Pyramid and the Private Practitioner’.

<sup>471</sup> Richard Titmuss et al., *The Health Services of Tanganyika*, 71.

<sup>472</sup> Richard Titmuss et al., *The Health Services of Tanganyika*, 43.

<sup>473</sup> ‘Wizara Ya Afya: Hotuba Ya Ndugu L. Stirling Waziri Wa Afya Katika Bunge’, 4; Bech et al., ‘Changing Policies and Their Influence on Government Health Workers in Tanzania, 1967-2009: Perspectives from Rural Mbulu District’.

<sup>474</sup> ‘Five Years of CCM Government Address given to the National Conference of the CCM by the Chairman, Ndugu Julius K. Nyerere, October 20, 1982 at Diamond Jubilee Hall, Dar Es Salaam’, 1982, 26.

<sup>475</sup> Illife, *East African Doctors: A History of the Modern Profession*; Bech Margunn.M et al, ‘Changing Policies and Their Influence on Government Health Workers in Tanzania, 1967-2009: Perspectives from Rural Mbulu District’, *The International Journal of African Historical Studies*, no. 46(1) (2013): 63.

<sup>476</sup> Staatsarchiv Basel-Stadt Geigy, ‘ED-REG 1 (2) 190-2-8 Rural Medical Training at Ifakara: Swiss Help to Tanzania’.

income, which are responsible for changing the living standards of people. In addition, the policy to control private practice was problematic because the country still needed doctors.

According to the statistics given by Dr Wilfred Barber at the Conference of Surgeons of East Africa at Kampala in 1961, the ratio of doctors to the population in Africa was still very low compared to the Global North. At the time, the rates were 1:900 for Britain, 1:1,250 for Sweden, and 1:714 for the USA, compared to 1:9,000 for Kenya and 1:22,000 for Tanzania.<sup>477</sup> These statistics suggest that, if health accessibility was the primary reason, Tanzania would have a justifiable basis for regulating the practice of doctors. In 1967, for instance, there were still forty-one vacant positions for medical officers, thirty-four for AMOs, and seventy-three for medical assistants, all of which remained unfilled.<sup>478</sup> In a nutshell, concerning medical training and deployment, the government was unable to manage staffing, especially to bridge the rural-urban divide, because it would still post those who had completed their training to district hospitals, rather than to health centres or dispensaries, or would send some for further studies. For instance, in 1963, 52 nurses completed from the Dar es Salaam school; 10 were sent to Britain for further studies, while the rest were posted to district hospitals.<sup>479</sup>

### **3.5 Triumphs and Trials: Challenges of Planning in the First Years of Independence**

The foregoing discussion outlines the various plans and developments that the Tanzanian government implemented in the first years of independence. Providing medical services was not easy for the government. The problem of access and coverage remained a fundamental one. The initial government plan to make health accessible to all, with the state as the sole provider of health services, was challenged by a lack of staff and finances. The promise of the TANU government and the expectation of the masses were that welfare was to be freely provided. Initially, though the government appreciated the role of voluntary agencies as instrumental, it wished to replace the services of any other provider, especially in rural areas. It soon became apparent to the government that voluntary agencies were indispensable and that the government could not handle all medical matters on its own. The government changed its tactic by cooperating with voluntary agencies, by providing them with either grants or staff.

In 1965, the government requested that certain voluntary agencies turn their hospitals into government-designated district hospitals (DDH). This was a request that many voluntary agencies paid heed to.<sup>480</sup> These hospitals included Mkomaindo in Masasi District, Mtwara,

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<sup>477</sup> 'Upcoming Private Practitioner', *Tanganyika Standard*, January 29, 1962.

<sup>478</sup> *United Republic of Tanzania. Annual Report of the Health Division, 1967, Vol 1, 1.*

<sup>479</sup> *Annual Report (Health) 1961, 32.*

<sup>480</sup> *The United Republic of Tanzania, Annual Report of the Health Division, Vol 1. Prepared by the Chief Medical Officer (1965).*

Kiomboi in Iramba District, Singinda, Sumve in Kwimba District Mwanza, Myakahanga and Ngara in Karagwe.<sup>481</sup> The government's policy was to expand its subsidy to these church-owned health facilities, allowing the majority of Tanzanians to access medical services. The idea was to fund voluntary agencies and hospitals as district hospitals and dispensaries to act as Rural Health Centres. The church-based medical facilities that were given the status of district hospitals experienced the challenge of increased patients, which made the initial subsidy of 49,500 pounds in 1965 inadequate. The government was forced to add 10,000 pounds. However, the subsidy was still so small that the facilities continued to charge fees to augment government aid.<sup>482</sup> By 1967, only seventy-seven facilities operated by voluntary agencies were being subsidised, and there was still no formal cooperation between the government and voluntary agencies.<sup>483</sup> Moreover, the government's efforts to cooperate with the voluntary agencies were smooth. The agreement was that the government would subsidise the recurrent expenditure to enable free hospital consultation and maintenance. However, inadequate resources made this unattainable.

Most of rural Tanzania continued to rely on voluntary agencies run by the churches. Christian churches and other voluntary agencies continued to build, improve and expand several hospitals.<sup>484</sup> Both the government and voluntary agencies provided medical services to the people. In Morogoro, missions such as the CMS, the Capuchin Mission and the Danish Lutheran had hospitals. Notably, the Capuchins in the Ulanga area (part of Kilombero today) had the largest hospital at Ifakara. It had a 200-bed capacity, which dealt with TB, Leprosy, surgery, and MCH, among other services. From their long experience in rural areas, the missionaries knew that rural medical centres and dispensaries were the primary points of contact between the people and the health services. The mission hospitals in Kilombero were well managed and supervised compared to government facilities.<sup>485</sup> In addition, well-mannered staff, clean wards, and religious teachings all contributed to improving people's confidence. Moreover, medicine in government hospitals was only available during the first week of the month, when the government distributed medicine to its hospitals.<sup>486</sup>

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<sup>481</sup> *The United Republic of Tanzania, Annual Report of the Health Division, Vol 1. Prepared by the Chief Medical Officer, (1965), 43.*

<sup>482</sup> *The United Republic of Tanzania, Annual Report of the Health Division, Vol 1. Prepared by the Chief Medical Officer, (1965), 43.*

<sup>483</sup> Jennings, 'Cooperation and Competition', 207.

<sup>484</sup> *Tanganyika, Ministry of Health and Labour, 1961, Annual Report of the Health Division, Vol 1. Prepared by the Chief Medical Office. (1965), 1.*

<sup>485</sup> Women in Ifakara, Focus Group Discussion at Lipangalala.

<sup>486</sup> Staatarchiv Basel Stadt, 'PA 940d H1 Health System Research Morogoro Region.', unpublished manuscript, June 1991, 8.

The independent government led by Nyerere was pro-equality as Tanzania moved from the stratification of the colonial era. However, the stratification of patients that existed during the colonial period continued after independence. Although the stratification in the colonial era was primarily based on race, the post-independence era saw patients divided into four grades. Grades 1, 2 and 3, were charged before receiving treatment, while grade 4 patients got free services. At Muhimbili Hospital, for instance, grade-one inpatients were attended to by a medical officer. They paid fifty shillings per day, while children under the age of fourteen in the same grade paid ten shillings. Grade two paid thirty-five, while grade three were charged six shillings every three days under the supervision of a medical assistant.<sup>487</sup> Some Members of Parliament (MPs) often regarded this as discriminatory. In 1973, for instance, the MP for Shinyanga, Bi Kulwa, wanted the minister to explain the need for this grading, which was perceived as discriminatory towards the poor. The minister of health explained that the arrangement was not biased, but rather a way of encouraging those with higher salaries to contribute to help meet the high expenses of providing medical care. He further said that doctors were the same in all the grades. To him, grade one was '*pahali pa faragha*' (private ward), where one was admitted into a closed ward instead of an open ward, but the services were the same.<sup>488</sup> However, in reality, this was far from the truth, as class differentiation was notable in the graded delivery of services. Although the government argued that these taxes were intended to collect revenue from the few 'able' citizens, the system exacerbated the situation for the poor. In Dar es Salaam, for instance, accouchement funds from the delivery fees amounted to more than those from any other section in the hospital in 1962.<sup>489</sup>

From a political economy perspective, the differing fees for healthcare services reflect broader issues of inequality and power dynamics within society. Grade-two patients, who paid significantly more than grade-three patients, highlight a stratified system where one's economic status determines access to quality healthcare. The fact that some MPs criticised this system, despite benefiting from it, underscores the contradictions within political structures that perpetuate these inequalities. Their critique may serve as a symbolic gesture to appear aligned with public concerns, while the underlying economic and political mechanisms that sustain such discriminatory practices remain intact. This aligns with the political economy analysis, which emphasises how economic interests, power, and policy decisions shape social outcomes and perpetuate unequal resource distribution.

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<sup>487</sup> Richard Titmuss et al., *The Health Services of Tanganyika*, 46.

<sup>488</sup> 'The Parliament of the United Republic of Tanganyika and Zanzibar. The Hansard: Parliamentary Questions to Minister (Number 598)', 1973.

<sup>489</sup> Richard Titmuss et al., *The Health Services of Tanganyika*, 47.

The rural-urban divide also remained equally visible. While the Titmuss report and most of the government development plans emphasised rural health as noted above, the expansion of hospitals followed the colonial plan, whose ripple effect was the over-reliance on curative facilities at the expense of preventive services, and the development of urban and productive areas at the expense of ‘infertile’ areas was notable. Although the process involved the expansion of rural medical facilities, the pace and standards were significantly lower compared to those in urban areas. Between 1964 and 1980, the construction of big hospitals continued in the metropolitan areas. Thus, planning and policymaking remained a political affair led by TANU. According to Green, politicians tend to portray the achievement of the laid plans as being possible, but ‘no healthcare system can meet all the health needs of its people’.<sup>490</sup> In Tanzania, especially in this era of strained resources and few qualified health workers, this could only remain as a vision, and the few resources were divided in a manner that continued to favour the urban. The country had to make choices and prioritise what was deemed urgent by the use of development plans. While there were many needs of the day, it was even more complex for such choices within a sector. For instance, in the health sector, the choice between various dualities, such as rural-urban, quality-quantity, and traditional versus modern, was not always easy. It was challenging to decide to abandon the already large hospitals in urban areas at the expense of rural areas, unless there was an overhaul of the political, social, and economic structure. Additionally, the global climate was conducive to the establishment of such facilities. Moreover, the political elite, who were the beneficiaries of established health systems in the cities, would not have ordinarily welcomed the move to neglect urban hospitals. Even with such a change, it was never a smooth process, as shown in the next chapter.

The five-year development plans were problematic in their own right. These plans were produced as blueprints, but in most cases, they were not followed. It is plausible to argue that these development plans were kept, only to be revisited in the next season to draw another plan. This made planning a one-moment affair, yet it is a never-ending process which needs frequent adjustments and monitoring. These plans ought to have been ‘regarded as a tool for implementers rather than an end product of the work of the planners’.<sup>491</sup>

The situation in Tanzania was not unique. In the case of Zambia, for instance, the need to prioritise rural health led to a go-slow of doctors in urban areas, which they argued was due to neglect and underfunding, resulting in poor working conditions and hence underutilisation of

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<sup>490</sup> Green, *An Introduction to Health Planning*, 4.

<sup>491</sup> Conyers, *An Introduction to Social Planning in the Third World*, 4.

already established structures.<sup>492</sup> The success of health systems in places such as China and Cuba was attributed mainly to the overhaul of the entire governance structure, which Tanzania attempted during the *Ujamaa* era. Where such drastic moves were made, there was always a counter-effect. The planning process was full of promises that never materialised, as implementation, resource allocation, planning, and policymaking were treated as separate entities, divorced from each other, yet they were interdependent and never independent of one another.

Understanding the health sector after independence was even more problematic because the available statistics were inaccurate, or worse still, some were not available at all.<sup>493</sup> The unavailability of medical and demographic data made planning difficult. Furthermore, health was secondary to other needs, as reflected in the budgetary allocation to the health department, as noted above. This was a continuation of the colonial mentality, where health was only considered essential in relation to production, such that healthy workers were equated with increased productivity.<sup>494</sup> Gottlich notes that colonialism introduced ‘regional specialisation, direct taxation, centralised authority, colonial medical institutions and colonial medical profession’.<sup>495</sup> Colonial medical structures were not easily changed in the postcolonial era. The critical issues identified by Gottlich continued to plague the country after independence, such that health was only important because it was seen as a prerequisite to building an economy, rightly following colonial ideas such as ‘the country would be richer in human capital if health care was organised properly’.<sup>496</sup> Thus, colonial policies prioritised medical developments in areas that would give economic returns.<sup>497</sup> Describing the situation in Senegal, Maghan Keita argues similarly, asserting that medical developments in the colonial period were closely tied to economic production.<sup>498</sup> These were areas with fertile soils, where agriculture thrived, or mining centres near vital infrastructure, such as ports or railways. The post-independence Tanzanian government planned to incorporate marginalised areas into the mainstream economic order.

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<sup>492</sup> Conyers, *An Introduction to Social Planning in the Third World*, 44.

<sup>493</sup> *Tanganyika, Ministry of Health and Labour, 1961, Annual Report of the Health Division, Vol 1. Prepared by the Chief Medical Officer.* (1961), 1.

<sup>494</sup> Maghan, *A Political Economy of Health Care in Senegal*; Coulson, *Tanzania: A Political Economy*, 179.

<sup>495</sup> Harrison Chase Gottlich, ‘Colonialism and the Development of the Tanzanian Health System’ (Honors Thesis, Baylor University., 2018), 19.

<sup>496</sup> Juhani Koponen, *Development for Exploitation: German Colonial Policies in the Mainland Tanzania, 1884-1914* (Lit Verlag, 1994), 461; Gottlich, ‘Colonialism and the Development of the Tanzanian Health System’.

<sup>497</sup> Conyers, *An Introduction to Social Planning in the Third World*, 27.

<sup>498</sup> Keita Maghan, *A Political Economy of Health Care in Senegal*, African Social Studies Series vol 10 (Brill, 2007), 10.

To conclude this section, I argue that the planning between 1961 and the early 1970s was therefore characterised by trial and error. Tanzania faced many health challenges. By 1965, the country's Africanisation process had the majority of government positions held by Africans; 4937 out of 6754 top positions. Kahama et al. argue that the Africanization process was conducted rapidly,<sup>499</sup> seemingly prioritising African identity over professional expertise. The surge in the African workforce also necessitated effective management. However, Tordoff argues that Nyerere and TANU lacked experience in operating a national-scale political system, often managing affairs from a predominantly political standpoint.<sup>500</sup> The medical sector posed specific hurdles due to the nature of the training and expertise required. Despite having a substantial number of African professionals, a significant obstacle was the prevalent low level of education and lack of necessary experience among the majority. In 1975, TANU members, led by Health Minister Dr. Stirling, initiated a TANU branch within the Health Department, indicating the intertwining of political and administrative spheres. Nevertheless, the alignment of political interests did not consistently match the social and economic needs. The developmental progress did not always meet the expectations of the masses or reflect the enthusiasm witnessed during the initial stages of *Uhuru*. What did this mean to specific medical departments? In the next section, I discuss how the government navigated the policy specifics of maternal health, using examples from the Kilombero Valley.

### **3.6 The Implications of Health Plans on Maternal Health**

Health-policy planning in the early years of independent Tanganyika had significant impacts on maternal health. As highlighted above, Tanzania's population was approximately ten million people at the time of independence. A closer examination of the demographic distribution revealed that the majority of the population was below the age of fifteen.<sup>501</sup> This demographic composition indicated potential future population growth.

Demography is pivotal in planning, not only for health but also for all sectors of the economy. In shaping Tanzania's development trajectory, demographic statistics influenced the government's focus on maternal and child health. At the time, challenges such as the maternal and infant mortality rate remained alarmingly high, primarily due to factors such as malaria, inadequate nutrition, deficient maternity services, and various illnesses. Recognising the significance of population-related concerns, the government prioritised maternity services, underscoring the crucial role they played in the overall health status of the nation. This section

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<sup>499</sup> Kahama et al., *The Challenge for Tanzanian's Economy*, 30.

<sup>500</sup> Tordoff, *Government and Politics in Tanzania*. xii

<sup>501</sup> <https://www.populationpyramid.net/united-republic-of-tanzania/1961>

examines the policy-planning issues surrounding maternal healthcare, particularly in the training of medical personnel, access to facilities, and the role of TANU in the initial years of independence.

### **3.6.1 Trained vs. Traditional Midwives: Issues in Maternal Health Workforce**

In 1961, the maternity section was reportedly overstrained due to high demand. As noted in the health division report, most health facilities were busy with maternity services throughout 1961.<sup>502</sup> During that year, 67,000 women sought maternity services, compared to 23,000 in 1951. While these government records indicate the popularity of the maternity section, it was likely measured by the capacity of health facilities and staff, rather than the population, for only 17 per cent of deliveries were handled by trained staff in 1961.<sup>503</sup> To put it more specifically, only 13 per cent of pregnant women received prenatal services, and only 11 per cent of deliveries occurred in a medical facility in 1961. In addition, infant mortality rates were between 200 and 250 per 1,000 births.<sup>504</sup>

Upon recognising the gap, the government developed a plan to train village midwives, enabling them to assist with home deliveries or domiciliary services. The plan was to have the attendant, who possessed little biomedical knowledge, which was believed to reduce the rate of infections and, by extension, reduce maternal and infant mortality rates.<sup>505</sup> It had dawned on the government that home delivery was not easy to eradicate. Even if the government wanted to do so, the existing health facilities were not enough for everyone. Therefore, the government advocated for domiciliary services, which were to be handled by a trained midwife.

As highlighted above, the medical sector has faced challenges, including limited facilities and a shortage of healthcare professionals. However, the preference for home delivery was not solely driven by the shortcomings of the medical sector. There were significant cultural considerations that biomedical practices did not address. In Kilombero, for example, the proximity to Ifakara Hospital could not dissuade women from seeking the services of traditional midwives. Traditional midwives were perceived as the solution to the various needs of the pregnant woman and her family as a whole. Beyond being present throughout all stages of

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<sup>502</sup> *Tanganyika, Ministry of Health and Labour, 1961, Annual Report of the Health Division 1961, Vol 1. Prepared by the Chief Medical Officer.*

<sup>503</sup> Ricahrd Titmuss et al., *The Health Services of Tanganyika*, 37.

<sup>504</sup> Kahama et al., *The Challenge for Tanzanian's Economy*, 24; Shija et al., 'Maternal Health in Fifty Years of Tanzania Independence: Challenges and Opportunities of Reducing Maternal Mortality'.

<sup>505</sup> 'Tanganyika, Ministry of Health. Annual Report of the Health Division 1962 Vol 1. Prepared by the Chief Medical Officer'.

pregnancy—before birth, during, and after delivery—the traditional midwife played a crucial role in facilitating important rituals.<sup>506</sup>

In Kilombero, a significant post-birth ritual involved the administration of *kilala*.<sup>507</sup> This medicinal practice was applied immediately after the baby's birth, accompanied by related rituals that were not openly discussed due to the secrecy surrounding the practice.<sup>508</sup> The purpose of *kilala* was to safeguard the child from ailments believed to be caused by a lack of protection from issues such as the father's promiscuity. Following delivery, the woman observed a period of seclusion for up to the period when the baby was at the breast.<sup>509</sup> However, some women said that it was frowned upon to be pregnant again until the baby learned to walk.<sup>510</sup> However, the short-term seclusion period for many communities was until a woman started her monthly period again after giving birth. In the seclusion period, the woman stayed with her mother-in-law until her first monthly period postpartum.<sup>511</sup> During the seclusion period, she was prohibited from engaging in sexual relations with her husband. However, if the husband had another partner, who was not part of the permissible polygamous nature of traditional African marriage, and then had contact with the baby, the child would promptly fall ill or experience bad luck in life or delayed milestones (*kubemenda*). As most of the men spent months in the fishermen's camp at the River Kilombero, such protective rituals were necessary.<sup>512</sup> This necessity accentuated the importance of traditional midwives who played a vital role not only in administering *kilala* but also in providing social support to the woman post-delivery, a dimension not typically addressed in a hospital setting.<sup>513</sup>

Cultural beliefs and practices around reproduction impacted broader government plans for maternal health. First, the government's failure to understand the place of the rituals and their significance within the overall culture only led to a replication of the colonial and missionary negative attitudes towards the rituals, culminating in a crossroads with Western medicine.<sup>514</sup> Perhaps if the medical practitioners and the government had understood these practices from a more neutral perspective, there might have been better collaboration and better results in

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<sup>506</sup> 'Interviewee B (a Traditional Midwife), at Lipangalala, Ifakara', September 21, 2023.

<sup>507</sup> This ritual involved herbal medicine treatment and rituals that involved invocation of the ancestors.

<sup>508</sup> Veronica Kimani and Ulrike Lindner, 'Seniority in Midwifery in Tanzania: Medical Local Practices Between Colonial Medicine and Postcolonial Modernization', *Nordic Journal of African Studies* 33, no. 4 (2024): 304–25, <https://doi.org/10.53228/njas.v33i4.1143>.

<sup>509</sup> Kotni, 'Midwifery in Cross-Cultural Perspectives'.

<sup>510</sup> Women in Ifakara, 'Focus Group Discussion at Lipangalala', September 21, 2023.

<sup>511</sup> Maurine R. Musie et al., 'African Indigenous Beliefs and Practices during Pregnancy Birth and After Birth.', in Fhumulani Mavis Mulaudazi and Rachel Lebeso (eds) *Working with Indigenous Knowledge: Strategies for Health Professionals* (Cape Town: Aosis Books, 2022), 105.

<sup>512</sup> Interview with Margret Kindidi at St Francis Hospital, Ifakara, on February 7, 2025.

<sup>513</sup> Women in Ifakara, 'Focus Group Discussion at Lipangalala', September 21, 2023.

<sup>514</sup> WHO archives, Geneva, 'Health H/8/6 PP/CDW/E.2/4 Letter from C. Davies (District Medical Officer) to Dr Cecily Williams (Director of Medical Services) Village Midwives'.

improving maternal health. However, the political economy was pro-modernisation, and traditional medicine was seen as being against this motive. While there was recognition of traditional medicine, the attempt to ‘improve’ can show its place in the hierarchy of medical systems in Tanzania.

Traditional midwifery nevertheless remained active. It garnered significant support not only from husbands but also from women within the family, including mothers, grandmothers, and aunts.<sup>515</sup> It was perceived as a means of upholding cultural and familial obligations, particularly for families or clans with a lineage of traditional midwives. In Mang’ula ward, Kilombero, having a family midwife was preferred over being attended to by strangers in a hospital setting.<sup>516</sup> The term ‘stranger’ also alluded to the introduction of unfamiliar practices, some of which were met with disapproval by concerned parties. Family planning, in particular, was not solely a concern for individual women; husbands also played a role in the decision-making process. The majority hesitated to fully embrace artificial family-planning methods due to concerns about potential side effects. Some husbands often encouraged their wives to seek advice from traditional midwives regarding family planning. Traditional medicalised family planning involved the traditional midwife mixing herbs with a woman’s menstrual blood, tying it with a *kanga*, or placing it in a snail shell.<sup>517</sup> This illustrates that the role of traditional midwifery retained relevance in the post-independence era, despite the efforts of both colonial and postcolonial governments.

The government continued with its efforts and plans to improve maternity care in the hospital setup. While maternity was recorded as the busiest section in all health facilities, there were only 35 government midwives and 39 nurses in 1961, while the voluntary agencies had 45 midwives and 105 nurses.<sup>518</sup> However, the number of women in need of services exceeded the number of midwives. The government planned not only to expand existing facilities and build new ones, but also to increase training in terms of both the number of training facilities and the number of health workers.<sup>519</sup> Between 1962 and 1966, an increase in rural health facilities and health workers was recorded. By 1967, this trend was given a new impetus by the combined efforts of the *Ujamaa* policy.

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<sup>515</sup> Focus Group Discussion with Kaduma Luo, Theresia Tamayamali, Zuhura Said, Alice Fande, Hamisi Kulengama, at Lipangalala, Ifakara, September 21, 2023.

<sup>516</sup> I am grateful to Emma Minja who brought out this point from her interviews at Mangula.

<sup>517</sup> Focus Group Discussion with Luoneko Kaduma, Theresia Tamayamali, Zuhura Said, Alice Fande, Hamisi Kulengama, at Lipangalala, Ifakara, September 21, 2023; *Kanga* is a colourful fabric worn by women in Africa.

<sup>518</sup> Richard Titmuss et al., *The Health Services of Tanganyika*, 68.

<sup>519</sup> *Tanganyika, Ministry of Health and Labour, 1961, Annual Report of the Health Division, Vol 1. Prepared by the Chief Medical Officer*, (1961), 31.

The scarcity of health facilities and staffing in maternal health was a significant problem, similar to that experienced by many other health departments. By the mid-1970s, the most feasible solution for the MCH was to train the MCHA. This category was selected from primary school leavers who were trained for 12 months at MCHA training centres in all regions of Tanzania, followed by 6 months of practical training in a hospital. Young girls were best suited for the job. MCHA replaced the village midwives. However, as noted in the previous chapter, they were not socially suited to performing the duties of delivery and maternity in society. Traditionally, among the Wabena, Wapogoro, and Wangindo, midwifery was conducted by senior women of good moral standing in the community.<sup>520</sup> These women were supposed to be married and should have given birth to and mothered children. This resonates with Thomas Lynn's 'Politics of the Womb', where the notion of being 'biologically able but not socially consecrated' is well articulated.<sup>521</sup> Therefore, while training girls straight from school was the easiest and perhaps the most successful way, the government also resorted to training older women whom their fellow villagers would accept.<sup>522</sup> This was a replica of the dilemma faced by the missionaries in the colonial days, when they opted to train young girls as opposed to old women who were believed to be propagating bad delivery and child-rearing techniques, as well as propagating 'satanic' habits.<sup>523</sup> Indeed, the missionary had advised the government against using young, unmarried girls because it was not culturally acceptable.<sup>524</sup> This was a reason why some women would shun the dispensaries and the health centres. A similar trend was observed immediately after independence, particularly since the majority of health workers were men.<sup>525</sup> Therefore, the government intensified midwife and MCH aide training.

The challenge lay in getting a person with the required qualifications. On the one hand, men, who had had a better education than women, were culturally excluded from midwifery. On the other hand, young girls were also socially unacceptable. Therefore, while training girls straight from school was the easiest and perhaps the most successful approach, the government proposed training older women, who would be accepted by their fellow villagers.<sup>526</sup> By the

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<sup>520</sup> Women in Ifakara, 'Focus Group Discussion at Lipangalala', 21 September 2023; Musie et al., 'African Indigenous Beliefs and Practices during Pregnancy Birth and After Birth.'; Kimani and Lindner, 'Seniority in Midwifery in Tanzania: Medical Local Practices Between Colonial Medicine and Postcolonial Modernization'.

<sup>521</sup> Lynn M Thomas, *Politics of the Womb: Women, Reproduction, and the State in Kenya* (California: California University Press, 2003), 10.

<sup>522</sup> 'Tanganyika, Ministry of Health, Annual Report of the Health Division, 1963, Vol 1', 33.

<sup>523</sup> Walter Bruchhausen, 'Practising Hygiene and Fighting the Natives' Diseases. Public and Child Health in German East Africa and Tanganyika Territory, 1900-1960', *DYNAMIS*. 23 (2003): 105.

<sup>524</sup> Jennings, 'Cooperation and Competition', 168.

<sup>525</sup> 'Report on the Rural Medical Aid Course Held at the RAC in Ifakaea from 17th July to 14th October 1961', unpublished manuscript, 1961.

<sup>526</sup> *Annual Report (Health) 1961*, 33; Kimani and Lindner, 'Seniority in Midwifery in Tanzania: Medical Local Practices Between Colonial Medicine and Postcolonial Modernization'.

1970s, the selection criteria for MCHA had added age as a consideration, requiring that a suitable candidate be 20 years or older. This was to counter the young girls' impact on trained midwives and to make them more acceptable in the villages.<sup>527</sup> It is worth noting, however, that in some places, the new MCHAs were readily accepted. These were individuals who had previously practised as village midwives or nurse assistants before being selected to train as MCHAs. Their familiarity with the people they were serving was an added advantage.<sup>528</sup> In addition, some MCHAs were selected through the church, and later they were to work in mission-owned churches, which also provided them with an opportunity to serve those who had already converted to Christianity.<sup>529</sup> As shown in the next chapter, the fact that one was a practising Christian did not mean that one did not consult traditional midwives.

Despite efforts to improve biomedicine between the 1960s and 1980s, most women therefore relied on traditional midwives.<sup>530</sup> These midwives were elderly women with years of experience that could not be compared to the basic knowledge possessed by the auxiliaries at the dispensaries and health centres after a few months of training.<sup>531</sup> Perhaps it was for this reason that women in rural areas opted to deliver under a traditional midwife rather than in a health facility, where they were not accorded the expected services. Apart from the social nature of traditional midwifery, which was lacking in clinics, Gish adds that 'the available chain of dispensaries was ill-equipped and manned by staff who were only capable of dispensing pharmaceutical palliatives when these were available'.<sup>532</sup> This meant that the situation was not good, either in terms of facilities or staffing. However, the availability of the 'ill-equipped' dispensary was better than nothing, as many villages in Tanzania still lacked either a dispensary or a health centre.

In 1967, the government brought the services of obstetricians and paediatricians to take up ANC clinics and child health.<sup>533</sup> This was intended to enhance MCH and, simultaneously, improve hospital services for child health. The MCH sections also planned home or school visits, which were designed to reach those who had not yet 'converted' to appreciating Western medicine, either due to 'ignorance or beliefs'. These visits, however, faced numerous challenges,

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<sup>527</sup> Oral Interview with Leah Mpombo, at Uwanja wa Ndege, Ifakara, September 25, 2023.

<sup>528</sup> Staatarchiv Basel-Stadt, '940 HI (1) I Tanzania Maternal and Child Health Programme' (1976), 32.

<sup>529</sup> Oral interview with Christina Isakwisa, Viwanja Sitini, Ifakara, 20.9.2023; Interview with Winfrida Mpangile, Posta, 20.9.23.

<sup>530</sup> Hannah Kasambala, 'Wakunga Wa Jadi Muhimu', *Mzalendo*, November 15, 1981.

<sup>531</sup> Women in Ifakara, Focus Group Discussion at Lipangalala. September 21, 2023.

<sup>532</sup> Oscar Gish, 'The Way Forward: World Health Organisation', 8.

<sup>533</sup> *Tanganyika, Ministry of Health and Labour, 1961, Annual Report of the Health Division 1961, Vol 1. Prepared by the Chief Medical Officer, 2.*

including a lack of transportation, the distance between homes in the villages, insufficient time due to the clinic's need for attendants, community opposition in some areas, and inadequate supervision.<sup>534</sup> An interviewee narrated how, on one occasion, his team of health workers were attacked by villagers who suspected that they were collecting blood from their children. The incidence was part of a health-education programme and malaria-testing initiative in a school. The villagers did not understand the need for laboratory tests that involved blood collection. This was perhaps associated with blood thirst and evil spirits (*mashetani*) related to divination and witchcraft.<sup>535</sup> This resonates with narratives by Louise Jilek-Aall, where, as a biomedical doctor in a rural village in Ulanga in the 1960s, she witnessed villagers referring to her and her assistant as '*wachinji-chinji*' (kuchinja means 'to slaughter').<sup>536</sup> Jilek-Aall adds that the villagers thought that she had come to collect blood.

Despite such incidents and the continued use of traditional medicine, MCHAs' training continued. Most of these training schools were concentrated in the capital city and other urban areas. Training in Dar es Salaam and the metropolitan regions was the reason most health workers opted to remain in urban centres. Contrary to the government's plan to improve rural health, it opted to close down some facilities to concentrate on those already established in Dar es Salaam. In 1963, for instance, some midwifery schools outside the capital were closed, and their students were integrated into three- and four-year training courses based in Dar es Salaam. This mirrored colonial strategies, as in 1959, when the midwifery school in Tanga was closed to concentrate on the one in the capital.<sup>537</sup> The closure of facilities outside Dar es Salaam could be attributed to their well-equipped and well-funded status, primarily through donor support. As shown in Chapter Five, these donors sponsored the start of 19 MCHA training schools in each region in 1976.

After training, MCHAs were deployed at the clinic. The clinics became centres of knowledge dissemination through the health-education programme. Women were educated as a group at the clinic about the importance of hygiene, proper nutrition, and vaccination. Each MCH centre was to have a fireguard, a meat safe and a baby cot always on display. A small vegetable and fruit garden was started as a guide for the mothers. Videos and films on health-related topics,

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<sup>534</sup> Staatsarchiv Basel-Stadt, 'PA 940 HI (1) I Tanzania Maternal and Child Health Programme' (1976), 33.

<sup>535</sup> Oral interview with Interviewee A at Viwanja Sitini, Ifakara, September 19, 2023.

<sup>536</sup> Jilek-Aall, *Call Mama Doctor: African Notes of a Young Woman Doctor*, 54.

<sup>537</sup> *Tanganyika, Ministry of Health. Annual Report: Report on Health Services, Prepared by the Principal Secretary Ministry of Health.*, 1959, 3.

such as safe delivery and family planning, were shown. The clinic also provided cards to monitor the wellness of the baby and the mother.<sup>538</sup>

According to women in Kilombero, the clinic was primarily attended due to the immunisation of children (see Figure 9). Therefore, medical plurality was embraced. The majority of the women argued that the clinic was not their first choice for delivery because, apart from cultural needs and a shortage of health officers, the available workers were accused of providing poor services (see Figure 10). The clinic was also running short of equipment, making it a place of uncertainty.



*Figure 9: Mothers and children queuing to attend the clinic holding their growth and antenatal cards.  
Source: Hart,1977:181*

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Women in Ifakara, 'Focus Group Discussion at Lipangalala', September 21, 2023.

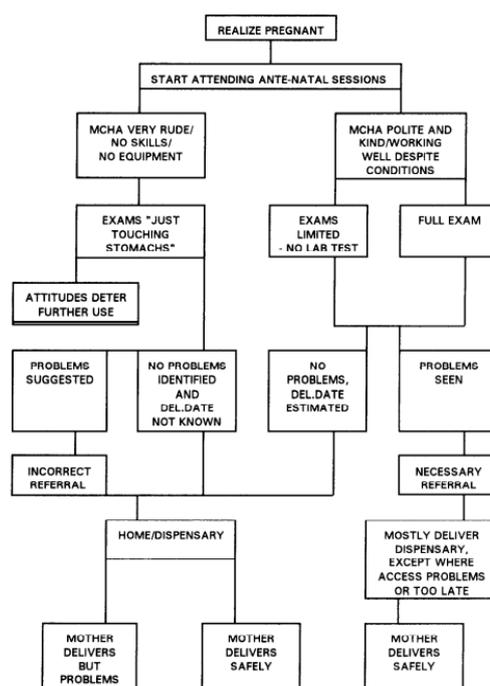


Figure 10: Showing different experiences of pregnant women at the clinic.  
Source: Adapted from Lucy Gilson et al. *Community experiences of the government antenatal care.*

### 3.6.2 Maternal Health Care and the Problem of Health Facilities

Maternal healthcare played a crucial role in the development of medical facilities, yet it also presented significant contradictions. In the Kilombero region, the number of dispensaries has increased over time; however, the services in rural areas were still rudimentary, and many dispensaries lacked a maternity section, as required by strict medical standards. In many dispensaries, only a few beds were set aside for maternity cases. Following independence, efforts were made to improve maternity services, aiming to ease congestion and prevent cross-infection in the general wards. In 1963, for instance, through self-help efforts, a new maternity ward was built at Morogoro Hospital. This was to support the different dispensaries and RHCs under it. The policy established in 1961 was that the central government would not establish a dispensary where a local government already had one. In addition, the government was to hand over dispensaries to the local authorities that were able to maintain or administer them.<sup>539</sup> However, there was still no clear demarcation because, out of the one thousand dispensaries, the central government was running eighteen, while over two hundred and fifty were run by voluntary agencies, and the rest by the local government. The central government retained the supervisory and policy-making roles, as well as the training of staff.

In the urban areas, the situation of maternal health was no better, especially for the urban poor. As noted in Chapter Two, Sewa Haji, Ocean Road, and Princess Margaret Hospital (later renamed Muhimbili) were the leading hospitals in Tanzania since the colonial period. They were all located in Dar es Salaam. Upon the completion of the 230-bed third ward block at Muhimbili in 1961, the Sewa Haji facility was closed because it had become dilapidated after more than sixty years of operation. The Muhimbili maternity section had only 50 beds and 42 cots, which were severely strained by the high number of mothers seeking services. The 1961 annual report shows that there were ten deliveries in a day in this facility, exclusive of abortion cases.<sup>540</sup> The section could not handle everything pertaining to maternity. For instance, matters to do with reproductive problems were not considered ‘urgent’. A case of infertility, for example, could only be handled through a waiting list, which is described as having ‘lengthened rapidly’.<sup>541</sup>

To partly address the problem, Ocean Road, the former European hospital, was in 1961 designated to handle obstetrics exclusively. By then, it had a capacity of seventy-five beds. The hospital could then handle only a few cases compared to the demand. All the general beds were replaced with maternity beds while patients were ‘evacuated and replaced with maternity patients’.<sup>542</sup> The number of maternity beds was increased to 116.<sup>543</sup> At both Ocean Road and Muhimbili hospitals, the maternity sections were inadequate for the population of Dar es Salaam, yet they were also expected to handle referral cases. The situation was the same in 1967. Congestion was inevitable. Women had to share what was available and, in some cases, the waiting list, especially for what was considered ‘not urgent’, such as vesico-vaginal fistula or hysterectomies, could go up to six or twelve months. Thus, the population of patients continued to rise year after year (see Table 7).

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<sup>540</sup> *Tanganyika, Ministry of Health and Labour, Annual Report of the Health Division 1961, Vol 1. Prepared by the Chief Medical Officer.*, 31.

<sup>541</sup> *Annual Report (Health) 1961*, 31.

<sup>542</sup> ‘Annual Report of the Health Division 1961 Vol 1’, 1.

<sup>543</sup> ‘Annual Report of the Health Division 1961 Vol 1’, 1.

Year	1963	1964	1965	1966	1967
Ocean Road total admissions	8,315	9,968	11,734	15,736	18,298
Ocean Road deliveries	7,062	9,025	11,027	13,443	14,878
Muhimbili Total Admissions	1,095	1,106	1,675	1,944	2,247
Total births in Tanzania	500,590	518,594	536,587	554,037	572,637

Table 7: Ocean Road Hospital maternity admissions.

Source: Modified from the annual medical report, <https://database.earth/population/united-republic-of-tanzania/births>

This demand necessitated the construction of a new maternity ward at Muhimbili, which was thought to save the situation, as evidenced by the total number of births. This, however, was unlikely because demand exceeded supply. In addition, the expansion plan was not based on population numbers, but rather on the availability of funds or donors, who were more interested in established facilities in urban areas. While medical facilities in urban areas were well-funded compared to those in rural areas, the urban poor suffered more than their rural counterparts. The political economy of health favoured the rich. In Dar es Salaam, for instance, the Temeke district was too far from Muhimbili and Ocean Road,<sup>544</sup> but the problem of the urban poor accessing services in the city was more of a class problem than one of geography.<sup>545</sup> Some of the women had to sleep on the floor because there were not enough beds (see Figure 11). The situation had remained unchanged in various places in Tanzania for several years. In 1966, the MP for Kahama District noted in Parliament that patients in his district hospital were forced to sleep on the floor.<sup>546</sup> The poor state of health facilities explains why, in addition to cultural needs, traditional midwifery continued to thrive, indicating a form of medical pluralism.<sup>547</sup>

<sup>544</sup> 'Mawazo ya Msomaji-Hospitali Temeke', *Ngurumo Newspaper*, December 21, 1964.

<sup>545</sup> Keita Maghan, *A Political Economy of Health Care in Senegal*, 46.

<sup>546</sup> 'Hansard, Majadiliano ya Mbunge. Mkutano wa Nne, Sehemu ya Pili. Julai 1, 1966', 2275.

<sup>547</sup> Maureen Malowany, 'Medical Pluralism: Disease, Health and Healing on the Coast of Kenya, 1840-1940' (McGill University, 1997).

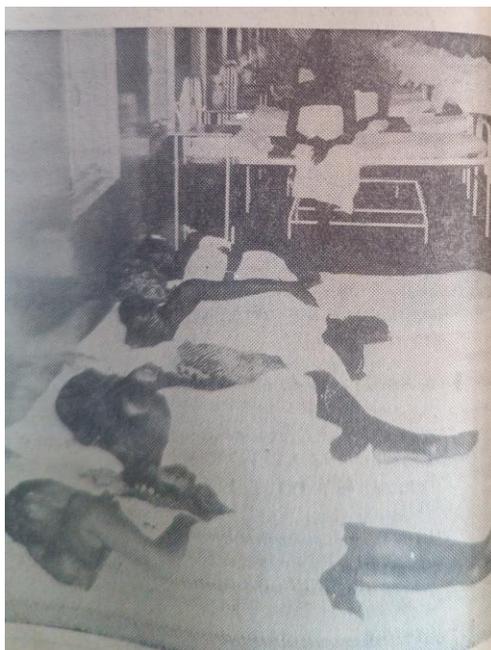


Figure 11: Women sleeping on the floor at Ocean Road in 1969.  
Source: *Uhuru* (Newspaper), Jumamosi, Oktoba 11, 1969.

As early as 1962, complaints were reported in local newspapers about issues such as women being forced to stand for extended periods or sit in the sick bay for lack of space, others being told to line up in hot weather while in labour, overcrowding, mistreatment of pregnant women, and staff shortages.<sup>548</sup> These concerns were often dismissed with responses like, ‘Report to the doctor, not the newspapers’. Such reactions highlight the hierarchical nature of the medical system, which left people powerless and vulnerable, with people describing such circumstances using phrases such as ‘*Hapa utaona hata mkoloni hakufanya hivi...*’<sup>549</sup> (You see, even the colonists did not do this!..) The poor state of hospitals was a topic that was continually debated in parliament.<sup>550</sup>

In rural areas, the maternity section was typically part of the main wards. Titmuss et al note that most beds in government hospitals were ‘general beds’ with a few set aside for maternity cases<sup>551</sup>. Thus, the lack of maternity beds made the delivery process difficult not only for the mothers but also for the health officers. The situation was not easy for the maternity section because, in a general district hospital, out of 100 beds, 60 were designated for short-stay admissions, 14 for patients with mental illnesses, 14 for Tuberculosis patients, 5 for infectious

<sup>548</sup> ‘Mawazo ya Wasomaji: Huruma kwa Wajawazito’, *Ngurumo*, June 8, 1964.

<sup>549</sup> ‘Mawazo ya Wasomaji: Huruma kwa Wajawazito’.

<sup>550</sup> ‘The Hansard. Proceedings of the National Assembly in the Parliament of URT and Zanzibar. Proceedings from 16th June to 3rd July 1964’; ‘Hansard. Majadiliano ya Mbunge. Mkutano wa Nne, Sehemu ya Pili. Tarehe 1-Julai 1966’; ; ‘Hansard. Majadiliano ya Mbunge. Mkutano Ishirini na Moja, Sehemu ya Pili. Tarehe 27 Juni 11-Julai 1970’.

<sup>551</sup> Titmuss et al., *The Health Services of Tanganyika*, 42.

diseases, and only 7 for obstetrics.<sup>552</sup> It is unclear what policy informed such a division. Still, with seven beds in a section described as the busiest, overcrowding in the maternity ward was inevitable, and, in most cases, it became a breeding ground for contamination and infections. It also meant that only complicated cases would be admitted, perhaps for observation, and those without complications were discharged immediately after delivery.<sup>553</sup> Based on political economy, it is clear that the challenge lay in distributing available resources to the population, but the pressure of doing so led to reduced standards and limited access.

The approach to handling complex medical cases was not conducive to maternity cases. If a case was too complicated for a Rural Health Centre (RHC) or dispensary, it would be referred to the nearest District Hospital, then to the Regional Hospital, and ultimately to a facility in Dar es Salaam. The nature of the maternity issues did not allow for such a bureaucratic approach, citing the major infrastructural problems that existed at the time. This negatively affected the community's attitude towards the health facility and workers. A study done in Morogoro captured the challenges of the MCH section, some of which were carryovers from the past.<sup>554</sup>

Most of the hospitals in rural areas lacked readily available ambulances. The majority relied on the Land Rovers provided by UNICEF (see Figure 12).<sup>555</sup> These Land Rovers were mainly used for mobile clinic activities. Some women were taken to the hospital by bicycle or carried on someone's back.<sup>556</sup> Despite the constant breakdowns, fuel shortages, and repairs, some local people interpreted the use of the Land Rovers as a form of holidaymaking by the health workers.<sup>557</sup> Moreover, the mobile clinics were seasonal, operating once a month during the dry season and, in most cases, halted during the rainy season as many roads were impassable.<sup>558</sup> However, in most cases, the travel budget was exhausted long before the intended time.<sup>559</sup> This is indicative of poor planning, and also corruption and misuse were cited. Although UNICEF provided Land Rovers for MCH services, not every centre had one. In other places, misuse of

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<sup>552</sup> Titmuss et al., *The Health Services of Tanganyika*, 43.

<sup>553</sup> *Annual Report (Health) 1961*, 5.

<sup>554</sup> Staatsarchiv Basel-Stadt, Lucy Gilson and Martin Serikiaeli Alilo, 'PA 940d Maternal Care in Primary Level Health Units with Some Aspects of Childcare: Experience from Morogoro', June 25, 1991.

<sup>555</sup> *Annual Report (Health) 1961*.

<sup>556</sup> Leader Stirling, *Tanzania Doctor* (London: C. Hurst and Company, 1977), 92; Interview with Margaret Kindasi, Kibaoni, Ifakara, September 25, 2023.

<sup>557</sup> Rene Dumont, *False Starts in Africa. Translated by Phylis Nants Ott*, 142.

<sup>558</sup> Gilson and Alilo, 'PA 940d Maternal Care in Primary Level Health Units with Some Aspects of Childcare: Experience from Morogoro', 1.

<sup>559</sup> Richard Hart, 'Maternal and Health Care Services in Tanzania', 180.

these vehicles by local authorities was reported. However, the recurrent expenditure was to be borne by the local authorities,<sup>560</sup> which proved to be a challenging task to handle.

Even with Land Rovers and the dispatch of MCHA to the rural areas, door-to-door coverage was still not possible. The outreach was organised in such a way that people met in shopping centres and party offices. These places were the most strategic places where people gathered to receive services on selected days. The mobile unit consisted of a team of health auxiliaries, including MCHA and health and nutrition officers. Thus, the mobile team provided health education, immunisation and nutritional surveillance.<sup>561</sup> The major challenge for the mobile team was that the vehicles were not always available; they would break down, and in some cases, the team had to walk long distances to access remote areas.<sup>562</sup>



*Figure 12: A portrayal of the Land Cruiser used in mobile clinic services.  
Source Lishe Journal, Toleo 2.4, 1978, pg 7*

The main challenge in maternal health planning was the question of reliable data. Reports concerning the maternity section were often contradictory. On the one hand, between 1961 and 1966, the annual medical reports indicated that it was still impossible to handle the many cases presented daily at the hospitals, except for maternity and child services. Indeed, the maternity section was very busy in both rural and urban areas. In the rural area, the most critical health facility, the RHC 'looked like just a maternity section'.<sup>563</sup> On the other hand, MCH services were not handled adequately, and many facilities were in poor condition. The challenge of

<sup>560</sup> *Annual Report (Health) 1961*, 31.

<sup>561</sup> Staatsarchiv Basel-Stadt, 'PA 940 HI (1) I Tanzania Maternal and Child Health Programme'.

<sup>562</sup> Oral interview with Leah Mpombo at Uwanja wa Ndege, Ifakara on 25.9.2023

<sup>563</sup> Richard Titmuss et al., *The Health Services of Tanganyika*, 53.

coverage lingered. The MCH section was not treated with the seriousness it deserved. Even though pregnancy and related matters, despite being potentially life-threatening, are not categorised as diseases, the risk they carry for both the mother and the child is high. Between 1966 and 1973, the *Ujamaa* policy focused on rural development and enhanced service delivery closer to the people (Chapter 4).

By 1974, a revolution had occurred in the provision of MCH services. At the time, MCH activities were harmonised such that services, including vaccination, nutrition, and family planning, could be offered in a single day instead of on different schedules for different days of the week. This arrangement made it easier for women to attend, and for the health workers to cover a wide range of services. While there was resistance from health workers, who said the new arrangement would increase their workload, pressure came from other sectors. For instance, in 1973, 'Young Child in Tanzania' advocated for harmonising MCH services and combining them into a single day.<sup>564</sup> The aims of MCH were now launched to ensure the health and safety of mothers and children before and after delivery, to reduce maternal and infant mortality, and to ensure that services reached 90 per cent of the population by 1980. Although other factors were also at play, the number of women attending clinics increased from 9,797,224 in 1976 to 1,090,635 in 1985.<sup>565</sup> The other changes introduced at this time involved the men who were often left out of MCH matters. The men were brought together with women and they were taught the usefulness of the clinic.

In a nutshell, discussing MCH-related health facilities between 1961 and 1974 is somewhat problematic and contradictory. While there was progress, challenges were also experienced, making it difficult to place the little progress that was made. The MCH section was described as being 'utilised to full capacity'.<sup>566</sup> While this might have been accurate for urban areas, rural areas presented a different scenario, with home deliveries still prevalent. It is plausible that the report may have been influenced to reflect the government's and other actors' vested interests and preferences. The term 'full capacity' seemed ambitious, given the insufficient available space to meet demand and the fact that the majority of women delivered outside the clinic. Nevertheless, it could also have been intended to convey the congestion or high demand within the facilities to gain political and economic currency.

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<sup>564</sup> UWT, 'Taarifa ya Jumuiya ya Wanawake ya Miaka Ishirini ya Azimio ya Arusha na Miaka Kumi ya CCM' (Elimu ya Watu wazima, 1987), 38.

<sup>565</sup> CCM Library, UWT, 'Taarifa Ya Jumuiya Ya Wanawake Ya Miaka Ishirini Ya Azimio Ya Arusha Na Miaka Kumi Ya CCM', 39.

<sup>566</sup> 'Tanganyika, Ministry of Health, Annual Report of the Health Division,' vol 1, 1963, 5.

### 3.6.3 The Role of TANU Women in Improving Maternal Health

As noted above, TANU was at the centre of health policy-making and implementation. TANU women and *Umoja wa Wanawake wa Tanzania* (UWT) promoted the government's agenda in MCH. These women were a crucial component of TANU from its inception in the mid-1950s. Indeed, the expansion of TANU as a political force can be primarily attributed to the women of Tanzania. Susan Geiger highlights that by 1955, TANU had a higher number of women as members than men.<sup>567</sup> Geiger emphasises that it was TANU women who disseminated nationalist ideologies to the remote areas of Tanzania.<sup>568</sup> As noted in Chapter One, women in Tanzania formed various singing groups such as *Lelemama*, *Bombakusema*, *British Empire*, *Warumba*, *Ratusadan*, and *Safina Submarine* through which women became the mouthpiece of TANU.<sup>569</sup>

The women organised themselves into groups, mainly by region. In Morogoro, for instance, women engaged in various activities, including farming, tailoring, knitting, reading, writing, and creating artworks, such as making mats.<sup>570</sup> A particular group of women in Kilosa, Morogoro, met three times a week to discuss matters concerning womenfolk, hygiene and agriculture.<sup>571</sup> In these meetings, women were taught how to care for their families and children (see Figure 13). Moreover, traditions were passed down through these meetings. In Ifakara, women's groups exchanged ideas about health, parenting and family living.<sup>572</sup> It was clear that while medical maternity was embraced, other issues regarding motherhood were passed down from one generation to another.

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<sup>567</sup> Susan Geiger, *TANU Women*, 1.

<sup>568</sup> Susan Geiger, *TANU Women*, 17.

<sup>569</sup> Susan Geiger, 1, 79, 58

<sup>570</sup> John Lance Geoghegan, 'The Movement for Independence in Tanganyika', 38.

<sup>571</sup> 'Kina Mama Kilosa Waendelea', *Ngurumo Newspaper*, Januari 8, 1970.

<sup>572</sup> Women in Ifakara, Focus Group Discussion at Lipangalala.



*Figure 13: Women listening to a Health Education session.  
Source: Adopted from Lishe: Tanzanian Food and Nutrition Journal 1978, pg 11*

TANU women, who formed the umbrella women's organisation, UWT, played a crucial role in advocating for maternal health in Tanzania. TANU and UWT were most concerned with maternal health, particularly in promoting policy among the masses. In villages, UWT popularised day care centres (see Chapter 4) where children could be left during the day, allowing mothers to engage in productive activities. These centres also served to instil morals and discipline in children, fostering unity among Tanzanians.

UWT emphasised good nutrition for pregnant mothers to combat maternal deaths and deficiencies such as anaemia. They promoted physical and environmental cleanliness, as well as the use of clean water, to eradicate diseases such as malaria, cholera, and dysentery. UWT leaders advocated for regular attendance at maternal health clinics and recommended breastfeeding for up to four months before introducing other foods, which continued up to 1.5 to 2 years. This was in support of the call by the health education department, which began advocating for breastfeeding over tinned milk as early as 1962 (see Figure 14). Women were also encouraged to seek health information from radios, health centres, MCH clinics, and dispensaries for regular health check-ups.<sup>573</sup>

The awareness women gained through regular health check-ups and radio programmes had a significant influence on the nation's overall health. Women became key advocates for

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<sup>573</sup> CCM Library, 'Sera ya Malezi ya Taifa kwa Watoto na Vijana Tanzania' (CCM, 1987), 7, 8.

promoting good health, not only among other women but within their families, particularly regarding nutrition. This increased awareness also contributed to the rising popularity of curative medicine, often at the expense of both preventive and traditional practices. Moreover, the organisation of women played a critical role during the *Ujamaa* era, as will be demonstrated in the following chapter.



*Figure 14: A photo illustrating a mother breastfeeding her baby.  
Source: David Clyde 1962 pg 160*

The women leaders emphasised environmental hygiene by urging the people to dig toilets, improve nutrition, address maternal health issues, and keep their homes clean.<sup>574</sup> The leaders also taught that, in contrast to the belief that good health starts at delivery and breastfeeding, the most sensitive part is when the baby is still in the womb because the fetus depends on the mother. As such, pregnant women were to be treated with respect and accorded peace of mind; thus, fighting at home and drunkenness were condemned. Pregnant women were advised to eat a balanced diet, especially one rich in protein, including foods such as milk, eggs, meat, fish, and cereals. In addition, retrogressive food taboos that prohibited eating eggs, goat meat, fish and dairy were condemned by TANU leaders. Men, especially, were sensitised to the fact that such taboos had been passed by time.<sup>575</sup>

<sup>574</sup>  
<sup>575</sup>

TNA HEA GR/G.19/20 'Utekelezaji Wa Mkutano Mkuu wa TANU wa 15/16.'  
TNA, TYLA6/63 'Ustawi Wa Jamii'.

### **3.7 Summary**

This chapter has examined the health layout of Tanzania in the early years of independence. It began by showing the organisation and complexities with which Tanzania had to start its self-determination journey. The chapter showed that after independence, Tanzania's social, political, and economic space was characterised by planning, which involved making choices between the numerous needs of the day. Through the various development plans, Tanzania embarked on a modernisation model. Most of what was in these plans, unfortunately, was a continuation of what the colonial government had started and propagated. In the medical sector, for instance, a colonial legacy was evident in the policies and structures of the medical industry established by the British, which continue to operate. In addition, the Titmuss Report and the three-year development plan (1961-64), were initiatives which were highly influenced by actors and factors outside Tanzania. The two documents became the basis for the government's development of its health sector.

Providing medical services in Tanzania after independence was not easy. While there was notable progress, challenges such as inadequate staff, equipment, and facilities, interference by politicians and TANU activities, and a lack of funds continued to be experienced. The government could not provide medical services entirely on its own. Thus, from 1961 to 1967, the annual reports from the medical department document the significant role played by voluntary agencies, donor agencies, and churches. Voluntary agencies, such as the missionaries, came in handy and continued to provide medical facilities to the people, especially in the rural areas and maternal health. In Kilombero for instance, the role of the voluntary agencies in the provision of medical services was seen in the construction of RHC, dispensaries and hospitals.

Several factors influenced medical planning after independence. Beyond the socio-economic issues, the political arm of government under TANU was at the centre of policy-making. To provide a specific illustration, this chapter used the maternity section to illustrate a medical department's unique progress and challenges. The interplay between the gendered aspects of society and their impact on the maternity section was delineated. The struggle to staff the maternity section, for instance, and how male health workers became a barrier to African women seeking services at a health facility, as well as the struggle between young and old women in midwifery. The complexities of this era demonstrated that, while colonial legacies lingered, African culture, as evident in the continued embrace of traditional medicine, remained alive and vibrant. The same breath has continued to illuminate the space of conventional medicine to date. The confusing path after independence resonates with the situation in many African states, where though optimism was high, the start of political freedom was the

beginning of a long struggle with poverty, ignorance and disease. The journey to such an end was not straightforward due to limited experience and inadequate resources. It appears that the political space took up the attention of the African leaders, such that everything else depended on it.<sup>576</sup> The ripple effect was that the independent government concentrated on seeking political legitimacy while economic and social development remained secondary. The rugged terrain of planning also allowed for trials and experiments, such that in the bid to find a better path, Tanzania adopted a 'socialist' system, popularly characterised by the promotion of *Ujamaa* in 1967. The trajectory of *Ujamaa* and its impacts on health planning is the concern of the next chapter.

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<sup>576</sup> Julius E. Nyang'oro, *The State and Capitalist Development in Africa: Declining Political Economies* (California: ABC-CLIO, 1989); Adom Getachew, *Worldmaking after Empire: The Rise and Fall of Self-Determination* (New Jersey: Princeton University Press, 2019).

## CHAPTER FOUR

### THE ERA OF SELF-RELIANCE: *UJAMAA*, MATERNAL HEALTH AND MEDICAL PLANNING IN TANZANIA, 1967-1980s

‘To Plan is to Choose.’

Nyerere<sup>577</sup>

#### 4.1 Introduction

This chapter builds on Chapter 3, which introduced the concept of health planning in Tanzania. The previous chapter demonstrated optimism about providing medical care to the entire country after independence. However, navigating the medical space was not straightforward, owing to inadequate health workers, facilities and equipment. Many adjustments were made to improve the situation, including training top and low-cadre medical staff and expanding biomedical facilities. However, the development space, not just in health but in almost all sectors, did not go as the government had envisioned, and therefore, there was an urgent need for a change of direction. The new route was found in socialism (*Ujamaa*). This chapter, therefore, examines the role of health planning in light of the principles outlined in the Arusha Declaration. The Arusha Declaration principles espoused socialism and self-reliance with agriculture at the centre of economic development. The chapter analyses the interplay between *Ujamaa* development policies and health needs. Using the conceptual framework of political economy. Using examples from the Kilombero Valley, the chapter illustrates how TANU dominated the development landscape, transforming and simultaneously continuing existing health policies.

#### 4.2 Background to *Ujamaa*: Rethinking Post-independence Development

After independence, there was an urgent need to steer Tanzania towards development and modernisation, far from the debris of colonialism. Ironically, development for Tanzania and many African nations at the time was interpreted to mean mirroring the advanced progress of industrialised countries to at least become ‘black Europeans’.<sup>578</sup> Tanzania overlooked differences in time and the unique socioeconomic, political, and historical path of the industrialised nations that it sought to emulate. At the time, the rhetoric of the stages of development, as propagated by Rostow, was widely embraced.<sup>579</sup>

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<sup>577</sup> Nyerere, ‘TANU National Conference: 10 Years After Independence’, 28.

<sup>578</sup> Julius Nyerere, *Freedom and Unity: Uhuru Na Umoja. A Selection from Writings and Speeches 1952-65* (London: Oxford University Press, 1967), 186.

<sup>579</sup> Rostow Whitman Walt, *The Stage of Economic Growth* (Cambridge: Cambridge University Press, 1960).

The pro-modernisation politics dominated Tanzania. However, the process of modernisation easily followed a continuation of colonial economic policies and political structures. Yet these were the same structures that, during the struggle for independence, had been termed demeaning and exploitative to the country by liberation movements, such as TANU. However, it was a challenge for the post-independent state because its origin, structures, makeup, apparatus and operations had been inherited from the colonial masters. Soon, it dawned on Tanzania that political independence did not equate to the total liberation that the majority had expected. A few years after independence, development geared towards modernisation, as per the yardstick of industrialised nations, proved difficult.<sup>580</sup> By 1965, new challenges had emerged, adding to the existing ones of the time. Rising unemployment among a large number of school leavers, inadequate agricultural production, diseases, famine, and hunger were among the urgent concerns.<sup>581</sup>

The continued challenges in Tanzania after independence were not unique to Tanzania. Many countries in Africa that were facing similar challenges called for a shift. The shift focused on appreciating local resources and adopting a practical, realistic, and context-specific approach.<sup>582</sup> While there were many reasons for this shift, including Cold War politics as illustrated below, the need for self-reliance and the elevation of African voices were key factors. From Senegal's Leopold Sedar Senghor's *Negritude* to Ghana's Kwame Nkrumah's 'Consciencism', for example, the new trends span the political, physical, social, and economic aspects, calling for an embrace of an Afrocentric approach to issues. Senghorian *Negritude*, for instance, was 'the awareness, defence, and development of African cultural values, but it also welcomes the complementary values of Europe and the White man'.<sup>583</sup> Senghor's assertion of '*Africanité*' while integrating European ideas underscores the hybrid nature of such concepts, raising doubts about their potential to bring meaningful change as alternative ideologies and about how they intended to navigate the complexities of implementation. It was within this context that Tanzania's vision of socialism and self-reliance was developed and was officially adopted six years after independence. This concept was widely known as *Ujamaa na kujitegemea*.

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<sup>580</sup> Getachew, *Worldmaking after Empire: The Rise and Fall of Self-Determination*.

<sup>581</sup> E. Ronald Watts (ed), *New Hope for Rural Africa: The Proceedings of a Conference Held at the Social Centre Kikuyu, Kenya, September 1967* (East Africa Publishing House, 1969), 1.

<sup>582</sup> Adom Getachew, *Worldmaking after Empire: The Rise and Fall of Self-Determination*.

<sup>583</sup> Senghor 1996:49 cited in Rabaka, *The Negritude Movement: W. E. B. Du Bois, Leon Damas, Aimé Césaire, Leopold Senghor, Frantz Fanon, and the Evolution of an Insurgent Idea*, 200.

### 4.3 Introducing *Ujamaa*: A Brief Overview

The concept of *Ujamaa* has been extensively studied and continues to dominate discussions in the media, academia, and public discourse regarding Tanzania's history, economy, and politics.<sup>584</sup> The prevalence of discussions about *Ujamaa* exceeded President Nyerere's vision of it being debated 'in a bar, on a bus, in school, market or *shamba*, office, in a shop, outside in the open...'.<sup>585</sup> *Ujamaa* went beyond this to become a dominant topic in political discourse, development studies, and economic discussions, particularly in relation to agriculture, which was central to the *Ujamaa* philosophy. However, to provide an entry point essential for locating the relationship between health development in the era of *Ujamaa*, a brief overview of *Ujamaa* is sufficient.

*Ujamaa* is a Swahili word that translates as 'familyhood' or 'brotherhood'. It was developed and popularised by President Nyerere as the most appropriate way to navigate politics, and social and economic development rooted in African philosophies and traditions as opposed to the colonial, capitalistic agenda of the West. As a response to capitalism, socialism was taken as a 'revolution—a way of liberating Africa from further exploitation and neo-colonialism'.<sup>586</sup> Therefore, *Ujamaa* became associated mainly with the writings and speeches of Nyerere. However, its historical, ideological, liberal, and indigenous roots are arguably old.<sup>587</sup> Cornelli, for instance, notes that the historical roots of *Ujamaa* date back to the era of the slave trade and colonialism. It is from this exploitative nature of the slave trade and colonialism that *Ujamaa* came as a counter-movement strongly advocating for equality, liberty and brotherhood.<sup>588</sup> Paul

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<sup>584</sup> 'Maendeleo ya Vijiji vya *Ujamaa*: Sehemu ya Mipango na Utafiti Kikundi cha Takwimu Ofisi ya Waziri Mkuu na Makamu wa Pili wa Rais', 1974; Evaristi Magoti Cornelli, 'A Critical Analysis of Nyerere's *Ujamaa*: An Investigation of Its Foundations and Values' (Doctor of Philosophy, Birmingham, The University of Birmingham, 2012); Donatus Komba, 'Contribution to Rural Development: *Ujamaa* and Villagisation', in *Mwalimu: The Influence of Nyerere*. (London: James Currey Ltd, 1995); Julius Nyerere, *Socialism and Rural Development* (Dar es Saalam: Government Printer, 1967); Watts, *New Hope for Rural Africa: The Proceedings of a Conference Held at the Social Centre Kikuyu, Kenya, September 1967*; Paul Bjerk, *Building a Peaceful Nation: Julius Nyerere and the Sovereignty of Tanzania, 1960-1964*. (New York: University of Rochester Press, 2015); C.K Omari, 'Villagisation and the Potential of the Peasant Reorganisation in Tanzania', in Shigeo Fukuda (ed) *Tanzania: Political Party, Rural Development, Nationalism and International Environment. First Preliminary Report of African Studies (Social Science 1)*, 1980; Goran Hyden, *Beyond Ujamaa in Tanzania: Underdevelopment and an Uncaptured Peasantry* (London: Heinemann, 1980); 'Wasikie Habari za *Ujamaa*', *Ngurumo Newspaper*, 6 January 1970; Julius Nyerere, '*Ujamaa* Vijijini', September 1967; Lal Priya, *African Socialism in Postcolonial Tanzania: Between the Village and the World* (Cambridge: Cambridge University Press, 2015); Emma Athanasio Minja and Julius Maximilian Chuhila, '*Ujamaa* in the Kilombero Valley: Msolwa and Signali Villages as a National Project ca 1967-1990', *Tanzania Zamani* xiv, no. 1 (2022); Gussai Sheikheldin, 'Ujamaa: Planning and Managing Development Schemes in Africa, Tanzania as a Case Study', *The Journal of Pan African Studies* 8, no. 1 (2015): 78–96; 'Maendeleo ya Vijiji vya *Ujamaa*: Sehemu Ya Mipango na Utafiti Kikundi cha Takwimu Ofisi ya Waziri Mkuu na Makamu wa Pili Wa Rais'.

<sup>585</sup> Julius Nyerere, *Freedom and Unity: Uhuru na Umoja. A Selection from Writings and Speeches 1952-65*, 185.

<sup>586</sup> 'TANU Guidelines (Mwongozo Wa TANU).' (University of Dar es salaam: Government Printer). 1971, 1.

<sup>587</sup> Evaristi M. Cornelli, 'A Critical Analysis of Nyerere's *Ujamaa*'.

<sup>588</sup> Evaristi M. Cornelli, 'A Critical Analysis of Nyerere's *Ujamaa*', 52.

Bjerk notes that the concept of *Ujamaa* originated in the traditional African way of life, citing the example of the Chagga people in Northern Tanzania, as described by Petro Itosi Marealle.<sup>589</sup>

The *Ujamaa* policy, as proposed by Nyerere, was therefore a complex and multifaceted concept. It was a product of Nyerere's personal experiences and thoughts, emanating from the traditional communal living of African culture, his experiences during colonialism, ideas from Christian values, and his experiences as a student with ideologies such as Fabianism.<sup>590</sup> Incorporating diverse ideas from various sources added to the complexity of *Ujamaa*. Although Tanzania declared itself non-aligned with either the East or the West, Cold War politics still influenced the situation. At the height of the Cold War, ideologies from the Eastern bloc, particularly those of Russia and China, appealed to many ex-colonies due to their anti-colonial agendas. However, these Eastern socialist ideas were not entirely original, having been influenced by Paris thinkers such as Rousseau, Fourier, and Proudhon. From Paris, these ideas later spread to Russia through Marxist thinkers like Lenin, Trotsky, and Plekhanov.<sup>591</sup>

The blend of anti-colonial ideologies from the East, in opposition to the colonial West, contributed to the development of alternative ideas such as *Ujamaa*. Disconnection from the West, particularly the colonial master, Britain, impacted Tanzanian health policy-making, as shown in the next chapter. In the 1960s, therefore, the prevailing belief that colonialism was the root cause of many issues offered Nyerere hope that *Ujamaa* could address the challenges facing post-independence Tanzania.

The new ideology of *Ujamaa* aimed to reset and restart the nation from a state of underdevelopment. This underdevelopment was due to the failure to detach from capitalistic and exploitative systems as a requisite for socialist development.<sup>592</sup> *Ujamaa*, however, was not an advocacy of returning to pre-colonial African life, but a synthesis of what was considered the best that Africa could learn from modern, industrialised states and the best traditions of African societies.<sup>593</sup>

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<sup>589</sup> Paul Bjerk, *Building a Peaceful Nation*, 100.

<sup>590</sup> David Piachaud, 'Fabianism, Social Policy and Colonialism: The Case of Tanzania.', in *Colonialism and Welfare: Social Policy and the British Imperial Legacy* (Edward Elgar Publishing, 2011).

<sup>591</sup> Sam Maghimbi, 'Populist Theory in Russia and Tanzania: A Collage of Ideas. Professorial Inaugural Lecture', Department of Sociology and Anthropology, University of Dar es Salaam, Serial No. 51 2012.

<sup>592</sup> Karim Hirji, 'Salient Implications of the Silent Class Struggle', *Cheche: Joint Organisation of the University Students Africa's Revolutionary Front (USAF) and TANU Youth League*, no. 3 (October 1970): 28, 32.

<sup>593</sup> Donatus Komba, 'Contribution to Rural Development: *Ujamaa* and Villagisation', 36.

African culture was highly emphasised. According to Nyerere, the traditional African culture was one in which people lived in unity and handled everything collectively.<sup>594</sup> Although the concept of unity was idealised as if no differences existed, *Ujamaa* may have served as a unifying force beyond tribal affiliations. Just as complex as its origin, the development of *Ujamaa* was not an easy task. Though officially launched in 1967, *Ujamaa* was first formally mentioned by Nyerere in 1962.<sup>595</sup> In his inaugural speech on December 10, 1962, Nyerere noted that schools, hospitals, and clean water were only possible if people lived in clustered villages, rather than scattered throughout the countryside.<sup>596</sup> Nyerere emphasised the village perhaps because the majority of the people were peasants and lived in rural areas. He was opposed to the movement of people to live in towns and towards adopting foreign ideas at the expense of African culture. Nyerere noted that one significant change he had made was to form a new ministry, the Ministry of National Culture and Youth, to uphold pride in African culture. For him, '*Utamaduni ni Uhai wa Taifa*' (Culture is the essence and spirit of the nation).<sup>597</sup> *Utamaduni* (culture) was not only displayed in folksongs and dances, but also a mindset that led to acceptance and contentment with one's culture.<sup>598</sup> Thus, he urged the citizens to take pride in their culture and also to embrace change. Nyerere assumed there was one national culture and, influenced by TANU politics, he broadly spoke of 'Tanganyikan Culture'.

The 'Tanganyikan culture', according to Nyerere, advocated for love, respect, and responsibility in work and family, and family members owned that property. However, he was quick to add the disclaimer that he was not for the bad old habits, such as disrespect towards women, and contentment with poverty, as if it was a good thing, yet it was a bad thing.<sup>599</sup> It is not clear how Nyerere defined poverty. However, he emphasised the unity of Tanzanians if they were to eradicate poverty, as well as droughts, diseases, wildlife attacks, human attacks, floods, and other problems. This was not just traditional unity and togetherness, but a 'modern' *Ujamaa*, which encompassed education, modern skills, and information.<sup>600</sup> His clarion call was '*Natuchukue Ujamaa wetu wa asili, tuondoe dosari zake na halafu tusaidiane kwa elimu, na maarifa ya kisasa, yetu yenyewe au ya kuazima kutoka nchi zilizoendelea*'.<sup>601</sup> (Let us take the traditional *Ujamaa* and improve from its shortcomings through education, with our

<sup>594</sup> Julius Nyerere, 'Ujamaa Vijijini', 1.

<sup>595</sup> Julius Nyerere, *Socialism and Rural Development*.

<sup>596</sup> CCM Library Dodoma 'Kuandikishwa kwa Vijiji, Vijiji vya *Ujamaa* na Uongozi Wake: Hotuba ya Waziri Mkuu na Makamu wa Pili wa Rais Akiwakilisha Ndani ya Bunge Muswada wa Vijiji na Vijiji vya *Ujamaa*', 1975.

<sup>597</sup> Julius Nyerere, *Freedom and Unity*, 186.

<sup>598</sup> 'CCM Library Dodoma, Malezi Bora ya Watoto Kitaifa' (Idara ya Ustawi wa jamii, 1976), 3.

<sup>599</sup> Julius Nyerere, 'Ujamaa Vijijini', 2.

<sup>600</sup> Julius Nyerere, 'Ujamaa Vijijini' 3.

<sup>601</sup> Julius Nyerere, 'Ujamaa Vijijini' 4.

contemporary knowledge, technology, or knowledge we have acquired from developed nations). This move was not to show dislike or intolerance for other cultures, for according to Nyerere, that would be retrogressive, and such a society would only be described as that of ‘idiots and lunatics’.<sup>602</sup> For accepting one’s culture did not mean dismissing other people’s ways of life but enhancing knowledge without thinking that the different cultures were either superior or inferior.

At the centre of national development and politics of *Ujamaa* was agriculture based on collective farming and the ‘villagisation’ of the countryside. Out of a population of ten million, only 250,000 to 300,000 lived in urban areas.<sup>603</sup> From these numbers, it was clear that Tanzania was a ‘country of peasant farmers’ whose plight could be improved only by improving agriculture. The postcolonial desire to change from the colonial line of agricultural development called for an ‘improvement approach’. The aim was to modernise agriculture. This was interpreted to mean incorporating tractors and ploughs in the place of the hand hoe. The ‘improvement approach’ was quickly followed by the ‘transformative approach’—leading to the formation of the Village Settlement Agency (VSA).<sup>604</sup> These ideas were not entirely new, as the colonial government had similar settlement strategies.<sup>605</sup> VSA aimed to improve agriculture speedily through the establishment of proper villages.<sup>606</sup> Without villages, Tanzania would not realise development. In trying to explain the question ‘why villages?’, Nyerere noted that:

...unless we do (*villages*,VK) we shall not be able to provide ourselves with the things we need to develop our land and raise our standards of living, we shall not be able to use tractors, we shall not be able to provide schools for our children, we shall not be able to build hospitals, or have clean drinking water, it will be pretty impossible to start small village industries and instead we shall have to go depending on towns for all our requirements and even if we had a plentiful supply of electric power, we should never be able to connect it up to each isolated homestead.<sup>607</sup>

The rural-urban divide was noticeable at independence. As noted in the previous chapter, migration to urban areas continued after independence, and most colonial structures and development were centred in these areas. Thus, the argument after independence was that colonialism had introduced capitalism and made urban living a measure of a ‘good life’. This illusion prompted young people to leave the rural areas in search of the ‘better life’ they thought

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<sup>602</sup> Julius Nyerere, *Freedom and Unity: Uhuru na Umoja. A Selection from Writings and Speeches 1952-65*, 187.

<sup>603</sup> Julius Nyerere, *Freedom and Unity: Uhuru Na Umoja. A Selection from Writings and Speeches 1952-65*, 183.

<sup>604</sup> Goran Hyden, *Beyond Ujamaa in Tanzania: Underdevelopment and an Uncaptured Peasantry*.

<sup>605</sup> Coulson, *Tanzania: A Political Economy*.

<sup>606</sup> Donatus Komba, ‘Contribution to Rural Development: *Ujamaa* and Villagisation’.

<sup>607</sup> Julius Nyerere, *Freedom and Unity: Uhuru na Umoja. A Selection from Writings and Speeches 1952-65*, 184.

they could find in the city. As a result, they abandoned agriculture, which affected the production of both cash and food crops.<sup>608</sup> According to Nyerere, life was only ‘better’ in the cities because people lived close together, which made the provision of services easier. However, the assumption that life in urban areas was always better than in rural areas was false because he viewed urban areas as ‘sites of decadence’ and thus advocated for rural life.<sup>609</sup> *Ujamaa*, therefore, would help to address the questions of African culture and unemployed youth in urban areas, simultaneously diffuse racial and tribal divisions, and help to navigate the Cold War.<sup>610</sup>

The majority of the citizens in Tanzania heeded the president’s call towards *Ujamaa*. Villages and settlement schemes became the plank of the Tanzanian independence development agenda. As early as 1962, in the Kilombero Valley, for instance, the government initiated construction of three settlement schemes at Sonjo, Ichonde, and Kichangani.<sup>611</sup> By 1963, the cooperative union in Ulanga had obtained tractors from the government on credit.<sup>612</sup> The call was for self-help schemes to supplement the slow growth and implementation process after the 1961/63 development plan.<sup>613</sup> Nyerere noted that, as a result of this development plan, people built schools and dispensaries, but in an uncoordinated manner, leaving some without staff. Similarly, roads were constructed that ended at streams with no bridges. Even before *Ujamaa*, some dispensary structures were built through people’s efforts, but often remained unused for a year due to a lack of equipment.<sup>614</sup> The people were eager to help themselves but needed ‘leadership and technical association’.<sup>615</sup> The 1962 schemes, however, relied heavily on the government for support.<sup>616</sup> By 1965, the schemes had proved to be expensive, had little impact on the majority, and were hence unsustainable.<sup>617</sup> The expected change of eradicating poverty through these programmes was not realised.<sup>618</sup>

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<sup>608</sup> Julius Nyerere, *Socialism and Rural Development*, 6.

<sup>609</sup> Paul Bjerck, *Building a Peaceful Nation*, 100.

<sup>610</sup> Paul Bjerck, *Building a Peaceful Nation*, 101.

<sup>611</sup> Emmanuel Sulle and Rebecca Smalley, *Kilombero Stakeholders Report: Study of Sugarcane Outgrowing at Kilombero*. (2015), 2.

<sup>612</sup> Jätzold and Baum, *The Kilombero Valley*, 69.

<sup>613</sup> Julius Nyerere, ‘TANU National Conference: 10 Years After Independence’, 8.

<sup>614</sup> ‘Hansard. Majadialiano ya Bunge, Mkutano wa Nne, Sehemu ya Pili. Tarehe 1-21 Julai 1966’, July 11, 1966, 2275.

<sup>615</sup> Julius Nyerere, ‘TANU National Conference: 10 Years After Independence’, 8.

<sup>616</sup> ‘Third Five-Year Plan for Economic and Social Development, 1st July 1974 to 30th June 1981, Vol 1’, 1974, 104.

<sup>617</sup> C.K Omari, *Villagisation and the Potential of the Peasant Reorganisation in Tanzania*, 48.

<sup>618</sup> Donatus Komba, ‘Contribution to Rural Development: *Ujamaa* and Villagization’.

Nyerere did not abandon the rural development agenda. By 1966, Nyerere realised that Tanzania's economic problems could only be solved through African socialism.<sup>619</sup> For him, it was through *Ujamaa* that Tanzanians would be freed from 'exploitation, laziness, and dependency'. *Ujamaa* would also cultivate hard work and self-sufficiency.<sup>620</sup> For Nyerere, *Ujamaa* was not only 'transformative but restorative'.<sup>621</sup> The difference between the newly proposed *Ujamaa* and the 1962 programmes was that the latter were not officially declared as a policy; therefore, the majority still preferred the city over the rural areas, and those in agriculture still had capitalistic tendencies.

In January 1967, the National Executive Council (NEC) of TANU held a conference in Arusha to address the numerous emerging and ongoing problems related to the country's economic situation and the way forward. The proceedings were made and adopted on 5<sup>th</sup> February 1967 as the Arusha Declaration (AD). The AD was a response to the deteriorating socio-economic and political problems, most of which were associated with the colonial past and Tanzania's continued alignment towards the policy of the colonial masters. The AD was thus a renewal of optimism that accompanied Tanzania's independence in 1961.<sup>622</sup> Additionally, the AD was intended to foster unity among Tanzanians by uniting them around a common goal.

Under the new dispensation of *Ujamaa*, rural life was to be self-reliant. The villages would not depend on the government but on the villagers' strength and morale. Instead of establishing villages in select places, as had been done in the past, the new plan was to establish villages in all regions of the country. The plan was for the villages to develop and implement their own programmes. In the villages, people would work together on farms, produce crops for sale and consumption, plan their development agenda, and take care of their welfare. The management was done through cooperatives. According to Nyerere, widows, orphans, and unmarried individuals were better positioned in *Ujamaa*.<sup>623</sup> A sick man, too, would be cared for by the other *wajamaa*.<sup>624</sup> Upon recovery, the person was expected to return to work for the benefit of the village. Pretence or feigning sickness or laziness was fined. The fine was in kind or cash, depending on the decision of the village council. In most cases, a chicken was taken as a fine,

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<sup>619</sup> Juhani Koponen, *Development for Exploitation: German Colonial Policies in the Mainland Tanzania, 1884-1914* (Hamburg: Lit Verlag, 1994), 95.

<sup>620</sup> Priya Lal, *African Socialism in Postcolonial Tanzania: Between the Village and the World*, 27.

<sup>621</sup> Priya Lal, 27.

<sup>622</sup> 'Background to the Budget: An Economic Survey 1968-69 Prepared Jointly by the Ministry of Economic Affairs and Development Planning and the Ministry of Finance', n.d., 2.

<sup>623</sup> Julius Nyerere, 'TANU National Conference: 10 Years After Independence', 22.

<sup>624</sup> Julius Nyerere, *Socialism and Rural Development*, 17.

but this sparked debate in parliament because it was seen as punitive.<sup>625</sup> The person being punished was supposed to appeal to the District Commissioner (DC). However, it is questionable whether such a person ever received justice, as the entire system was deeply intertwined with TANU politics.

In *Ujamaa*, illness was an opportunity for a ‘therapy management group’ formed by relatives and fellow *wajamaa*.<sup>626</sup> Living together was assumed to enable the government to deliver services to the people much more easily, efficiently and cheaply.<sup>627</sup> The language of *Ujamaa* was that of accord, such that people spoke of ‘chakula chetu (our food), ardhi yetu (our land), mama fulani (mother to...), baba fulani (Father to...) and the fruits of their hard work were the benefit of the whole village’.<sup>628</sup> Nyerere opposed the competitive nature of farmers; instead, they were expected to work in cooperation with one another.<sup>629</sup> This is how, according to Nyerere, pre-colonial Africa understood and handled life.<sup>630</sup> However, this does not imply that life in pre-colonial Africa was devoid of competition. Nyerere recognised that competition existed, it was multi-layered, but not as extreme as the capitalistic tendencies that later emerged with colonialism. What did these developments mean to health-policy planning?

#### **4.4 National Health Policy Planning and *Ujamaa***

In 1967, *Ujamaa* politics framed health as both a communal right and a shared responsibility. As a right, this meant prioritising healthcare access for underserved areas, especially rural regions. As a shared responsibility, it emphasised that healthcare provision was not solely the government’s duty but a collective effort involving everyone. However, by 1967, the majority of the Tanzanians in rural areas had yet to access biomedical healthcare. Hospitals, as well as health workers and equipment, were scarce. Even though the urban poor faced challenges accessing healthcare, as noted in the previous chapter, the vast majority of peasants living in rural areas were in a worse position. This situation replayed the colonial plans described in Chapter 2, where health facilities were concentrated in the urban and productive regions. This reality portrayed a sustained colonial and postcolonial economic agenda in which health was often secondary to agricultural or industrial needs and was closely tied to economic output. Thus, it was a failure on the part of the postcolonial government's promise in 1961 to provide

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<sup>625</sup> ‘Hansard, Majadiliano ya Bunge Taarifa Rasmi Mkutano wa Kumi na Tano, 7-10 Januari 1969’, Januari 8, 1969, 110.

<sup>626</sup> J.D Goodyear, ‘Review of John Janzen Quest for Therapy: Medical Pluralism in Lower Zaire’, *International Journal of Africa Historical Studies*, 1978, 561.

<sup>627</sup> ‘Third Five-Year Plan for Economic and Social Development, 1st July 1974 to 30th June 1981, Vol 1.’

<sup>628</sup> Julius Nyerere, *Ujamaa Vijijini* 1,16.

<sup>629</sup> Julius Nyerere, *Socialism and Rural Development*, 6.

<sup>630</sup> Julius Nyerere, *Ujamaa Vijijini* 1.

health as a way of dignifying and restoring freedom and pride to the nation.<sup>631</sup> Instead, the health system was the most neglected of all sectors, as shown in the budgetary allocations in the previous chapter.

The *Ujamaa* policy was pro-rural development. The argument was that through rural development, the country would realise a speedy socio-economic development. Rural development through *Ujamaa* was seen as the only way to end ignorance, disease and hunger.<sup>632</sup> In an era where rural development and agricultural productivity were the basis on which all the other sectors depended, rural health gained increased attention. The provision of social services in rural areas became a central component of the *Ujamaa* agenda. This coincided with the shifts in the field of planning during the late 1960s and early 1970s, which called for a worldwide emphasis on social aspects in their development strategies. This attention gave birth to what Diana Conyers calls ‘Social Planning’.<sup>633</sup> In social planning, there was concern for neglected areas, and in the ex-colonies, it led to a call for increased attention to rural regions such as the Kilombero Valley. Providing health services to these underserved areas was seen as a path to achieving equality and justice.<sup>634</sup>

In Tanzania, health equality and justice were envisioned in a *Ujamaa* village. The plan sought to achieve dual objectives: ensuring that individuals were healthy enough to return to farming and be productive, while also addressing nutritional deficiencies through agricultural activities. As already noted, both the colonial and postcolonial eras needed healthy people to be productive economically. The willingness to be self-reliant added to the motivation of the people. It was time to live by the words of *Mwalimu* Nyerere that Tanzania would be built by the Tanzanians (*Tanzania itajengwa na watanzania wenyewe*).<sup>635</sup>

With *Ujamaa*, there was renewed hope for better health. The improvement of the health sector was aligned with other socio-political and economic agendas. TANU was at the forefront of popularising the anticipated glorious ‘healthy’ future. The Minister of Health at the time, Lawi Sijaona, assured the people that with *Ujamaa*, the ministry would facilitate, more than before, the raising of the living standards and health of the people.<sup>636</sup> Apart from the futuristic hope in

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<sup>631</sup> Editorial, ‘Food and National Prestige’, *The Nationalist*, January 24, 1967; Julius Nyerere, *Freedom and Development: A Selection of Writings and Speeches, 1963-1978*. (Dar es Salaam: Oxford University Press, 1973), 58.

<sup>632</sup> President’s Office, ‘1-20’, 1.

<sup>633</sup> Conyers, *An Introduction to Social Planning in the Third World*, 1.

<sup>634</sup> Diana Conyers, *An Introduction to Social Planning in the Third World*.

<sup>635</sup> ‘TNA, HE/150/2 Mchango wa Jengo la TANU’ (1973).

<sup>636</sup> ‘*Ngurumo Newspaper*, Juni 3, 1972, *Huduma za Afya kwa Wajamaa*’, 5.

government health facilities and biomedicine, the *Ujamaa* set-up promoted a holistic perspective of healthcare. The living conditions in the village were designed to be inclusive and supportive, ensuring that no one needed to worry about old age, illness, or death. The sick, children of vulnerable individuals, and the elderly, as well as widows, orphans, and other vulnerable members of the community, would all be cared for. Older people would care for the children while their mothers worked on the farms.<sup>637</sup> In the spirit of self-reliance, the village would include teachers, doctors, carpenters, and other professionals working for the benefit of the entire community. This idealised vision of a perfect *Ujamaa* village was compelling to many, especially in regions such as the Kilombero Valley, where most people still lived on limited economic means.

In each village, a village health post was to be established. It would be located in a school or public building whose primary role was to provide basic first aid. It was also used to treat minor illnesses and injuries, as well as serve as a centre for health campaigns.<sup>638</sup> In a worst-case scenario, if a village lacked a health post, it would ensure that there was a first aid box. The 'First-aid-kit scheme' was launched in 1969 to help reduce the long distance covered to access health care and also to prevent minor ailments from getting to the hospitals. The health post was to be staffed by a Village Medical Helper (VMH), an individual selected by the villagers, thus ensuring community involvement and accountability in the provision of healthcare services.<sup>639</sup> The qualification for a VHM was to be aged 25-45 years old, married, and living with their spouse in the village in a permanent residence on their farm or house. They were to be liked by all and a diligent member of TANU.<sup>640</sup> Choosing and deciding about the health post at the village level was based on the argument that no other entity could understand the problems within a particular unit better than the people themselves.

Villages were to decide their priorities; whether they needed water, schools or dispensaries. Health needs were localised down to the village level. The 'village(r)s could define their destiny as party instruments without linkage to the district'.<sup>641</sup> The independence of village decision-making, however, is questionable in an era when TANU's political and economic programmes were primarily aligned with the national agenda, as shown below. For instance, while Nyerere

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<sup>637</sup> Julius Nyerere, 'Ujamaa Vijijini', 16.

<sup>638</sup> Gish, 'The Way Forward: World Health Organisation', 10.

<sup>639</sup> 'Third Five-Year Plan for Economic and Social Development, 1st July 1974 to 30th June 1981, Vol 1.', 106.

<sup>640</sup> Andrea Kifyasi, 'Neither a Saviour nor Exploiter: A Historical Study of China's Medical Assistance in Post-Colonial Tanzania.' (University of Basel, 2021), 90.

<sup>641</sup> Innocent A.J. Semali et al., 'Health Reform Cycles in Tanzania: 1924-1994', *Tanzania Journal of Development Studies* 7, no. 2 (2007): 92.

advocated for village development, his statement that he would create a ‘new Department of Development Planning—directly under his control’—to rapidly develop plans for village progress across the country,<sup>642</sup> raises concerns about the autonomy of local governance at the village level.<sup>643</sup>

By the end of 1967, through the *Ujamaa* spirit, many village posts run by the village health workers were in operation. There was a progressive increase in the number of health facilities and health workers (See Table 8). The goal was that with the increased population and revenue, the health post would graduate to a dispensary, which was tasked with providing outpatient services and a centre for organising maternity services.<sup>644</sup> This was a replica of the spirit of unity portrayed after independence, when the communities mobilised and built many dispensaries.<sup>645</sup>

Facility/health worker/year	1961	1972	1980(Actual)	1980 (Target)
<b>Health Centres</b>	22	99	239	300
<b>Dispensaries</b>	975	1,501	2,600	2,300
<b>Medical Assistants</b>	200	335	1,400	1,200
<b>RMA</b>	380	578	2,310	2,800
<b>Village Midwives/MCHA</b>	400	700	2,070	2,500
<b>Health Auxiliaries</b>	150	290	681	1,800

Table 8: Development of the Rural Health Care between 1961 and 1980.  
Adopted from Heggenhougen et.al 1987, pg 28

*Ujamaa*’s efforts aligned with the policy of the MOH of expansion of the health sector in terms of facilities, personnel and equipment. The overall goal of the MOH was to add 100 dispensaries per year. The construction cost for each dispensary was \$7,000, with an annual operating cost of \$4,000.<sup>646</sup> For a developing country like Tanzania, this was a significant expense, which could not be realised without the collective efforts of all Tanzanians. Therefore, villagers united to build dispensaries and health posts in line with the *Ujamaa* policy of self-reliance. However, just as their predecessors, these dispensaries lacked equipment and personnel, and, as shown below for the case of the Kilombero Valley, not every village managed to build a dispensary, let alone operate one. ‘A standard dispensary had two maternity beds, a latrine, one-staff

<sup>642</sup> Julius Nyerere, *Freedom and Unity: Uhuru na Umoja. A Selection from Writings and Speeches 1952-65*, 184.

<sup>643</sup> See also Paul Bjerk, *Building a Peaceful Nation*.

<sup>644</sup> Oscar Gish, ‘The Way Forward: World Health Organisation’, 11.

<sup>645</sup> Innocent J. Semali *et al*, ‘Health Reform Cycles in Tanzania: 1924-1994’, 92.

<sup>646</sup> Oscar Gish, ‘The Way Forward: World Health Organisation’, 11.

quarter, waiting area, an examination, treatment, storage and a laboratory “corner” all in a two-roomed building.<sup>647</sup> This was far too demanding for an economically unstable village.

The implementation of *Ujamaa* followed a specific set of guidelines. The Arusha Declaration was followed by the publication of policy documents, parliamentary acts, and other documents that emphasised, simplified, or elaborated on the *Ujamaa* concept. Documents such as ‘Education for Self-reliance’, ‘Socialism and Rural Development’ and ‘TANU guidelines’, among others, were published.<sup>648</sup> At the top of the agenda were infrastructural and agricultural development. Although health was termed a key criterion for development,<sup>649</sup> No single document was published regarding health matters. It was only mentioned in the broader development plans. In other words, no policy document addressed the National Health Policy directly.<sup>650</sup> This does not imply that health was absent from the agenda; rather, it reflects the priorities shaped by TANU’s political economy.

In the following section, I discuss health policies, health development, health needs, and planning within the broader context of *Ujamaa* pronouncements and policies. These policies were centred around the primary goal of *Ujamaa* agriculture development, which was closely connected to rural health, nutrition, and health education in villages. Health planning also involved the use of campaigns, which impacted general health and maternal health in particular.

#### **4.5 Rural Health and *Ujamaa* Planning in the Kilombero Valley**

The Arusha Declaration and the Second and Third Five-Year Development Plans (1969–1974 and 1974/75–1980/81) were conceived as mutually reinforcing frameworks, each intended to influence and shape the other in an integrated manner.<sup>651</sup> These plans prioritised preventive healthcare, as it was considered more cost-effective than curative care. The four main health-related issues covered in the second five-year development plan included water, MCH, nutrition, and prevention of communicable diseases.<sup>652</sup> Dr. Sifuel J. Mamuya summarised the

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<sup>647</sup> Oscar Gish, ‘The Way Forward’ 11.

<sup>648</sup> Julius Nyerere, *Socialism and Rural Development*; Julius Nyerere, ‘Education for Self-Reliance’, March 1967; ‘TANU Guidelines (Mwongozo Wa TANU)’.

<sup>649</sup> CCM Library ‘Sera ya Wanawake Katika Maendeleo Tanzania’ (Wizara ya Maendeleo ya Jamii, Utamaduni, Vijana na michezo., August 1988), 2.

<sup>650</sup> The first National Health Policy document was in 1990.

<sup>651</sup> ‘United Republic of Tanzania, Second Five-Year Plan for Economic and Social Development, 1st July 1969 to 30th June 1974 Vol 1’; ‘Third Five-Year Plan for Economic and Social Development, 1st July 1974 to 30th June 1981, Vol 1’.

<sup>652</sup> ‘United Republic of Tanzania, Second Five-Year Plan for Economic and Social Development, 1st July 1969 to 30th June 1974 Vol 1’.

goals in this plan as more food, more education and more health (*'shibe zaidi, elimu zaidi, afya zaidi'*).<sup>653</sup> The TANU biennial meeting in 1971 also emphasised the need for schools, water and health. According to Oscar Gish, the Ministry of Health 'was ordered to translate the Party's decision into specific actions'.<sup>654</sup> The Party had then decided to prioritise preventive health.

Preventive services included MCH services. Maternal health campaigns, for instance, were crucial because they played an essential role in the development of rural dispensaries and health centres. MCH services were required throughout the year. MCH policy plans emphasised vaccinations, which were to be increased to cover 9 per cent of the population by 1975. Additionally, a pregnant woman was required to attend the clinic at least once before she delivered. The plan also promised to increase mobile health services by utilising bicycles to access remote areas, thereby enabling more people to access health services. In the Kilombero Valley, these plans were crucial in addressing the inadequate transportation infrastructure. Although a railway existed from Mikumi to Ifakara, even before TAZARA, and a road connected Kidatu to Ifakara, the interior of the vast Kilombero region remained inaccessible. Some of the health workers narrated how they trekked for long distances in the interior.<sup>655</sup>

The *Ujamaa* organisation transformed maternal healthcare. *Ujamaa's* main agenda of raising the living standards spoke directly to what affected the daily lives of women and children. For instance, daily chores such as farming, cooking, and gathering water and firewood, which were often relegated to women's work, significantly impacted the overall health status of society.

#### **4.5.1 Rural Women, Agriculture and MCH**

With agriculture at the centre, the implementation of *Ujamaa* was inherently dependent on access to land, as agriculture was the primary driver of economic development.<sup>656</sup> Paul Bjerck adds that 'land was an element of *Ujamaa's* power'.<sup>657</sup> This was particularly significant in rural areas, where agricultural potential determined the viability of communal production and broader development initiatives.

Traditionally, each community had its system of land tenure. In some societies, land was communally owned, with rights extending from the community level to individual families and

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<sup>653</sup> Dr. S.J Mamuya, *Maarifa Mapya ya Kuelimisha Afya* (Nairobi: EALB, 1971), 1.

<sup>654</sup> Oscar Gish, 'The Way Forward: World Health Organisation', 8.

<sup>655</sup> Oral Interview with Margret Naftali Kidasi at Ifakara on September 25, 2023.

<sup>656</sup> Julius Nyerere, *Socialism and Rural Development*, 10.

<sup>657</sup> Paul Bjerck, *Building a Peaceful Nation*, 100.

clans.<sup>658</sup> Regarding land tenure, Julius Nyerere opposed the freehold system, viewing it as an imposition of foreign concepts on African societies. Instead, he advocated for a leasehold system in which land was held by the nation of Tanganyika rather than by individuals. Nyerere argued that freehold tenure would lead to the tribalisation of land, undermining its status as a national asset. However, this approach largely mirrored the colonial land ordinance, with the key modification being the replacement of the term ‘governor’ with ‘president’, thereby consolidating land ownership under the authority of the presidency.<sup>659</sup>

Without land, agriculture was impractical, and without labour, it could not reach its full potential. As noted in Chapter 2, the recognition that labour was a crucial output in economic development can be traced back to colonial times. Labour was inherently linked to human health (see Figure 15). The relationship between labour and agriculture necessitated an emphasis on health during *Ujamaa*. In the design of *Ujamaa*, working on the farm was the plank upon which progress rested. Although there was a call to use more advanced methods, such as tractors, human labour was still primarily used.

Agriculture in the Kilombero Valley, like in many other African agricultural communities, was heavily dependent on women.<sup>660</sup> Therefore, women were at the core of the revolution in *Ujamaa* life and self-reliance.<sup>661</sup> The women tilled the land, planted the seeds and did the harvesting. They were also responsible for preparing food for the family and fetching water and firewood.<sup>662</sup> As noted by Priya Lal, ‘if men were the guardians of the Tanzanian national security, women were to be the guardians of the food security and wellbeing of their families and therefore, a true female soldier of *Ujamaa* socialism was a devoted mother both to her children and by extension to the nation as a whole’.<sup>663</sup>

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<sup>658</sup> James Roden Williams, *Land Tenure and Policy in Tanzania*. (EALB, 1971); ‘Shivji, Issa G. “Land Tenure Problems and Reforms in Tanzania.” Sub-Regional Workshop on Land Tenure Issues in Natural Resource Management in the Anglophone East Africa with a Focus on the IGAD Region,’ Addis Ababa, Ethiopia 1996.

<sup>659</sup> ‘Land Ordinance, 1923 (Ordinance No.3 of 1923)’, accessed on <https://faolex.fao.org/docs/pdf/tan44821.pdf> on October 11, 2024.

<sup>660</sup> René Dumont and Marie Mottin, *Stranglehold in Africa* (Andre’ Deutsch, 1983), 133.

<sup>661</sup> ‘Akina Mama Katika Picha’, *Uhuru*, Oktoba 4, 1969. Oral interview Marrietta Kindindi February 7, 2025.

<sup>662</sup> Focus Group Discussion with women at Uwanja wa Ndege, Ifakara on September 25, 2023.

<sup>663</sup> Priya Lal, *African Socialism in Postcolonial Tanzania: Between the Village and the World*, 6.

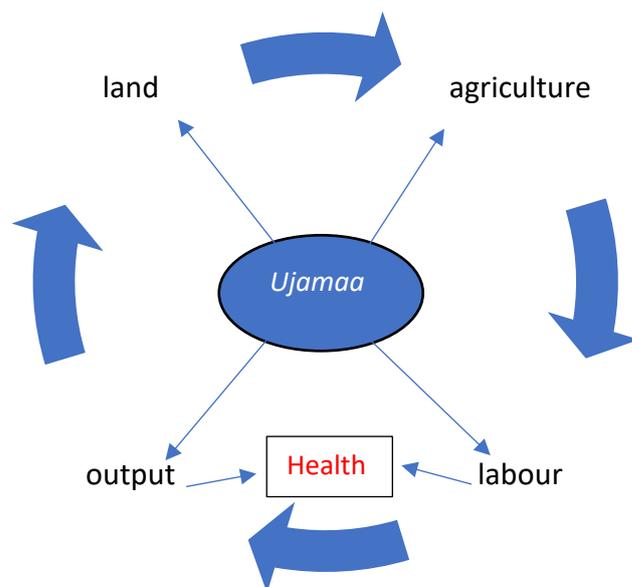


Figure 15: Relationship between Agriculture, Health and Labour.

Marrieta Kindindi observed that the majority of men in the Kilombero Valley were often characterised by a lack of industriousness and a reliance on women’s labour.<sup>664</sup> Unfortunately, many women did not own ancestral land, nor did they control the proceeds from the private farms, except for the small kitchen garden from which they fed the family.<sup>665</sup> At Ifakara, women narrated their displeasure with men who wanted to control the rice harvest while women did all the work.<sup>666</sup> There was a conspicuous disconnect between those who controlled the proceeds and those who undertook most of the responsibilities on the farm. This illustrates the fact that, insofar as *Ujamaa* was said to resemble African culture, traditional African life and *Ujamaa* exhibited both similarities and differences in several aspects. In the Arusha Declaration, Nyerere acknowledged that while *Ujamaa* drew from African traditions, there was a pressing need to enhance the status of women.<sup>667</sup> He explicitly condemned the discrimination and oppression of women, recognising their crucial roles in both production and reproduction within society.

Despite President Nyerere’s call to improve the plight of women, the new *Ujamaa* arrangement failed to reflect this initiative. The existing structure, in particular, reflected the ill health of society. Cholera, intestinal worms and malaria were common. The presence of lice, bedbugs, and fleas was commonly accepted as usual, reflecting the poor hygiene conditions within

<sup>664</sup> Oral interview with Marrieta Kindindi at St Francis Hospital, Ifakara February 7, 2025.

<sup>665</sup> CCM Library Dodoma ‘Sera ya Wanawake katika Maendeleo Tanzania’.

<sup>666</sup> Focus Group Discussion with women at Uwanja wa Ndege, Ifakara on September 25, 2023.

<sup>667</sup> Julius Nyerere, *Socialism and Rural Development*.

households. But ‘how could we enhance cleanliness when even soap had to be bought by the fathers, many of whom were irresponsible or managing many households in a polygamous setup?’<sup>668</sup> The woman was responsible for managing the domestic sphere, although she often had to depend on her husband for almost everything.

In the Kilombero Valley, daily home chores were considered the domain of women, even pregnant women, who were rarely exempt from domestic work. Structurally, the socio-political and economic make-up of Tanzania expected rural women to take care of the domestic sphere. Women in Ifakara recounted how, before the drilling of boreholes near their homes, they had to fetch water from the Lumemo River, often navigating steep terrain, regardless of whether they were pregnant or not.<sup>669</sup> After fetching water, they still had to perform other duties on the farm and at home. This situation echoes the observations of Dumont and Mottin, who noted that some peasant women in Tanzania walked many kilometres barefoot with babies on their backs until they finished an acre’s worth of harvest, or 20 km and back, to bring back a bucket of water for domestic use. Such labour was highly demanding for women, yet it became so commonplace that it often went unrecognised, and even when recognised, nothing was done about it. For instance, men resisted putting their cattle to work, yet had no problem with women doing the labour.<sup>670</sup>

In *Ujamaa* politics, men were quick to request machinery and tractors, despite their expense and unsustainability, rather than carts, because the latter were associated with women’s work.<sup>671</sup> This practice persisted because *Ujamaa* political councils were composed mainly of men, with few women who rarely had a voice. Consequently, women worked more than anyone else, seven days a week, but were largely excluded from decision-making and policy-making.

*Ujamaa*’s policy, which advocated for collective involvement in nation-building, can be argued to have increased women’s workload rather than alleviating it. In addition to farm work, women also had to seek medical services, for instance, which often included their own needs as well as those of their children. On January 8, 1969, the role of women in *Ujamaa* activities was debated in parliament. The general mood was opposed to a law granting pregnant and breastfeeding women up to 3 years of maternity leave post-delivery, exempting them from participating in everyday *Ujamaa* activities. MP Kasubi argued that by raising children, these women were

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<sup>668</sup> Oral interview with Marrietta Kindindi at St Francis Hospital, Ifakara February 7, 2025.

<sup>669</sup> Focus Group Discussion with women at Uwanja wa Ndege, Ifakara on September 25, 2023.

<sup>670</sup> René Dumont and Marie-France Mottin, *Stranglehold in Africa*, 75, 134.

<sup>671</sup> René Dumont and Marie-France Mottin, *Stranglehold in Africa*, 84.

already making significant contributions to the nation. However, most MPs favoured reducing this exemption period to one year.<sup>672</sup>

The challenges associated with women taking on these roles raise important questions about their impact on well-being. First, apart from weakening their bodies, it left them with no time to pursue other activities, such as seeking medical care. Secondly, women were encouraged to participate in nation-building beyond the home and farm. This involved engaging with other sectors, such as industries and professional fields, including teaching, nursing, and other jobs in schools, dispensaries, and companies like Kilombero Sugar.<sup>673</sup> It was assumed that one way to combat women's 'oppression' was to integrate them into the workforce, thereby reducing their domestic confinement, where men often controlled them. However, TANU politics were highly patriarchal, and the majority of the women in TANU supported the status quo. Most of the women leaders of the *Umoja wa Wanawake wa Tanzania* (UWT), such as Susan Kawawa, were the wives of prominent TANU politicians.<sup>674</sup> These women leaders promoted topics such as home and baby care, nutrition, and health issues.<sup>675</sup> In both rural and urban areas, particularly in Dar es Salaam, women leaders were concerned about maintaining a conservative image that would not be tarnished by the city's evils.<sup>676</sup> These attitudes perpetuated the colonial curriculum on gendered education, focusing on basic hygiene and nutrition at the family level, which was perpetuated in the postcolonial political economy.

The conservative TANU women leaders supported initiatives to involve women in work beyond the farm, extending to other sectors within the 'precepts' of social norms of the Tanganyika people. By doing so, they envisioned Tanzania as a homogeneous space reflecting TANU's agenda of national unity, regardless of the unique differences and needs of the people. UWT, for instance, came up with publications on 'good parenting', which were used in many places in the country, in seminars and other educational meetings.<sup>677</sup> In 1975, UWT conducted workshops in various regions, covering a range of topics, including politics and economics; however, matters of nutrition and home economics took precedence (see Table 9). It was recorded that by 1975, 4,543 women were taught. It was not clear why these teachings were explicitly conducted in these regions, but the expectation was that they would take the information back to *Ujamaa* villages.<sup>678</sup> In the Kilombero area, some of our female respondents

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<sup>672</sup> 'Hansard, Majadiliano ya Bunge Taarifa Rasmi Mkutano wa Kumi na Tano 7-10 Januari 1969', 8 January 1969, 109, 110.

<sup>673</sup> Oral interview with Grace Nakuyoa at Kidatu, October 1, 2023.

<sup>674</sup> Priya Lal, *African Socialism in Postcolonial Tanzania: Between the Village and the World*.

<sup>675</sup> TNA, CD/CD.U.4. /8 (18) PMS's Office Dodoma (PMO) cited by Priya Lal, 2015, 7

<sup>676</sup> Callaci, *Street Archives and City Life: Popular Intellectuals in Postcolonial Tanzania (Radical Perspectives)*.

<sup>677</sup> CCM Library, 'Malezi Bora ya Watoto Kitaifa'.

<sup>678</sup> CCM Library, 'Umoja wa Wanawake wa Tanganyika (UWT). Taarifa ya Mwaka 1975' (1975).

recalled such teachings and activities. Through UWT, activities and health education were brought to the rural areas.

Region	Topics
<b>Morogoro</b>	<ul style="list-style-type: none"> <li>• Taking care of babies</li> <li>• Good leadership</li> <li>• Good Food and upbringing</li> </ul>
<b>Lindi</b>	<ul style="list-style-type: none"> <li>• Food is life</li> <li>• Economic activities</li> <li>• the status of women</li> <li>• Marriage law</li> </ul>
<b>Iringa</b>	<ul style="list-style-type: none"> <li>• The History of the Party</li> <li>• Discipline of school children</li> <li>• Manual labour</li> <li>• Politics</li> <li>• Home economics</li> </ul>
<b>Arusha</b>	<ul style="list-style-type: none"> <li>• The History of the Party</li> <li>• Discipline of school children</li> <li>• Health Education</li> <li>• Party activities (economics)</li> <li>• Establishment of day-care centres</li> </ul>
<b>Dar es Salaam</b>	<ul style="list-style-type: none"> <li>• The responsibility of women</li> <li>• Economics</li> <li>• Marriage law</li> <li>• Maternity leave law</li> </ul>

*Table 9: The teachings organised by UWT in different regions in 1975.  
Source: UWT, Taarifa ya Mwaka, 1975.*

TANU women leaders concentrated on the domestic sphere. In addition to the teachings in seminars and workshops, they advocated for the establishment of daycare centres (see Figure 16). These centres were designed to care for young children aged 2-5 years while their mothers were at work.<sup>679</sup> Initially, the centres were managed by community organisations, city councils, village governments, various communities, and voluntary agencies. These centres promoted parity and aimed to nurture individuals who would serve the nation with a sense of equality, a love for the people, and fraternity, in line with *Ujamaa*'s vision.

<sup>679</sup> CCM Library, 'Sera ya Malezi ya Taifa kwa Watoto na Vijana Tanzania' (CCM, 1987), 16.

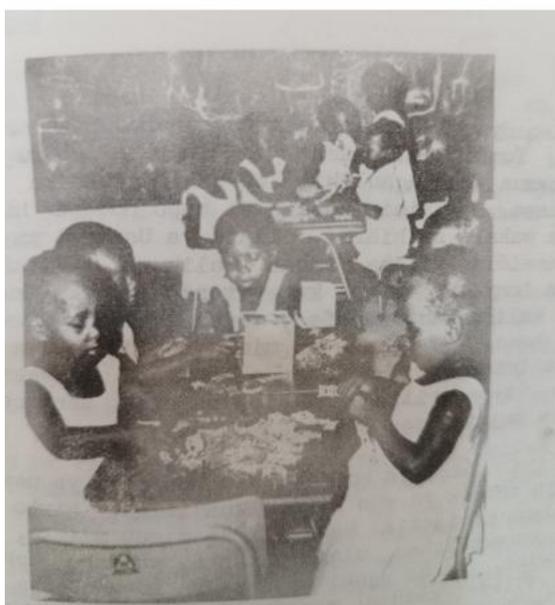


Figure 16: Children in a daycare centre in the 1970s.  
Source: SJ Mamuya, 1971, 23

The daycare centres played many roles. In the Kilombero Valley, as well as many other places in Tanzania, these centres were viewed as a means of collective upbringing aimed at instilling good habits in children and a sense of togetherness. This was particularly important in light of TANU's call for unity. In the centres, children would be taught counting, moulding, drawing and writing. The children were taught patriotic, traditional, and revolutionary songs, which is why they were of interest to TANU, as shown in the previous chapter, allowing membership to children as young as six years old. The centres acted as a preparation and recruitment area for the '*chipukizi*' cadre (Chapter 3). The materials, such as papers and toys for the centres, were provided by TANU-UWT, while some items, including strings, ropes, and clay toys, were made by the teachers.<sup>680</sup> Moreover, the centres were a preparation for primary education. These centres were seen as a way of liberating the women to engage in other nation-building activities. It was expected that the centres would give women the 'freedom' to no longer rely on men, allowing them to earn a living. The political significance of these centres underscores the state's designation of women as primary caregivers for the nation's children.<sup>681</sup>

What is particularly important to this study concerning these centres is that they became avenues for improved health. First, women were able to go to work while leaving their children at the centre. For instance, in Kidatu, women formerly employed by Kilombero Sugar Company (KSC) reported that their jobs allowed them to provide better lives for their families, as they

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<sup>680</sup> CCM Library, 'Sera ya Malezi ya Taifa kwa Watoto na Vijana Tanzania' (CCM, 1987).  
<sup>681</sup> Anna Davin, 'Imperialism and Motherhood', *History Workshop* 5 (1978): 9–65.

earned incomes, had access to the company's hospital, and received foodstuffs such as green vegetables from the company.<sup>682</sup> This employment significantly contributed to the health and well-being of their families and the broader community. Secondly, the day centres also became avenues for the propagation of MCH activities such as vaccinations, as they took advantage of the centralised access for children.<sup>683</sup> Thirdly, these stations served as places where nutrition would be observed. A balanced diet was prepared for the children, with some of the food sourced from the garden maintained around the centres. Accessing food from these gardens was seen as the true reflection of self-reliance. The schedules of the centres were based on agricultural activities, particularly farm work and clinic attendance, and other MCH activities were arranged to fit the work schedule. By 1979, the number of daycare centres in Tanzania had grown to 3,065 with over 173,958 children and 1,805 teachers.<sup>684</sup>

Apart from their positive roles in women's welfare, the daycare centres faced challenges. For instance, they did not adequately address the needs of working women in specific fields, particularly in medicine. Under the political economy promoted by TANU at the time, the needs of women working in the formal sector did not seem to be a primary consideration for the centres, but rather those of women working on farms and in the informal sector. Nurses and other healthcare workers often had to work night shifts. Retired nurses at Ifakara recalled that the daycare centres were not operational at night. Therefore, it was challenging to balance their careers with domestic responsibilities. Some nurses depended on family members for support or hired nannies, while others brought their young children to work.<sup>685</sup> One retired nurse noted that it was common for health workers to bring their children to St. Francis Hospital, Ifakara, until a new administrator declared it a health hazard, leading to a change in policy.<sup>686</sup> When I asked why they did not leave their children with their husbands, they responded, 'That was not a man's job'.<sup>687</sup> This was a depiction of the social organisation of society in the Kilombero Valley and Africa at large, where childbearing and rearing were traditionally a woman's job, despite the changes that came with women being employed outside the home.

Managing the centres was also problematic. Initially, it was a communal affair, and parents were responsible for providing the necessary facilities and paying the teachers. This, however, was not always possible. In some centres, teachers complained about the lack of parental

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<sup>682</sup> Interview with Grace Nakuyoa at Kidatu, October 2, 2023.

<sup>683</sup> 'CCM Library Dodoma, Malezi Bora ya Watoto Kitaifa'.

<sup>684</sup> UWT, 'Jumuiya ya Wanawake wa Tanzania: Taarifa ya Mwaka 1978-1979' (1979).

<sup>685</sup> Interview with Christina Isakwisa, Posta, Ifakara on 20<sup>th</sup> September 2023.

<sup>686</sup> Interview with Christina Isakwisa, Posta, Ifakara on 20<sup>th</sup> September 2023.

<sup>687</sup> Women in Ifakara, Focus Group Discussion at Lipangalala, 21 September 2023; Interview with Christina Isakwisa, Posta, Ifakara on 20<sup>th</sup> September 2023.

facilitation and support. What remained, in many cases, was for the centres to be facilitated by the help of UWT and some churches. It was not until 1979, dubbed the ‘Year of the Child’, that UWT in Dodoma sent a plea urging the government to be involved in daycare centres.<sup>688</sup> Following the request, in July 1981, the parliament passed a law that compelled the government to establish and manage daycare centres.<sup>689</sup>

The challenges of engaging women outside the home further exposed the misalignment of the politics of *Ujamaa*. While women were encouraged to contribute to nation-building just like everyone else, the issue of maternity leave became a thorny topic in Tanzania during the early years of independence. As already noted, during *Ujamaa*, more women left their homes to take up jobs in industries as casual workers, as well as in professions such as teaching, medicine, policing, and nursing. The introduction of women to the labour market came with other implications that transcended the cultural, legal, and family arena, yet the belief systems of many communities in Tanzania had not changed. Internationally, according to the International Labour Organisation (ILO), the issue of maternity had been addressed as early as 1952 and revised in 2000.<sup>690</sup> However, every country has domesticated its concept of maternity, and most postcolonial states in Africa had to address this new issue in their labour laws after independence. How did the government of Tanzania navigate the concept of maternity leave?

Postcolonial records show that maternity leave was not granted in Tanzania in the initial years after independence. It was common for women to resign after getting married to concentrate on motherly or wifely duties or align their careers with the new status of a married woman.<sup>691</sup> Speaking on the status of the health sector, President Nyerere noted that, besides retirement, the marriage of nurses was a reason for the wastage of trained health workers.<sup>692</sup> Culturally, working at home as a wife and mother was a higher calling. However, few stuck to the system where they were employed or followed their husbands to their places of work, where they got jobs. In Ifakara, nearly every retired female health worker I spoke with answered the question ‘When did you come to Ifakara?’ by saying, ‘I followed my husband after he was posted here’.<sup>693</sup>

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<sup>688</sup> CCM Library Dodoma, UWT, ‘Jumuiya ya Wanawake wa Tanzania: Taarifa ya Mwaka 1977-1982’, 1982.

<sup>689</sup> CCM Library Dodoma, UWT, 1982.

<sup>690</sup> ‘C183-Maternity Protection Convention, 2000 (No. 183)’, 2000, [https://normlex.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100\\_ILO\\_CODE:C183](https://normlex.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_ILO_CODE:C183). Accessed on 11.10.2024

<sup>691</sup> Oral interview with Christina Isakwisa, Posta, Ifakara on September 20, 2023.

<sup>692</sup> ‘Five Years of CCM Government Address given to the National Conference of the CCM by the Chairman, Ndugu Julius K. Nyerere, on October 20, 1982 at Diamond Jubilee Hall, Dar Es Salaam’, 26.

<sup>693</sup> Oral interviews cited in Kimani, ‘Maternal Healthcare and Health Policy Planning in Tanzania, 1961-1970s’ pg 20.

Maternity leave later came with caveats and conditions. After three years of independence, unpaid maternity leave was granted only to married women.<sup>694</sup> In July 1969, the government approved paid maternity leave for married women.<sup>695</sup> The assumption was that pregnancy was a result of a man and a woman who were married, and therefore any pregnancy outside of wedlock was a disgrace. Any woman who conceived out of wedlock was a disgrace and a ‘bad example’ to society and had to be punished. This debate dominated the policy space for the entire decade of the 1960s and half of the 1970s. Unmarried or widowed females, particularly teachers and policewomen, bore the burden of the politics of maternity leave in Tanzania.<sup>696</sup> In June 1966, Member of Parliament (MP) Bi Makato asked why widowed female teachers were denied maternity leave. The minister of education responded by saying that the situation would remain as it was because the teacher was supposed to lead by example in all spheres, physically, mentally, and spiritually (*kimwili, kiakili na kiroho*) and be a role model to young people.<sup>697</sup> Such teachers were often forced to quit their jobs, apply for leave, and reapply for their positions after giving birth, which was not guaranteed. When reinstatement did occur, it was often accompanied by a transfer to a different school to avoid ‘shame’. Notably, the minister did not address the accountability of the men involved in these pregnancies.

Female police officers faced the same consequences as female teachers: they were dismissed as soon as they were found to be pregnant. If the father of the child was also a police officer, he was not dismissed but instead demoted by one rank—a punishment that some viewed as less severe compared to the complete dismissal given to the woman. Some MPs even suggested that the punishment should be equal for both parties; whether it was dismissal or demotion, it should be applied to both. However, on 27<sup>th</sup> June 1970, the Minister of Interior responded to a question in parliament, stating derisively that a policewoman would indeed be dismissed because:

*...hatoweza kufanya kazi barabarani, anakuwa hawezi kuonekana vizuri katika kuvaa katika kazi yake...wakati ana mimba vile. Na anaweza kuwa katika beat, mara atoke akayonyeshe, mara askari wa kike yuko-mama mtoto yuko katika kazi fulani atoke sijui akakoroge uji. Basi huo utaratibu unaweza kuwa mbaya kwa kazi ya kiaskari (Makofi na Kicheko).*<sup>698</sup> (She will not be able to handle outdoor activities, her appearance in uniform is not appealing, and she may be on duty and has to go out and breastfeed, sometimes she is there, but the next minute, she has to go out and prepare porridge, these procedures are not good for police work) (applause and laughter).

<sup>694</sup> ‘Wajane Waharikisha Mipango Ya Arusi Wafadike Na Malipo Ya Kujifungua’, *Uhuru*, Juni 12, 1969.

<sup>695</sup> ‘Waja Wazito Hubeba Mzigo Wa Taifa. Likizo Ya Kujifungua Italipwa’, *Uhuru*, Juni 6, 1969.

<sup>696</sup> ‘Walimu Wachukua Mimba Wataendelea Kutimuliwa’, *Uhuru*, Januari 10, 1969.

<sup>697</sup> ‘Waalimu Wa Kike Wawe Mfano’, *Uhuru*, Juni 21, 1966, 2.

<sup>698</sup> ‘Hansard. Majadiliano Ya Mbunge. Mkutano Ishirini Na Moja, Sehemu Ya Pili. Tarehe 27 Juni 11-Julai 1970’, 1970, 329.

The minister explained that the demotion of male police officers was also punitive, as it came with a loss of income. However, MP Chibwana argued that this punishment was still insufficient, suggesting that the male officer, who may have initiated the relationship, should bear more responsibility. He questioned why the female officer could not simply be granted maternity leave and allowed to return to work afterwards.<sup>699</sup> The minister concluded by stating that the dismissed female officer could reapply for her position if she wished. This situation highlights the persistent struggle with gender inequality, even as *Ujamaa* politics professed to advocate for equality, including through maternity leave provisions for married women.

In 1971, through the chairperson, Sophia Kawawa, UWT emphasised the need for the removal of discrimination in paid maternity leave. She argued that unmarried women needed to be paid maternity leave because they suffered even more than their married counterparts. Additionally, discriminating against the unmarried and labelling them as prostitutes and irresponsible was only propagating vices such as abortions.<sup>700</sup> It was argued that such single women who became pregnant were gallant enough to have kept the pregnancies because, in such a situation, many would choose to abort. Not giving them paid maternity leave was also argued to be discriminatory because the men responsible for the pregnancies were not punished.<sup>701</sup> This confirms the notion that policy-making and TANU politics were still dominated by men.

Until 1974, the issue of discriminatory maternity leave continued to be raised in parliament. On 13 June 1974, in response to question no. 58 from MP Kaombwe on the same topic, the matter was dismissively addressed: ‘This question has been repeatedly answered in this house, and the parliament has no further position to provide’.<sup>702</sup> The efforts by UWT and other interested parties, however, bore fruit in 1975, when paid maternity leave was introduced regardless of marital status. The granting of maternity leave to all women was again associated with the fruits of the Arusha Declaration, which emphasised equality. However, equality was not always understood to mean equity or fairness, as notable loopholes persisted.

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<sup>699</sup> ‘Hansard. Majadiliano ya Mbunge. Mkutano Ishirini na Moja, Sehemu ya Pili. Tarehe 27 Juni 11-Julai 1970’, 330.

<sup>700</sup> ‘Pay Maternity Leave for All Says UWT’, *Sunday News*, August 8, 1971.

<sup>701</sup> CCM Library, Dodoma, ‘Sera ya Wanawake katika Maendeleo Tanzania’, 10; Callaci, *Street Archives and City Life: Popular Intellectuals in Postcolonial Tanzania (Radical Perspectives)*.

<sup>702</sup> ‘Hansard, Majadiliano ya Bunge. Mkutano wa Kumi na Sita. Sehemu ya Kwanza. Tarehe 11 Juni -13 Juni 1974’, Juni 13, 1974, 97.

#### 4.5.2 Villagisation and Health Development in the Kilombero Valley

One of the principles of *Ujamaa* was communal living. The concept of communal living or residing in settlements was not exclusive to the *Ujamaa* era. In the pre-colonial era, Africans often lived together in communities or fortified villages. During the colonial period, Africans were settled in schemes near plantations to facilitate labour provision and the production of cash crops.<sup>703</sup> However, after colonisation, social living had been weakened, as the unifying fabrics, such as the clan, had been debilitated by colonial policies. These policies included land alienation and labour policies that led Africans to move from their ancestral lands in search of job opportunities in urban, agricultural, or mining areas. While the majority of people lived in rural areas, the ideals of family, clan and communal unity were enfeebled in the process.

Through *Ujamaa*, Nyerere sought to restore communal cohesion by encouraging people to live in villages and share resources. Nyerere envisioned villages built on socialist principles. The movement to villages was originally intended to be implemented as per President Nyerere's Circular No. 1 of 1969. In this circular, people were to move together and form villages without force, but through 'education, persuasion, voluntary and systematic development stage by stage until a social unit reached the desired socialist stage'.<sup>704</sup> However, from 1973, the villagisation process became ad hoc, especially after the compulsory movement was introduced. According to Kweka, forced villagisation did not give people a chance to consider and plan their settlements.<sup>705</sup>

In some places, houses were built, but they were unoccupied, while in others, there were no houses at all, and people used tents instead. Forced movement alienated people from their shrines and burial sites, leading to resistance.<sup>706</sup> The use of force in the postcolonial state was comparable to the colonial era. Freyhold, for example, observed that in 1962, caning was used to punish those who did not participate in development projects.<sup>707</sup> The continued use of force in the 1970s highlights how the postcolonial state operations were influenced by the colonial system. Despite public resistance, the government proceeded with its policy of forced collectivisation, known as *Ujamaa*.

Ideally, the movements to new villages were planned and prearranged. The plan was to make the process of moving to the new villages as seamless as possible. Men were to move to these villages during the dry seasons and use the tents as they built the houses. However, in the

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<sup>703</sup> C.K Omari, *Villagisation and the Potential of the Peasant Reorganisation in Tanzania*, 39.

<sup>704</sup> Omari, *Villagisation and the Potential of the Peasant Reorganisation in Tanzania*, 50.

<sup>705</sup> A.N Kweka, 'One Party Democracy and the Multiparty State', in *Mwalimu: The Influence of Nyerere* (London: James Currey Ltd, 1995), 74.

<sup>706</sup> C.K Omari, *Villagisation and the Potential of the Peasant Reorganisation in Tanzania*, 50.

<sup>707</sup> Michaela Von Freyhold, *Ujamaa Villages: Analysis of a Social Experiment* (Nairobi: Heinemann, 1979), 36.

process, family life was disrupted.<sup>708</sup> As noted above, this suffering gave rise to resentment and hatred because it was argued that the people were suffering at the hands of a government that was supposed to take care of them. According to many of our respondents, villagisation was rushed without planning.<sup>709</sup> *Ujamaa* villages were created as political projects intended to prove certain political statements, rather than to enhance the welfare of the people. In the end, the *Ujamaa* villagisation project was not very different from the village settlement scheme that it was meant to replace and improve. This indicates that most policies were implemented without thorough planning assessments, often based on broad, internationally formulated concepts and objectives that were difficult to implement or sustain within the local Tanzanian political economy.<sup>710</sup>

Villagisation during the *Ujamaa* era had its pros and cons, especially in the health sector. On the positive side, *Ujamaa* led to improved healthcare. According to Gish, ‘the heart of rural health expansion was the *Ujamaa* policy’.<sup>711</sup> Through rural development programmes and villagisation, the government improved health in rural areas. Apart from directly building health facilities, the government created an atmosphere for mobilisation. Additionally, some villages came together and contributed to the construction of clinics in a bid deemed in line with the fight against disease. TANU leaders advised those who had not joined the *Ujamaa* villages to do so, to access medical and other services closer to them.<sup>712</sup>

Villagisation also proved advantageous towards healthcare. The government, for instance, subsidised the efforts of the people by providing materials to build their health facilities. It also provided health workers to work in the dispensaries. Msolwa *Ujamaa* village was the perfect example of a socialist village. Through *Ujamaa*, the villagers gained access to social services. Msolwa *Ujamaa* village had a dispensary, a school, and a well-functioning system that the village elders had established. The foundation of the village dates back to the 1970s when President Nyerere nationalised the land that was previously owned by an Indian named Sadru Meju whose father had bought the land from the German rubber planters.<sup>713</sup> On January 27,

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<sup>708</sup> Julius Nyerere, ‘Ujamaa Vijijini’, 24.

<sup>709</sup> Interview with Mzee Mwambeta Viwanja sitini, Ifakara on September 20, 2023; interview with Amina Bundi at Mang’ula B, on September 28, 2023; Interview with Jisbert Aloyce at Mang’ula B on September 28, 2023.

<sup>710</sup> Michaela Von Freyhold, *Ujamaa Villages: Analysis of a Social Experiment*; Goran Hyden, *Beyond Ujamaa in Tanzania: Underdevelopment and an Uncaptured Peasantry*; Coulson, *Tanzania: A Political Economy*; Piachaud, ‘Fabianism, Social Policy and Colonialism: The Case of Tanzania’.

<sup>711</sup> Oscar Gish, ‘The Way Forward: World Health Organisation’, 10.

<sup>712</sup> *Ngurumo Newspaper*, Januari 20, 1970 ‘Vianzisheni Vijiji’.

<sup>713</sup> Oral Interview with Mtendaji wa Kijiji at Msolwa Ujamaa on September 30, 2023; Smalley Rebecca et al, ‘The Role of the State and Foreign Capital in Agricultural Commercialisation: The Case of Sugarcane Outgrowers in Kilombero District, Tanzania. Working Paper 106’, 2014, 7; CCM Library ‘Kuandikishwa kwa Vijiji, Vijiji vya

1971, the village was transformed into a *Ujamaa* village, with a total of 379 members: 67 men, 77 women, 202 children, and 33 elderly individuals.<sup>714</sup> The village was initially involved in rice cultivation but later shifted its focus to sugarcane, a cash crop deemed more profitable and less susceptible to pests and diseases. They also grew palm trees.<sup>715</sup> Between 1971 and 1972, the village had 110 acres of sugarcane, 50 acres of maize, 90 acres of rice, 10 acres of palm trees, 4 acres of peanuts, 2 acres of cashew nuts, a half-acre of sweet potatoes, and 2.75 acres of vegetables, bananas, and fruits.<sup>716</sup> The village was almost self-sufficient, and the proceeds were used to build schools, daycare centres and teachers' houses.<sup>717</sup> The village's activities, in addition to the government's policy of seeking assistance from friendly nations, specifically China (Chapter 5), worked to the village's advantage. By 1974, Msolwa *Ujamaa* was named the best in Morogoro, with a well-organised village council comprising eight members assisted by four smaller committees: health, education, finance, and labour.<sup>718</sup>

Following President Nyerere's 1977 visit to China, an agreement was reached for collaboration between the two nations. As expanded in the next chapter, it is through such collaborations that the Chinese presence in Tanzania has increased. Agriculture was one of the main agendas for the Chinese. In Msolwa *Ujamaa*, the Chinese introduced an agricultural training institute and built a dam to provide clean water for consumption and irrigation. The leader of Msolwa *Ujamaa* village, Idd Mkangamo, was granted permission to visit China to learn the Chinese agricultural production model. The goal was to adopt better farming methods, improve agriculture, and, consequently, enhance nutrition. In 1977, the Chinese built the first dispensary in Msolwa *Ujamaa* (see Figure 17). This dispensary, however, received considerable support from the Chinese, who had come to Msolwa for other projects, primarily agricultural and infrastructural developments. At the same time, the Chinese were involved in helping out the *Ujamaa* villages and started agricultural training centres in Mang'ula.

At Mang'ula, there was also Sonjo village. The village was heterogeneous in terms of tribal and religious composition. Some Sonjo inhabitants argued that the village was established in 1959, even before the *Ujamaa* villagisation policy. In the 1970s, this village had a significant number

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*Ujamaa* na Uongozi Wake: Hotuba ya Waziri Mkuu na Makamu wa Pili wa Rais Akiwakilisha Ndani ya Bunge Mswada Wa Vijiji Na Vijiji Vya *Ujamaa* '.

<sup>714</sup> CCM Library 'Kuandikishwa kwa Vijiji, Vijiji vya *Ujamaa* na Uongozi Wake: Hotuba ya Waziri Mkuu na Makamu wa Pili wa Rais Akiwakilisha Ndani ya Bunge Mswada wa Vijiji na Vijiji vya *Ujamaa*', 10.

<sup>715</sup> Oral Interview with Mtendaji wa Kijiji at Msolwa *Ujamaa* on September 30, 2023.

<sup>716</sup> CCM Library 'Kuandikishwa kwa Vijiji, Vijiji vya *Ujamaa* na Uongozi Wake: Hotuba ya Waziri Mkuu na Makamu wa Pili wa Rais Akiwakilisha Ndani ya Bunge Mswada wa Vijiji na Vijiji vya *Ujamaa* '.

<sup>717</sup> CCM Library 'Kuandikishwa kwa Vijiji, Vijiji vya *Ujamaa* na Uongozi wake: Hotuba ya Waziri Mkuu na Makamu wa Pili wa Rais Akiwakilisha Ndani ya Bunge Mswada wa Vijiji na Vijiji vya *Ujamaa* '.

<sup>718</sup> CCM Library 'Kaundikishwa kwa Vijiji, Vijiji vya *Ujamaa* na Uongozi Wake: Hotuba Ya Waziri Mkuu Na Makamu Wa Pili Wa Rais Akiwakilisha Ndani ya Bunge Muswada wa Vijiji na Vijiji vya *Ujamaa* '.

of people who were relocated from Dar es Salaam, following Nyerere's policy of returning people to the villages to work on farms, rather than focusing on city life. The village's location, not far from Msolwa Ujamaa, was strategically placed. It was where Mang'ula Machine Mechanical Tools (MMMT), was located. The Chinese started MMMT to produce tools, spare parts, posho mill, water pumps, and machines, which were primarily used in the Mbeya Cement factory, Mtimbwa and the K1 sugar companies and the construction of the TAZARA. MMMT worked closely with the Railway Bar Manufacturing company and Tanzania Wood Industries Corporation (TWICO). All these companies were under the National Development Corporation (NDC).



Figure 17: The first dispensary at Msolwa Ujamaa, built by the Chinese in the 1970s.  
Photo by author 30.9.2023

In Mang'ula, those who came from Dar es Salaam were labelled as undisciplined. They had *tabia za Mjini* (city-life mannerisms), such as drunkenness and bhang smoking, but the village was vibrant. It conducted farming on both individual and *mfumaki* basis. Unlike many villages that had a school and no dispensaries in the initial stages, Sonjo Village had a dispensary and health workers. This could be associated with the fact that Nyerere wanted to keep his word to the people he had moved to Dar es Salaam, that village life would translate to social services.<sup>719</sup> The members noted that both traditional and biomedicine were embraced. This hybridity may

<sup>719</sup>

Interview with Father Luanda [he grew up in Sonjo], at Mahenge February 6, 2025.

have been due to the heterogeneity of the population, as stated above, and the nature of the illness or need, and cultural beliefs.

The dispensary served everyone in the village and its surroundings, including the Chinese. It became one of the most important features in the village. It saved the villagers from the problem of access to health services. Before its construction, the nearest hospital was 30km away in Kidodi, and the other one was the Kilombero Sugar Company (KI) hospital, which was 9km away. Such distances were very limiting in those days, at a time when public transport was a nightmare.<sup>720</sup> According to the locals, there were very few bicycles in Msolwa *Ujamaa* in the 1970s. Transport problems affected access to health facilities. The informants noted that in terms of maternal health, the majority of the women were attended to by traditional midwives.<sup>721</sup> However, they were quick to appreciate the role of the dispensary, especially in vaccination and curbing of diseases such as diarrhoea, which were hitherto common. When the Chinese left the village in 1982, the dispensary continued to be run by the village with government support until the village built a better, more modern one.

After 1973, the government's efforts to forcibly relocate Africans into villages intensified. The number of people in villages at a certain point in time is indicative of the government's impact through the application of force. In 1968, for instance, there were 180 villages, a number which had increased to 5,556 by 1973.<sup>722</sup> In 1975, the Villages and *Ujamaa* Villages Act was enacted. This act was dubbed 'Operation *Vijijini*.' Most of the villages advanced a particular 'operation' in a given time. There was, for example, *Operation Rufiji* in Rufiji and *Operation Songea* (advance) in Ruvuma, which later spread to other regions.

In Kilombero, the operation was known as '*Kando kando ya reli*' (alongside the railway—TAZARA), where villages were built along the railway to protect it from vandalism.<sup>723</sup> Additionally, the proximity to the road ensured that officials could easily access the village.<sup>724</sup> The significant migration of people to the region facilitated its development for both settlement and agriculture. Under the *Ujamaa* policy, construction camps were transformed into new structures designed to foster rural development.<sup>725</sup> This population influx created a demand for healthcare facilities in the Kilombero area. The railway contributed to economic empowerment,

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<sup>720</sup> Interview with Mtendaji wa Kijiji at Msolwa *Ujamaa* on September 30, 2023.

<sup>721</sup> Interviewer F at Msolwa *Ujamaa* on September 30, 2023.

<sup>722</sup> Donatus Komba, 'Contribution to Rural Development: *Ujamaa* and Villagization', 34.

<sup>723</sup> TNA, CT.8/51 'Mkurungenzi wa Maendeleo kwa Katibu Mtendaji wa TANU. Ulinzi wa Reli ya Uhuru', Oktoba 1976.

<sup>724</sup> Michaela Von Freyhold, *Ujamaa Villages: Analysis of a Social Experiment*, 45.

<sup>725</sup> Minja and Chuhila, 'Ujamaa in the Kilombero Valley: Msolwa and Signali Villages as a National Project ca 1967-1990', 57.

as people, including women, were employed as workers, enabling them to improve their nutrition, become more aware of their health needs, and access medical services provided by the government, voluntary agencies, companies such as Kilombero Sugar Company, and railway authority hospitals.<sup>726</sup>

Villagisation was to enable the provision of services. However, even after the formation of the villages, not every village was provided with health facilities. In a study conducted between 1978 and 1979, the distance between many villages and a health facility in Morogoro was still a concern. In Morogoro, half of the population was within a 0-5km radius of a health facility which was walkable, while 12 per cent were within a radius of more than 10km (See Table 10), which was difficult for a pregnant mother or a child of 2 to 5 years as shown by the table below.

Distance in Km	Number of Villages	% of Villages within the given range
<b>0-5</b>	14	58.3
<b>0-6</b>	7	29.2
<b>10+</b>	3	12.5

*Table 10: The Distance between Villages and Health Facilities.  
Source: Adopted from Staatsarchiv Basel-Stadt, PA 940d H1, 1976*

Despite its challenges, villagisation significantly raised awareness, improved access, and promoted understanding of health issues. While concerns about witchcraft and social discord persisted, the initiative facilitated the exchange of ideas among diverse communities in Tanzania who were brought together in the villages.<sup>727</sup> What is interesting is that people were constantly exposed to new medical ideas that, in the end, did not deliver the expected turnaround. The introduction of Chinese medicine was expected to overhaul the health system to mirror the Chinese barefoot doctors' system; however, each doctor was supposed to remain in Tanzania for 2 years, and these doctors intermittently visited various regions.<sup>728</sup>(see Chapter 5).

### **4.5.3 Rural Maternal Health and Nutrition**

Health is closely linked to nutrition. Indeed, proper nutrition is the harbinger of good health. From colonial times, the problem of malnutrition was identified as a key issue not only in

<sup>726</sup> Interview with Mtendaji wa Kijiji at Msolwa *Ujamaa* on September 30, 2023.

<sup>727</sup> Freyhold, *Ujamaa Villages: Analysis of a Social Experiment*; Lal Priya, 'Militants, Mothers and the National Family: *Ujamaa*, Gender and Rural Development in Postcolonial Tanzania', *The Journal of African History* 51, no. 1 (2010): 20; Priya, *African Socialism in Postcolonial Tanzania: Between the Village and the World*.

<sup>728</sup> 'Hongera Kwa Madaktari Wa Kichina', *Ngurumo*, Agosti 3, 1972; 'TNA/HEA/90/5/493 Technical Health Assistance China, Vinyago Kama Zawadi'.

Tanzania but also in many countries across Africa.<sup>729</sup> In Tanzania, concerns about nutrition date back to the German colonial era. It is recorded that after noting their bodily weakness, the African prisoners detained by the Germans were provided with a balanced diet, with an emphasis on beans and vegetables, to ensure they had the energy required for labour.<sup>730</sup> However, colonial policies such as labour migrancy and cash crop production have been argued to contribute to increased malnutrition in Tanzania.<sup>731</sup> The malnutrition may not have been caused solely by food shortages, but rather by a knowledge gap, such that even with adequate food, cooking, eating habits, and taboos became a hindrance.<sup>732</sup>

During the British era, Tanzania also faced similar nutritional challenges. As a result, the Committee for Human Nutrition was established in 1936.<sup>733</sup> In 1953, an advisory committee to the Ministry of Health (MOH) was formed, comprising representatives from the ministries of Social Welfare, Health, Agriculture, and Education. Among the many initiatives, the committee proposed introducing a school feeding programme to support students.<sup>734</sup> The school was seen as a free space where what was eaten went beyond the cultural taboos at home.

At independence, malnutrition remained a significant issue in the country. In a radio address 1963, President Nyerere underscored the critical importance of nutrition, marking a pivotal moment in the nation's efforts to combat this problem. Following this address, numerous initiatives aimed at improving nutrition were launched, supported by both domestic efforts and international assistance, particularly from Germany, the United Kingdom, and the Catholic Church. Locally, the Tanganyika National Freedom from Hunger Committee (TNFHC) was created.<sup>735</sup> There was also a strong emphasis on enhancing the understanding of food and nutrition-related issues. In 1968, *Lishe (nutrition)* section was started under the Ministries of Health and Agriculture. Agriculture, nutrition, and health were inseparable. Responsibility for food production fell under the Ministry of Agriculture, while food consumption, eating habits, and their impacts on health were under the Ministry of Health. Consequently, training nutrition officers locally, who would then train the communities was emphasised. Further training was

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<sup>729</sup> T.K Maletnlema, 'The Problem of Food and Nutrition in Africa', in *Nutritional Problems and Education: Selected Topics*, 1986, 30–79; G.H Bourne and A.G Karger, *Nutritional Problems and Education: Selected Topics*, vol. 27, World Review of Nutrition and Dietetics, 1986; Slobodkin Yan, *The Starving Empire: A History of Famine in France's Colonies* (London: Cornell University Press, 2023).

<sup>730</sup> 'Shirika La Chakula Bora Tanzania', *Lishe* 1 (1976), 1.

<sup>731</sup> Meredith, 'The Impact of Colonialialism on Health and Health Services in Tanzania'; Oswald Masebo, 'Nutrition Surveys and Labour in Colonial Tanzania, 1920-1950', *Tanzania Zamani* 8, no. 2 (2016).

<sup>732</sup> Ralph Jätzold and Eckhard Baum, *The Kilombero Valley*; Bourne and Karger, *Nutritional Problems and Education: Selected Topics*.

<sup>733</sup> 'Shirika la Chakula Bora Tanzania', 3.

<sup>734</sup> 'Shirika la Chakula Bora Tanzania'.

<sup>735</sup> CCM Library, Dodoma, UWT, 'Taarifa ya Jumuiya ya Wanawake ya Miaka Ishirini ya Azimio ya Arusha na Miaka Kumi ya CCM' (Elimu ya Watu Wazima, 1987), 41.

done outside the country and through the WHO.<sup>736</sup> By 1976, three Tanzanians were sent to London to pursue studies in human nutrition.<sup>737</sup> All these efforts reflected the country's commitment towards addressing the ongoing challenge of malnutrition.

Freedom from hunger became a preoccupation of the ruling party, TANU. In the 1970s, TANU, which was by then actively involved and concerned about the liberation of the African continent, argued that such liberation would only happen if Tanzania and Africa at large had won the fight against hunger and malnutrition.<sup>738</sup> Nyerere argued that lack of food should not be seen as punishment by God, through famine and drought, but a result of laziness, ignorance, and poor leadership.<sup>739</sup> Proper nutrition, especially for children and pregnant mothers, was emphasised. There were campaigns against bad traditions such as feeding the babies on porridge instead of the breast due to the belief that 'breast milk had gone bad'.<sup>740</sup>

On many different occasions, TANU addressed the nutrition issue in relation to MCH. In 1970, Raphael Nenetwa, the chair of TANU in the Mwanza region, urged citizens to consume healthy foods, follow the advice of health officers, and protect themselves from diseases.<sup>741</sup> Such sentiments spread to the whole country. On June 6 1975, the TANU National Executive Council (NEC) argued that the future of the nation was determined by how the children were brought up. Yet the situation was dire with 'the picture of a swollen-bellied child playing in the dust of the village square...'.<sup>742</sup> Therefore, the NEC emphasised that food and nutrition, as well as the general health and upbringing of children, should be considered. It was argued that the future depended on sharp and strong brains who were capable of defending *Ujamaa*.<sup>743</sup> The fight against poverty could not be done in isolation, but it depended on the battle against ignorance and disease. It was poverty that led people to lack access to food, but it was also ignorance that denied them the knowledge to prepare healthy meals or abandon unhealthy cultural habits. It was on the same breath that Nyerere encouraged the rearing of chickens to increase egg production to mitigate the protein deficit.<sup>744</sup>

Food production and good nutrition were central to the key agenda of *Ujamaa*. People were encouraged to use vegetable oil and to consume a balanced diet.<sup>745</sup> The *Ujamaa* policy, which

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<sup>736</sup> WHO Archives Geneva, WHO22. 0572.WH0022-TAN006 'Training of Health Personnel 1972 to 1976', 1976,

<sup>737</sup> CCM Library, Dodoma 'Shirika la Chakula Bora Tanzania', 4.

<sup>738</sup> CCM Library, Dodoma 'Shirika la Chakula Bora Tanzania', 1.

<sup>739</sup> *Ngurumo*, July 8, 1967 'Njaa Sio Amri ya Mungu', .

<sup>740</sup> 'Shirika la Chakula na Lishe Tanzania', *Mzalendo*, Machi 11, 1984.

<sup>741</sup> 'Kuleni Chakula Kizuri', *Ngurumo Newspaper*, Januari 17, 1970.

<sup>742</sup> Kenneth W Newell, 'Introduction', in *Health by the People* (W.H.O, 1975), 1.

<sup>743</sup> CCM Library Dodoma, Malezi Bora ya Watoto Kitaifa', 1.

<sup>744</sup> 'Kutoka Kwa JN Nyerere Kwa Wakuu wa Mikoa, Wilaya na Makatibu wa Vijana Tanzania Bara. Matatizo ya Kuwashirikisha Vijana Katika Mpango wa Taifa', Januari 1, 1970, NRC A/10/102.

<sup>745</sup> Women in Ifakara, Focus Group Discussion at Lipangalala.

centred around collective farming and community living, aimed to align food production and good nutrition with its agricultural agenda. This involved promoting diversity in agricultural production alongside enhancing staple crop productivity. The policy sought to invest in agricultural and food systems research to develop technologies for the cost-effective production of pulses, fruits, and vegetables.

Through *Ujamaa*, people living together in the villages were taught about nutrition. The plan was for every village to cultivate different varieties of food, develop food companies, offer nutritional education, and plan what food to buy or sell.<sup>746</sup> Pregnant women were taught how to take care of themselves and their children. A change of attitude was needed. Some of these habits could only be eradicated through health education as shown below. In some cases, health education proved difficult, especially in a diverse cultural space such as Tanzania and food habits were tied to deep-rooted culture and beliefs.

Educating a culturally diverse population about nutrition required both wisdom and cultural sensitivity. On one occasion, a nurse conducting a lesson on maternal and child health (MCH) gathered women to discuss nutrition. She displayed a photo of a malnourished child and advised that feeding the child an egg would resolve the problem. The nurse suggested mixing porridge with eggs as a remedy. However, an elderly woman in the group responded, saying, ‘We know the problem, the child has been impaired by his mother, and it is shameful to discuss these matters in public’ (*Tunajua shida, mtoto ameharibiwa na mamake, ni aibu kuongea hayo mambo hadharani*).<sup>747</sup> The elderly woman then called for the ‘child’ (the nurse) to be sent home, dismissing the advice. In response, all the women present for the talk abruptly stood up and dispersed, as they believed the image depicted a child suffering from a condition of ritual impurity called *kilala* (Chapter 3).

The nurse was unaware of the cultural taboo in that community against consuming eggs, particularly among women. Eggs were thought to be harmful to pregnant women and children, and taboos were developed to discourage women from overindulging in protein. Beyond the taboo, it is believed this practice aimed to prevent the development of a large foetus, which could complicate delivery.<sup>748</sup> In the Kilombero Valley, some communities did not eat eggs, meat, or other protein sources except on special occasions.<sup>749</sup> There was a notable protein

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<sup>746</sup> ‘Pasenti 40 ya Watoto Hufa, Sababu?’, *Ngurumo*, January 14, 1970.

<sup>747</sup> S.J Mamuya, *Maarifa Mapya ya Kuelimisha Afya*, 39.

<sup>748</sup> Musie et al., ‘African Indigenous Beliefs and Practices during Pregnancy Birth and After Birth.’, 94.

<sup>749</sup> Jätzold and Baum, *The Kilombero Valley*.

deficiency.<sup>750</sup> Most of the high protein food was eaten by men. In many TANU meetings, men were blamed for engaging in alcoholism and eating a lot of meat, while not taking care of the needs of the family, such that children from such families suffered from Kwashiorkor, low blood count or stunted growth.<sup>751</sup> Moreover, by referring to the nurse as a ‘child’, and influencing the gathered crowd to leave the elderly woman, underscored the importance of age and experience in matters related to midwifery and motherhood.<sup>752</sup> This incident highlighted the need for health educators to consider various factors when teaching: the audience’s cultural background, location, crowd size, subject matter, timing, and available resources.<sup>753</sup> Despite these challenges, health campaigns continued, resulting in gradual and noticeable changes.

By 1971, Nyerere expressed satisfaction that significant improvements in public health were evident, as more people consumed protein-rich foods such as eggs, milk, meat, and fish.<sup>754</sup> However, these changes were not uniform across the country. In the Kilombero Valley, there were reactions towards the changes. However, with movement of people to the Kilombero Valley and teachings by UWT, gradual changes were noted.

At the national level, the government’s plans for nutrition continued. Through an act of Parliament No. 24 of 1973, the government established the Tanzanian Food and Nutrition Centre (TFNC).<sup>755</sup> TFNC worked closely with government ministries, parastatals and regional authorities, to

have a policy objective on nutrition and food in the country, promote production and preservation of food in the country, work towards eradicating malnutrition, educate people on nutritious food, increase production of locally manufactured food, implement the country's food laws and overall reduce malnutrition by between 30-50 per cent in every region by 1980/81.<sup>756</sup>

It was believed that with proper nutrition (*lishe bora*), the incidence of most of the diseases in Tanzania would be cut by half. This conclusion was based on the fact that most of the recorded diseases were food-related, including a lack of food, inadequate food knowledge, food taboos,

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<sup>750</sup> ‘Pengo la Protein’, *Ngurumo*, January 14, 1970.

<sup>751</sup> ‘Kuleni Chakula Kizuri’, *Ngurumo*, Januari 17, 1970; ‘Uvivu, Ulevi, Ujinga Chanzo cha Vifo vya Watoto’, *Uhuru*, Februari 28, 1979.

<sup>752</sup> Veronica Kimani and Ulrike Lindner, ‘Seniority in Midwifery in Tanzania: Medical Local Practices Between Colonial Medicine and Postcolonial Modernization’, *Nordic Journal of African Studies* 33, no. 4 (2024): 304–25, <https://doi.org/10.53228/njas.v33i4.1143>.

<sup>753</sup> S.J Mamuya, *Maarifa Mapya ya Kuelimisha Afya*, 43.

<sup>754</sup> Julius Nyerere, ‘TANU National Conference: 10 Years After Independence’, 25.

<sup>755</sup> ‘The Tanzania Food and Nutrition Act, 1973’, <https://www.tfnc.go.tz/uploads/publications/sw1559225926-TFN%20ACTs.1973.pdf>. Accessed on Oktoba 11, 2023

<sup>756</sup> ‘Third Five-Year Plan for Economic and Social Development, 1st July 1974 to 30th June 1981, Vol 1’, 92.

and poor preparation methods. In 1970, for instance, 40 per cent of deaths of children under the age of five were attributed to a lack of sufficient protein in their diets.<sup>757</sup>

The nutritional gap was a complex one which went beyond the political and economic approaches. There was a need for a comprehensive approach to addressing the issue of nutrition. As discussed earlier, dietary improvements were necessary, particularly for women, who not only bore children but also worked long hours. Chapter 2 highlights that in the Kilombero Valley, rice was the primary crop, a labour-intensive endeavour in which women carried out most of the work. Therefore, a typical meal of rice and fish was often nutritionally inadequate, and when consumed continuously, it became monotonous. The availability of this meal was sometimes uncertain. While fish were said to be abundant in the Kilombero River, fishing was predominantly controlled by men.<sup>758</sup> Women recounted how some men, who specialised in fishing, would remain at fishing camps for extended periods, neglecting their households. These men would return only after exhausting their earnings, while simultaneously asserting authority over the rice harvest.<sup>759</sup> This dynamic, which still revolved around patriarchy, caused tension within families and brought the issue of malnutrition back into focus.

The nutritional challenge was also caused by the political economy of TANU, which focused on cash crops. Beyond food crops, *Ujamaa* farming emphasised the production of cash crops, including tobacco, tea, sugarcane, groundnuts, and cashew nuts, for the market. In the Kilombero Valley, food crops primarily included rice, beans and maize. However, food crops generally performed worse than cash crops, negatively impacting the population's nutrition.

Since agriculture was closely tied to economic advancement, the colonial practice of prioritising large-scale production of crops not consumed locally, but grown for sale, persisted. This was exemplified by the emphasis on cash crops such as sugarcane, as seen in Msolwa *Ujamaa* village.<sup>760</sup> The expansion of Kilombero Sugar Company indicates the increased attention given to sugarcane. The demand for sugarcane led individuals and villages to convert to sugarcane farming.<sup>761</sup> One can argue that with increased cash flow, people could afford a decent living, but this is not the case. Food-crop production would have been more effective in ensuring better nutrition than purchasing food with proceeds from cash-crop sales.

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<sup>757</sup> 'Pasenti 40 ya Watoto Hufa, Sababu?' January 14, 1970.

<sup>758</sup> Focus Group Discussion with women at Lipangalala on September 25, 2023.

<sup>759</sup> Focus Group Discussion with women at Uwanja wa Ndege on September 28, 2023.

<sup>760</sup> Interview with Mtendaji wa Kijiji Msolwa *Ujamaa* on the September 30, 2023.

<sup>761</sup> Interview with Mtendaji wa Kijiji Msolwa *Ujamaa* on the September 30, 2023.

In the postcolonial era, the focus on food crops versus cash crops closely mirrored colonial policies. Agricultural research initiatives in Kilombero and the broader Morogoro region continued to follow colonial-era plans. Although the villagisation policy aimed to bring people together for easier access to government services, villages ultimately became centres of commercial production, with output measured mainly in economic terms. This economic focus made it easier to shift toward cash crop cultivation, as government policy prioritised economic development over social services. Health ideas and nutritional information were passed through pamphlets. It was assumed that people would read and follow the recommendations. However, it soon became evident that a more comprehensive programme was needed—one that addressed the underlying reasons behind people’s dietary choices, including cultural factors influencing what they ate and avoided. This gap was often addressed through short-term campaigns and health education efforts.

#### **4.6 The Era of Campaigns and Health Education Policies**

The implementation of the Arusha Declaration proved difficult. Most health plans and policies, such as having a health facility in every village, were not easy to fully implement, so health campaigns proved helpful. Mobilisation, as already noted, was an essential tool for *Ujamaa*, which primarily focused on bringing the masses together. At the time, the radio became a vital tool for reaching the majority and conveying messages related to Ujamaa politics nationwide.<sup>762</sup> TANU issued radios in many villages countrywide. This was a transformative period for the health sector, particularly in maternal health, mainly through health education and campaigns such as ‘*Mtu ni afya*’ (man is health).<sup>763</sup>

##### **4.6.1 Health Education Campaigns and the Question of Preventive or Curative Health Care**

The Ministry of Health (MOH) in Tanzania recognised that its transformative agenda could not succeed without integrating health education. The idea was that many health challenges in the country could be addressed by empowering people with knowledge about the causes and prevention of diseases, and dispelling myths surrounding specific health issues. Establishing a dedicated health education department within the MOH was seen as a key strategy for achieving this goal.<sup>764</sup>

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<sup>762</sup> ‘Wasikie Habari Za Ujamaa’, *Ngurumo Newspaper* Januari 6, 1970, 10.

<sup>763</sup> ‘Man is health’ is a direct translation which makes no sense in English, however, it can meaningfully be translated to mean that good health is key to a functional individual.

<sup>764</sup> For more on the structure of the MOH, refer to Chapter 4, section 3.3

Health education gained increased attention because it aligned with the prevailing belief that preventive health measures were more effective than curative medicine. In the second five-year development plan (1969-1974), the emphasis on preventive health called for more health education.<sup>765</sup> Connected to this plan was the Arusha Declaration, which, through *Ujamaa*, gave health education meaning, agency, and urgency. In addition to education and agriculture, the coming together of many people in *Ujamaa* villages necessitated the need for health provision. However, the construction of health facilities and the provision of equipment and medicine were insufficient when the people were still largely unaware of the basics of their health needs. To remedy this gap, the government policy emphasised health education, delivered in schools, hospitals, daycare centres, and through MCH. In the 1970s, the use of health campaigns to popularise and teach about selected issues was notable.

One of the most popular health campaigns in Tanzania was launched in 1973. It was dubbed *Mtu ni Afya*. This popular campaign only ran for three months, which was shorter than the time it took to plan. As outlined by Budd Hall, the radio was a tool for mass communication in this campaign.<sup>766</sup> The use of radio for campaigns was not unique to Tanzania; it had been successfully used in Canada, India, Cuba, Ghana, Togo, and Dahomey (present-day Benin).<sup>767</sup> For the *Ujamaa* era in Tanzania, Cuba's literacy campaign and China's 'mass line' for Health were perfect examples from socialist nations.

The programme of *Mtu ni Afya* was as follows (see Table 10 below);

DURATION	DISEASES/MALADY ADDRESSED
week 1-3	Malaria
week 4-5	Waterborne diseases
week 6-7	Dysentery
week 8-9	Hookworms
week 10	Schistosomiasis
week 11-12	Tuberculosis

Table 10: Health issues addressed in the *Mtu ni Afya* Campaign.  
Source: Compiled from Budd Hall's '*Mtu ni Afya*' pg. 31.

<sup>765</sup> 'United Republic of Tanzania, Second Five-Year Plan for Economic and Social Development, 1st July 1969 to 30th June 1974 Vol 1'.

<sup>766</sup> Hall Budd, *Mtu Ni Afya ('Man Is Health'): Tanzania's Health Campaign*. (International Council for Adult Education, 1978).

<sup>767</sup> Hall Budd, *Mtu ni Afya*.

The table above shows how the *Mtu ni Aya* campaign was organised. It was based on the common illness in the land. According to Budd, all stakeholders, men, women, and leaders, were brought on board. The business community was not left behind. *Urafiki* textiles, for instance, printed *kitenge* and *kanga* bearing the campaign messages.<sup>768</sup> Musicians and bands such as Super Volcanoes recorded songs (see Table 11).

Original song in Swahili	English Translation
<i>1. Jambo bora la kulitekeleza, nchini mwetu hapa Tanzania, Tuzilinde sana Afya Zetu, tuijenge vyema miili yetu.</i>	The best thing to do, in our country here in Tanzania, is to protect Our Health, let's build our bodies
<i>Chorus</i> <i>Mtu ni afya mwananchi elewa, Tusiwe wavivu kuzilinda vyema Afya zetu X2</i>	<b>Chorus</b> Man is health, you citizens understand, Let's not be lazy to protect our health well X2
<i>2. Ikumbuke afya yako sana sana, ukiumwa naenda upesi ukajitibie, zifue nguo zako, safisha chumba chako, Mtu ni Afya. Ukilinde vyema sana chakula chako, kifunike kwenye chombo kilicho safi, wasijue nzi, kisiingie vumbi mtu ni Afya</i>	2. Take care of your health very much, when you are sick, seek treatment as soon as possible, wear clean your clothes, and clean your room, a Man is health. Protect your food very well, store it in clean container and cover it to protect it from flies and dust, Man is health
<i>3. Uwaue mbu wote nyumbani kwako, yachemshe maji ya kunywa kila siku, uoge kila siku, usafishe meno, mtu ni Afya,</i>	3. Kill all the mosquitoes in your house, boil drinking water every day, take a bath every day, brush your teeth, man is health,
<i>4. Zichome takataka, funika choo chako, usikose chandarua nyumbani kwako, Mtu ni Afya. Fukia madimbwi ya maji, vaa viatu vya bora, nawa mikono kabla ya kula Mtu ni Afya</i>	4. Burn garbage, cover your latrine, and don't miss a mosquito net in your house, man is health. Drain all pools of stagnant water, wear good shoes, and wash your hands before eating. Man is Health

Table 11: A song composed to popularise the health campaign. Translation by the author.  
Source: transcribed from <https://www.youtube.com/watch?v=aWAQsVO8DMk>

The song highlighted the importance of hygiene as a means to prevent the spread of diseases. The argument was that some of the diseases, such as cholera, worms, diarrhoea, and malaria, were preventable through behavioural change. Malaria, worms and diarrhoea diseases were

particularly notoriously prevalent among pregnant mothers and children in the Kilombero Valley.<sup>769</sup> Women were identified as key actors in the eradication of these diseases through a simple change of behaviour.<sup>770</sup> In addition, the sensitisation was taken to schools, and school children composed and narrated poems.<sup>771</sup> These and other materials were distributed all over *Ujamaa* villages.

The campaign stressed the practicality of achieving health. As per the political economy of TANU, health structures and having trained doctors were important, but the eradication of diseases was, at this stage, not only to be supported by the construction of rural health facilities such as dispensaries and health centres, but also social change through the agency of the people.

Digging a latrine, for instance, was not enough if one was not going to use it.<sup>772</sup> People dug latrines, but usage was not always guaranteed.<sup>773</sup> In some communities, the latrine was believed to be a dangerous place to be, not only for a pregnant woman but also for the whole family, and the majority preferred going to the bush.<sup>774</sup> Therefore, despite people being forced to dig the latrines, they would rarely use them. They also learnt tricks to play on the health inspectors who came to check if the latrines were in use. To avoid being fined, they would put leaves and various types of dirt inside the latrines and instruct the children to play along the path leading to the latrine, making it appear as if the path was regularly used.<sup>775</sup> Thus, there was a need for health policies to focus on the total transformation of the people's mindset, because human beings are, most of the time, inherently equipped with a tendency to resist coercion.

The most critical need was to have a transformative health education that would encourage people to accept change willingly, rather than forcing it upon them. Through the *Mtu ni afya* campaign, every home was to have a latrine. Beliefs such as the idea that a pregnant woman should never use the toilet or cannot breathe in a latrine, or a father-in-law could not share a toilet with daughters or sons-in-law, were dispelled.<sup>776</sup> According to Budd, having a toilet and access to clean water were among the most important defences rural people had against

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<sup>769</sup> Jilek-Aall, *Call Mama Doctor: African Notes of a Young Woman Doctor*.

<sup>770</sup> 'Maradhi ya Kuhara Yanvyopigwa Vita Katika Africa', *Mzalendo Jumapili*, January 20, 1985.

<sup>771</sup> Hall Budd, *Mtu ni Afya ('Man is Health'): Tanzania's Health Campaign*, 28.

<sup>772</sup> S.J Mamuya, *Maarifa Mapya ya Kuelimisha Afya*, 4.

<sup>773</sup> *Tanganyika Standard*, 'Upcoming Private Practitioner', 2.

<sup>774</sup> Oral interview with Amina Sambiliana at Mangula B, September 29, 2023.

<sup>775</sup> Hall Budd, *Mtu Ni Afya ('Man Is Health'): Tanzania's Health Campaign*.

<sup>776</sup> 'Maradhi Ya Kuhara Yanvyopigwa Vita Katika Africa', *Mzalendo Jumapili*, Januari 20, 1985, Kifyasi, 'Neither a Saviour nor Exploiter: A Historical Study of China's Medical Assistance in Post-Colonial Tanzania', 56.

maladies.<sup>777</sup> A clean environment was also emphasised. To combat malaria, for instance, there was an emphasis on draining stagnant water and emptying water collected in broken pots.

In the Kilombero Valley, malaria was a threat to pregnant mothers and children. It has been notorious for causing miscarriages in pregnant women, low birth weight and killing a child every 30 seconds in Africa.<sup>778</sup> Moreover, malaria made the infected susceptible to other diseases.<sup>779</sup> The Kilombero Valley, being a rice-production area, with its swamps, irrigation furrows, and intensive labour in the wet rice fields, made malaria and Bilharzia a serious threat. However, ignorance led to some life-threatening habits. Mosquito nets, for instance, were used as curtains for windows or on farms, rather than being used to protect against mosquito bites.<sup>780</sup> Such behaviours emphasised the need for health education.

Health education was both transformative and collaborative. As Nyerere clearly stated, *Ujamaa* required a change in mindset because rural development necessitated a shift beyond policy formulation and mere discussion. Health education was a concerted effort. It involved all health workers, including doctors, nurses, midwives, and health officers. Additionally, teachers in schools, social workers, rural development officers, agricultural workers, TANU leaders, government leaders, MPs, and councillors spoke about health education in their respective capacities.<sup>781</sup> Different government ministries, such as agriculture, health, education, finance, and planning, were involved. According to Dr Stirling, a doctor-cum-politician and former health minister, collaboration between various ministries was a must-have if good health was to be achieved. He linked poor irrigation (under the Ministry of Agriculture) and poor drainage (under the Ministry of Transport) to malaria and schistosomiasis, similarly associating poorly constructed houses (under the Ministry of Housing) with tuberculosis.<sup>782</sup>

This kind of collaboration is comparable to what was happening in Buganda, where it was similarly argued that stakeholder collaboration was crucial for better health improvement results. As noted by Michael Church,

It is only at the detached academic level that agriculture, sociology, medicine, etc. have firm boundaries, but at the rural level, these boundaries overlap

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<sup>777</sup> Hall Budd, *Mtu ni Afya ('Man is Health'): Tanzania's Health Campaign*, 46.

<sup>778</sup> J Schantz-Dunn and NM. Nour, 'Malaria and Pregnancy: A Global Health Perspective.', *Rev Obstet Gynecol.* 2, no. 3 (2009): 186–92; Randall M. Packard, *The Making of a Tropical Disease: A Short History of Malaria* (The Johns Hopkins University Press, 2007).

<sup>779</sup> Randall M. Packard, *A History of Global Health: Interventions into the Lives of Other Peoples*. (Baltimore: John Hopkins University Press, 2016), 57.

<sup>780</sup> Interview with Mzee George Mwambeta September 20, 2024 at Ifakara.

<sup>781</sup> S. J Mamuya, *Maarifa Mapya Ya Kuelimisha Afya*, 43; *Ngurumo*, Juni 3, 1972 'Huduma za Afya kwa Wajamaa'; *Ngurumo*, Januari 17, 1970 'Kuleni Chakula Kizuri'; *Ngurumo*, Julai 8, 1967 'Njaa Sio Amri ya Mungu'; *Ngurumo*, Desemba 21, 1967 'Pengo la Protein'.

<sup>782</sup> 'Hansard. Majadialiano ya Bunge, Mkutano wa Nne, Sehemu ya Pili. Tarehe 1-21 Julai 1966', 2278.

extensively, and the lack of integration between these disciplines as they affect rural people is tragic.<sup>783</sup>

Church adds that in Luteete, maternity and child-health care in Buganda, everybody was involved; mothers planted gardens and dug toilets. Health education was interwoven with the local political system. The parliament (*Lukiiko*), the county and sub-county chiefs, (*Miluka* and the *Gombolola* chiefs) mobilised the people. Dubbed ‘let us rise up and help each other’ (*Tusitikirewamu*), the method achieved more than just the narrative of improved hygiene.<sup>784</sup> The Buganda system, which existed even before colonialism, was utilised in the postcolonial period to communicate and reach the rural population. Although the Buganda Kingdom and TANU are fundamentally different entities, it is evident that political organisations played a crucial role in the development and implementation of health policy. The question of TANU’s role and impact on health-policy planning in Tanzania is intriguing, especially in shaping and disseminating medical policies. (see Chapter 3).

The significant influence of TANU politics in shaping key health decisions underscores the interconnectedness of health, politics, and economics, contributing to the overall success of the *Mtu ni Afya* campaign.<sup>785</sup> Although short-lived, the overall success of the *Mtu ni Afya* campaign was attributed to TANU politics, right from the village level to the national level. Fellow villagers selected the village medical helpers.<sup>786</sup> Villagers, led by village heads, were part of the larger political system under TANU. After all, the Arusha declaration was TANU’s policy statement.<sup>787</sup>

In the Kilombero Valley, TANU members taught the importance of better health and proper child-rearing. TANU campaigners reiterated what was taught by nutritional officers. They urged women to feed correctly. Men were encouraged to provide the necessary support to their families, avoid drunkenness, be good role models, and create a peaceful environment for mothers and children.<sup>788</sup>

During the *Mtu ni Afya* campaign, there was elaborate planning and organisation to enable smooth operations. Harvesting and planting seasons were to be avoided because people were

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<sup>783</sup> Dr Michael Church, ‘Extension by Health Centre: Luteete Maternity and Child Health Centre, Uganda.’, in *New Hope for Rural Africa: The Proceedings of a Conference Held at the Social Centre Kikuyu, Kenya*, September, 1967 (Nairobi: East Africa Publishing House, 1969), 70.

<sup>784</sup> Dr Michael Church, ‘Extension by Health Centre: Luteete Maternity and Child Health Centre, Uganda’, 70.

<sup>785</sup> Heggenhougen et al., *Community Health Workers: Tanzanian Experience*, 17.

<sup>786</sup> Oscar Gish, ‘The Way Forward: World Health Organisation’, 8.

<sup>787</sup> Oscar Gish, ‘The Way Forward: World Health Organisation’, 10.

<sup>788</sup> ‘CCM Library Dodoma, Malezi Bora ya Watoto Kitaifa’, 9.

too busy to follow any campaigns. These were lessons learnt from the previous campaigns — *Wakati wa Furaha* (Time for Rejoicing) and *Uchaguzi ni Wako* (The Choice is Yours), which did not receive wide acceptance, unlike *Mtu ni Afya*.<sup>789</sup> In *Mtu ni Afya*, there was a collective responsibility in line with the spirit of *Ujamaa*. In addition to the activities of the MOH, the ministries of national education and the treasury were also involved. The argument was that no single person, ministry, or body could change health for the better except through cooperation, an assertion made by Michael Church, as shown above.

The government's emphasis on preventive health education did not mean curative medicine was ignored. The medical structures in the hospitals and clinics emphasised the campaign teachings. In 1974, for instance, changes were made in the MCH that seemed to resonate with the teachings already incorporated into health education campaigns. The printing and information on the MCH cards were improved. The cards were made to be more colourful. Figures and drawings, particularly of different types of food, were added to capture matters related to nutrition (See Figure 18). The figure also shows immunisation cards printed with information not only on injections and a baby's weight monitoring chart, but with different colours showing the path for normal and abnormal weight. By the late 1970s, distinct colours had been added to make it easier for everyone, including the illiterate, to differentiate the meaning of the information portrayed.<sup>790</sup> For instance, any weight outside the green-shaded area was to be checked, and if it fell within the red-shaded area, that was considered a danger zone.

The card highlighted high-nutrient foods, particularly proteins. This was crucial because it made the information more relevant to the mothers, the primary recipients. This allowed mothers to take ownership of both the card and the medical process. Previously, the card was viewed as a document solely for doctors and health workers, which had negatively affected the uptake of antenatal care (ANC) and maternal and child health (MCH) services.<sup>791</sup> Going to the MCH was just a routine because the majority of women did not know how to ensure a successful pregnancy, why children were weighed or what diseases they were being immunised against.<sup>792</sup> The card was able to track the growth of a baby, and the medical workers and mothers would now have a medical history, unlike in the past when the information was recorded on paper that could not be traced in the next clinic.<sup>793</sup>

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<sup>789</sup> Hall Budd, *Mtu ni Afya ('Man is Health'): Tanzania's Health Campaign*.

<sup>790</sup> Women in Ifakara, Focus Group Discussion at Lipangalala.

<sup>791</sup> Women in Ifakara, 'Focus Group Discussion at Lipangalala', September 21, 2023.

<sup>792</sup> Staatsarchiv Basel-Stadt 'STABS PA 940 HI (1) I Tanzania Maternal and Child Health Programme' (1976), 38.

<sup>793</sup> Focus Group Discussion with Women at Lipangalala, Ifakara on 21<sup>st</sup> September 2023.

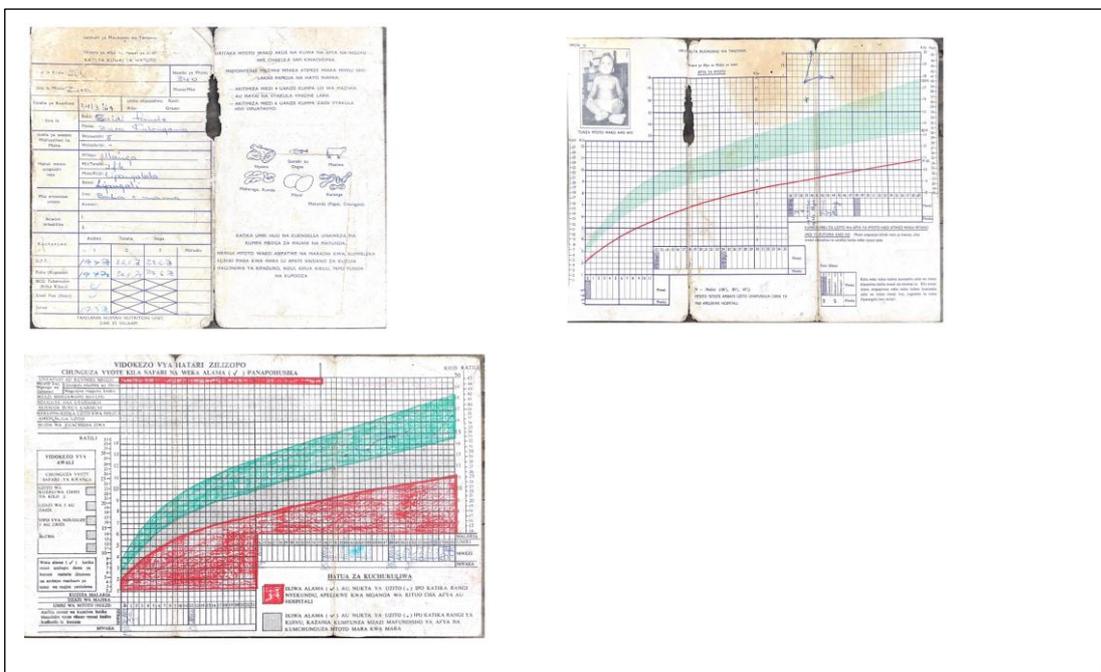


Figure 18: The 1969 to 1970s immunisation cards showing the transformation and the emphasis on colour shades to show baby weight. Source: shared with the author by women in Ifakara in a Women’s Focus Group discussion on 21.9.2023

Health education in the *Ujamaa* era was deemed highly successful. During this period, maternal and infant mortality rates reduced (see Table 12). Women led by UWT were at the forefront of health education campaigns. People were encouraged to take personal responsibility for cleanliness and activities such as garbage collection and disposal, promoting these tasks as self-reliant efforts that did not require government or municipal council involvement.<sup>794</sup>

Year	Maternal Mortality per 100,000 births	Av. mortality rates for children under 5 per 1,000 live births
1961	453	239
1967	351	224
1972	252	207
1985	167	177
1986	197	175
1987	190	173
1990	190	165
1991	215	163
1996	529	152

Table 12: Maternal and under-5 mortality from 1961 to 1996. compiled from Shija, Msovela and Mboera 2011 and <https://www.indexmundi.com/facts/tanzania/mortality-rate>, accessed on 30.10.2024

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Julius Nyerere, ‘TANU National Conference: 10 Years After Independence.’, 26.

Being self-reliant implied an essential concept that Nyerere called ‘Think Tanzanian’, which meant using what was easily affordable. This was a way of encouraging people to think locally and use what was available. Nyerere noted:

Why have big and elaborate plans yet we cannot afford to build the 100 *dispensaries* but one or two? It is important even if it is a mud hut, provided it is clean and light and air can get through, and has some means of sterilising, thermometers and other instruments...Just an improved local type of building, whitewashed inside, every few months and thoroughly scrubbed every day, with a simple water tank...can be provided cheaply.<sup>795</sup> (Italics added)

The focus of development had shifted after the Arusha Declaration. It was no longer delivering services previously denied by the colonial government and treating Tanzanians with dignity, but rather getting what was available with the resources at hand. The desired goals may not have been realistically attainable. This speaks to the political economy of the TANU government, as the resources available were a significant factor in development, as well as the choices, plans, and policies. The provision of medical care, whether preventive or curative, involved a dynamic process of negotiation, planning, and revising plans, which often meant deviating from the original strategy to address emerging challenges.

#### **4.6.2 Obstacles Experienced in Health Education and Campaigns**

While the uptake of health education bore fruit, particularly in the uptake of the vaccines, challenges were experienced. The biggest challenge in the villages remained the accessibility of vaccines. First, most of these vaccines were given through donations. From Dar es Salaam, they were transported by air and then by road to the nearest District hospital.<sup>796</sup> Due to the sensitive nature of vaccines, a phone call was made in the morning to notify the receiving hospital to collect the vaccines at the airport.<sup>797</sup> This measure helped prevent spoilage and minimise wastage. Where there were no airports, road transport was used. After 1975, in the Kilombero Valley, TAZARA proved useful for transporting medicine.<sup>798</sup>

The question of storage, however, remained a big challenge. In many areas, vaccines would be dispensed from district hospitals in small doses because few dispensaries had refrigerators. It was not until 1974, with the expansion of MCH, that the use of Kerosene refrigerators was

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<sup>795</sup> Julius Nyerere, ‘TANU National Conference: 10 Years After Independence’, 27.

<sup>796</sup> Oscar Gish and Godfrey Walker, ‘Alternative Forms of Transport and their Use in the Health Services of Developing Countries’, *International Journal of Health Services* 8, no. 4 (1978): 633–51.

<sup>797</sup> Oscar Gish and Godfrey Walker, 1978.

<sup>798</sup> Oral interview with Mzee Mwambeta at Viwanja sitini, Ifakara, September 20, 2023.

made widespread.<sup>799</sup> In the Kilombero Valley, storage facilities at St Francis Hospital, Ifakara, served as the centre of operations.<sup>800</sup> From here, the vaccines could be dispensed to other facilities that had kerosene refrigerators. The plan was to provide each refrigerator with two 20-litre paraffin cans to ensure a continuous supply while one was being refilled. Paraffin was used in most villages and health centres as a substitute for the lack of electricity. Electricity connectivity also followed the colonial supply plan, favouring urban over rural areas. As a result, kerosene-powered refrigerators became so common that a fridge-maintenance course was incorporated into the MCH training programme.<sup>801</sup>

The second notable challenge was the inequality among the health workers. Health educators, for instance, were paid low salaries. This led to demotivation, leading to the resignation of many nutritional health officers. By 1976, for example, eleven nutrition officers resigned, and others left the country for greener pastures.<sup>802</sup> The low-cadre officers, on whom the health sector was anchored, especially in rural areas, were also poorly remunerated.

Preventive health was underfunded, which contradicted the government's policy as announced in the Arusha Declaration and the Second Development Plan.<sup>803</sup> It was assumed that preventive health was easy to provide, but it ended up being expensive and difficult to coordinate. Curative, on the other hand, was an unending venture because some diseases, such as malaria reinfection, were common.<sup>804</sup> Therefore, by 1977, 70-80 per cent of the health budget was still being used for curative care.<sup>805</sup> The rapid shift in policy from curative to preventive remained at the level of documentation. Also, the expectation was for fast results, yet 'preventive health is not immediate but gradual'.<sup>806</sup> The government was therefore hesitant to invest a lot of money in preventive health, leading to complaints and criticism from health practitioners and experts. The general attitude of the state was that placing monetary value on preventive health was immoral and inhumane, but public health practitioners such as Lyimo argued that '...to be realistic, it must be admitted that life has a monetary value'.<sup>807</sup> Lyimo added that it cost Shs

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<sup>799</sup> Dr. Richard Hart, 'MCH Nutrition: Tackling the Malnutrition Problem in the Ministry of Health', *Lishe: Tanzania Food and Nutrition Journal*, no. 2.4 (1978).

<sup>800</sup> Interview with Christina Isakwisa, retired Nurse at Ifakara, September 20, 2023.

<sup>801</sup> Hart, 'Maternal and Health Care Services in Tanzania', 184.

<sup>802</sup> Illife, *East African Doctors: A History of the Modern Profession*; Bech et al, 'Changing Policies and Their Influence on Government Health Workers in Tanzania, 1967-2009: Perspectives from Rural Mbulu District'; 'The Annual Plan for 1977/78', n.d.

<sup>803</sup> Nyerere, *Socialism and Rural Development*; 'United Republic of Tanzania, Second Five-Year Plan for Economic and Social Development, 1st July 1969 to 30th June 1974 Vol 1'.

<sup>804</sup> Diana Conyers, *An Introduction to Social Planning in the Third World*, 43.

<sup>805</sup> Diana Conyers, *An Introduction to Social Planning in the Third World*, 44; Oscar Gish, 1977

<sup>806</sup> Dr. Malcom Segall, 'The Politics of Health in Tanzania', *The Standard*, 1972.

<sup>807</sup> B.A Lyimo, 'Public Health Workers Face Difficult Position', *Sunday News*, September 12, 1971.

1,400 to cure smallpox, but only Shs 5 to vaccinate, and Shs 900 to treat bilharzia. In contrast, it only required a change in behaviour, such as the responsible use of water sources to prevent diseases.

Preventive measures, therefore, were only addressed through these short-term campaigns. The budget for preventive measures was the first to be cut in the event of an emergency.<sup>808</sup> Spending continued to be disproportionately high on curative facilities, despite numerous calls for reduced spending in hospitals, where curative services received 75-80 per cent of the health budget, while preventive services received only 5 per cent.<sup>809</sup> The government seemed to have contradictory and opposing sides because, as Nyerere argued;

Why provide facilities to get a few people advanced treatment for special heart disease while the masses of our people are not able to get treatment for common diseases? It is a hard doctrine, but it's a question of priorities. To plan is to choose.<sup>810</sup>

This statement captures the helplessness of the president in trying to fathom the quagmire that seemed unsolvable, and perhaps beyond the context of Tanzania, because it involved other actors (Chapter 5).

The quagmire noted by President Nyerere was indeed complex and could be analysed at different levels. First, as shown in the previous chapter, a hierarchy existed between health workers, particularly between the preventive and curative systems. It remained a paradox that curative health system workers were paid more, while preventive health workers earned less and were perceived as being lower in the hierarchy of medical workers. Yet, as the example given by Lyimo above illustrates, it is the preventive system that laboured more to save public money.<sup>811</sup>

Secondly, the government's political economy was organised in a way that it could only solve pressing needs in the health sector, which were primarily urgent, and this was mostly in curative health. Ignoring curative health was almost impossible because it was the plank upon which the biomedical system was anchored and organised since its inception. According to Conyers, the only way to reduce curative health expenditure was to 'close hospitals, reduce doctors, drugs, and equipment', which was not feasible.<sup>812</sup> Lastly, health education and preventive medicine,

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<sup>808</sup> 'The Hansard. Proceedings of the National Assembly in the Parliament of URT and Zanzibar. Proceedings from 16th June to 3rd July 1964', 737.

<sup>809</sup> Mayer, 'Implementation and Control Under Decentralisation: Tanzanians Rural Health Centre Programme', 17.

<sup>810</sup> Julius Nyerere, 'TANU National Conference: 10 Years After Independence.', 28.

<sup>811</sup> B. A Lyimo, 'Public Health Workers Face Difficult Position'.

<sup>812</sup> Diana Conyers, *An Introduction to Social Planning in the Third World*, 44.

in general, require coordination and a willingness on the part of the people. However, the curative approach was popular because it did not involve many sanctions and worked as a preventive measure. It was not until 1982, in an address marking five years of the CCM party, that President Nyerere acknowledged that preventive and curative medicine needed to be addressed together, rather than being viewed separately. Luckily for the MCH, this integration was already feasible, particularly in incorporating vaccines and nutrition training during clinic days.<sup>813</sup>

Health education, despite its challenges, left a lasting mark on the health sector. As shown above, campaigns such as the *Mtu ni Afya* did not have maternal health as one of their direct topics. However, a closer analysis shows that it brought a wealth of health knowledge to people on matters related to pregnancy, disease, well-being, and childbearing. Some problems that were thought to be incurable without supernatural intervention, for instance, were demystified.<sup>814</sup> A good example was convulsion (*degedege*) and Epilepsy (*Kibaba*), which were noted to be simply caused by malaria and not an attack by evil spirits.<sup>815</sup> The primary challenge with health education through campaigns was that their impact was short-lived, and it was only hoped that they would have a lasting effect on the people.

#### **4.7 Ujamaa and the Attempt to Revive African Traditional Medicine in Kilombero Valley**

Medicine, as noted in Chapter 2, was used as a tool for the empire's expansion and civilisation.<sup>816</sup> It was at this time that hierarchies and hegemonies within and between medical therapies were pronounced. The distinction between African and Western medicine was particularly notable. Such distinctions persisted into the postcolonial period, in which traditional medicine is often portrayed as inferior to biomedicine.

The *Ujamaa* period is a prime example of the revival of African traditional medicine. *Ujamaa* strongly upheld African values. It was also during this period that it became clear that health facilities and staff were not enough, and that the inadequacies would not be addressed conclusively soon. In addition, biomedicine was not inclusive, as it did not address Africans' medical needs holistically within their cultural context. During the *Ujamaa* era, a prevailing

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<sup>813</sup> Richard Hart, 'Maternal and Health Care Services in Tanzania'.

<sup>814</sup> Interview with Amina Sambiliana at Mang'ula B, on September 29, 2023.

<sup>815</sup> Hall Budd, *Mtu ni Afya ('Man is Health'): Tanzania's Health Campaign*.

<sup>816</sup> Tilley, *Africa as a Living Laboratory*.

sentiment emerged that African culture needed to be appreciated, as Nyerere advocated self-reliance and the 'Think Tanzanian' concept.<sup>817</sup>

The use of local knowledge was interpreted to be self-reliance. There were dual consultations between traditional healers and hospitals. In the *Ujamaa* era, the government was to shed the unattainable desire to mirror the industrialised nations, and instead embrace what was locally available. In the villages, the traditional health practitioners and midwives gained renewed prominence. It was argued that the opposition to traditional midwives and healers originated from missionaries in the colonial period, who viewed them as a hindrance to women seeking medical care at clinics.<sup>818</sup> At the time, the clinic was an avenue for spreading Western civilisation and Christianity, and any barrier to achieving this goal had to be removed.<sup>819</sup> Therefore, the activities of the missionaries led to the polarisation of traditional midwifery.

The colonial government also shared the same view as the missionaries, albeit for politically inspired reasons.<sup>820</sup> Maghan Keita provides three reasons why traditional medicine was problematic for the colonial order. First, traditional practitioners lent legitimacy to the political order, as they also served as spiritual leaders. In the African cosmology, religion and politics were interwoven, and healing was theocentric. Secondly, the healers also had the authority to 'restore the social fabric, or thirdly lead people into a revolt.'<sup>821</sup> This arrangement had to be stopped by all means, leading to the suppression of social, political and religious organisations of Africans, including medicine.<sup>822</sup>

*Ujamaa*, however, played a vital role in reawakening the practice of traditional medicine. Maternal health services offered by traditional midwives were now openly recognised.<sup>823</sup> As most African women still sought the services of traditional midwives, during the *Ujamaa* season, the inadequacies of biomedicine added to the significance accorded to traditional midwives, especially by the state apparatus. While the government propagated biomedicine and called women to attend health facilities, the clinic was not always the best. Even in the 1970s

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<sup>817</sup> Julius Nyerere, 'TANU National Conference: 10 Years After Independence', 114.

<sup>818</sup> 'Wakunga Wa Jadi ni Muhimu', *Mzalendo*, November 15, 1981.

<sup>819</sup> WHO archives, Geneva, 'Health H/8/6 PP/CDW/E.2/4 Letter from C. Davies (District Medical Officer) to Dr Cecily Williams (Director of Medical Services) Village Midwives'; Walter, 'Practising Hygiene and Fighting the Natives' Diseases'; Hunt, 'Le Bebe en Brousse'.

<sup>820</sup> WHO archives, Geneva, 'Health H/8/6 PP/CDW/E.2/4 Letter from C. Davies (District Medical Officer) to Dr Cecily Williams (Director of Medical Services) Village Midwives'

<sup>821</sup> Maghan, *A Political Economy of Health Care in Senegal*, 40.

<sup>822</sup> Ann Beck, *Medicine, Tradition and Development in Kenya and Tanzania 1920 – 1970*. (Massachusetts: Crossword Press, 1981), 61 (Massachusetts: Crossword Press, 1981); Abiodun, 'Medicinal Practice in Western Science and African Traditional Thought: A Comparative Analysis'; Gyamfi and Anderson, 'Indigenous Medicine and Traditional Healing in Africa: A Synthesis of the Literature'.

<sup>823</sup> Kasambala, 'Wakunga Wa Jadi Muhimu', Novemba 15, 1981

and 1980s, a shortage of equipment and inadequate blood preservation facilities still existed.<sup>824</sup> As noted in Chapter 3, there were poor services, often manned by young girls who had trained as MCHAs after grade seven, while other facilities were inaccessible due to long distances between homes and clinics and a poor transport network.<sup>825</sup>

In Morogoro Hospital, midwives hurling insults at women in labour was a common complaint.<sup>826</sup> Such a treatment became repellent to the majority of women. Additionally, maternal healthcare offered in clinics in the 1970s was still largely inaccessible to the majority. In addition to the inaccessibility, many women preferred the traditional midwives because the medical clinic was seen as a place of fear.<sup>827</sup> Women were not allowed to accompany their mothers, grandmothers, or aunts, as was the case during home deliveries under traditional midwives.<sup>828</sup> The clinics failed to understand that African life was cyclical, where conception was connected to the ancestral world and where there was no separation between the physical, social, and spiritual realms.<sup>829</sup> For instance, when maternal deaths occurred, they were seen as occasioned by the evil spirits and a ritual intervention was needed to prohibit such a recurrence.<sup>830</sup> In the mission-operated clinics, such a misfortune was often seen as the will of God, whereas the public state-run clinics did not permit such interpretations. These contradictions led to the preference for traditional midwives.

The *Ujamaa* era boosted both the modern and traditional medical systems. For instance, the government's policy advocated for MCH activities to be aligned with the agricultural calendar. In the Kilombero Valley, it was planned that home visits by health officers would be conducted at the closure of the clinic, when the villagers had returned home from their farms.<sup>831</sup> While this was a good strategy, it did not appear to consider the workload overload of the health workers, which led to demotivation. It was noted that some of the MCHA would not wake up at night for duty, and worse still, others chose to work on their farms during the day because of the low pay at the clinic. There was also a lack of supervision, and when it was available, it was poorly conducted, eliciting opinions and complaints such as the need for supervisors to be assessed as well.<sup>832</sup> Bech et al. record that an RMA opted to go fishing, which was more profitable than his

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<sup>824</sup> 'Sababu za Vifo Wakati wa Uzazi Zaelezwa', *Uhuru*, Agosti 9, 1984.

<sup>825</sup> Kasambala, 'Wakunga Wa Jadi Muhimu'; Gish and Walker, 'Alternative Forms of Transport and Their Use in the Health Services of Developing Countries'.

<sup>826</sup> 'Hospitali Ya Moro Imezidisha Matusi', *Uhuru Newspaper*, Jumanne, Machi 27, 1979.

<sup>827</sup> Dreier, 'Health, Welfare and Development In Rural Africa'.

<sup>828</sup> Interview with Zuhra Hamisi, a traditional midwife at Lipangalala on September 21, 2023

<sup>829</sup> Jane Jane Mutambirwa, 'Health Problems in Rural Communities, Zimbabwe', *Social Science and Medicine* 29, no. 8 (1989): 928.

<sup>830</sup> Interview with Amina Sambiliana at Mang'ula B, on September 29, 2023.

<sup>831</sup> Staatsarchiv Basel-Stadt (StABS), PA 940 HI (1) I Tanzania Maternal and Child Health Programme', 5.

<sup>832</sup> Staatsarchiv Basel-Stadt (StABS), PA 940d H1 Health System Research Morogoro Region.' (June 1991), 14.

medical job.<sup>833</sup> These health workers thus reported high workloads, a lack of equipment, inadequate staff housing, and prolonged stays in a single unit, which added to their frustration and demotivation.<sup>834</sup> Such scenarios at the dispensaries prompted the majority of the people to opt for the traditional healers, even though cultural factors were at play as noted in chapter 3.

The *Ujamaa* era coincided with the new call by the WHO on the role of traditional medicine. In 1978, the WHO called for the integration of traditional medicine as a complementary approach to biomedicine to achieve ‘Health for All’ by the year 2000.<sup>835</sup> The doctor-to-person ratio indicated the urgent need to incorporate traditional healers. What is interesting is the fact that the government of Tanzania planned to train traditional midwives so that they could adopt modern ways of handling pregnant women and children.<sup>836</sup> In this training, traditional midwives were taught about the hygiene of the mother and child, including the care of the umbilical cord wound, with an emphasis on keeping it clean by avoiding the application of saliva, cow dung, or any other substance. They were also to prevent the use of traditional herbs and rituals before, during, and after delivery, as well as the baby’s feeding schedule.<sup>837</sup> The use of gloves was advocated to promote cleanliness during delivery, and the use of unsterilised items and nails to cut the umbilical cord was strongly condemned. Moreover, traditional midwives were not permitted to attend to primigravida cases, and where possible, the midwife was to accompany the woman to the clinic and serve as an advocate for the clinic.<sup>838</sup> While this plan was essential, it shows that the government remained pro-biomedicine and was not focused on improving traditional medicine. The attempts towards hybridity, therefore, were not fully embraced by government policy; instead, the government sought to modernise traditional medicine.

The government’s attempt to train traditional midwives began in 1960 and continued into the 1990s. The move was intended to enhance domiciliary services, ensuring that even if a woman gave birth at home, she would be in the care of a skilled health practitioner, a reflection of colonial approaches (Chapter 3). These sessions were conducted through discussions, role-playing, and singing, enabling those who could not read and write to participate.<sup>839</sup>

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<sup>833</sup> Margumm Bech M. *et al*, ‘Changing Policies and Their Influence on Government Health Workers in Tanzania, 1967-2009: Perspectives from Rural Mbulu District’, *The International Journal of African Historical Studies*, no. 46(1) (2013): 61–103.

<sup>834</sup> Staatsarchiv Basel-Stadt, Lucy Gilson and Martin Serikiaeli Alilo, ‘PA 940d Available Health Resources: The Pattern of the Use and Implications for Development of the Health System in the Morogoro Region Tanzania’ (26 June 1991); Harrison Chase Gottlich, ‘Colonialism and the Development of the Tanzanian Health System’ (Honors Thesis, Baylor University, 2018), 19.

<sup>835</sup> Mangst Mayne, ‘WHO Refers to it as Traditional Medicine’, *Sunday News*, September 10, 1978; ‘Herbs Have Proved Indispensable’, *Sunday News*, January 8, 1978.

<sup>836</sup> Oral interview with Zuhura Hamisi at Lipangalala, September 21, 2023.

<sup>837</sup> Interview with Zuhura Hamisi, a Traditional Midwife, September 21, 2023

<sup>838</sup> Interview with Magret Kidasi, a retired nurse, September 28, 2023

<sup>839</sup> Christina Isakwisa, interview by Veronica and Luoneko, Viwanja sitini, Ifakara, September 20, 2023.

However, the government's move to acknowledge traditional medicine presented several challenges. The dominance of Western medicine continued. For instance, it was ironic that the use of rituals by the traditional health practitioners was discouraged, which was the very essence of traditional medicine and midwifery. The government was more concerned with incorporating herbs into mainstream biomedicine.<sup>840</sup> This affected the intended integration of different actors in health and midwifery. It was against the expectations of the masses to eliminate rituals and herbs from health procedures, as they formed the core of the entire practice of traditional medicine. As a result, the government's training initiatives for traditional midwives in the 1960s through the 1980s confined them to the role of auxiliaries and 'allies', whose primary responsibility was to educate women on the importance of using health facilities. For midwives living near health facilities, their role was to escort pregnant women to clinics, an assignment that many did not enjoy.<sup>841</sup>

In Ifakara, for instance, traditional midwives residing near the St Francis Hospital were discouraged from providing care or conducting deliveries, as it was argued that the hospital was conveniently nearby.<sup>842</sup> The distinction led to notable disparities in the allocation of equipment. The NGOs and the government provided equipment to traditional midwives situated further from the hospital, including a delivery kit equipped with essentials such as gloves, razor blades, and strings. In contrast, those closer to the hospital were only provided with gumboots to navigate the flooding seasons caused by the overflow of the River Kilombero.<sup>843</sup> The irony was that the differentiation in approach assumed that a traditional midwife would put the life of the pregnant woman in danger, yet in rural places where they were no access to a health facility, midwives were allowed to conduct the delivery procedures.<sup>844</sup>

The integration of traditional midwives was intended to meet the needs of state policies, rather than the needs of the people. In the Kilombero Valley, the integration of traditional midwives into the health system as allies of trained midwives was particularly problematic because cultural values were often detached from the process. The cultural needs of the society, such as the administration of *kilala* (Chapter 3), were not considered helpful by the clinics and the government structures. As a result, women continued to seek the services of the traditional midwives. This meant that people continued to be attended to by traditional midwives and only sought medical attention in a health facility when it was necessary. This resonates with the situation in Indonesia, where the integration of the *paraji* (traditional midwife) into the health

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<sup>840</sup> 'Herbs Have Proved Indispensable', *Sunday News*, January 8, 1978.

<sup>841</sup> Interviewee B (a Traditional midwife), at Lipangalala, Ifakara, September 21, 2023.

<sup>842</sup> Interviewee B (a Traditional Midwife), at Lipangalala, Ifakara, September 21, 2023.

<sup>843</sup> Interviewee B (a Traditional midwife), at Lipangalala, Ifakara, September 21, 2023.

<sup>844</sup> Women in Ifakara, 'Focus Group Discussion at Lipangalala', September 21, 2023.

system also failed. Indrayani Indiryani notes that the integration meant too much work, such as documentation and reports for the *paraji*, which did not have any meaning to her work, because in traditional midwifery, keeping records was not a priority.<sup>845</sup> Thus, there was a disconnect between the government, trainers and the trainees. Nevertheless, by the 1980s, when the campaign to ‘improve traditional medicine’ became more pronounced, the government gave traditional workers support by giving them ‘instruments’ to use in their work.<sup>846</sup> A traditional health worker had to evolve to meet modern standards, as this was deemed necessary at the time. The traditional midwives were taught ‘modern’ ideas through training camps organised by the government and NGOs.<sup>847</sup>

Despite the challenges and the skewed approach towards traditional medicine, the government of Tanzania became more interested in conventional medicine than any other government in East Africa, thanks to the *Ujamaa* policy and its emphasis on self-reliance. For instance, in 1974, a research organisation was established at Muhimbili for the study of herbs.<sup>848</sup> By 1981, the Traditional Medical Research Unit at Muhimbili Medical Centre had collected 2435 herbs out of which 1503 specimens had been identified botanically after the research team consulted with 500 traditional ‘doctors’ in Dar es Salaam, Coast, Morogoro, Tanga and Kilimanjaro regions.<sup>849</sup> There was a countrywide campaign urging the herbalists to share their knowledge with biomedical researchers.

The unit was also working closely to have a national organisation of traditional medical workers registered.<sup>850</sup> However, it was clear from the onset that not every traditional health practitioner would be admitted, but only those who had fulfilled the ‘laid down conditions’.<sup>851</sup> It was not clear what these conditions were. However, recognition as a renowned herbalist, with extensive knowledge of herbs, was crucial. There was also a serious effort to differentiate between a diviner (*mpiga ramli*), a witch doctor (*mchawi*), and a herbalist (*mganga wa tiba asilia*).<sup>852</sup> While this is appreciated as a significant step in the field, it overlooks the holistic traditional healing practices that encompassed a diverse range of methods beyond herbal remedies,

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<sup>845</sup> Indrayani Indiryani, ‘Village Midwives Experiences in Rural Areas’, *J. Ilmich Permata Med.* 4, no. 1 (2015): 1–24.

<sup>846</sup> Omar Bawaziz, ‘Warsha Wa Madaktari Wa Mikoa Yaanza’, *Uhuru*, Agosti 26, 1980.

<sup>847</sup> ‘Interviewee A (a Retired Nurse), Viwanja Sitini, Ifakara’, September 20, 2023; ‘Interviewee B (a Traditional Midwife), at Lipangalala, Ifakara’, September 21, 2023.

<sup>848</sup> ‘Moshi Arrests 21 “Herbalists”’, *Daily News*, July 29, 1986.

<sup>849</sup> ‘Waganga Wa Kenyenji Watakiwa Wajitokeze Zanzibar’, *Uhuru*, April 4, 1984; ‘Drugs from Local Herbs in Pipeline’, *Daily News*, December 12, 1981.

<sup>850</sup> ‘Herbalists to Get Society’, *Daily News*, February 10, 1981.

<sup>851</sup> ‘Herbalists to Get Society’. *Daily News*.

<sup>852</sup> Bawaziz Omari ‘Warsha wa Madaktari wa Mikoa Yaanza’.

including ritual-based treatments and often reflected colonial fears that did not differentiate between traditional medicine and witchcraft.

The cooperation and integration that the government, through the Ministry of Health, popularised was ‘improving’ traditional medicine toward ‘modernity’. Therefore, modernising traditional medicine became a prominent but controversial agenda, a situation which Rebecca Marsland had aptly described with the oxymoronic term ‘modern traditional medicine’.<sup>853</sup>

While a national campaign emphasised the need for a hybrid of traditional medicine and other medical therapies, the government’s support for the biomedicine hegemony was apparent. The propagation of biomedicine indicated the binaries that emerged from colonialism, and the superiority of biomedicine over traditional medicine was evident. This was in line with the development agenda that had started in 17th-century Europe. In this era, for instance, childbirth was transformed from a social to a medical affair.<sup>854</sup> This is the same development agenda that was spread to the colonies. Postcolonial Tanzania perpetuated the same colonial agenda, where medical matters, specifically maternity, were to be ‘medically managed’.<sup>855</sup>

The hierarchy was openly apparent, and traditional medicine was at the bottom of the health system’s pyramid. Traditional practitioners and their traditional medicine were subordinate within the broader medical system.<sup>856</sup> There was, therefore, continued neglect of reproduction as a social component of culture; instead, the government chose to advance the power dynamics where the dominance of the scientific process was preferred.<sup>857</sup> Worse still, there was a fragile link between the dispensary-based system and the traditional midwives whom they trained.<sup>858</sup>

The *Ujamaa* era, despite the challenges, changed the attitude and outlook of traditional medicine. The previous situation of an imaginary binary evolved into hybridity, although it was not fully integrated into the medical system due to the existing political and economic structures. In the Kilombero Valley, traditional midwifery persisted, but it also continued to evolve. Traditional midwifery, although still consulted, has evolved to incorporate modern ideas, such as the use of gloves and sterile instruments.

As the government trained more MCHAs, it added to the spread of education, religion, and urbanisation, which extended further into the interior regions, leading to a gradual

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<sup>853</sup> Marsland, ‘The Modern Traditional Healer’, 756.

<sup>854</sup> Elizabeth Ettore and Carol Kingdon, ‘Reproductive Regimes: Governing Gendered Bodies’, in *The Palgrave Handbook of Gender and Healthcare*. (New York: Palgrave Macmillan, 2010), 145.

<sup>855</sup> Elizabeth Ettore and Carol Kingdon, 145.

<sup>856</sup> Maghan, *A Political Economy of Health Care in Senegal*, 49.

<sup>857</sup> Elizabeth Ettore and Carol Kingdon, ‘Reproductive Regimes: Governing Gendered Bodies’, 143.

<sup>858</sup> ‘Staatsarchiv Basel-Stadt ‘PA 940d H1 Health System Research Morogoro Region.’, 14.

transformation of attitudes towards medical therapies. African youth were selected for medical training based on Western medical principles. Maghan Keita notes that this training alienated the African youth from their environment. It also created a particular kind of dependency because the medical personnel were trained in knowledge and techniques only acceptable in a specific hospital or clinic setting.<sup>859</sup> In Western midwifery, the assumption was that a pregnant woman being confined in a clinic was less likely to result in the baby's or mother's death. This was not always the case. It was also very disconnected from the African understanding of midwifery. Nevertheless, with these changes brought about by the revival of traditional medicine, women had to choose between the services of traditional midwives and clinics. From our respondents, the necessity of the service depended on the situation at a given time.<sup>860</sup> Indeed, traditional healers, midwives, and trained medical workers were consulted. The need for vaccinations topped the list of reasons why women visited clinics, likely due to the campaigns and incentives offered to them, as described in Chapter 3. *The Ujamaa* policy indeed marked an era that revived the African medical spirit and practice.

#### **4.8 Challenges in the *Ujamaa* era and their Impacts on Health, Provision, and Planning**

The Arusha Declaration introduced *Ujamaa* as a catalyst for rapid development. This rapid development was primarily targeted at the rural areas. There were many positive changes and gains during this era. Regarding healthcare, rural areas became increasingly aware of their health needs, and villagers came together to build dispensaries and select those who would take care of the health of their community. However, many challenges were anticipated by the change to socialism.

*Ujamaa* remained an abstract concept that most people did not understand. According to Erick Svendsen, the Arusha Declaration itself was a surprise to many.<sup>861</sup> Priya Lal notes that *Ujamaa* was a complex concept rife with contradictions, making it difficult for both leaders and citizens to interpret. The principles of *Ujamaa* were operating at 'macro (national) and very different from the micro (village)', which was the very contradiction of the logic of *Ujamaa*.<sup>862</sup> Therefore, *Ujamaa* was never sufficiently domesticated to function in Tanzania; instead, it borrowed too many ideas from other sources, especially socialist nations, which were synthesised into something new, far from the traditional African socialism Nyerere had initially proposed. The traditional values and familyhood that Nyerere called for, which are locally referred to as *Ujima*,

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<sup>859</sup> Keita Maghan, *A Political Economy of Health Care in Senegal*, 43.

<sup>860</sup> Women in Ifakara, Focus Group Discussion at Lipangalala.

<sup>861</sup> Knud Erick Svendsen, 'Development Strategy and Crises Management', in *Mwalimu: The Influence of Nyerere* (London: James Currey Ltd, 1995), 115.

<sup>862</sup> Priya Lal, *African Socialism in Postcolonial Tanzania: Between the Village and the World*, 28.

differed from *Ujamaa*.<sup>863</sup> Communalism (*Ujima*) operated within related groups in the pre-colonial era. However, during *Ujamaa*, a village was composed of people from diverse origins and backgrounds, and it was the people, not the government, who were responsible for building and maintaining *Ujamaa*.<sup>864</sup>

While *Ujamaa* was about the people, controlled by the people, and managed by the people in the villages, it ultimately became party-centred. The party, TANU, was too involved in *Ujamaa* politics.<sup>865</sup> The *Ujamaa* period was a time when the government in Tanzania was primarily based on centralised statism.<sup>866</sup> The government wanted to develop the rural areas, but still controlled them ‘from above’.<sup>867</sup> This was perhaps the fear of the development of alternative voices that would question the dominant authority of TANU, in an era of consolidated ‘national unity’ and centralised governance. Some scholars described TANU’s position as authoritarian, which led to many internal problems.<sup>868</sup> However, it should be understood that in many communist/socialist regimes, such as China, Cuba, Russia, and Mozambique, the party was at the centre of development politics, and Tanzania was no exception.

The fact that TANU sought to influence African social life in the villages, despite having already disbanded the traditional leadership structure of chiefdoms, was problematic. There was a significant disconnect between TANU leadership and the local population. As noted above, some Village Executive Officers (VEOs), appointed by TANU to implement policies and collect taxes under the Village District Committees (VDCs), were perceived to be extortionists.<sup>869</sup> Even after the VDCs were replaced by the Ward Development Committees in 1967, little change was observed at the local level. By 1969, the proposal was to encourage the ward administrators to live in the villages so that they could advance *Ujamaa* politics.<sup>870</sup>

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<sup>863</sup> Oral Interview with Mzee George Mwambeta, at Uwanja wa Ndege, Ifakara, September 20, 2023.

<sup>864</sup> ‘Jeshi La Kujenga Ujamaa’, *Ngurumo Newspaper*, January 23, 1970, 10.

<sup>865</sup> Rene’ Dumont and Marie-France Mottin, *Stranglehold in Africa*, 112.

<sup>866</sup> Havnevik J. Kjell, *Tanzania The Limit to Deveelopment from Above*. (Nordiska Afrkainstitutet, Sweden in Cooperation with Mkuki na Nyota Publishers, 1993), 19; Scott, *Seeing Like a State: How Certain Schemes to Improve the Human Condition Have Failed*.

<sup>867</sup> Havnevik J. Kjell, *Tanzania The Limit to Deveelopment from Above*.

<sup>868</sup> Shigeo Fukuda, ‘Tanzania: Political Party, Rural Development, Nationalism and International Environment. First Preliminary Report of African Studies (Social Science 1)’ (Published with the Financial Assistance of the Grant in Aid for scientific Research (Overseas Scientific Survey) of the Japenese Ministry of Education, Science and Culture., March 1980); Andrew Coulson, *Tanzania: A Political Economy* (Oxford: Clarendon Press, 1982); Julius E. Nyang’oro, *The State and Capitalist Development in Africa: Declining Political Economies* (California: ABC-CLIO, 1989); John A.A Ayoade, ‘State Without Citizen: An Emerging African Phenomenon’, in *The Precarious Balance: The State and Society in Africa* (New York: Routledge, 1988), 100–118.

<sup>869</sup> Michaela Freyhold, *Ujamaa Villages: Analysis of a Social Experiment*, 37.

<sup>870</sup> ‘Madiwani Waishi Katika Vijiji vya Ujamaa’, *Uhuru*, Oktoba 1969.

Kilombero provides a good example of the disconnect between the state leaders and the villagers. In Msolwa *Ujamaa*, as noted above, one of the best-performing *Ujamaa* villages, the members attribute the collapse of the good performance to the external leadership of ‘experts’ introduced by the party bureaucracy. It was the external involvement that led to the deterioration of the village economy, as external managers and experts embezzled the money intended for the villagers.<sup>871</sup> The so-called experts were primarily focused on political power struggles and greed, rather than the needs of the people.<sup>872</sup> There was no prior groundwork or research to understand the village’s needs; TANU assumed that the expertise provided through the party was sufficient. As a result, decisions such as whether to plant millet, cassava, coconut, or cashew nuts were challenging to make because villagers had to wait for the ‘expert’ opinion. By 1982, it was clear that the interference by party leadership was one of the problems of *Ujamaa*, with Nyerere noting that:

There is still too great a tendency to lecture the village leaders and interfere unnecessarily with village priorities, rather than discuss with them the problems inherent in their task. We have not yet accepted that the experts on the problems of the villages are the villages themselves.<sup>873</sup>

The leadership of *Ujamaa* villages required more than the ‘expertise’ leadership imagined by TANU. The founder of Msolwa *Ujamaa*, for instance, Idd Mkangamo, although not trained in management, was committed to seeing his village prosper. It was his dedication, rather than formal education, that enabled him to advance the village, unlike the managers, whose leadership led to its decline.<sup>874</sup> However, TANU saw illiteracy as a problem in village management. Still, the educated managers who were supposed to help turned out to be the problem, mainly because of embezzlement. TANU viewed leadership through a colonial lens, defining it by the ability to read and write. Sending managers to some villagers was an acknowledgement that the ‘community may not have the capacity or skills...but...the support they needed (was) not imposition or guidance but partnership in making decisions between those with knowledge of what is required, and those with technical expertise’.<sup>875</sup>

Even so, the use of managers was not uniform in all *Ujamaa* villages. While in some places the manager was not welcomed, in others, managers did their job. Therefore, planning of the management of *Ujamaa* villages was complex. On the one hand, the government posted very

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<sup>871</sup> Interview with Mtendaji wa Kijiji at Msolwa *Ujamaa* on September 30, 2023.

<sup>872</sup> Michaela Freyhold, *Ujamaa Villages: Analysis of a Social Experiment*, 49.

<sup>873</sup> ‘Five Years of CCM Government Address given to the National Conference of the CCM by the Chairman, Ndugu Julius K. Nyerere, on the October 20, 1982 at Diamond Jubilee Hall, Dar Es Salaam’, 24.

<sup>874</sup> Interview with Mtendaji wa Kijiji at Msolwa *Ujamaa* on 30<sup>th</sup> September 2023.

<sup>875</sup> Staatsarchiv Basel-Stadt ‘PA 940d H1 Health System Research Morogoro Region.’, 17.

experienced people in the villages, expecting a change.<sup>876</sup> On the other hand, the so-called illiterate leaders were brilliant enough to know their members, yields, and the size of their land in acres.

Another challenge of *Ujamaa* was that the party forced people to move to unsuitable living sites. The new locations led to the uprooting of the majority from social and daily life, only to be ‘abandoned in the bush’.<sup>877</sup> Moreover, some villages were relocated more than once, often far from water sources and fertile, well-drained lands.<sup>878</sup> It is argued that the movement near the railway or road was more political than social, ostensibly to have the villagers guard the infrastructure from vandalism. However, from an economic perspective, these areas were characterised by vast areas of land, allowing villagers to practice large-scale agriculture. Therefore, they used their excessive powers to force people into *Ujamaa* to the extent of using the army and the militarised TYL to burn down the houses of those who were slow to move into the designated areas.<sup>879</sup> Some of these movements, according to René Dumont, were hurriedly done at night.<sup>880</sup> The use of force was detrimental because socialism is built on a foundation of willingness and cooperation. This force necessitated the clearing of more land to establish the villages.

The government ordered everyone to participate in land clearing, except for married women and young children. A woman in Kilombero narrated how many women were forced into marriage to escape the labour and the pressure that came with *Ujamaa*.<sup>881</sup> This only led to a shaky family institution. As noted by Priya Lal in the case of Mtwara, marital relations became casual, and people came together and parted at will.<sup>882</sup> A destabilised family was detrimental to the overall health of the family. The ideal strategy was for the movement to proceed to a village with already planned infrastructure, including clean water, dispensaries, arable land, and ready agricultural inputs; however, this was not the case. This led to fear and demotivation. To some, living together with strangers was challenging, while others feared witchcraft, making the idea of working together problematic.<sup>883</sup>

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<sup>876</sup> René Dumont and Marie-France Mottin, *Stranglehold on Africa*, 131.

<sup>877</sup> René Dumont and Marie-France Mottin, *Stranglehold on Africa*, 116.

<sup>878</sup> René Dumont and Marie-France Mottin, *Stranglehold on Africa*, 158.

<sup>879</sup> Priya Lal, ‘Militants, Mothers and the National Family: *Ujamaa*, Gender and Rural Development in Postcolonial Tanzania’, *The Journal of African History* 51, no. 1 (2010): 20.

<sup>880</sup> Dumont and Mottin, *Stranglehold on Africa*, 115.

<sup>881</sup> Interview with Amina at Mang’ula A on October 10, 2023.

<sup>882</sup> Priya Lal, ‘Militants, Mothers and the National Family: *Ujamaa*, Gender and Rural Development in Postcolonial Tanzania’.

<sup>883</sup> René Dumont and Marie-France Mottin, *Stranglehold in Africa*, 113.

The local leaders were eager to showcase the benefits of *Ujamaa*, perhaps to solidify their political influence and gain legitimacy within the party. Yet some of the members did not live up to the principles of *Ujamaa*. As Nyerere noted, ‘we have gotten rid of the foreign government, but we have not yet rid ourselves of the individualistic societal attitude which they represented and taught’.<sup>884</sup> Until the late 1970s and early 1980s, political leaders, who were thought to lead from the front, were still being encouraged to practise *Ujamaa*.<sup>885</sup>

Although education was a key factor in *Ujamaa*, the education reform in Tanzania did not depart significantly from previous systems, resulting in little to no change. The publication of the ‘Education for Self-Reliance’ (ESR) policy document emphasised agriculture as a subject in practice.<sup>886</sup> Schools were to run farms where students would work, and the same was to be extended to homes. The plan was to make agriculture dominant in rural areas, which was envisioned to contribute to national economic goals through sufficient food production and the sale of surplus food and cash crops. Unfortunately, as argued by many scholars, ESR did not ‘modify the capitalist second-class nature of the education system of the colonial era’.<sup>887</sup> The insistence on ‘agriculture by the masses’ was the same colonial attitude that agriculture did not need ‘school-manufacture skills’.<sup>888</sup> Therefore, in most villages, massive agricultural production yielded less than expected, and many farms recorded losses rather than profits. Even though a shortage of rain was a key factor in poor agricultural performance, a poor choice of crops and inadequate planning in *Ujamaa* politics were also observed.<sup>889</sup>

Agriculture was tailored toward the global economy rather than addressing existing problems, such as nutritional deficiencies. For instance, maize was widely grown in a monoculture style, favoured by the World Bank, and among the approved crops in Tanzania it consistently topped the list.<sup>890</sup> Maize matures faster and yields more than the other small grains, such as millet and sorghum.<sup>891</sup> However, it is less nutritious. There was a disconnect between economic production, agricultural modernisation and nutrition. In most cases, land use was not considered in terms of what crops could be grown well, but rather what was deemed necessary

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<sup>884</sup> Julius Nyerere, *Socialism and Rural Development*, 4.

<sup>885</sup> ‘Conform to Ideology-Ali Mwinyi Tell Leaders’, *Daily News*, September 21, 1983.

<sup>886</sup> Julius Nyerere, ‘Education for Self-Reliance’. 1968

<sup>887</sup> Majorie J Mbilinyi, ‘African Education during the British Colonial Period 1919-61’, in *Tanzania Under Colonial Rule* (London: Longman, 1979), 271.

<sup>888</sup> Majorie Mbilinyi, ‘African Education during the British Colonial Period 1919-61’, 248.

<sup>889</sup> ‘Economic Survey 1974-1975’ (United Republic of Tanzania, 1975); Mtendaji wa Kijiji, Moslwa *Ujamaa* Village., October 1, 2023.

<sup>890</sup> ‘National Agriculture Research Program (A Summary of Crop Research Projects). 1974-1975’, United Republic of Tanzania, Ministry of Agriculture, October 1974.

<sup>891</sup> Keith Phiri, et al., ‘Small Grains “Resistance”? Making Sense of Zimbabwean Smallholder Farmers’ Cropping Choices and Patterns within a Climate Change Context.’, *Cogent Social Sciences* 5, no. 1 (2019), <https://doi.org/doi:10.1080/23311886.2019.1622485>.

by the government and the larger global economy. In most cases, the land was used for crops that were unsuitable for the area, resulting in low yields and losses. By 1974, Tanzania was experiencing a grain shortage.<sup>892</sup> What did the challenges of the *Ujamaa* era mean to the health sector?

The challenges described above extended to the health sector. Notably, the macro health operations, mainly policy-making and planning, continued to operate from the top at Afya (MOH). However, micro-planning at the village level was left to the villagers. There was a lack of coordination and supervision at the centre. It is only in villages where there was willingness and proper leadership that things worked, for example, in Msolwa *Ujamaa*. The dispensary system, which was adopted after Arusha's Declaration as the panacea for rural health, continued to experience a shortage of workers. The plan to fill low-cadre jobs in rural areas was never fully implemented. There were still low-cadre health workers who worked in large hospitals and urban regions. In 1976, for instance, out of the 752 MCHAs, 28 per cent worked in hospitals, 43 per cent in rural dispensaries, 18 per cent in RHCs, 4 per cent in UHC, and 7 per cent in urban dispensaries. This was despite plans to concentrate on rural health by improving existing dispensaries and focusing more on rural healthcare. In addition to rural expansion, the plan also included the construction of new large hospitals in Musoma and Dodoma, as well as the expansion of hospitals in Kigoma, Bombo, Utate, Tarima, Sumbawanga, Kahama, and Singinda.<sup>893</sup> This indicates that the consumption of the most significant portion of the budget was still concentrated in large hospitals, either through construction or maintenance. The finances were mainly sought as aid or support from 'friendly' nations (Chapter 5). Even in such arrangements for assistance and loans, in most cases, it didn't translate to proper medical access in the rural areas.

In many villages in Tanzania, villagers provided labour for the construction of dispensaries. Therefore, challenges arose when construction coincided with other farming activities, leaving the villagers feeling overwhelmed. Additionally, some villagers believed that the government was responsible for providing these services and were therefore unwilling to work. Labour mobilisation in the village relied on the villagers, and the availability of materials, such as sand

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<sup>892</sup> United Republic of Tanzania 'Economic Survey 1974-1975', 1975, 1.

<sup>893</sup> 'CCM Library. Mpango wa Watu kwa Maendeleo ya Watu. Maelezo Mafupi ya Mpango wa Pili wa Maendeleo wa Watu wa Miaka Mitano, 1969-1974' (Wizara ya Uchumi na Maendeleo ya Watu, May 1969), 57; 'United Republic of Tanzania, Second Five-Year Plan for Economic and Social Development, 1st July 1969 to 30th June 1974 Vol 1'.

and timber, varied by region.<sup>894</sup> Consequently, the location of the dispensary was a key factor in determining the accessibility of construction materials.

The construction of these dispensaries, however, was just one of the many requirements. The availability of materials in the villages was not uniform. Some had sand, others had timber. One of the most significant planning problems was the transportation of materials. Transporting timber from Iringa to Kilombero, for instance, was problematic due to inadequate planning for the materials' transportation.<sup>895</sup> After construction, there was a need for equipment, healthcare workers, and other essential items to make the health facility functional, including staff housing. These staff houses were supposed to be built by the villagers. However, there was a belief that a government worker earning a salary could rent a house in the neighbouring town.<sup>896</sup> This notion led to delays in the opening of some centres. When the government constructed health facilities, delays were more common compared to when a private firm handled the construction. The big question remained: why was it easier for a private contractor to build a dispensary than for the government? The delays were attributed to the government's complex bureaucracy, which slowed the supply of items, some of which had to be procured from offices in Dar es Salaam, as well as to the need for cooperation among the health ministry, construction engineers, and water departments.<sup>897</sup>

The *Ujamaa* era brought both success and challenges to the health sector. Between 1962 and 1972, only 7 per cent of the total health budget was spent on rural areas (see Table 13).<sup>898</sup> By the end of the 1970s, the government's budgetary allocation to the Ministry of Health was far below the required level, and by 1983, the budget had risen only to 33 per cent of the national budget.<sup>899</sup> Many structural changes were introduced during this era. This shift marked a significant change in the country's governance structure and decision-making processes. In practice, however, the goals and development needs of Tanzania were no different from those of the three-year plan of 1961/64. The priority was still given to productive projects (agriculture, industry, and mining). The second priority was given to infrastructural projects (communication, water, power, and construction). Third came health, education, and water

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<sup>894</sup> Mayer, 'Implementation and Control Under Decentralisation: Tanzanian's Rural Health Centre Programme'.

<sup>895</sup> William P. Mayer, 'Implementation and Control Under Decentralisation: Tanzanian's Rural Health Centre Programme', 34.

<sup>896</sup> William P. Mayer, 'Implementation and Control Under Decentralisation: Tanzanian's Rural Health Centre Programme', 34.

<sup>897</sup> William P. Mayer, 'Implementation and Control Under Decentralisation: Tanzanian's Rural Health Centre Programme', 12.

<sup>898</sup> Innocent Semali Semali et al., 'Health Reform Cycles in Tanzania: 1924-1994', 93; Dalmás A.R. Dominicus and Takashi Akamatsu, 'Health Policy and Implementations in Tanzania', *Keiko J Med* 38, no. 2 (1989): 199.

<sup>899</sup> Innocent Semali et al. 93.

supplies.<sup>900</sup> While the emphasis was on providing rural health to villages, the planning and implementation proved otherwise. The little efforts through *Ujamaa* attempted to fill this gap.

Financial year	Rural	Urban
1970/71	20%	80%
1974/75	37%	63%
1976/77	41%	59%
1979/80	42%	58%

Table 13: Budgetary allocation in Rural and Urban between 1970 and 1980.  
Source: Compiled from data from Dominicus and Akamatsu, 1989, pg 199.

#### 4.9 Summary

The chapter has examined the health policies and planning that followed the Arusha Declaration. It began by providing an overview of the Arusha Declaration and its tenets, particularly self-reliance and *Ujamaa*. The overview enabled locating the health agenda within the *Ujamaa* discourse, for unlike education and agriculture, health did not receive a direct policy document in the central planning of *Ujamaa*. Instead, health was only relatable to the aspects that were deemed necessary in the key economic agenda of *Ujamaa*, particularly agriculture. Therefore, in this chapter, I connected agriculture, nutrition, education and health education to health policy planning and provision. Additionally, I examined some of the policies that also impacted health planning, particularly MCH in Kilombero. These issues included maternity leave, women's participation in the labour market, and the revival of traditional medicine during the *Ujamaa* era.

The chapter has demonstrated that the new focus following the Arusha Declaration was on rural development, particularly in rural health provision. This led to a collective effort from villages, community groups, voluntary agencies, and local and central governments to advocate for the construction of dispensaries. This new approach brought medical services closer to the people in rural areas. It was geared towards easing the perceived exploitation of rural peasants by urban dwellers. The latter had access to larger hospitals and specialised medical care, while rural workers contributed significantly to the economy through agriculture. However, *Ujamaa* did not go as planned because, indeed, 'socialism was a convenient alibi for many shortcomings'.<sup>901</sup> While the people gathered to build dispensaries, either the local government was unable to maintain them or did not have sufficient health workers, or worse still, equipment was lacking.

<sup>900</sup> 'The Annual Plan for 1977/78'.

<sup>901</sup> Dumont, *False Starts in Africa*. Translated by Phylis Nants Ott, 100.

The chapter employed the concept of political economy as a framework to demonstrate how the government, through TANU, was at the centre of the governance process, even when the Arusha Declaration advocated for self-reliance. This framework also showed that the socialist government was not significantly different from either the colonial government or the government immediately after independence, as the economic agenda took precedence over other social priorities. Moreover, self-reliance was continuously put to the test because the agricultural sector, which was intended to alleviate people from poverty and disease, was still controlled by the political and economic interests of both the state and other actors beyond Tanzania. The cultivation of crops, such as maize, was driven mainly by the World Bank and the global economy. Secondly, as before, the Tanzanian health sector was still dependent on voluntary agencies. In Kilombero, the St. Francis Hospital Ifakara, sponsored by the Catholic Church (Chapter 5) and with assistance from Switzerland, remained the most preferred place for women to access MCH and other services for two reasons. First, there was no alternative nearby, except for the Kibaoni dispensary, which was built much later. Secondly, it provided better services, which were lacking in many government-sponsored hospitals.

Although the *Ujamaa* era had its positives, such as the dissemination of medical knowledge through campaigns and the expansion of medical facilities, the policy of expanding facilities, especially in rural areas, had several ripple effects. One of the effects was that the health facilities required medical staff, which added another strain to the budget. Therefore, from 1975, the expansion of hospitals was not feasible, and it ceased to be a priority.

Health campaigns, health education, communal responsibility, and a revival of traditional medical practices led to a hybrid of different medical therapies, not only from outside Tanzania but also locally through the interaction of *wajamaa*. However, the existing political and economic structures did not fully support the formal adoption of multiple medical therapies. The chapter concludes that, although marred by challenges, the *Ujamaa* era had positive impacts on the growth of the health sector, as the government utilised the policy to expand and promote health policy and planning by providing medical knowledge and awareness through campaigns. The period also led to an attempt towards the integration of different types of medical knowledge which led to learning, unlearning and relearning not only for the state but for the people of Tanzania.

By the end of the 1970s and the beginning of the 1980s, the gains made in Tanzania's health sector were put to the test. With a burgeoning population and a global financial crisis,

Tanzania's self-reliance agenda was hardly feasible. Getting help from 'friendly' nations became more pronounced than before. It is ironic that even during the era of self-reliance, Tanzania was highly favoured by international donors. In the health sector, Tanzania has benefited immensely from numerous nations, receiving material assistance, training for medical staff, equipment, and the construction of facilities, which is the focus of the next chapter.

## CHAPTER FIVE

### ENTANGLED FUTURES: TRANSNATIONAL ACTORS AND HEALTH POLICY PLANNING IN TANZANIA, 1961-1980s

‘Tanzania is willing to collaborate in a friendly manner with any country that wishes it well, whether from the West or the East’.<sup>902</sup>

#### 5.1 Introduction

The previous chapter examined health-policy planning during *Ujamaa* and its emphasis on self-reliance as a cornerstone of Tanzania’s postcolonial development vision. This chapter shifts its focus to international cooperation, demonstrating that self-reliance did not preclude transnational engagement; instead, the Tanzanian state actively sought and managed external partnerships, albeit on its terms, which remained crucial in health policy, planning, and provision.

In this chapter, I focus on Tanzania’s international partnerships with Switzerland and China, as two prominent examples of health cooperation amongst the many states and NGOs that supported Tanzania’s health system after independence. These two partners are particularly important in the Kilombero region, which I am focusing on in my case studies, and therefore make a good choice for analysing transnational health in this context, down to the grassroots level. Secondly, the involvement of both countries reflects Tanzania’s pragmatic and inclusive approach to international cooperation, welcoming support from diverse sources regardless of ideological orientation. Switzerland, for instance, is a case of early engagement of monastic orders in ‘medical missions’ during colonial times.<sup>903</sup> Indeed, the medical assistance to Tanzania was closely intertwined with missionary work, tracing its origins to the aftermath of World War I. After World War II, Switzerland often presented itself as a humanitarian, ‘neutral’ partner, focusing on a scientific, technical health model rooted in public health and scientific experimentation. Its health support was shaped by the pharmaceutical firms and voluntary agencies, which had many interests, as shown in this chapter.

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<sup>902</sup> ‘TANU Guidelines (Mwongozo wa TANU).’ (Dar es Salaam: Government Printer, 1971), 5.

<sup>903</sup> Daniel Flahault, ‘Swiss Technical Cooperation. Swiss-Tanzania Joint Evaluation of Swiss Cooperation to Tanzania Health Projects. Sectoral on Education and Training in the Field of Health.’, April 1977; Lukas Meier, ‘Striving for Excellence at the Margins: Science, Decolonisation and the History of the Swiss Tropical and Public Health Institute (Swiss TPH) in (Post-) Colonial Africa 1943-2000’ (Basel, 2012); Sabina Widmer, *Switzerland and Sub-Saharan Africa In the Cold War, 1967-1979. Neutrality Meets Decolonisation* (Leiden: Brill, 2021).

China, on the other hand, came under communist rule in 1949, led by Mao Zedong. Mao was keen to help the newly independent African states as ‘brothers’ and ‘comrades’, but was equally eager to show the world the ability of China as a ‘modern’ nation able to lend development support to developing countries.<sup>904</sup> Similar to Swiss medical aid, Chinese assistance was not without conditions, reflecting broader strategic and political considerations. The climax of Sino-Tanzanian’ collaboration was reinforced by shared socialist ideological orientations that began in the 1960s.

China’s and Switzerland’s medical help to Tanzania facilitated an analysis of two distinct models of transnational engagement: A South-South and a North-South cooperation. However, it is essential to clarify that this chapter is not intended to provide a formal comparative analysis of China and Switzerland. While it highlights specific contrasts between the two, the primary aim is not to conduct a systematic comparison, but rather to explore the distinct forms of engagement each country had with Tanzania. It is within these entanglements that the intricate web of interactions in which postcolonial states, such as Tanzania, pursued national goals while simultaneously navigating the influence, resources, and agendas of transnational actors is revealed.

This chapter is guided by the concept of travelling models, which explores how policy ideas and practices circulate across borders. The flow of ideas in the travelling model is often assumed to follow a diffusionist logic from contexts with higher to those with lower institutional or technological concentration. As a developing country, Tanzania was usually cast as a passive recipient of medical aid. However, the chapter demonstrates how internal political and social dynamics influenced the reception, negotiation, and adaptation of transnational health initiatives. It indicates that such models were neither uncritically received nor uniformly implemented; therefore, the adoption of medical help and ideas was not entirely diffusionist, as the Tanzanian state and local people in Kilombero were also active actors. The chapter demonstrates how these connections typically influenced healthcare in Tanzania and also highlights how these relationships shaped maternal health policy and practice in the Kilombero Valley from 1961 to the 1980s.

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See further arguments in Larkin, *China and Africa 1949-1970: The Foreign Policy of the People’s Republic of China*.; Bailey, ‘China and Tanzania: A Friendship between Most Unequal Equals’; Dobson, ‘Health Care In China After Mao’; Xun, *The People’s Health: Health Interventions and Delivery in Mao’s China, 1949-1983*.

## 5.2 A Background to Health Cooperation in Tanzania

The preamble to the 1967 World Health Day (WHD) statement emphasised that health is a result of deliberate and coordinated teamwork.<sup>905</sup> This teamwork manifests across multiple tiers, encompassing individual health practitioners, institutional frameworks, and state-level partnerships. Teamwork, in the form of sharing and exchanging ideas and expertise in healthcare provision, has a long-standing tradition. In precolonial East Africa, for instance, the healers and medicine people travelled across regions beyond their community borders to spread their products and knowledge.<sup>906</sup> According to Muriuki, the Agikuyu medicine men were renowned among the Maasai, indicating that these two communities exchanged their medical expertise in the pre-colonial era.<sup>907</sup> Later in the colonial era, Maureen Malowany observed that the coastal populations of East Africa sought treatment from traditional, Islamic, or biomedical medicine, selecting whichever approach proved most effective for their illnesses.<sup>908</sup> The observations by Muriuki and Malowany provide evidence that the exchange of medical ideas among African communities has historical roots.

The legacy of knowledge circulation also resonates at the state level, where cooperation in health services has long been a part of regional and international engagements. As nations collaborate, health ideas and practices continue to ‘travel’ across borders. In modern history, the ‘travelling’ of health ideas has been recorded since the transatlantic slave trade, during which African pharmacopoeia and divination practices could be traced in the Caribbean.<sup>909</sup> Additionally, the movement of medical knowledge through the colonial masters and missionaries has been documented since the 16th Century in the Americas and, more significantly, since the 19<sup>th</sup> Century in Africa. Rebekah Lee adds that the medical profession also became part of the global transnational network through the training and dissemination of acquired biomedical knowledge.

In recent times, through international bodies such as the League of Nations Health Commission after World War I and the WHO after World War II, health ideas continued to spread globally, particularly in the fields of vaccines, disease control, and population control.<sup>910</sup> This movement

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<sup>905</sup> ‘Partners in Health’, W.H.O, 7 April 1967, 2.

<sup>906</sup> Hansjörg Dilger, Abdoulaye Kane, and Stacey A. Langwick, *Medicine, Mobility and Power in Global Africa: Transnational Health and Healing* (Indiana: Indiana University Press, 2012), 1.

<sup>907</sup> Muriuki, *A History of the Kikuyu, 1500-1900*.

<sup>908</sup> Maureen Malowany, ‘Medical Pluralism: Disease, Health and Healing on the Coast of Kenya, 1840-1940’ (McGill University, 1997), 3, 59.

<sup>909</sup> Lee, *Health, Healing and Illness in African History*, 8.

<sup>910</sup> Packard, *A History of Global Health*.

embeds transnationalism and travelling models in health. In the process, health support between nations emerged as a significant point of transnational networks, either through donations or declarations by international agencies. Medical aid, particularly when directed toward the ‘poor’, was often framed as a humanitarian gesture: a selfless act of concern for humanity. However, such assistance usually had underlying political, economic, strategic, technological, and scientific interests. While recipients were typically portrayed as the primary beneficiaries, donor countries also gained significantly. Due to strict drug-testing regulations in many Western nations, populations in the Global South were often used as test subjects for experimental vaccines and new medications—trials frequently backed by Western pharmaceutical companies and international organisations, as shown below.

After independence, Tanzania quickly became a favoured destination for donors, receiving substantial medical support. As briefly noted in Chapter 3, international organisations such as the WHO and UNICEF provided financial support for vaccination campaigns, the purchase of bicycles and vehicles for the transportation of equipment and personnel, as well as x-ray machines and generators.<sup>911</sup> OXFAM provided Land Rovers for public-health use. Governmental agencies, such as NORAD and SIDA, supported the construction of health centres in Kibaha and provided BCG vaccinations in Mbulu, and also funded the construction of the public-health teaching block at the Faculty of Medicine in Dar es Salaam in the 1970s.<sup>912</sup>

The cooperation between Tanzania and other nations for medical support was closely tied to efforts towards scientific progress. Between 1945 and 1960, colonial governments accelerated the dissemination of scientific ideas, a trend that continued after independence, to promote scientific progress and enhance social welfare.<sup>913</sup> The post-independence cooperation, however, can also be seen in light of Tanzania’s postcolonial government’s financial constraints, which made it dependent on loans, grants, technical assistance, and human-resource support. President Nyerere explicitly stated that Tanzania was willing to collaborate ‘in a friendly manner with any country that wished it well, whether from the West or the East’.<sup>914</sup> However, the medical assistance was closely tied to the national health policy, which was still largely tied to the broader national policies, such as the need for self-reliance, medical access in rural areas and the need for national and state control over private practice. Such policies, on the one hand,

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<sup>911</sup> ‘United Republic of Tanzania. Annual Report of the Health Division, 1967, Vol 1.’, 1967, 2.

<sup>912</sup> Elisabeth Michanek, *NAN, TAN 023-013.1. Report to the SIDA on the Most Appropriate Assistance for a National Food and Nutrition Programme for Tanzania*. (SIDA HQ, 1972).

<sup>913</sup> ‘TNA ACC 450, HL1424 WHO and UN EPTA Technical Aid, 1959-1960’, 1960; Lukas Meier, ‘Striving for Excellence at the Margins: Science, Decolonisation and the History of the Swiss Tropical and Public Health Institute (Swiss TPH) in (Post-) Colonial Africa 1943-2000’ (Basel, 2012).

<sup>914</sup> Nyerere, ‘TANU Guidelines (Mwongozo Wa TANU)’, 5.

increased reliance on the state as a health provider, which in turn led to greater dependence on donor funding; on the other hand, they brought Tanzania to the forefront as an active actor in medical negotiations.

By 1972, Tanzania had established diplomatic relations with a diverse range of nations, including Bangladesh, Bulgaria, Cuba, Czechoslovakia, East Germany, Hungary, India, Indonesia, Israel, Japan, North Korea, Mongolia, Pakistan, Syria, Turkey, the Soviet Union, North Vietnam, and Yugoslavia. These countries were categorised mainly as the Eastern Bloc or non-Western states at the time.<sup>915</sup> However, ‘Tanzania had no intention of being anti-West’.<sup>916</sup> Therefore, Tanzania also received support from West Germany, Norway, Sweden, and the UK.<sup>917</sup> This diversification in international relations ensured that no single country held political or economic dominance over Tanzania.<sup>918</sup> It was assumed that by securing aid from multiple nations rather than relying on a single donor, Tanzania sought to maintain its independence.

The entry of the USA, the Scandinavian states, Switzerland, and China into the development race added to the large pool of ‘willing helpers.’<sup>919</sup> The ‘non-colonial’ badge made the USA, China, Switzerland and the Scandinavian countries more attractive to Tanzania. Nyerere, on the other hand, with his non-aligned policy, was seen in many countries as the hope for Africa, and donors and partners were willing to invest in development aid. At the time, most of the former colonies, including Tanzania, struggled not only with planning and a shortage of skilled labour but also with finances. Health budgets, for instance, were particularly low.<sup>920</sup> Such situations led Tanzania to seek any available help. Between 1973 and 1974, 70 per cent of Tanzania’s health department budget was funded through aid.<sup>921</sup> It was a case of a willing donor and a willing recipient, but the assistance was not unconditional; it came with a donor-driven agenda.

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<sup>915</sup> Valerie Bunce, ‘The Empire Strikes Back: The Evolution of the Eastern Bloc from a Soviet Asset to a Soviet Liability’, *International Organisation* 39, no. 1 (1985): 1–46; Marcus Goncalves, ‘Eastern Europe Regional Bloc: CEE and CIS’, in *Eastern Economies: A Region in Transition*, 1st ed. (Business Expert Express, 2016).

<sup>916</sup> Yu, *China’s African Policy*, 49.

<sup>917</sup> ‘TNA/HE/A/90/16: Technical Assistance Japan’ (n.d.); Daniel Flahault, ‘Swiss Technical Cooperation. Swiss-Tanzania Joint Evaluation of Swiss Cooperation to Tanzania Health Projects. Sectoral on Education and Training in the Field of Health’, April 1977; ‘TNA, HE 1674/5: Technical Assistance U.K.’ (63 1962); ‘TNA/HEA/90/5/493 Technical Health Assistance China, Vinyago kama Zawadi.’ (Tanzania National Archives, 1976); Lillemor Anderson-Brolin, Ingrid E. Cornell, and Frants Staugard, ‘Cooperation for Health Development in Tanzania: An Evaluation of Parts of the Swedish Support to the Health Sector Development in Tanzania 1972-1985’ (SIDA-MOH, Dar es Salaam/Stockholm, March 1987).

<sup>918</sup> Yu, *China’s African Policy*, 50.

<sup>919</sup> Fredrick Cooper, ‘Writing the History of Development’, *Journal of Modern European History: Modernizing Missions: Approaches to ‘Developing’ the Non-Western World after 1945* 8, no. 1 (2010): 5–23.

<sup>920</sup> *Tanganyika Standard*, ‘Health Grant Attacked’; *Tanganyika Standard*, ‘Health to Get the Lowest Sum’.

<sup>921</sup> W.K Chagula and E. Tarimo, ‘Meeting the Basic health Needs in Tanzania’, in *Health by the People* (Geneva: W.H.O, 1975), 158.

Fredrick Cooper notes that the situation enabled the developed nations to experiment in Africa under the guise of development aid.<sup>922</sup> The scale of medical assistance received by Tanzania is reflected in the significant number of international actors involved. Consequently, the landscape of medical assistance in Tanzania is both broad and complex.

### **5.3 Tanzania and international health support**

Between 1960 and 1980, Tanzania engaged in numerous international partnerships that provided support to its healthcare sector. It would not have been possible to investigate all the international actors involved; therefore, this study focuses on engagements with Switzerland and China, as stated earlier.

#### **5.3.1 Laying the Groundwork: The Swiss Capuchins and Baldegg Sisters**

After the Second World War, Switzerland's development aid to developing countries gained impetus. Unlike many other countries that operated directly, Swiss aid was channelled mainly through NGOs, voluntary agencies and private companies.<sup>923</sup> Therefore, post-independence Tanzania's cooperation with Switzerland is best understood within the framework of Swiss missionaries who laid the groundwork for Swiss development aid. Through the efforts of Swiss missionaries, NGOs, and private companies, their biomedical work was introduced in Tanzania. In Tanzania, the German and Swiss missionaries are credited with introducing biomedical ideas in the Kilombero Valley. In many African nations, it was through missionaries that medical work began and was sustained.<sup>924</sup> Likewise, it was through missionary works that Swiss aid gained a foothold in Tanzania.

Missionary work in Tanzania began in 1863 with the arrival of the Holy Ghost Fathers (HGF), who first established their mission in Zanzibar.<sup>925</sup> At the time, Zanzibar was known for its plantation economy, particularly the cultivation of spices, which relied heavily on enslaved labour. The HGF's mission coincided with anti-slavery campaigns that condemned the practice

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<sup>922</sup> Cooper, 'Writing the History of Development'.

<sup>923</sup> Meier, 'Striving for Excellence at the Margins: Science, Decolonisation and the History of the Swiss Tropical and Public Health Institute (Swiss TPH) in (Post-) Colonial Africa 1943-2000'.

<sup>924</sup> Ann Beck, *Medicine, Tradition and Development in Kenya and Tanzania 1920 – 1970*. (Massachusetts: Crossword Press, 1981), 61 (Massachusetts: Crossword Press, 1981); Debby Gaitskell, "'Getting Close to the Hearts of Mothers": Medical Missionaries among African Women and Children in Johannesburg between the Wars', in *Women and Children First: International Maternity and Infant Welfare 1870-1945*. (London: Routledge, 1992), 178–202; Haller Dirr, Marita, 'Missionary Work in Tanzania', *Ite: Miaka 75 Katika Tanzania*, 1996; Marcel Dreier, 'Health, Welfare and Development in Rural Africa: Catholic Medical Mission and Configuration of Development in Ulanga, Tanzania, 1920-1970' (Ph.D. Dissertation, University of Basel, 2015); Michael Jennings, 'Cooperation and Competition: Missions, the Colonial State and Constructing a Healthy System in Colonial Tanganyika', in *Beyond the State: The Colonial Medical Service in British Africa*. (Manchester University Press, 2016), 206.

<sup>925</sup> Dirr, Marita, 'Missionary Work in Tanzania', 7.

as both un-Christian and inhumane. The missionaries actively rescued enslaved individuals from traders, and many of these freed individuals became their first converts. This anti-slavery stance helped the HGF gain significant support, particularly among Africans who had been subjected to enslavement. In 1868, the HGF expanded their work to the mainland, establishing a mission station at Bagamoyo.<sup>926</sup> They were later joined by the White Fathers, who continued evangelisation efforts in the region. Notably, these missionary activities occurred before the convening of the Berlin Conference (November 1884 – February 1885), which formalised European colonial rule in Africa.

The Berlin Conference laid down the rules for engagement in the demarcation of the African continent. As a result of Karl Peters's prior activities, Tanganyika was declared a German sphere of influence. The division of East Africa, however, was decisively determined through the Anglo-German treaties of 1886 and 1890 (Heligoland), respectively. Tanganyika and Rwanda-Urundi became a German colony named '*Deutsch-Ostafrika*'. However, as colonialism was closely intertwined with missionary work, German colonial officials preferred to collaborate with German missionaries. Therefore, German missionaries collaborated closely with the colonial administration.<sup>927</sup> Both Catholic and Protestant missionaries, specifically the Lutherans and Moravians, were present in '*Deutsch-Ostafrika*'.

In Kilombero, the Catholic Church, specifically through the St. Benedict missionaries of Othilien and the Benedictine sisters of Tutzig, were in operation. Initially, they had a station in Pugu and another in Dar es Salaam. These stations were destroyed during the Abushiri revolt on January 13, 1889. However, they reopened in 1890 and expanded to Mahenge.<sup>928</sup> Administratively, Kilombero was still part of the larger Ulanga region in Mahenge. From Dar es Salaam, Mahenge is approximately 489 Kilometres by road. At the time, the road network was almost non-existent, which complicated the journey. However, the climatic conditions of Mahenge were favourable and attractive. At Mahenge, the German missionaries established several stations and, by 1913, had built a permanent church at Tabora.<sup>929</sup> (See Figure 19).

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<sup>926</sup> 'Miaka 75 Katika Tanzania', *Ite*, no. 1 (1996).

<sup>927</sup> Larson, 'A History of the Mahenge (Ulanga) District c. 1860-1957'.

<sup>928</sup> Lorne Erling Larson, 'A History of the Mahenge (Ulanga) District c. 1860-1957' (Ph.D. Dissertation, University of Dar es Salaam, 1976), 40; Haller Dirr, Marita, 'Missionary Work in Tanzania', *Ite: Miaka 75 Katika Tanzania*, 1996, 11.

<sup>929</sup> For clarity, Tabora in Mahenge which was then part of the Kilombero Valley, should not be confused with the Tabora in Tabora Region, famous as a centre for the 19<sup>th</sup> Century long-distance trade between the Coastal traders and the interior.

Mahenge had fertile soils. The early missionaries recorded that at Mahenge they ‘drank milk, ate rice, chicken, oranges and mangoes’.<sup>930</sup> This indicates that the weather was suitable for agriculture, although poor nutrition would later become a significant issue, as shown below. According to Jamie Monson, the Kilombero Valley was strategically important for rice cultivation, an idea that was carried into postcolonial Tanzania, where health and nutrition policies were closely linked to food production. The Germans were particularly interested in the valley to avoid the heavy importation of rice from British India for consumption in both German East Africa and Germany.<sup>931</sup> Agriculture in the colonial era relied heavily on human labour, and access to labour brought health concerns to the fore. A healthy worker was more productive. Additionally, the transfer of health ideas was part of the civilisation agenda.<sup>932</sup> Both German Colonial officers and missionaries provided rudimentary health services. Health facilities and health research initiatives by the German colonial government included the Sewa Haji Hospital for Africans in Dar es Salaam, as well as research on Malaria by Robert Koch (see Chapter 2).



Figure 19: St Raphael's Archangel Tabora Parish. Photo taken by author 6.2.2025.

Rural health was left mainly to the missionaries. The colonial political economy focused on establishing extensive medical facilities in Dar es Salaam to demonstrate its presence in the capital city. Although the majority of people lived in rural areas, it was in urban areas that the politically conscious minority resided. In short, developing the urban areas was not only a centre

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<sup>930</sup> ‘Mitteilungen Aus Den Missionen Dar Es Salaam and Seychellen. Jahresbericht 1921-1941’, *Die Schweizer Kapuziner in Africa*, 1941.

<sup>931</sup> Monson, ‘Agricultural Transformation in the Inner Kilombero Valley of Tanzania 1840-1940.’, 20.

<sup>932</sup> Lindner, ‘The Transfer of European Social Policy’.

of operation but a way of announcing presence and seeking legitimacy. Although the postcolonial government explicitly sought to reverse the urban bias through its primary healthcare strategy, it was not easy, as urban areas received more funding, had the primary health facilities, and had more health workers than the rural areas.<sup>933</sup>

At Mahenge, the German missionaries constructed both dispensaries and health centres (see Figure 20 below). Figure 20, showing a photo captured at Tobora, Mahenge, was one of the earliest dispensaries used by the Germans in the early 20<sup>th</sup> century. Oral accounts suggest that the name of the area, *Tobora*, originated from the immunisation campaigns conducted by German missionaries as early as 1913. The locals who spoke the Pogoro language would ask each other, '*Ugenditkala kutobola?*' meaning '*Have you been pierced/injected (immunised)?*' or '*Wakutobola kala?*' meaning '*Have they immunised you?*'.<sup>934</sup> This oral account made it clear that the missionaries and the German government were concerned about the health situation and that health was one of the tools of civilisation.<sup>935</sup>



Figure 20: A structure used as a dispensary during the German colonial era at Tobora Mahenge. Source: Photo taken by author 6.2.2025

World War I (1914-1919) culminated with Germany losing all its colonies. The League of Nations assigned Tanganyika to the British administration as a trust territory. All the German colonial officers and missionaries left Tanganyika. However, through the intervention of Pope Benedict XV, the Catholic Church's office for missions in Rome replaced the German Catholic

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<sup>933</sup> Heggenhougen et al., *Community Health Workers: Tanzanian Experience*.  
<sup>934</sup> Interview with Father Luanda at Tobora, Mahenge, 6<sup>th</sup> February, 2025  
<sup>935</sup> Tilley, *Africa as a Living Laboratory*.

missionaries in Tanganyika with Swiss Franciscans, specifically the Capuchins and the Baldegg Sisters.<sup>936</sup> Given the geopolitical context of the time, Swiss missionaries were perceived to be neutral.<sup>937</sup>

The Swiss missionaries arrived in Dar es Salaam on June 18, 1921 (see Figure 21). They immediately took over the work of the German missionaries, the Benedictines of St. Ottilien. The Swiss missionaries noted that the German missionaries had worked tirelessly to pioneer Catholic Mission work in Dar es Salaam and Mahenge. The Swiss and German missionaries continued to work together. The Capuchins, for instance, received advice and support from the Benedictines, especially on matters related to language, from Father Thesbosius Schall.<sup>938</sup> Mahenge and Dar es Salaam were described as being twice the size of Switzerland, and therefore, the vastness of the region alone added to the already complex task for the Swiss Missionaries.<sup>939</sup>



Figure 21: On the Left is the first group of Capuchins to Tanzania. Right, the first group of Baldegg sisters in 1921. Source: Dirr Haller Marita, *History in the Making*, 1997, 53, 54

From Dar es Salaam, the Swiss missionaries travelled to Mahenge, which was one of their most significant areas of operation. Father Guido Kapelli described the twelve-hour train ride from Dar es Salaam to Kilosa, and from Kilosa to Mahenge, as a fourteen-day, perilous caravan march.<sup>940</sup> While missionary zeal and evangelism were among the reasons missionaries

<sup>936</sup> *Missionsbote*, 'Der Schweizer Kapuziner in Africa'.

<sup>937</sup> However, Richard Behrendt challenged the notion of Swiss neutrality, arguing that some countries benefited from colonialism without the struggles of building and sustaining an empire. See Meier, 'Striving for Excellence at the Margins: Science, Decolonisation and the History of the Swiss Tropical and Public Health Institute (Swiss TPH) in (Post-) Colonial Africa 1943-2000', 15.

<sup>938</sup> MDA *Die Schweizer Kapuziner in Africa*, 'Mitteilungen Aus Den Missionen Dar Es Salaam and Seychellen. Jahresbericht 1921-1941'.

<sup>939</sup> MDA *Die Schweizer Kapuziner in Africa*, 'Mitteilungen Aus Den Missionen Dar Es Salaam and Seychellen. Jahresbericht 1921-1941'.

<sup>940</sup> MDA *Die Schweizer Kapuziner in Africa*, 'Mitteilungen Aus Den Missionen Dar Es Salaam and Seychellen. Jahresbericht 1921-1941'.

undertook such endeavours, these journeys should also be understood as missionaries' colonial agency, with a belief in their own superiority that imposed new ideas on Africans, with medicine at centre stage.

In Mahenge, the Swiss missionaries continued their evangelical and medical work, subsequently extending their efforts to Sofi, Ifakara, and Sali.<sup>941</sup> Both the Capuchins and the Baldegg Sisters embraced the philosophy of 'service to the body and soul', viewing physical healing as a means to achieving spiritual salvation and emulating Jesus Christ, who they believed came to the world primarily as a healer.<sup>942</sup> Consequently, preaching the gospel and curing treatable diseases were regarded as equally important aspects of their mission. The Baldegg sisters mainly managed the medical component of the missionary work. Given the extensive health needs in Mahenge, their medical endeavours later culminated in the establishment of St. Francis Hospital in Ifakara, along with a network of dispensaries. Even though Switzerland allowed NGOs and missionaries to act on behalf of the state, as shown below, the sequence of missionary activities, the founding of St. Francis Hospital, and the subsequent arrival of Swiss development aid suggest a coordinated progression of events, which may give the impression that these developments were strategically planned from the outset, further questioning the neutrality of Switzerland.

### **5.3.2 Sister Arnolda, St Francis Hospital, Ifakara and Swiss Development Aid**

St. Francis Hospital, Ifakara, has its roots in a dispensary established by the Baldegg Sisters in 1927, marking the start of a medical facility that would grow significantly over time. The most prominent figure was Sister Arnolda Kury, who was in charge of the medical issues. Lucas Meier describes Sister Arnolda as the pioneer of medical services in Ifakara.<sup>943</sup> From the local women in Ifakara, Sister Arnolda was concerned about the health of the inhabitants, particularly maternal and child health (MCH).<sup>944</sup> The missionaries believed that African midwives had little knowledge of maternity and childcare. According to the missionaries, African mothers in Mahenge were treated harshly during delivery, especially if it was a complicated birth, which was interpreted as punishment for marital infidelity.<sup>945</sup> The missionaries felt obligated to change

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<sup>941</sup> MDA *Die Schweizer Kapuziner in Africa*, 'Mitteilungen Aus Den Missionen Dar Es Salaam and Seychellen. Jahresbericht 1921-1941'.

<sup>942</sup> MDA *Missionsbote*, 'Der Schweizer Kapuziner in Africa', 72.

<sup>943</sup> Meier, 'Striving for Excellence at the Margins: Science, Decolonisation and the History of the Swiss Tropical and Public Health Institute (Swiss TPH) in (Post-) Colonial Africa 1943-2000'.

<sup>944</sup> Women in Ifakara, Focus Group Discussion at Lipangalala.

<sup>945</sup> MDA 'Der Schweizer Kapuziner in Africa', 74; Also see Louise Jilek-Aall, *Call Mama Doctor: African Notes of a Young Woman Doctor* (London: George Allen and Unwin LTD, 1980). Jilek-Aall provides a comprehensive analysis of her experience as a young female doctor in Tanzania in the 1950s and 60s; in one particular instance she narrates how a young girl in labour was beaten by the older women as they told her to '*fanya bidii*' (work

the medical situation at Ifakara. The Baldegg sisters, therefore, encouraged others from Switzerland to come to Africa to ‘save’ the mothers from their struggles and ‘backwardness’ in maternity methods. The attitude toward African maternity and child rearing played a significant role in shaping attitudes that persisted into the postcolonial era, reinforcing the duality between biomedicine and traditional medicine.

In addition to MCH, the medical needs in Kilombero Valley were immense. As early as 1927, the dispensary in Ifakara recorded approximately 25,000 consultations annually. Interestingly, the name Ifakara, derived from the Ndamba language, originally meant ‘a place of death’, reflecting the devastation caused by the Lipangalala group’s attacks.<sup>946</sup> However, the name also resonates with the area’s harsh environmental conditions, which contributed to the prevalence of diseases such as malaria, cholera, and leprosy. (For a detailed description of the Kilombero setting, see Chapter 2.) To cater for the increased medical needs, a small hospital with 30 beds was built in 1931, and in 1937 a maternity ward was attached to it. The Baldegg sisters also called for the training of African sisters who would assist in midwifery.

By 1947, the training of African sisters had commenced. It was argued that training suitable virgins for the maternity service was ideal.<sup>947</sup> The virgins were assumed to be ‘uncontaminated’ in cultural beliefs.<sup>948</sup> However, this was problematic because seniority played a key role in African midwifery.<sup>949</sup> In addition, experiential midwifery, when a midwife was already a mother, was more important than medical qualifications.<sup>950</sup> Therefore, being a Catholic nun and a midwife was more challenging as one would be considered unsuitable for the job.

Sister Arnolda, however, was the force behind the transformation of midwifery in Kilombero Valley. By 1947, her clinic had between 100-150 patients per day. Arnolda gained popularity throughout Kilombero for several reasons. First, she attended to everyone—traditionalists, Muslims, ‘pagans’, and Christians.<sup>951</sup> Secondly, instead of condemning African medical

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harder) and bring the child out. At one point the husband to the girl was called to speak to the wife and asked her to confess her infidelity as they believed that was the cause of her prolonged labour, pg. 101.

<sup>946</sup> Larson, ‘A History of the Mahenge (Ulanga) District c. 1860-1957’.

<sup>947</sup> WHO archives, Geneva, ‘Health H/8/6 PP/CDW/E.2/4 Letter from C. Davies (District Medical Officer) to Dr Cecily Williams (Director of Medical Services) Village Midwives’.

<sup>948</sup> Walter, ‘Practising Hygiene and Fighting the Natives’ Diseases’.

<sup>949</sup> WHO archives, Geneva, ‘Health H/8/6 PP/CDW/E.2/4 Letter from C. Davies (District Medical Officer) to Dr Cecily Williams (Director of Medical Services) Village Midwives’; Walter, ‘Practising Hygiene and Fighting the Natives’ Diseases’; Veronica Kimani and Ulrike Lindner, ‘Seniority in Midwifery in Tanzania: Medical Local Practices Between Colonial Medicine and Postcolonial Modernization’, *Nordic Journal of African Studies* 33, no. 4 (2024): 304–25, <https://doi.org/10.53228/njas.v33i4.1143>.

<sup>950</sup> Women in Ifakara, Focus Group Discussion at Lipangalala, September, 21, 2023.

<sup>951</sup> Sir Maria Marty, ‘Tumempata Tumempata’, *Missionsbote: Der Schweizer Kapuziner in Africa*, no. 3 (1959).

practices in totality, she was curious to learn and understand the principles and practices of African medicine. In 1949, she noted that,

There are still many herbalists among the blacks. It cannot be denied that in certain cases, they have obvious success. We, too, sought to uncover the secrets of African herbal medicine. We have accompanied two herbalists and grown medicinal plants in our herb gardens to test their effects.<sup>952</sup>

The fight for space for biomedicine over African traditional medicine is, in many instances, selectively silent about sentiments such as those expressed by Arnolda. In many cases, the missionaries were expected to align with the civilisation agenda through the dissemination of European medical ideas. Travelling medical ideas from Europe were believed to be superior. In most cases, the medical sisters travelling for missionary work in Africa were called to evangelise, fight diseases and parasites and ‘senseless, often harmful, outdated African customs’.<sup>953</sup> Even as late as 1960, the attitude towards traditional medicine was that it was inferior and oppressive to the African woman. The *1960 Missionsbote* magazine recorded that pregnant women were not allowed to eat melon because the many seeds would cause them to have multiple children. They were also not allowed to go through the front door and then immediately return through it, as this would complicate the delivery.<sup>954</sup> To the missionaries, such beliefs were related to witchcraft. To counter this ‘hopeless’ situation, the education of girls was seen as the lasting solution to medical problems because they were the mothers of the next generation.<sup>955</sup> The missionaries, however, rarely questioned the reasons behind such beliefs and the culture in which they were embedded; the failure to capture how such beliefs were framed always affected the intended outcome. In many cases, this resulted in resistance or the blending of medical beliefs. For example, oral accounts from Ifakara revealed that women would remove charms and amulets from themselves or their children before visiting clinics, only to put them back on afterwards.<sup>956</sup>

Sister Arnolda called not only for improved maternity services but also for improved hygiene. Women were not required to deliver on hard and dirty surfaces, and were required to be freed from ‘exploitative and oppressive situations supported by polygamy and exploitative agricultural labour.’<sup>957</sup> The use of a dirty toilet, or the lack of one altogether, was discouraged. In Ifakara, Arnolda and the other sisters conducted door-to-door bicycle visits to assess hygiene

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<sup>952</sup> *Missionsbote*, ‘Der Schweizer Kapuziner in Africa’, 76.

<sup>953</sup> ‘Our Missionary Sisters: In Dienste Der Kranken.’, *Missionsbote: Der Schweizer Kapuziner in Africa*, no. 3 (1957).

<sup>954</sup> ‘Der Schweizer Kapuziner’, *Missionsbote*, no. 1 (1960).

<sup>955</sup> *Missionsbote: Der Schweizer Kapuziner in Africa*, ‘Our Missionary Sisters: In Dienste Der Kranken.’, 75.

<sup>956</sup> Women in Ifakara, Focus Group Discussion at Lipangalala, 21<sup>st</sup> September, 2023.

<sup>957</sup> Dreier, ‘Health, Welfare and Development in Rural Africa’, 153.

while calling on people to receive treatment at the mission.<sup>958</sup> This dedication earned sister Arnolda the name Mama Ifakara.<sup>959</sup> Oral accounts also revealed that women in Ifakara had nicknamed her Mama Noda.<sup>960</sup> In 1958, Sister Arnolda had worked as a nurse-midwife for 30 years. That same year, she celebrated the delivery of her 4,000th child, an event that coincided with her relocation to a new clinic (see Figure 22). In the new clinic, it is noted, that she attended to women day and night.<sup>961</sup> At the time, a nurse took the place of doctors. Therefore, a nurse had to be competent not only in caring for the patient but also in diagnostic and laboratory work.<sup>962</sup> This posits the biomedical scientific progress that travelled from Switzerland to Tanzania, calling for diseases to be identified scientifically, rather than through ‘guesswork’.

In the 1950s, it was unimaginable for a nurse to serve in the mission without a microscope. Sister Arnolda exemplified this type of nursing practice, and the people of Ifakara warmly accepted her despite her status as a nun. This case illustrates how ‘otherness’ can be readily embraced in a new cultural setting. Although she was not a mother herself, the ‘travel’ of medical, religious knowledge and expertise from Switzerland enabled her to transcend the traditional belief systems of the Wapogoro and Wabena communities. The indication here is that people are receptive to new ideas; only the approach matters. Sister Arnolda was able to convince the elders, the sultan, men, women, and particularly the husbands of pregnant women about her medical maternity approach, showing that her passion went beyond her training as a nurse.<sup>963</sup>

The work of the Baldegg sisters drew significant attention from medical professionals and missionaries in Switzerland. Letters and missionary magazines from Tanzania reveal active appeals to encourage others to join the mission field.<sup>964</sup> These appeals reached a broad audience, including children in Switzerland, some of whom wrote letters inquiring about what their future endeavours entailed, specifically about what service in the tropics involved.<sup>965</sup> Moreover, both the Swiss government and various non-governmental organisations closely followed these developments. In 1951, Dr. Mueller arrived as the first medical officer. The medical needs in

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<sup>958</sup> *Missionsbote*, ‘Der Schweizer Kapuziner in Africa’, 76.

<sup>959</sup> Markus Frei, ‘St Francis Hospital, Ifakara’, in *75 Years Baldegg Sisters, Capuchin Brothers in Tanzania*, Edited by Dirr-Haller, Marita (Stans, 1997), 144.

<sup>960</sup> Women in Ifakara, Focus Group Discussion at Lipangalala, September 21, 2023.

<sup>961</sup> Marty, ‘Tumempata Tumempata’.

<sup>962</sup> *Missionsbote: Der Schweizer Kapuziner in Africa*, ‘Our Missionary Sisters: In Dienste Der Kranken’, 67.

<sup>963</sup> Dreier, ‘Health, Welfare and Development In Rural Africa’, 162.

<sup>964</sup> *Missionsbote: Der Schweizer Kapuziner in Africa*, ‘Our Missionary Sisters: In Dienste Der Kranken’

<sup>965</sup> *Die Schweizer Kapuziner in Africa*, ‘Mitteilungen Aus Den Missionen Dar Es Salaam and Seychellen. Jahresbericht 1921-1941’.

Ifakara led to an increase in clinic bed capacity to 52 in 1952. In 1953, Dr Schoeff introduced surgery, leading to a rise in consultations to 65,700 that year.<sup>966</sup>



*Figure 22: Sister Anorlda Kury 'mama Ifakara'.  
Source: Kimani and Ulrike 2024, cited from Frei Markus, 1997, 144.*

In summary, the Baldegg Sisters ensured that women in the Kilombero Valley had access to Western medical maternity care, including immunisation, and food supplements such as cooking oil and powdered milk, which were instrumental in meeting the nutritional needs of babies.<sup>967</sup> Therefore, Kilombero had access to biomedical facilities long before government-owned medical facilities were built. In 1955, the initiative of Dr Schoeff and Arch. Bishop Maranta witnessed the construction of the new St. Francis Hospital in Ifakara, which replaced the old one initiated by Sister Arnolda. It was completed in 1960.<sup>968</sup> Between 1960 and 1976, St Francis Hospital was gradually expanded (see table 14 below).

The opening of the St. Francis Hospital, Ifakara, crowned the medical work of the Capuchin Fathers and Baldegg sisters in the Kilombero Valley.<sup>969</sup> Although the hospital was primarily established for the Kilombero Valley, it gained such fame and strategic importance that in July 1976, it became the Designated District Hospital (DDH) for the Kilombero region. Today, it serves as a referral hospital for the Morogoro region. Indeed, some oral accounts noted that St.

<sup>966</sup> Staatarchiv Basel-Stadt (StABS), Klaus E Gyr, 'Swiss-Tanzania Joint Evaluation of Swiss Cooperation to Tanzania Health Project.', 1971.

<sup>967</sup> Interview with Christina Isakwisa, a retired nurse, at Uwanja Sitini, September 20, 2023.

<sup>968</sup> Staatarchiv Basel-Stadt (StABS), Gyr, 'PA 940d F2 (1) Ifakara Reiseberichte, Jahresberichte, Kursunterlagen 1960-1977: Swiss Joint Evaluation of Swiss Cooperation to Tanzania Health Projects.'

<sup>969</sup> Staatarchiv Basel-Stadt (StABS), Geigy, 'ED-REG 1 (2) 190-2-8 Rural Medical Training at Ifakara: Swiss Help to Tanzania'.

Francis Hospital, Ifakara, was one of the largest hospitals not just in the area but in the entire country.<sup>970</sup> The growth and expansion of the hospital are illustrative of the power of the bilateral aid from Switzerland at a time when the nation was struggling financially. This expansion, however, was not always beneficial to the locals. Expansion meant that the hospital was elevated to the status of a DDH, and with more services and equipment, it also brought more people from a larger geographical area who were also expected to pay more. However, as noted in Chapter 3, DDH hospitals represented a move to collaborate with voluntary agencies to provide health services where no government facility was available.

The DDH received a government grant to cover the hospital's recurring expenditures and related services. This support was expected to enable the DDH to provide free hospital care and outpatient services, or subsidised medical services to the people. Unfortunately, the grant was so small that offering free services was impossible.<sup>971</sup> Additionally, the oral accounts revealed that not everyone could access the hospital, for various reasons. First, the infrastructural problem due to poor roads left many of the population alienated from the services. Secondly, the Kilombero River crossing, which relied on ferry services, made access difficult. The ferry services operated from 6 am to 6 pm; after that, the canoes (*mtubwi*) were the only means used.<sup>972</sup> *Mtubwi* accidents caused many deaths in the Kilombero River. Thirdly, the assumption that the biomedical needs provided at the hospital were the only ones in Kilombero overlooked the role played by traditional healers and midwives.

Year	Activity
1960	Completion of the New hospital
1962	TB hospital added
1967	Medical officers increased
1969	A new outpatient section developed
1971	A new surgical unit
1973	A new recuperation unit
	A centre for teaching the MAs trained at the MATC
1976	A new maternity ward, Approved DDH

Table 14: *The gradual expansion of St. Francis Hospital, Ifakara.*  
Source: compiled with data from Gyr, 1977.

<sup>970</sup> Women in Ifakara, Focus Group Discussion at Lipangalala, September, 21, 2023.

<sup>971</sup> Achilleus, Ndege, 'The Challenge of Financing Designated District Hospitals in Tanzania: St. Francis Designated District Hospital Case Study.' (MA Hospital Management, Nuffield Institute for Health, 1998).

<sup>972</sup> Oral Interview with Marrietta Kindidi, at St Francis Hospital Canteen, February 5, 2025.

Nevertheless, the works of the missionaries in Kilombero served as the foundation on which other Swiss medical and agricultural aid efforts in Tanzania were built. Through missionary groundwork, medical research on tropical diseases in Kilombero was initiated. Such works are notable in the activities of Professor Geigy and his team, with whom he started the Rural Aid Centre, Ifakara, in 1960,<sup>973</sup> as elaborated in the next section.

### **5.3.3 ‘Hilfe am Ort’ by Switzerland: The Rural Aid centre, Medical Assistants Training centre and Mlimba Health centre**

From 1945 onward, the world’s political landscape changed dramatically, defined by the aftermath of World War II. The development of the colonies was given a new pace. Ideally, developed countries believed it was their responsibility to spread ‘development’ to less developed countries. However, the post-World War development was also a move to transform the former raw material producers into potential markets and consumers for United States and European goods.<sup>974</sup> As in the early colonial period, the post-World War II transformation marked an expansion of Western economic interests, with health playing a central role in this agenda. Packard notes that developing the underdeveloped was a justification to intervene in the lives of millions of people across the globe.<sup>975</sup> During this period, Swiss scientific influence expanded to the underdeveloped parts of the world. By 1950, Switzerland had built research laboratories in African countries, including the Swiss Tropical Field Laboratory in Tanzania (STIFL) and the Ivory Coast.<sup>976</sup> How did Tanzania become an area of interest to Switzerland?

In 1960, Switzerland's publicly declared foreign policy was ‘pro-development’. The dissemination of this development was facilitated through scientific knowledge, which relied on established relations already in place, as described above. Thus, East Africa topped the priority list of beneficiaries of Swiss Development aid. However, the new wave in the 1960s saw Switzerland move away from ‘economic and religious reasoning’ toward a ‘new ethic of giving’.<sup>977</sup> According to Geigy, the new ethic of giving would be driven ‘not by political or economic considerations nor by Christian values...but by international responsibility and the motive of bringing people close together...’.<sup>978</sup>

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<sup>973</sup> Prof. Geigy belonged to a family which owned one of Basel’s biggest chemical companies, J. R. Geigy AG Zeleza, *Manufacturing African Studies and Crises*, 218; Packard, *A History of Global Health*, 91.

<sup>974</sup> Packard, *A History of Global Health*, 91.

<sup>975</sup> Lukas Meier, ‘Striving for Excellence at the Margins: Science, Decolonisation and the History of the Swiss Tropical and Public Health Institute (Swiss TPH) in (Post-) Colonial Africa 1943-2000’ (Basel, 2012), 2.

<sup>976</sup> Meier, ‘Striving for Excellence at the Margins: Science, Decolonisation and the History of the Swiss Tropical and Public Health Institute (Swiss TPH) in (Post-) Colonial Africa 1943-2000’, 125.

<sup>977</sup> Rudolf Geigy, cited in Meier, ‘Striving for Excellence at the Margins: Science, Decolonisation and the History of the Swiss Tropical and Public Health Institute (Swiss TPH) in (Post-) Colonial Africa 1943-2000’, 125.

The involvement of the Swiss government through NGOs in the provision of aid necessitated a decision on where they would base their 'aid' in Kenya, Tanganyika or Uganda. Professor Rudolf Geigy, affiliated to both the Swiss Tropical Institute and J. R. Geigy, a pharmaceutical company, was at the centre of the plans by the Swiss Tropical Institute (STI), the Basel foundation and the Swiss Government. Prof. Geigy had conducted an expedition in Ifakara in 1949 at the invitation of Bishop Edgar Maranta.<sup>979</sup> In 1954, Bishop Maranta again invited Geigy to Ifakara, and two years later, the Swiss Tropical Institute Field Laboratory (STIFL) was opened to research on tropical diseases. Therefore, in 1960, Prof Geigy was not new to Ifakara. Nevertheless, in 1960, Prof Rudolf Geigy and Dr Arthur Wilhelm of '*Chemische Industrie Basel*' (CIBA) embarked on a one-month journey to East Africa to assess the best location for Swiss development aid in Africa. While this trip may have been presented as a demonstration of Switzerland's neutral approach to aid, free from political, economic, or religious motives, it ultimately revealed that Geigy and his team were not without their own interests.

The team arrived in Nairobi on 15<sup>th</sup> August 1960. The following day, they landed in Dar es Salaam, where they were received at the seat of Bishop Edgar Maranta for three days. From August 20 to 25, they travelled to Ifakara, where they visited St. Francis Hospital, Ifakara, and the STIFL. They later travelled to Kampala and Entebbe between September 5 and 12, before returning to Nairobi and Basel by September 14.<sup>980</sup>

The assignment for Prof. Rudolf Geigy and Arthur Wilhelm was to choose between Kenya, Uganda or Tanzania. The journey itinerary described above showed that, based on the days and areas they visited, interest in Tanzania was evident from the outset. Tanzania was preferred because of the high number of Swiss missionaries, whose long history in Ifakara is described above. Secondly, Kilombero was home to a modern hospital operated by the Capuchin Missions and a Swiss Tropical Institute Laboratory. Thirdly, the region which Prof Geigy described as a 'bush' was a natural habitat for medical experiments.<sup>981</sup> Prof Geigy's descriptions leave the question of what he meant by 'bush.' The sentiments resonate with Helen Tilley's remarks that '...Africa was indeed a laboratory for scientific research, development, experiment...and transnational methods'.<sup>982</sup> In such a natural habitat, it was even more enticing if the local government was supportive of your dealings and if Tanzania was positive towards Prof. Geigy's

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<sup>979</sup> Geigy, 'ED-REG 1 (2) 190-2-8 Rural Medical Training at Ifakara: Swiss Help to Tanzania'.

<sup>980</sup> Staatarchiv Basel-Stadt (StABS), 'Bericht Ueber Die Reise Dr Herren Arthur Wilhelm, CIBA Und Prof. Rudolf Geigy, Schweizerisches Tropeninstitut, Zum Studium Der in OstAfrika Bestehenden Moeglichkarten Fuer Schweizerische Entwicklungshilfe-Zu Handen Des Basler Iniativ-Komitees'.

<sup>981</sup> Staatarchiv Basel-Stadt (StABS), 'Bericht Ueber Die Reise Dr Herren Arthur Wilhelm, CIBA Und Prof. Rudolf Geigy, Schweizerisches Tropeninstitut, Zum Studium Der in OstAfrika Bestehenden Moeglichkarten Fuer Schweizerische Entwicklungshilfe-Zu Handen Des Basler Iniativ-Komitees'.

<sup>982</sup> Tilley, *Africa as a Living Laboratory*, 27.

initiative.<sup>983</sup> Prof Geigy noted how Prime Minister Nyerere received them in a private audience'.<sup>984</sup>

As noted in Chapter Two, the 'rural bush' identified by Prof. Geigy was fertile, supporting many agricultural activities. This consideration enhanced the Swiss project's suitability because agriculture was vital to the new postcolonial government, which, as noted in Chapter 4, formed the backbone of the economy. Therefore, in addition to medical ventures in Ifakara, the Swiss were tasked with training field assistants and inspectors. To the Swiss government, however, such a place was an ideal experimental ground for fertilisers, irrigation, insecticides and weed killers.<sup>985</sup> So, the team decided to locate their training institute at Ifakara. Notably, the earlier activities by Geigy and the opening of STIFL in Ifakara were almost an obvious indicator of the intended plan. Additionally, the association of both Prof. Geigy and Wilhelm with the Geigy and Ciba pharmaceutical companies explains their interest in transferring medical knowledge from Switzerland to rural Africa. The transfer of medical expertise from Switzerland to rural Africa often raises questions about its framing as an 'experimental ground', a concept that can imply underlying dynamics of knowledge extraction, testing, and external control, frequently justified under the guise of development aid.

The visit by Prof. Geigy and his team also proposed two possibilities: selecting suitable Africans for scholarships for further training in Switzerland or establishing educational facilities to teach Africans on African soil, referred to as *Hilfe am Ort* (on-site help).<sup>986</sup> According to Prof. Geigy and Wilhelm's report, the *Hilfe am Ort* was the most favoured after 'consulting widely with government offices, education institutions, research institutions and business enterprises, down to the man on the street'.<sup>987</sup> According to Prof. Geigy and Wilhelm, *Hilfe am Ort* was preferred as it would help create the 'much-needed' middle class quickly, as compared to scholarships to Switzerland, which favoured the highly qualified. However, the creation of a middle class was contrary to Nyerere's *Ujamaa* ideology and local needs in Tanzania, as it was perceived as fostering class division. While the Swiss focused on creating

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<sup>983</sup> Staatarchiv Basel-Stadt (StABS), 'Ref: 200/31/2 Letter from the Chief Medical Officer of the MOH to Prof R. Geigy.', personal communication, 29 August 1960.

<sup>984</sup> Staatarchiv Basel-Stadt (StABS), Gyr, 'PA 940d F2 (1)Ifakara Reiseberichte, Jahresberichte, Kursunterlagen 1960-1977: Swiss Joint Evaluation of Swiss Cooperation to Tanzania Health Projects'

<sup>985</sup> *History of Swiss TPH*, n.d., accessed 8 July 2025, <https://www.swisstph.ch/en/about/swiss-tph-history>.

<sup>986</sup> Staatarchiv Basel-Stadt (StABS), 'Bericht Ueber Die Reise Dr Herren Arthur Wilhelm, CIBA Und Prof. Rudolf Geigy, Schweizerisches Tropeninstitut, Zum Studium Der in OstAfrika Bestehenden Moeglichkarten Fuer Schweizerische Entwicklungshilfe-Zu Handen Des Basler Iniativ-Komitees'.

<sup>987</sup> Staatarchiv Basel-Stadt (StABS), 'Bericht Ueber Die Reise Dr Herren Arthur Wilhelm, CIBA Und Prof. Rudolf Geigy, Schweizerisches Tropeninstitut, Zum Studium Der in OstAfrika Bestehenden Moeglichkarten Fuer Schweizerische Entwicklungshilfe-Zu Handen Des Basler Iniativ-Komitees'.

a middle class, for instance, Nyerere focused on rural dwellers and rural areas.<sup>988</sup> Secondly, Geigy and his team argued that Tanzania lacked a high level of educated graduates, with only a few from the University College of Makerere. Thirdly, Geigy noted that a wide range of scholarship already existed from Britain and the USA, which meant there was no need to replicate what other countries were doing.<sup>989</sup>

The preference for *Hilfe am Ort* was also based on a set of imagined challenges that a student from Tanzania would face in Switzerland. The challenges were based on socio-cultural concerns. It was argued that Switzerland would have proved difficult for Tanzanian students who did not speak German. Additionally, the living conditions, suitable accommodation, social life, and connections within Switzerland would have been challenging.<sup>990</sup> Moreover, foreign influence was perceived as leading to false arrogance, which could have led to a challenge to reintegration after training. *Hilfe am Ort*, therefore, was considered because most of these challenges would be avoided; placement after training, for instance, would be easier because the trained people were in great demand. On the positive side, the government would give the necessary support.<sup>991</sup> Although these concerns were rooted in the need for context-appropriate capacity-building, Switzerland's decision to prioritise local development also reflected broader geopolitical considerations.

In the competitive landscape of international aid, donors often sought to distinguish themselves and maximise their relative impact. Switzerland's emphasis on local training enabled it to stand out among other developed countries by presenting itself as a responsible and innovative donor, thereby avoiding the pitfalls of aid fragmentation often associated with overseas programmes. The idea raised questions about whether Switzerland's approach was primarily motivated by altruism or by a desire to gain diplomatic leverage and emerge as a leader in development cooperation. Moreover, while concerns about survival in Switzerland and the challenges of reintegration were legitimate, it is notable how African learners were often framed as inherently

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<sup>988</sup> Meier, 'Striving for Excellence at the Margins: Science, Decolonisation and the History of the Swiss Tropical and Public Health Institute (Swiss TPH) in (Post-) Colonial Africa 1943-2000', 129.

<sup>989</sup> Staatarchiv Basel-Stadt (StABS), Gyr, 'PA 940d F2 (1) Ifakara Reiseberichte, Jahresberichte, Kursunterlagen 1960-1977: Swiss Joint Evaluation of Swiss Cooperation to Tanzania Health Projects'

<sup>990</sup> Staatarchiv Basel-Stadt (StABS), 'Bericht Ueber Die Reise Dr Herren Arthur Wilhelm, CIBA Und Prof. Rudolf Geigy, Schweizerisches Tropeninstitut, Zum Studium Der in OstAfrika Bestehenden Moeglichkarten Fuer Schweizerische Entwicklungshilfe-Zu Handen Des Basler Iniativ-Komitees'.

deficient or unable to adapt, an assumption that overlooks the normality of such adjustment difficulties among all humans.

The venture towards a medical training ground at Ifakara commenced. The initial goal was to acquire land; however, transferring land in Tanzania, especially to a foreign entity, proved to be challenging. There was fierce resistance from the local population, who, when construction work began, constructed a wooden shack overnight to claim the land.<sup>992</sup> However, through the intervention of Bishop Maranta and the Mission, the venture was allocated 10 acres of land for 33 years, with the possibility of renewal.<sup>993</sup> on this land, the Rural Aid Centre (RAC) in Ifakara was constructed with the assistance of the Basel Foundation Aid for Developing Countries, in collaboration with the Ministry of Health and Labour of Tanganyika, with the approval of Julius Nyerere.<sup>994</sup> Following this agreement, the RAC was inaugurated on July 22, 1961.<sup>995</sup>

RAC was tasked with conducting a 3-month training programme for Rural Medical Aides (RMAs) selected by the Ministry of Health. The training at RAC was an upgrade and a refresher course, particularly in the practical aspects of laboratory and clinical work (see Table 15 below), following a year of training in Mwanza. The daily routine at the centre began at 7:00 am, except for those in charge of the animals and laboratory, who were to start at 6:15 am. These animals included monkeys, guinea pigs, rats, mice, and insects (such as mosquitoes, tsetse flies, and ticks), which were kept for practical lessons.<sup>996</sup> This exercise was believed to bring the student closer to the epidemiological problems. Classes would then start from 8 am and run until 4:30 pm with a tea and lunch break in between.

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<sup>992</sup> Meier, 'Striving for Excellence at the Margins: Science, Decolonisation and the History of the Swiss Tropical and Public Health Institute (Swiss TPH) in (Post-) Colonial Africa 1943-2000', 131.

<sup>993</sup> Staatarchiv Basel-Stadt (StABS), 'Bericht Ueber Die Reise Dr Herren Arthur Wilhelm, CIBA Und Prof. Rudolf Geigy, Schweizerisches Tropeninstitut, Zum Studium Der in OstAfrika Bestehenden Moeglichkarten Fuer Schweizerische Entwicklungshilfe-Zu Handen Des Basler Iniativ-Komitees'.

<sup>994</sup> Staatarchiv Basel-Stadt (StABS), 'Report on the Rural Medical Aid Course Held at the RAC in Ifakara from 17th July to 14th October 1961' (1961).

<sup>995</sup> Staatarchiv Basel-Stadt (StABS), 'Report on the Rural Medical Aid Course Held at the RAC in Ifakaea from 17th July to 14th October 1961'.

<sup>996</sup> Staatarchiv Basel-Stadt (StABS), 'Report on the Rural Medical Aid Course Held at the RAC in Ifakara from 17th July to 14th October 1961'.

Lessons (theory and practical)	Teachers
General Biology and epidemiology with excursions to the village and field	Prof. Rudolf Geigy and Dr Thierry Freyvogel (STI Basel)
Laboratory on Pathogenic Agents Microscopy	Mrs Nina Geigy and Ms Marriam Kauffman (STI Basel)
Venomous animals in Tanzania	Dr Thierry Freyvogel
Action and Application of insecticide on vectors of tropical disease with practical demonstration in the village and field.	R. Wyniger (STI Basle)
Systematic Medicine and Surgery with Clinical demonstration in the hospital	Dr Carl Shoepf (M.O in Charge St Francis Hospital Ifakara).
Pathology with clinical demonstrations	Dr Peter Peham (M.O at St Francis Hospital Ifakara)
Rural Health with practical demos in the village.	Dr Edwin Hofman (STI Basel).

*Table 15: Syllabus at the RAC Ifakara and the facilitators.*

*Source: StABS 'Report on the Rural Medical Aid Course Held at the RAC in Ifakara from 17th July to 14th October 1961'.*

The RAC was one of the most advanced institutes in Tanzania at the time. In the 1961 farewell party, Prof. Geigy affirmed that,

We wish to emphasise that this is a well-furnished centre seated in this typically rural area is certainly an excellent place for this kind of course...considering the staff available now accustomed to African training, the RAC may serve in future as a centre for high-level courses in medical and perhaps agricultural line.<sup>997</sup>

The table and Professor Geigy's remark indicate that the RAC curriculum was technically robust and well-developed. However, it mainly focused on clinical and curative medicine, whereas the Tanzanian MOH primarily promoted preventive, environmental, and sanitation-based health strategies in the 1970s, albeit only in theory. Nevertheless, true to Prof. Geigy's words, RAC developed speedily. In 1962, it offered courses for Medical Assistants (MAs), and by 1964, it was offering upgrading courses for MAs to Assistant Medical Officers (AMOs), as

<sup>997</sup>

Staataarchiv Basel-Stadt (StABS), 'Report on the Rural Medical Aid Course Held at the RAC in Ifakara from 17th July to 14th October 1961'.

explained below. In the same year, RAC started receiving students from the Dar es Salaam Medical School (DMS) who were being trained as Medical Officers (MOs).<sup>998</sup> The intention was to expose students to the rural context of Ifakara, reflecting the national health policy's strong focus on rural-based health services.

The RAC was strategically positioned, not only geographically but ideologically. It partly aligned with the goals of the MOH, primarily focusing on rural areas and rural health as well as the concept of upgrading courses, which were more affordable and trained numerous auxiliary health workers in a short period (see Chapter 3). It was noted that many medical schools in Africa lacked opportunities to address hygiene, epidemiology, tropical medicine, pathology, and clinical work. By 1964, the centre had students from as far as Kenya and Uganda.<sup>999</sup>

The Rural Aid Centre (RAC), despite its esteemed reputation, faced challenges. One significant issue was the language barrier, as many students from Tanzania were accustomed to Kiswahili and struggled with English, as the medium of instruction. This linguistic difficulty contributed to poor academic performance and, for some, to failure rates in final examinations.<sup>1000</sup> Another shortcoming, particularly to the MCH, was that between 1961 and 1965, all students at the centre were men. It was not until 1966, five years after its inception, that the institution admitted its first three female students.<sup>1001</sup> Archival records indicate that one of these women was allocated a private room due to pregnancy.<sup>1002</sup> This was a rare accommodation, as other government institutions at the time required women to undergo pregnancy tests before enrolling in medical training programmes. Pregnant applicants were denied admission.<sup>1003</sup> Furthermore, correspondence from some students reveals complaints about expulsions based on alleged abortions. However, these gendered barriers extended beyond admission policies. Some women declined opportunities for professional advancement, citing family responsibilities or

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<sup>998</sup> Staatarchiv Basel-Stadt (StABS), 'Report on Courses for MO and AMO at RAC-Ifakara 10th October July 1964', unpublished manuscript, 1964.

<sup>999</sup> Staatarchiv Basel-Stadt (StABS), 'Report on Courses for MO and AMO at RAC-Ifakara 10th October July 1964'.

<sup>1000</sup> Staatarchiv Basel-Stadt (StABS), 'Report on the Rural Medical Aid Course Held at the RAC in Ifakara from 17th July to 14th October 1961'.

<sup>1001</sup> Staatarchiv Basel-Stadt (StABS), 'Report on the Course of MO at the RAC-Ifakara on 18th July to 10th October 1966' (1966).

<sup>1002</sup> Staatarchiv Basel-Stadt (StABS), 'Report on the Course of MO at the RAC-Ifakara on 18th July to 10th October 1966'.

<sup>1003</sup> 'TNA ACC 450 HET/30/178. Mwanafunzi Kwa Muunganishi Wa Mashule Ya MCHA. Maombi Ya Kuomba Msamaha Wa Kumaliza Masomo', personal communication, October 12, 1982.

opposition from their husbands.<sup>1004</sup> In this context, many women opted for marriage over career development. These experiences reflect the gendered nature of access to education and the traditional perceptions of women's roles. They also highlight the challenges women faced in a male-dominated profession within a profoundly patriarchal society, which eventually affected MCH.<sup>1005</sup> However, at the time, such restrictions and norms were broadly accepted as standard practice.<sup>1006</sup>

In the 1970s, *Ujamaa* was at its peak, with village living becoming an order in 1973, and so were the calls for nationalisation, self-reliance, and centralisation of political power in Tanzania. The state-centred approach eventually influenced how Tanzania interacted with transnational actors. Lukas Meier aptly describes the strife between the RAC and the members of the medical faculty in Dar es Salaam, who urged an integrated approach between Swiss experts and faculty members, with the latter taking the primary leadership.<sup>1007</sup> The politics of domination extended to the student body, which complained about the unequal relationship between the African and Swiss staff. Africans were relegated to 'flyboys' tasked with catching tsetse flies and other disease vectors for research purposes.<sup>1008</sup> One resident, a former *Bwana Nyuki*,<sup>1009</sup> confirmed that the Swiss only came with theoretical knowledge, but that when they got to Ifakara, they became the bosses.<sup>1010</sup> The strife led to the gradual withdrawal of the Basel foundation, with Victor Umbritch, a Ciba-Geigy AG board member, stating that RAC could be handed over to the Tanzanian government, an opinion Rudolf Geigy considered premature.<sup>1011</sup> To solve the impasse, the RAC was transformed to train Medical Assistants (MAs).

On 18<sup>th</sup> August 1972, the RAC was upgraded to train Medical Assistants, who, as per the MOH, were instrumental in promoting both preventive and curative services. The agreement between the United Republic of Tanzania (URT) and the Basel Foundation for aid to developing countries noted that the centre would then be handed over to the government after six years. The estimated cost was CHF 1,400,000.<sup>1012</sup> (see Table 16 below). The establishment was aided by the goodwill of the government of Tanzania, the Basel Foundation, Swiss Capuchin

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<sup>1004</sup> 'TNA ACC 450 PF/2779/16. Mafunzo Ya MCH Kwa Wakunga Vijijini', unpublished manuscript, December 30, 1982.

<sup>1005</sup> As noted in Chapter 4, it was considered taboo to be attended by a male during delivery.

<sup>1006</sup> Oral interview with Christina Isakwisa at Posta, Ifakara, September 20, 2023.

<sup>1007</sup> Meier, 'Striving for Excellence at the Margins: Science, Decolonisation and the History of the Swiss Tropical and Public Health Institute (Swiss TPH) in (Post-) Colonial Africa 1943-2000', 171.

<sup>1008</sup> Meier, 'Striving for Excellence at the Margins: Science, Decolonisation and the History of the Swiss Tropical and Public Health Institute (Swiss TPH) in (Post-) Colonial Africa 1943-2000', 172.

<sup>1009</sup> *Bwana Nyuki* was a title for those who were trained in matters to do with insects, particularly bees.

<sup>1010</sup> Interview with a former employee of STI at Viwanja sitini, Ifakara, 20.9.23.

<sup>1011</sup> Meier, 'Striving for Excellence at the Margins: Science, Decolonisation and the History of the Swiss Tropical and Public Health Institute (Swiss TPH) in (Post-) Colonial Africa 1943-2000', 173.

<sup>1012</sup> 'MATC, Ifakara Annual Report 1973', unpublished manuscript, 1973.

Province, the Baldegg sisters, and the Swiss Technical Cooperation at a total cost of CHF 1,675,1977.

Name of the funding entity	Amount (CHF)
Government of Tanzania	100,000
Basle Foundation	800,000
Government of Switzerland	300,000
Swiss Capuchin Fathers	300,000
Sister of Baldegg, Switzerland	100,000

Table 16: The distribution of the money offered by different bodies for the construction of the MATC.  
Source: STABS, MATC, Ifakara Annual Report (1973).

The name of the centre was effectively changed to Medical Assistance Training Centre (MATC). With 10 hectares of land, MATC increased its capacity from 40 students for RAC to a hostel capacity of 120 students.<sup>1013</sup> The hostel was divided into 10 bungalows of 6 beds and a 60-bed dorm. The architect, Mr. Ernst Heusser, worked to have the institute take its first intake of 41 students in April 1973.<sup>1014</sup> MATC was fully operational by 1977.

Training commenced with very positive results. At the height of *Ujamaa*, the curriculum was all-inclusive, including agricultural courses. The Agricultural Department donated six acres of land to MATC. Teaching was also intended to be conducted in Swahili to encourage and promote the integration of health with rural development. There was also the inclusion of political education (*siasa*) and later civic education (*Uraia*) offered by TANU.<sup>1015</sup> In medical works, the MATC Ifakara offered a broad-based curriculum covering hygiene, housing, and pollution, water supply and sanitation, vectors and their control, communicable diseases, immunisation, epidemiology, and disinfection.<sup>1016</sup> However, MATC experienced challenges, including high student wastage and brain drain after training. As a result, in 1977, there was a proposal to regulate the intake of Indian students who enrolled in the programme but emigrated upon graduation.<sup>1017</sup> Additionally, most students were not motivated by *Ujamaa* and self-reliance projects.<sup>1018</sup> Worse still, the land given by the agricultural department was located an hour's walk away from RAC, and the tools and farm implements were locked by a headman

<sup>1013</sup> STABS 'MATC, Ifakara Annual Report 1973'.

<sup>1014</sup> STABS 'MATC, Ifakara Annual Report 1973'.

<sup>1015</sup> STABS Flahault, 'Swiss Technical Cooperation. Swiss-Tanzania Joint Evaluation of Swiss Cooperation to Tanzania Health Projects. Sectoral on Education and Training in the Field of Health', 40.

<sup>1016</sup> Staatarchiv Basel-Stadt (StABS), 'MATC, Ifakara Annual Report 1973'.

<sup>1017</sup> Staatarchiv Basel-Stadt (StABS), Flahault, 'Swiss Technical Cooperation. Swiss-Tanzania Joint Evaluation of Swiss Cooperation to Tanzania Health Projects. Sectoral on Education and Training in the Field of Health', 6.

<sup>1018</sup> Staatarchiv Basel-Stadt (StABS), 'MATC, Ifakara Annual Report 1973'.

who was often unavailable, which was further exacerbated by a lack of communication. The biggest demotivation was that the farm incurred losses on several occasions rather than making a profit.<sup>1019</sup>

MATC Ifakara continued to work closely with St. Francis Hospital. The staff at the hospital taught clinical medicine, while those at the MATC supported clinical work in the hospital.<sup>1020</sup> By 1976, the first group of 40 MAs had graduated from MATC Ifakara, and another 33 completed their studies in 1977. The government recruited staff throughout the MOH in various hospitals, RHCs, and MATCs.<sup>1021</sup>

The ripple effect of MATC's expansion was the establishment of Mlimba Health Centre. According to Meier, some partners vetoed the original budget, arguing that it would turn MATC into a complex facility. Instead, they proposed having a health centre at Mlimba.<sup>1022</sup> In 1972, the MATC establishment argued that there was a need to build a new RHC for students trained at the MATC Ifakara to provide a place for training and practice, as not all of them could fit at the St Francis Hospital Ifakara.<sup>1023</sup> Additionally, from the perspective of *Ujamaa* politics at the time, it was agreed that the RHC was more important than the construction of a large hospital. The RHC would be built at Mlimba. Mlimba was on the outskirts of Ifakara. The residents of Mlimba sought medical attention at Ifakara. Therefore, the RHC was believed to alleviate the burden of the long journey for the residents of Mlimba, as well as provide a good training centre for the MATC Ifakara students. On the other hand, the politics of possession, nationalisation, and self-reliance may have also been factors that deterred the partners from entirely investing at MATC.<sup>1024</sup>

The attention turned to Mlimba Health Centre. The architectural design and construction of the Mlimba facility were once again entrusted to Mr. Ernst Heusser. The materials to build this centre were to come from Mang'ula and Ifakara. Mr Heusser noted that there were over 100 tons of equipment to be transported and 60 tons of cement.<sup>1025</sup> The architect argued that the

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<sup>1019</sup> Staatarchiv Basel-Stadt (StABS), 'MATC, Ifakara Annual Report 1973'.

<sup>1020</sup> Staatarchiv Basel-Stadt (StABS), Gyr, 'PA 940d F2 (1) Ifakara Reiseberichte, Jahresberichte, Kursunterlagen 1960-1977: Swiss Joint Evaluation of Swiss Cooperation to Tanzania Health Projects.'

<sup>1021</sup> Staatarchiv Basel-Stadt (StABS), 'MATC, Ifakara Annual Report 1973'.

<sup>1022</sup> Meier, 'Striving for Excellence at the Margins: Science, Decolonisation and the History of the Swiss Tropical and Public Health Institute (Swiss TPH) in (Post-) Colonial Africa 1943-2000', 175.

<sup>1023</sup> TNA ACC 450 HEH/41/4 'Rural Health Centres-Ulangu. Rekodi Ya Mazungumzo Kuhusu Ujenzi Wa Mlimba Kati Ya E. Hausser, Shayo Na Manumbu TAZARA', unpublished manuscript, September 28, 1974.

<sup>1024</sup> Meier, 'Striving for Excellence at the Margins: Science, Decolonisation and the History of the Swiss Tropical and Public Health Institute (Swiss TPH) in (Post-) Colonial Africa 1943-2000'.

<sup>1025</sup> TNA ACC 450 HEH/41/4 'Rural Health Centres-Ulangu. Rekodi Ya Mazungumzo Kuhusu Ujenzi Wa Mlimba Kati Ya E. Hausser, Shayo Na Manumbu TAZARA'.

road network was not capable of handling such a load. The only solution was to use the TAZARA. Mr Heusser requested the Chinese, who were in charge of TAZARA, to transport this load. However, the Chinese refused to transport the materials. There was no record from the Chinese as to why they did not. However, Mr Heusser went to the Ministry to register his frustrations. On 29<sup>th</sup> November 1974, Mr Heusser was so frustrated that he informed the Ministry he was ready to quit his job if the materials were not transported by the end of November. The MOH intervened by talking to Liang and Cheng, who were in charge of TAZARA at Ifakara. In a correspondence, the PS of the MOH noted that the ‘attitude and approach’ of Mr Heusser was not appealing to the Chinese, and that may have been the reason for the stalemate. The Chinese agreed to transport the materials within 2-3 days, and the cement up to March 1975.<sup>1026</sup> On 7th December, Mr. Heusser received a directive requiring him to offload the rail coaches, as they were urgently needed for other purposes, such as transporting materials to Zambia.<sup>1027</sup> Although Mr. Heusser’s attitude was described as uncooperative, the incident reflects broader tensions and competing influences between Switzerland and China in Tanzania, also highlighting Tanzania’s dual engagement with the East and West blocs during the Cold War era. It illustrates how Tanzania was often compelled to navigate a delicate balance between different transnational powers. Nevertheless, by 1975, the Mlimba Rural Health Centre (RHC) was eventually opened.

The cooperation between Tanzania and Swiss development aid continued. In 1977, another delegation was sent to Tanzania, comprising Dr A. Dahoma and Mr E. Manumbu of Afya (MOH), Dr D. Frahault (WHO), Dr J.P. Habicht (HEW, USA), and Dr K. Gry as the coordinator of Basel University. This team reaffirmed the reasons why Tanzania remained a suitable partner for Swiss assistance. The justification was that, by then, 94 per cent of the population lived in rural areas, the population was young, with the majority under 20 years old, and life expectancy was 47 years.<sup>1028</sup> The development of the rural regions was the government’s main priority, and the Swiss development agenda aligned accordingly. The construction of rural health centres and dispensaries, along with staff training, focused on expanding rural health services. The projection was that by 1980, out of a population of 17.4 million, 15.6 million would be living in rural areas.

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<sup>1026</sup> TNA ACC 450 HEH/41/4 Rural Health Centres-Ulanga. Rekodi Ya Mazungumzo Kuhusu Ujenzi Wa Mlimba Kati Ya E. Hausser, Shayo Na Manumbu TAZARA’.

<sup>1027</sup> TNA ACC 450, ‘Regional Commissioner, Morogoro to TAZARA, ‘Transportation of Building Materials for Mlimba Health Centre’, November 18, 1974.

<sup>1028</sup> Staatarchiv Basel-Stadt (StABS), Gyr, ‘PA 940d F2 (1) Ifakara Reiseberichte, Jahresberichte, Kursunterlagen 1960-1977: Swiss Joint Evaluation of Swiss Cooperation to Tanzania Health Projects’.

### 5.3.4 The Impact of Swiss Involvement in MCH in Kilombero

The Swiss assistance in training staff on-site largely contributed to improved maternal health. From the Baldegg sisters, including notable figures such as Sister Anorlda, and the Swiss Tropical Institute Field Laboratory, which was instrumental in research on malaria.<sup>1029</sup> Malaria was noted as one of the most dangerous diseases in the region, especially to children and pregnant women. Research on vectors and insects helped to control malaria. Control measures were also taken. Women at Ifakara testified to receiving mosquito nets from the Swiss establishment at Ifakara.<sup>1030</sup> MCH also included control measures for malaria through health education, environmental control, and chemoprophylaxis for infants, children under 5 years old, and expectant mothers.<sup>1031</sup>

With *Ujamaa*, respiratory and gastrointestinal diseases were expected to rise as people lived together in villages that, in most cases, lacked necessities such as water. Health education came in handy. Management of the environment and the use of mosquito nets were emphasised.<sup>1032</sup> Most of these supplies were obtained through Swiss aid. These included vaccines, medicine, supplements (particularly folic acid and iron), immunisation cards, food supplements, and refrigerators and sterilisers.<sup>1033</sup> Vaccines were transported directly from the airport to the cold room at the MOH, and a distribution list was created every three months for each of the 20 regions.<sup>1034</sup> As noted in Chapter 3, the cooperation was linked to other establishments, such as USAID, which contributed to the construction of the MCHA Schools in various regions.

The Swiss aid also supported the training of MCHAs. In 1975, the Tanzanian government requested Swiss Technical Cooperation to support the construction of a Public Health Nurse (PHN) training institute in Ifakara. These were B-nurses and former health nurses who, for 9 months, upgraded to PHN. They could also start as an MCHA at the dispensary level, then transition to community work at the health centre, and then upgrade to a PHN at the district or regional level.<sup>1035</sup> The PHN course was practically connected to hospital work, labour ward work, postnatal care and paediatrics. Physicians offered the theoretical work. PHN duties after graduation included serving as MCHA tutors in any of the 19 MCHA schools in each region,

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<sup>1029</sup> Women in Ifakara, Focus Group Discussion at Lipangalala, 21<sup>st</sup> eptember, 2023.; Interview with George Mwambeta, 20<sup>th</sup> September, 2023.

<sup>1030</sup> Women in Ifakara, Focus Group Discussion at Lipangalala, 21<sup>st</sup> September, 2023.

<sup>1031</sup> Staatarchiv Basel-Stadt (StABS), Gyr, 'Swiss-Tanzania Joint Evaluation of Swiss Cooperation to Tanzania Health Project'.

<sup>1032</sup> Interview with George Mwambeta at Ifakara, September 20, 2023.

<sup>1033</sup> Focus Group Discussion with Women at Lipangalala, Ifakara, September, 21, 2023.

<sup>1034</sup> Richard H. Hart, 'Maternal and Health Care Services in Tanzania', *Tropical Doctor*, no. 7 (1977): 183.

<sup>1035</sup> Staatarchiv Basel-Stadt (StABS), Gyr, 'PA 940d F2 (1) Ifakara Reiseberichte, Jahresberichte, Kursunterlagen 1960-1977: Swiss Joint Evaluation of Swiss Cooperation to Tanzania Health Projects', 58.

coordinating MCH at the district level, and overseeing MCH clinics in the districts. The request was granted, and the PHN training commenced.<sup>1036</sup> The training of the PHN was a significant boost to MCHA training, considering that USAID had also sponsored the establishment of an MCHA training school in every region, thereby reducing the reliance on foreign trainers.

In 1978, the MATC was handed over to the government. This was in line with the nationalisation process and the fact that Switzerland, like other countries, was trying to reduce its help towards development aid. However, the centre was far from being independent. The teaching staff consisted of expatriate physicians. At the time, both the MATC and St Francis Hospital, Ifakara, could not function without the expatriate physician. The ‘handing over’ of the Swiss establishments at Ifakara to the Tanzanian government was essentially a theoretical process. To date, Switzerland has exerted influence behind the scenes due to its power dynamics. Meier calls it a strategy to ‘remain on the spot...through “research partnership”’.<sup>1037</sup> ‘Remaining on the spot’ was also a way of safeguarding the set standards of the projects. This contributed to a dependency syndrome affecting both the government and the local population, as reflected in oral accounts from Ifakara residents who expressed frustration that services declined after the government took over the facility.<sup>1038</sup>

To conclude this section, I argue that, viewed through the lens of the travelling model, the missionaries’ activities illustrate how religious and medical practices, initially developed in European contexts, were transplanted, adapted, and reconfigured within the Tanzanian setting. The establishment of St. Francis Hospital and the subsequent arrival of Swiss development aid represent a trajectory of ideas and institutions ‘travelling’ across geographical and cultural boundaries, transforming in response to local conditions and needs. This process was not simply a one-way imposition but involved negotiation, adaptation, and hybridisation, as missionary medicine and Swiss aid merged with indigenous understandings of health and healing. Critically, the travelling of missionary medicine and development aid also reveals the entanglement of spiritual, medical, and political agendas. The missionaries’ dual focus on healing body and soul reflects a broader ‘civilising mission’ discourse, where European

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<sup>1036</sup> Staatarchiv Basel-Stadt (StABS), Gyr, ‘PA 940d F2 (1) Ifakara Reiseberichte, Jahresberichte, Kursunterlagen 1960-1977: Swiss Joint Evaluation of Swiss Cooperation to Tanzania Health Projects’

<sup>1037</sup> Meier, *Striving for Excellence at the Margins*, 11.

<sup>1038</sup> Focus Group Discussion with Women at Lipangalala, Ifakara, September 21, 2023; Focus Group Discussion at Uwanja wa Ndege, Ifakara, September 25, 2023.

religious and medical models were positioned as superior and universal, yet had to be reinterpreted within the local context.

The legacy of such travelling practices is complex. While they contributed to the establishment of vital health infrastructure, they also created dependencies on foreign expertise and resources, shaping the contours of development cooperation in ways that persist to this day. The medical care provided was both a form of humanitarian assistance and a means of extending religious influence, raising essential questions about the conditionality of aid and the power dynamics embedded in these exchanges. Moreover, the travelling model highlights how these missionary-led health initiatives became embedded within Tanzania's evolving postcolonial development framework, influencing national health policies and international aid relationships. The role of the Geigy company, later merged with Ciba to form Ciba-Geigy (now known as Novartis), demonstrates that it supported initiatives, including entomological studies and field trials using DDT and other insecticides. Swiss researchers researched malaria vectors in Tanzania's Kilombero Valley.<sup>1039</sup> These efforts were part of broader global campaigns, such as the WHO's Global Malaria Eradication Programme (1955–1969).<sup>1040</sup> This case thus exemplifies the travelling model's emphasis on movement, adaptation, and hybridity, challenging simplistic narratives of missionary work as either purely altruistic or wholly hegemonic.

#### 5.4 China-Tanzania Cooperation

Written and archaeological records indicate that the Chinese interactions with the East African Coast date back to before the 15th century.<sup>1041</sup> Although the connection did not operate at the level of the two modern states, trade relations between China and Tanzania can be traced back to the Tang Dynasty (618–907).<sup>1042</sup> The Chinese presence in East Africa is evident through archaeological remains, including Chinese coins and porcelain bowls.<sup>1043</sup>

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<sup>1039</sup> Although it falls outside the chronological scope of this study, it is worth noting that in 1991, Ciba-Geigy admitted to violating both international guidelines and its own internal policies by supplying 450,000 litres of insecticide containing DDT to Tanzania's Cotton Marketing Board. The company described the delivery as a 'mistake,' raising retrospective concerns about the ethics of such partnerships. See *Tanzanian Affairs*, "Ciba Geigy Admits Mistake", no. 39 (May 1991): .

<sup>1040</sup> 'Our History', *Ifakara Health Institute*, n.d., accessed 21 October 2023, <https://ihi.or.tz/>; 'A Brief History of Selected Malaria Vaccines and Interventions in Africa 1943-2021', *Ifakara Health Institute*, n.d., accessed, July 7, 2025, <https://ihi.or.tz/our-blog/5/>.

<sup>1041</sup> Sherrif Abdul, *Dhow Culture of the Indian Ocean: Cosmopolitanism, Commerce and Islam* (New York: Columbia University Press, n.d.).

<sup>1042</sup> Yu, *China's African Policy*, 14.

<sup>1043</sup> Bing Zhao, 'Chinese-Style Ceramics in East Africa from the 9th to 16th Century: A Case of Changing Value and Symbols in the Multi-Partner Global Trade', *Afriques* 6, no. 06 (2015).

Postcolonial Tanzania's relationship with China was often framed by the Chinese state as a revival of ancient ties that had supposedly been severed by Western colonisation, first by Germany, then by Britain.<sup>1044</sup> Chinese Premier Chou En-Lai's remarks during his 1965 visit to Tanzania emphasised that direct ties between China and Tanzania represented a renewal of an old relationship.<sup>1045</sup> However, this narrative departs markedly from historical facts. For much of its imperial past, particularly during the Ming (1368–1644) and Qing (1644–1911) dynasties, China pursued an isolationist foreign policy, enforcing strict bans on emigration and limiting diplomatic and commercial contact with the outside world.<sup>1046</sup> Notably, following the early maritime expeditions of Admiral Zheng He under the Ming, China sharply curtailed its overseas engagement. It was only in the mid-19th century, under the pressures of European imperial aggression and wars such as the Opium Wars, that China was compelled to adopt a more outward-facing posture.<sup>1047</sup> Against this backdrop, this chapter treats China's post-1960s outreach to Tanzania not as a revival of old ties but as part of a new, ideologically driven foreign policy strategy shaped by Cold War dynamics and the global competition for influence.

The 1960s were a pivotal decade for both China and Tanzania. For Tanzania, it marked the beginning of nation-building following colonial rule, while China sought to assert its presence on the global stage. China's classification as a 'Third World' country and its history of foreign domination resonated with many newly independent African nations. Therefore, China's stance on colonialism and imperialism played a crucial role in strengthening its ties with Tanzania and other former colonies, especially in the wake of decolonisation. To Tanzania, China was a comrade and sympathetic ally, '...not exploitative or willing to dominate'.<sup>1048</sup>

China underwent a significant transformation after 1949. The establishment of the People's Republic of China in 1949, following the victory of the Communist Party of China (CPC) led by Mao Zedong over Chiang Kai-shek's Nationalist government, marked a significant turning point. Before 1949, China was plagued by internal strife and instability, poverty, poor sanitation and bacterial, viral, infectious and parasitic diseases.<sup>1049</sup> Malnutrition was a harbinger of many

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<sup>1044</sup> Yu, *China's African Policy*, 15.

<sup>1045</sup> George T. Yu, *China and Tanzania: A Study in Cooperative Interaction* (Berkeley: University of California Press, 1970).

<sup>1046</sup> Spence Jonathan D., *The Search for Modern China*. (W. W. Norton & Company, 1990).

<sup>1047</sup> John King. Fairbank, *The Chinese World Order: Traditional China's Foreign Relations*. (Harvard University Press, 1968); Julia Lovell, *The Opium War: Drugs, Dreams and the Making of China*. (Picador, 2011).

<sup>1048</sup> Jamie Monson, 'Liberating Labour? Constructing Anti-Hegemony on the TAZARA Railway in Tanzania 1965-1976', in *China Returns to Africa: A Rising Power and a Continental Embrace*. (Columbia University Press, 2008), 198.

<sup>1049</sup> Victor W Sidel and Sidel Ruth, 'Healthcare Delivery System of the People's Republic of China.', in *Health by the People* (W.H.O, 1975), 15.

diseases. As a result, China was commonly referred to as the ‘sick man of Asia,’<sup>1050</sup> a term initially applied to the 19th-century Ottoman Empire as the ‘sick man of Europe’.<sup>1051</sup> However, Mao Zedong’s leadership launched large-scale public health campaigns, including initiatives against schistosomiasis and the control of flies. Within two decades, these efforts significantly improved public health, transforming China’s reputation from the ‘sick man of Asia’ to a model for state-led health interventions.<sup>1052</sup>

The transformation of China’s medical landscape proved appealing to Tanzania and numerous other nations in the Global South. Mexico, Somalia, Algeria, Mozambique, and Tanzania were among the countries that benefited from Chinese medical assistance.<sup>1053</sup> China provided medical aid to these countries as a means of positioning itself in the global politics of the time. Perry argues that the ‘attention to public health catapulted China to the global map.’<sup>1054</sup> The alliance with these countries is argued to have played a significant role in China’s admission to the United Nations General Assembly (UNGA) on October 25, 1971, and its superior position over Taiwan.<sup>1055</sup>

The most notable transformation in the medical sector was China’s transition from relying on doctors and missionaries from abroad to training its own health professionals, thereby improving the country’s medical situation.<sup>1056</sup> By the mid-1950s, China began to attract considerable attention not just from the newly independent states of the Global South but also from developed countries, the media, scholars, and research institutions.<sup>1057</sup> At the time, China’s health system was organised hierarchically, from the ministerial policies trickling down to the provinces, cities, townships, and villages.<sup>1058</sup> Health provision was organised to cater to the peasants in rural areas, an idea that Tanzania’s health policy had advocated for since its independence. The implementation of these health ideas in China was through programmes such as the barefoot doctors and by involving everyone through the ‘massline’ concept, as

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<sup>1050</sup> Zhou Xun, *The People’s Health: Health Interventions and Delivery in Mao’s China, 1949-1983*. (Montreal & Kingston: McGill-Queen’s University Press, 2020), 9.

<sup>1051</sup> ‘The Sick Man of Europe’, *Federal Reserve Bank of San Francisco*, 16 March 1979, [efaidnbmnnnibpajpcglclefindmkaj/https://fraser.stlouisfed.org/files/docs/historical/frbsf/frbsf\\_let/frbsf\\_let\\_19790316.pdf](https://fraser.stlouisfed.org/files/docs/historical/frbsf/frbsf_let/frbsf_let_19790316.pdf).

<sup>1052</sup> Xun, *The People’s Health: Health Interventions and Delivery in Mao’s China, 1949-1983*, 256.

<sup>1053</sup> Xun, *The People’s Health: Health Interventions and Delivery in Mao’s China, 1949-1983*.

<sup>1054</sup> Elizabeth J. Perry, ‘Public Health, National Strength and Regime Legitimacy: China’s Patriotic Health Campaign’, *The China Journal*, no. 91 (2024): 2.

<sup>1055</sup> Kifyasi, ‘Neither a Saviour nor Exploiter: A Historical Study of China’s Medical Assistance in Post-Colonial Tanzania’.

<sup>1056</sup> Sidel and Sidel Ruth, ‘Healthcare Delivery System of the People’s Republic of China’.

<sup>1057</sup> Xun, *The People’s Health: Health Interventions and Delivery in Mao’s China, 1949-1983*.

<sup>1058</sup> Li Chen et al., ‘Coverage, Quality of and Barriers to Postnatal Care in Rural Hebel, China: A Mixed Method Study’, *BMC Pregnancy Childbirth* 14, no. 31 (2014): 1.

shown below. The involvement of the masses was reflected in the later call by the UN, dubbed 'health for all, health by all'.<sup>1059</sup> The most impressive attraction was the cumulative transformation 'from a sick man of Asia, to a healthy nation without any dependence on Western aid'.<sup>1060</sup>

Tanzania and China's medical *modus operandi* had a lot in common. Anchored in socialist principles, both countries' national health policies were ideologically directly connected to national wealth and strength. TANU's call for a healthy population had an economic angle. This argument was propagated right from the colonial era, as it was believed that a healthy nation was also a productive one. Moreover, in both China and Tanzania, healthcare was deeply intertwined with politics. The provision of medical services played a crucial role in strengthening regime legitimacy both domestically and internationally.<sup>1061</sup> TANU's approach to legitimacy bore significant similarities to that of the CPC.

Mao Zedong was a key proponent of using healthcare as a tool for both domestic governance and international influence. From World War I onwards, Mao emphasised the strategic importance of public health, viewing it as essential for national strength and military success. He believed that a healthy population was vital for overcoming adversaries and that healthcare policies could enhance both national unity and China's global standing.<sup>1062</sup> Therefore, China launched health campaigns for everyone, including schoolchildren who were taught hygiene and proper sanitation as part of their political responsibility. The structured planning and organisation of a unified China were highly appealing to many African nations, which, upon gaining independence, sought to foster national unity, development, and peaceful coexistence simultaneously.

Beyond the medical aspects, the political orientation of China was also of interest to Tanzania. From the mid-1960s, Tanzania's relationship with the West worsened. As noted in Chapter 3, Tanzania's national budget was heavily reliant on aid, grants and loans.<sup>1063</sup> By 1964, Tanzania had fallen out with its traditional donors due to numerous geopolitical issues, including the Cold War and the liberation of African countries that were still under colonial rule. Tanzania, for

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<sup>1059</sup> 'TNA ACC 450 U/20/12 WHO Health Begins at Home.', 1973; 'Primary Health Care: Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978. Jointly Sponsored by the World Health Organization and the United Nations Children's Fund' (WHO, 1978); Kenneth W Newell, *Health by the People* (WHO, 1975).

<sup>1060</sup> Xun, *The People's Health: Health Interventions and Delivery in Mao's China, 1949-1983.*, 263.

<sup>1061</sup> Perry, 'Public Health, National Strength and Regime Legitimacy: China's Patriotic Health Campaign.', 1.

<sup>1062</sup> Perry, 'Public Health, National Strength and Regime Legitimacy: China's Patriotic Health Campaign.', 5.

<sup>1063</sup> 'Tanganyika: Development Plan for Tanganyika 1961/62-1963/64'.

instance, fell out with Britain over the question of Ian Smith's Unilateral Declaration of Independence (UDI) government in Zimbabwe.<sup>1064</sup> The UDI government had called for collaboration with the South African apartheid regime and the Portuguese colonial rule in Mozambique, which was against the course dubbed the Liberation of Africa, in which Tanzania had taken a central position. Tanzania also fell out with West Germany after the merger with Zanzibar and the subsequent recognition of the German Democratic Republic (GDR).<sup>1065</sup> These events, by design, brought China even closer to Tanzania. China became a perfect ally—not only one that condemned colonialism and imperialism, but also one that had endured suppression from different powers. Thus, Tanzania and China shared similar historical experiences of exploitation and subjugation.

Tanzania's ideological and demographic structure paralleled that of China, particularly in rural population dominance and a shared commitment to socialism. Like Tanzania, the majority of China's population was illiterate and lived in rural areas in a socialist set-up, an idea that Nyerere spoke of as early as 1962.<sup>1066</sup> At the time, the African voice was magnified through the Non-Aligned Movement (NAM). NAM member countries were to remain neutral in the face of the Cold War forces. On the question of Tanzania's orientation towards socialist China, Nyerere emphasised that 'non-alignment should not be equated with neutralism'.<sup>1067</sup> The dual cooperation between the two nations was therefore seen as a symbiotic relationship, where Tanzania sought to sever its ties with the dominant West. At the same time, China aimed to expand its influence in the Global South.

In 1962, Sino-Tanzanian relations kicked off. In October of the same year, China and Tanzania signed a cultural agreement through the Minister of National Culture and Youth. Three years later, the Sino-Tanzania friendship treaty was signed by Nyerere, Mao Zedong, and Premier Zhou Enlai in February 1965.<sup>1068</sup> Nyerere's socialist idea found fertile ground to grow. By the end of the 1960s, the relationship between Tanzania and China had been amplified not just

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<sup>1064</sup> Arrigo Palloti, 'Post-Colonial Nation-Building and Southern African Liberation: Tanzania and the Break of Diplomatic Relations with the United Kingdom, 1965–1968', *African Historical Review* 41, no. 2 (2009): 60–84; George Robert, 'Dilemmas of Non-Alignment: Tanzania and the German Cold War', in *Revolutionary State-Making in Dar Es Salaam: African Liberation and the Global Cold War*, (Cambridge: Cambridge University Press, 2022). Terence Ranger, *The Making of Zimbabwe: Decolonization in Regional and International Politics* (Indiana University Press, 2004); J.R.T Wood, *So Far and No Further!: Rhodesia's Bid For Independence During the Retreat from Empire 1959–1965*. (Trafford Publishing, 2005).

<sup>1065</sup> Robert, 'Dilemmas of Non-Alignment: Tanzania and the German Cold War'.

<sup>1066</sup> Julius Nyerere, 'Ujamaa: The Basis of African Socialism', April 1962; Kahama et al, *The Challenge for Tanzanian's Economy*, 205.

<sup>1067</sup> Yu, *China's African Policy*, 49, 50.

<sup>1068</sup> Kifyasi, 'Neither a Saviour nor Exploiter: A Historical Study of China's Medical Assistance in Post-Colonial Tanzania', 57.

through medical networks but also through notable joint ventures, such as the Chinese-Tanzanian Joint Shipping Company (SINOTASHIP), Urafiki Textile Mills, and Ubungo Farm Implements (UFI).<sup>1069</sup>

In 1967, socialism was officially adopted in Tanzania through the Arusha Declaration. It officially aligned Tanzania towards socialism, which further cemented the alliance between China and Tanzania. The capitalist nature of the West and the model of the USA were now seen as problematic and not in tandem with the African traditional way of life.<sup>1070</sup> It is in such an environment that the Sino-Tanzania network thrived. The cooperation between China and Tanzania extended beyond medicine to encompass other areas, including economic, political, social, and technical cooperation.

The cooperation was accompanied by the spread of Mao's ideologies to Tanzania (see Figures 23 and 24 below). Though this was not part of the bargain for Tanzania, it was unavoidable. These photos exemplified a shift from colonial dominance to an anti-imperialist ideology and revolutionary solidarity from a 'friendly' ally. On the other hand, the images also represent a continued interference in African affairs through the Chinese 'soft power strategy', which utilises visual and friendship diplomacy as a subtle yet powerful means to assert presence and cultivate emotional connections.<sup>1071</sup> The results showed that while Tanzania had an open-door policy for foreign capital, there was a bias towards working with socialist nations after the Arusha Declaration. As Hirji notes, the first step towards becoming socialist was to cultivate solidarity with the states that had already embraced socialism.<sup>1072</sup> However, ideological dissonance and dependency risks could not be avoided, as portrayed in the following section.

#### **5.4.1 Chinese medical aid to Tanzania**

Chinese medical aid to Tanzania, which began in the late 1960s, has evolved into one of the most enduring and symbolically significant examples of South-South cooperation. As such, the long relationship in this sector has been widely documented. This section presents two arguments that relate to overall medical assistance and its specific concern for MCH: Firstly, that there were similarities between China's and Tanzania's political, economic and social

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<sup>1069</sup> H.N Kida, 'Ubungo Farm Implements Manufacturing Company', *Tanzania Journal of Engineering and Technology* 2, no. 1 (1975).

<sup>1070</sup> Nyerere, 'Ujamaa: The Basis of African Socialism'.

<sup>1071</sup> Joseph S. Nye Jr., *Soft Power: The Means to Success in World Politics* (PublicAffairs, 2004); David Shambaugh, 'China's Soft-Power Push: The Search for Respect', *Foreign Affairs* 86, no. 4 (2007): 30–44.

<sup>1072</sup> Karim Hirji, 'Salient Implications of the Silent Class Struggle', *Cheche: Joint Organisation of the University Students Africa's Revolutionary Front (USAF and TANU Youth League*, no. 3 (October 1970): 32.

organisation that made it easy for the connection between the two, and secondly, and often ignored point, that there are differences beyond the often obviously assumed similarities, between the two systems, and these meant that the Chinese medical system had indirect influences on Tanzania's medical system.



*Figure 23: A local holding Mao's photo (undated, likely 1970s).*

*Source: Health Department of the Shandong Province, The Chinese Medical-Aid Team in the United Republic of Tanzania, 1968–1998 as cited by Andrea Kifyasi, pg 119*



*Figure 24: Africans showing reverence to Mao's portrait.*

*Source: Zhou Xun, The People's Health, pg. 282*

The similarities between China and Tanzania went beyond socialist ideological tendencies. To start with, Nyerere's emphasis on agriculture resonated with Mao's calls towards a sustainable China through food production. Mao Zedong emphasised that a revolution in agriculture could only be successful with a healthy population. As part of these reforms, private medical practice was gradually phased out, ensuring that healthcare was no longer treated as a business but as a public service.<sup>1073</sup> The fact that China achieved these transformations within 20 years provided Tanzania with a sense of optimism. Just as Mao had played a transformative role in China, Nyerere was seen as leading a similar effort in Tanzania.

In Tanzania, therefore, the Chinese medical system was viewed with notable admiration and considered a desirable model. The most attractive aspect was acquiring a sense of self-reliance in medical provision. This was partly achieved through the barefoot doctors' program, which was an inspiration. Barefoot doctors were peasants selected by the people. Their selection was based on attitude towards the party, willingness to serve, attainment of minimum educational qualifications 'consistent with the local democratic practices',<sup>1074</sup> and perceived as 'politically reliable'.<sup>1075</sup> Although barefoot doctors did not receive a formal salary, they earned 'work points' within the agricultural communes they served. These points eventually translated into some form of remuneration through the Cooperative Medical Service.<sup>1076</sup> They worked in the most basic health facilities in rural areas and participated in agricultural work, just like any other villagers. Ironically, the same attractive factors also presented many challenges, such that even when these ideas were adopted in different countries, like Tanzania, implementation proved difficult, as will be shown below.

By the 1970s, China had become a centre for UN learning programmes. This was not only in health but also in agriculture, where collaborating with FAO delegates from selected countries in the Global South learnt food-processing technologies, river basin planning and scale-integrated wood processing. By 1977, China had established itself as a WHO learning centre not only for other countries in the Global South but also for the West. Following the mid-1970s shift in attitude by the WHO towards traditional medicine (see Chapter 4).

In the 1973 World Health Assembly (WHA), China positioned itself as a platform for revolutionary health ideas, particularly for the 'Third World', a move that the WHO welcomed.

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<sup>1073</sup> Miriam Gross, 'Between Party, People, and Profession: The Many Faces of the "Doctor" during the Cultural Revolution', *Med. Hist* 62, no. 3 (2018): 333, <https://doi.org/doi:10.1017/mdh.2018.23>.

<sup>1074</sup> Allen Dobson, 'Health Care in China After Mao', *Health Care Finance Review* 2, no. 3 (1981): 47.

<sup>1075</sup> Xun, *The People's Health: Health Interventions and Delivery in Mao's China, 1949-1983*, 224.

<sup>1076</sup> Dobson, 'Health Care in China After Mao', 47; Xun, *The People's Health: Health Interventions and Delivery in Mao's China, 1949-1983*, 225.

Later, various courses and tours to China were supported by the UN agencies.<sup>1077</sup> In August 1977, for instance, the WHO approved a study tour on the role of traditional medicine in community health, exchange in the organisation of childcare delivery, training of personnel, the function of integrated services, and preparation of herbs and plants.<sup>1078</sup> During this tour, delegates from Tanzania were among the representatives from 24 countries in the Global South.<sup>1079</sup>

Direct engagement with China as a key partner in Tanzania's medical sector began in 1964, with its initial engagement in Zanzibar.<sup>1080</sup> On the mainland, medical assistance was initiated following a consultative meeting in Beijing in 1967. This meeting followed a request for medical help by the Minister for Economic Affairs and Development Planning, Paul Bomani, in 1966. At the Beijing meeting, an agreement was reached for Tanzania to receive medical assistance from China.<sup>1081</sup> The nature of the help was threefold. Firstly, it was to include the construction of medical projects, which later led to the establishment of the *Mabibo* vaccination firm and a *Keko* Pharmaceutical plant in Dar es Salaam.<sup>1082</sup> Secondly, it involved medical and technical support, and thirdly, it entailed the arrival of Chinese medical teams (CMTs) in Tanzania.<sup>1083</sup> CMT were medical workers with various specialisations. Following the meeting in Beijing, the Tanzanian government approved the CMT's arrival through Economic Committee Paper No. 16 of 1968.<sup>1084</sup>

In Tanzania, the Arusha Declaration emphasised the rural areas. Therefore, the health policy at the time focused on preventive medicine, particularly in rural areas. The policy aligned with the second development plan (1969-1974) and the principles of *Ujamaa*. The Minister of Health argued that CMT would help Tanzania achieve the *Ujamaa* dream. Unlike other medical workers from abroad, CMT would focus on the villages.<sup>1085</sup> It was noted that 95 per cent of the

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<sup>1077</sup> TNA, HEA/90/5/PRO 300 SEM/UN/GEN UNDP 'Resident Representative. Multi-Regional Study Tours and Course 1977-78', personal communication, May 18, 1977.

<sup>1078</sup> 'TNA HEA 90/5 PRO 300 SEM/GEN Letter Form UNDP PRO Dar Es Salaam to Principal Secretary Ministry of Finance and Planning. WHO Approved Courses in China', personal communication, 1977.

<sup>1079</sup> 'TNA HEA 90/5 PRO 300 SEM/GEN Letter Form UNDP PRO Dar Es Salaam to Principal Secretary Ministry of Finance and Planning. WHO Approved Courses in China', 1977.

<sup>1080</sup> Yu, *China's African Policy*, 110.

<sup>1081</sup> 'TNA/HEA/90/5/493 Technical Health Assistance China' (Tanzania National Archives, 1976).

<sup>1082</sup> 'TNA, ACC 450, HEA/90/5 Chinese Medical Assistance to Tanzania', unpublished manuscript, 1971.

<sup>1083</sup> 'TNA/HEA/90/5/493 Technical Health Assistance China, Vinyago Kama Zawadi.'; Kifyasi, 'Neither a Saviour nor Exploiter: A Historical Study of China's Medical Assistance in Post-Colonial Tanzania'; Yu, *China's African Policy*.

<sup>1084</sup> 'China Yasaidia Tanzania Dawa Na Madaktari', *Ngurumo Newspaper*, 7 May 1968, 1; Kifyasi, 'Neither a Saviour nor Exploiter: A Historical Study of China's Medical Assistance in Post-Colonial Tanzania', 112.

<sup>1085</sup> 'Hansard, Majadiliano Ya Bunge Taarfia Rasmi Mkutano Wa Kumi Na Tano 7-10 Januari 1969.'

population lived in rural areas.<sup>1086</sup> The projection was that with villagisation, more people would settle in the villages. However, as noted in Chapter 2, the rural medical situation had been neglected since the colonial era. In the post-independence era, numerous medical needs existed in rural areas. In 1969, for instance, the Minister of Health, highlighting the severity of the rural health crisis, remarked that even if all schools and government buildings were turned into hospitals, they would still fall short of meeting the population's needs.<sup>1087</sup> Though clearly hyperbolic, the statement underscored the scale of health challenges facing Tanzania at the time. In these areas, bilharzia, malaria, tuberculosis, infant mortality, malnutrition and leprosy were still a concern. With the coming of CMT, the minister was optimistic that the situation would be alleviated.

In 1968, a team of seven medical professionals from China arrived in Tanzania, consisting of five doctors, one nurse, and an interpreter. Led by Dr. Tsao Yueh-chung, their primary objective during their one-month stay was to assess medical and pharmaceutical facilities in four rural regions: Dodoma and Singinda (Central), Mara (North), and Mtwara (Southern Tanzania).<sup>1088</sup> Following this assessment, Dr. Tsao confirmed that China would soon deploy a team of doctors and nurses to support Tanzania's healthcare system.<sup>1089</sup> Between the request for medical aid and the arrival of the first team in April 1968, a two-year delay occurred. This delay was attributed to the fact that the then British-born Minister of Health, Derek Bryceson, was sceptical about the quality of Chinese medicine. However, his attitude shifted after attending a lecture by Chinese Professor Wu Jieping at a conference held at the University of Dar es Salaam in 1967.<sup>1090</sup> It became clear that the Chinese doctors taught and focused more on Western biomedicine rather than Traditional Chinese Medicine (TCM).

The medical team deployed to mainland Tanzania originated from Shandong Province, following the Chinese government policy requiring each of its 22 provinces to send medical personnel to an African country. Within East Africa, Shandong was assigned to Tanzania, Yunnan to Uganda, and Jiangsu to Zanzibar.<sup>1091</sup> These doctors were aged between 30 and 55

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<sup>1086</sup> 'TNA/HEA/90/5/493 Technical Health Assistance China-Rekodi ya Mkutano Uliofanyika katika Ofisi ya Waziri (AFYA) baina ya Waziri wa Afya Bw. Ali Mwinyi na Viongozi Wapya wa Timu ya Daktari aa Kichina June 9, 1973 Jumamosi Saa tatu Asubuhi.' (1973).

<sup>1087</sup> 'TNA/HEA/90/5/493 Technical Health Assistance China-Rekodi ya Mkutano Uliofanyika Katika Ofisi ya Waziri (AFYA) Baina ya Waziri wa Afya Bw. Ali Mwinyi na Viongozi Wapya wa Timu ya Daktari wa Kichina June 9, 1973 Jumamosi Saa Tatu Asubuhi'.

<sup>1088</sup> Yu, *China's African Policy*; Altofer-Ong, 'They Came as Brothers, Not Masters: Chinese Experts in Tanzania in the 1960s and 1970s'.

<sup>1089</sup> Yu, *China's African Policy*, 110.

<sup>1090</sup> Kifyasi, 'Neither a Saviour nor Exploiter: A Historical Study of China's Medical Assistance in Post-Colonial Tanzania.', 109.

<sup>1091</sup> Hsu, 'Medicine as Business: Chinese Medicine in Tanzania.', 225; Li Ashan, 'Chinese Medical Cooperation in Africa: With Special Emphasis on the Medical Teams and Anti-Malaria Campaign', Nordiska Afrikainstitutet, 2011, 11.

years, primarily male, with 5-10 years of training.<sup>1092</sup> The qualification documents were verified by the Medical Council of Tanzania (MCT). One of the documents required from the visiting Chinese doctors was a physician's qualification certificate (see figure 25).

Upon their arrival in Tanzania, the Chinese Medical Team (CMT) was received by a delegation from the Ministry of Health (MOH) for a two-week briefing and orientation in Dar es Salaam. During this period, they also toured various medical institutions in the city. It was also at this time that the new batch of doctors from China would meet with their counterparts who had completed the two years of rotational engagement in various regions. After the orientation, the doctors were sent to several provinces of Tanzania by air, train, or road. A telegram was sent to the Regional Medical Officer (RMO), who was responsible for receiving the CMTs in their respective regions.<sup>1093</sup> Then, the RMO and his team would plan according to the region's needs, which necessitated determining the location of the CMT. The deployment of the Chinese Medical Teams (CMT) required extensive logistical coordination, which was not without flaws, as shown below. The criterion used to select the region to which they were sent is unclear. While it was argued to be based on need, the general public in some areas and some members of parliament would complain that their constituencies had yet to receive Chinese doctors.<sup>1094</sup> The minister would say that such areas should wait for their turn because the distribution was being done on a rotational basis per province.

In April 1968, the first Chinese medical Team arrived on the mainland.<sup>1095</sup> The records of the MOH noted that they included 43 doctors. However, other documents have explicitly shown that it was a group of 31 doctors, including surgeons, gynaecologists, ENT specialists, paediatricians, and pharmacologists, as well as six nurses and five interpreters.<sup>1096</sup> They came with equipment and medicine. The group was divided into teams of 8 and dispatched to the rural villages and hospitals.<sup>1097</sup> The group was to work between 1968 and 1970 as per the 2-year signed agreement. In 1970, another team of 46 doctors were dispatched and assigned work in rural areas. This group was divided into 14 teams. The organisation of doctors into teams

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<sup>1092</sup> Kifyasi, 'Neither a Saviour nor Exploiter: A Historical Study of China's Medical Assistance in Post-Colonial Tanzania', 115.

<sup>1093</sup> 'TNA/HEA/90/5/493 Technical Health Assistance China-Rekodi Ya Mkutano Uliofanyika Katika Ofisi Ya Waziri (AFYA) Baina Ya Waziri Wa Afya Bw. Ali Mwinyi Na Viongozi Wapya Wa Timu Ya Daktari Aa Kichina June 9, 1973 Jumamosi Saa Tatu Asubuhi'.

<sup>1094</sup> 'TNA/HEA/90/5/493 Technical Health Assistance China-Rekodi Ya Mkutano Uliofanyika Katika Ofisi Ya Waziri (AFYA) Baina Ya Waziri Wa Afya Bw. Ali Mwinyi Na Viongozi Wapya Wa Timu Ya Daktari Aa Kichina June 9, 1973 Jumamosi Saa Tatu Asubuhi'; 'TNA/HEA/90/5/493 Ref A/90/5 Raza Fazal (Acupuncture Beneficiary) Writes to the Chinese Embassy, on Behalf of Bukoba General Traders Requesting for Chinese Doctors to Be Stationed in Bukoba.', personal communication, January 2, 1974.

<sup>1095</sup> Altofer-Ong, 'They Came as Brothers, Not Masters: Chinese Experts in Tanzania in the 1960s and 1970s'.

<sup>1096</sup> 'TNA/HEA/90/5/493 Technical Health Assistance China, Vinyago Kama Zawadi.'; Yu, *China's African Policy*, 112.

<sup>1097</sup> Yu, *China's African Policy*, 110.

was a direct acquisition from the Chinese system, where a team worked in a particular village to handle various issues, supplementing and complementing each other, and supporting one another. A team consisted of between 3 and 10 members and would stay in a village for several days to a month, after which another team with a different specialisation would take over. These teams not only treated diseases, they also offered health education and preventive measures towards diseases.<sup>1098</sup> In certain villages, some doctors actively participated in *Ujamaa* village farming activities, integrating themselves into daily life much like the local villagers.<sup>1099</sup> This mirrored practices in China, where doctors and other professionals were considered integral members of the village community.<sup>1100</sup> However, in Tanzania, those with ‘skills’ were exempt from farm work, as their careers were considered work.<sup>1101</sup>



Figure 25: These figures show a doctor’s degree and registration certificate of one of the doctors who came to Tanzania as part of CMT. Source: Tanzania National Archive-Chinese Technical Assistance.

The Chinese doctors served for two years, rotating between different places within a region or beyond. After completing their two-year service, it was customary for the MOH to host a farewell ceremony for the Chinese doctors. During this event, they were presented with gifts such as *vitenge* (East African cotton fabric), local artwork, including wood carvings (*vinyago*)

<sup>1098</sup> Yu, *China’s African Policy*, 112.

<sup>1099</sup> ‘TNA, ACC 450, HEA/90/5 Chinese Medical Assistance to Tanzania’.

<sup>1100</sup> Xun, *The People’s Health: Health Interventions and Delivery in Mao’s China, 1949-1983*.

<sup>1101</sup> Oral interview with a retired MCHA at Ifakara, 26<sup>th</sup> September, 2023; Interview with a Catholic priest at Mahenge, February 4, 2025.

and drawings, as well as traditional Pemba stools.<sup>1102</sup> At a farewell party on August 3, 1972, the PC of Shinyanga praised the Chinese doctors for their selfless work in Shinyanga, where the hospital received aid from China in the form of medicine worth Shs 60,000 and a machine to clean medical items.<sup>1103</sup> In return, the lead Chinese doctor, Dr Hsueh Ch Ying, praised the locals of Shinyanga for their cooperation over the past two years. The CMT doctors worked alongside health auxiliaries. Some of the auxiliaries would later be selected for scholarships in China.<sup>1104</sup> The challenge was that upon return to Tanzania, work equipment was lacking.<sup>1105</sup>

To strengthen this collaboration, both countries facilitated exchange visits, allowing Tanzania to gain insights from China's healthcare system. For instance, between August 18 and September 22, 1977, a delegation from the Tanzanian Ministry of Health (MOH), led by Principal Secretary G.J. Kileo, visited Beijing, Shanghai, Shandong, Jinan, and Guangzhou. The report highlighted their positive impressions of China's healthcare delivery. In Beijing, the delegation toured a vaccine production centre, observed tuberculosis (TB) treatment using local herbs and acupuncture therapy, and engaged with China's medical training system. In Shanghai, they visited an orthopaedic hospital and a brigade dispensary, where they interacted with barefoot doctors and several pharmaceutical companies specialising in tablet and injection production.<sup>1106</sup> In Guangzhou, the delegation examined China's doctor training system, which had progressively reduced the training period from seven years to five years, and later to three years.<sup>1107</sup> Finally, in Jinan, they visited a provincial hospital and an environmental sanitation centre, further enriching their understanding of China's healthcare model.

The Chinese government has adopted the concept of upgrading medical workers, and in most cases, the barefoot doctors, after gaining considerable experience, would be chosen for university training. Mao was particularly clear about the need for training from a low grade to upgrade later. Using the example of Li Shizhen (1518-1593), who was christened the father of Chinese medicine, and Hua Tuo, a Chinese physician who is believed to have been the first to use anaesthesia in surgery, he noted that:

Medical education should be reformed. There's no need to read so many books. How many years did Hua T'o [Hua Tuo] spend at college? How many years [of] education did Li Shih-chen [Li Shizhen] of the Ming dynasty receive? In medical education, there is no need to accept only higher middle school graduates or lower middle school graduates. It will be

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<sup>1102</sup> 'TNA/HEA/90/5/493 Technical Health Assistance China, Vinyago Kama Zawadi'.

<sup>1103</sup> 'Hongera Kwa Madaktari Wa Kichina', *Ngurumo*, Agosti 3, 1972.

<sup>1104</sup> 'TNA HEA 90/5 EL/MMW/WU/7 Barua Kutoka Wizara Ya Elimu Ya Taifa JMT Kwa Katibu Mkuu-Ndugu Lema Kipewa Skolaship Ya China Kusoma Udaktari', personal communication, Oktoba, 1976.

<sup>1105</sup> 'TNA HEA 90/5, TEPS/E 160 Ambassador to China to Minister of Health-Leader Sterling No Reply on Purchase Items', personal communication, March 16, 1976.

<sup>1106</sup> *TNA HEA 90/5 Report by Dr Saitoria E.P on the Visit of the Ministry of Health Delegation to the PRC (1977)*.

<sup>1107</sup> Xun, *The People's Health: Health Interventions and Delivery in Mao's China, 1949-1983*.

enough to give three years to graduates from higher primary schools. They would then study and raise their standards mainly through practice. If this kind of doctor is sent down to the countryside, even if they haven't much talent, they would be better than quacks and witchdoctors and the villages would be better able to afford to keep them. The more books one reads, the more stupid one gets.<sup>1108</sup>

Chairman Mao was against intellectualism. Mao's principle emphasised a practical approach to the curriculum, which involved training people with low qualifications quickly and then sending them back to serve the people. To him, political allegiance was also more important than academic qualification. Dobson, arguing in the same vein, notes that after 1969, students admitted to medical schools were evaluated on their political skills more than their academic skills.<sup>1109</sup> The Barefoot doctors, for instance, were selected by the people and sent for a 3-month training in a commune or county hospital. They were trained in environmental sanitation, health education, first aid, pest control, drinking-water purity, immunisation, and waste disposal. They were the backbone of the rural medical organisation.<sup>1110</sup>

Tanzania adopted and implemented many lessons from the Chinese system. These lessons reflected on the widespread poverty and disease in China before the revolution, which contributed to low productivity. Secondly, the colonial attitude towards traditional medicine was changed as Mao Zedong redefined the role of conventional medicine, initially regarded as outdated and unscientific. Afterwards, Mao instructed practitioners of traditional medicine to collaborate with those trained in Western medicine, integrating traditional herbal therapies into mainstream healthcare. The mass line concept, which emphasised community involvement, also promoted hygiene. Advocacy for population control was linked to concerns about grain distribution and overall nutritional adequacy. This approach had a significant positive impact on public health. Life expectancy increased from 30 to 70 years, while infant mortality declined from 250 per 1,000 live births to 10 by 1977.<sup>1111</sup> Moreover, diseases such as malaria, whooping cough, smallpox, and various fevers were brought under control.<sup>1112</sup> Tanzania adopted similar strategies as elaborated below.

Taken together, the ideological, structural, and political overlaps between China and Tanzania facilitated their cooperation. However, Tanzania and China had many cultural and systemic

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<sup>1108</sup> Mao Tse-tung, "Directive on Public Health" cited in Kifyasi, 'Neither a Saviour nor Exploiter: A Historical Study of China's Medical Assistance in Post-Colonial Tanzania', 136.

<sup>1109</sup> Dobson, 'Health Care in China After Mao', 43.

<sup>1110</sup> Sidel and Sidel Ruth, 'Healthcare Delivery System of the People's Republic of China'

<sup>1111</sup> 'TNA HEA 90/5 Report by Dr Saitoria E.P on the Visit of the Ministry of Health Delegation to the PRC'; 'TNA ACC 450, HE/A/90/537 Appreciation Letter from the PS MOH G.J Kileo to the Vice Minister Public Health, MOH, People's Republic of China, H.E Chien Hsin-Chung', October 13, 1977.

<sup>1112</sup> Sidel and Sidel Ruth, 'Healthcare Delivery System of the People's Republic of China.'; Xun, *The People's Health: Health Interventions and Delivery in Mao's China, 1949-1983*.

differences that made implementation difficult. The Chinese culture, politics, and traditions differed significantly from those of Tanzania. The notions of ‘they came as brothers’<sup>1113</sup> and ‘unequal equals’,<sup>1114</sup> were quickly proven to be idealistic, a notion that Jamie Monson further elaborates.<sup>1115</sup> By the early 1970s, China had largely achieved its goal, primarily through its efforts to secure a position at the UN. Additionally, there were striking differences between Tanzania and China. While Mao’s China pursued socialism based on Confucian philosophy, Tanzania’s approach was one of modernisation.<sup>1116</sup> These differences influenced Tanzania’s medical landscape. As will be shown in the section on the Chinese impact in Kilombero, the Confucian principle indeed led the Chinese to live an isolated and simple life, as well as the spread of Maoism through Mao’s Little Red Book.<sup>1117</sup> The similarities, indirect influences, and differences between China and Tanzania had a significant impact on health-policy planning, as outlined in the section below.

### **5.5 The Impact of the Chinese medical work on Maternal health in Kilombero**

MCH was particularly emphasised in China’s medical system. It was viewed as a means to enhance the nation’s overall health and care for its rapidly growing population. In the 1950s, a three-tier system for maternal and child health (MCH) services was established in China, comprising county, township, and village-level facilities. These tiers provided essential MCH services, including immunisation, antenatal care (ANC), and postnatal care (PNC).<sup>1118</sup>

The Chinese medical system, particularly its emphasis on community-driven healthcare and integration of traditional and Western medicine, shared parallels with Tanzania’s postcolonial health initiatives, which eventually trickled down to MCH. Mao Zedong’s approach, which mobilised the masses to participate in healthcare through the ‘mass line’ concept, was echoed in Tanzania by Julius Nyerere’s efforts to promote health, primarily through *Ujamaa*. Therefore, almost everyone was inclined toward better healthcare. Additionally, in both countries, the political parties, TANU and CPC, respectively, played a central role in unifying communities and disseminating health policies from national to local levels. In Tanzania, this was exemplified by campaigns such as ‘Politics is Agriculture’ (*Siasa ni Kilimo*) in 1972, ‘Man is Health’ (*Mtu ni Afya*) in 1973, and ‘Food is Life’ (*Chakula ni Uhai*) in 1975 (see Chapter 4), which aimed to integrate health into broader socio-economic development.

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<sup>1113</sup> Altofer-Ong, ‘They Came as Brothers, Not Masters: Chinese Experts in Tanzania in the 1960s and 1970s’.

<sup>1114</sup> Bailey, ‘China and Tanzania: A Friendship between Most Unequal Equals’.

<sup>1115</sup> Monson, ‘Liberating Labour? Constructing Anti-Hegemony on the TAZARA Railway in Tanzania 1965-1976’.

<sup>1116</sup> Altofer-Ong, ‘They Came as Brothers, Not Masters: Chinese Experts in Tanzania in the 1960s and 1970s’, 79.

<sup>1117</sup> Altofer-Ong, ‘They Came as Brothers, Not Masters: Chinese Experts in Tanzania in the 1960s and 1970s’.

<sup>1118</sup> Chen et al, ‘Coverage, Quality of and Barriers to Postnatal Care in Rural Hebel, China: A Mixed Method Study.’

Initially, from the 1960s to the 1980s, there was no direct collaboration in maternal health between China and Tanzania; however, this relationship later developed.<sup>1119</sup> However, the holistic medical approach had a positive impact on the MCH in Tanzania, particularly in Kilombero. First, the improvement of agricultural practices in Msolwa Ujamaa and other villages helped to tackle the malnutrition problem. Secondly, the provision of various clinics in the villages and specific railway construction centres brought about a general awareness of the need for healthcare such as the control of Bilharzia (*Kichocho*) (see Figure 26 below).



*Figure 26: Chinese and local medical workers offering preventive health education to villagers on Bilharzia (undated, likely 1970s) Source: Health Department of the Shandong Province, The Chinese Medical-Aid Team in the United Republic of Tanzania, 1968–1998 as cited by Andrea Kifyasi, 2021 pg. 39.*

The Kilombero region, rich in diverse agricultural opportunities and infrastructure development, attracted settlers from urban areas who aimed to engage in farming and community development, as well as take employment opportunities in companies such as the Kilombero Sugar Company, Mang’ula Machine Mechanical Tools (MMMT), and the Tanzania-Zambia Railway (TAZARA). In the post-independence *Ujamaa* era, the Kilombero area became home to many different people brought from the city and elsewhere, mainly to break the forest, settle, farm or work in the Chinese-initiated projects.<sup>1120</sup> This was during a period when Nyerere called for a focus on rural life. The population increase in Kilombero became a focal point for implementing these health initiatives in the post-independence era.

<sup>1119</sup> China, Tanzania Launch Dar Es Salaam Midwifery Training Center to Reduce Infant Mortality Rates, December 2024, <https://www.youtube.com/watch?v=IM55QrlX7ss>.

<sup>1120</sup> Oral interview at Tobora, Mahenge with Father Luanda, February 4, 2025.

In February 1965, the first large group of Chinese workers arrived in the Kilombero region to conduct a feasibility study for the railway.<sup>1121</sup> Between 1965 and 1969, however, actual construction did not commence. Zambia's President Kenneth Kaunda remained sceptical about any help from China and was also afraid of jeopardising his relations with Britain. Nyerere also expected to receive assistance from Western donors, which was not forthcoming.<sup>1122</sup> In January 1967, Kenneth Kaunda visited China, a journey that positively impacted his earlier scepticism. On September 6 of the same year, China, Zambia, and Tanzania signed an agreement in which China agreed to fund the construction of the railway with an 'interest-free loan' of USD 406 million, repayable between 1973 and 2013.<sup>1123</sup> The leaders agreed that the railway would be built from Dar es Salaam, Tanzania, to Kapiri Mposhi, Zambia.

In Kilombero, Chinese medical assistance was experienced on two levels: first, through the influence of Chinese-led projects such as TAZARA and MMT; and second, through the Chinese Medical Teams (CMTs).<sup>1124</sup> When Zambia and Tanzania agreed to construct the TAZARA, a significant part of the railway passed through the Kilombero region. There were also other establishments related to railway construction. As a result, from the mid-1960s in Kilombero, the Chinese presence increased. In 1970, the construction work started. The official building of the railway necessitated the recruitment of local labourers for the construction work, as well as the production of rails and other equipment at MMT.<sup>1125</sup> Ramadhan migrated to Mang'ula as one of the workers in the MMT. During the interview, he noted that the Chinese transformed the region through the company. The company produced not only bars and nuts for the railways but also spare parts for vehicles and machines used in the Kilombero sugar company. The workers could afford basic needs, including healthcare. Most of the workers, such as Ramadhan, bought land and settled in the region.<sup>1126</sup> Among the Chinese engineers and construction workers were doctors whose role was to attend to the medical needs. In the various camps for the construction work, a dispensary was also constructed. One such camp was at Mang'ula. The clinic attended to both the Chinese railway workers and the local people.<sup>1127</sup>

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<sup>1121</sup> Monson, 'Liberating Labour? Constructing Anti-Hegemony on the TAZARA Railway in Tanzania 1965-1976'.  
<sup>1122</sup> Jamie Monson, *Africa's Freedom Railway: How Chinese Development Changed Lives and Livelihoods in Tanzania* (Indiana University Press, 2009).

<sup>1123</sup> 'Tanzania-Zambia Railway: A Bridge to China?', *New York Times*, January 29, 1971.

<sup>1124</sup> Oral interview at Tobora, Mahenge with Father Luanda, February 4, 2025.

<sup>1125</sup> Interview with Ramadhan Mtunga Mangula B, September 28, 2023; Interview with Jisbirt Aloyce at Mangula B

<sup>1126</sup> Interview with Ramadhan Mtunga Mangula B, September 28, 2023.

<sup>1127</sup> Interview with Marieta Kindidi at Ifakara on February 7, 2025; Oral interview at Tobora with Father Luanda, February 4, 2025.

The completion of the railway in 1975 had a direct impact on health provision in Kilombero. Apart from facilitating the movement of people, medicine, and equipment, the railway was also used to transport materials for constructing health facilities in areas where the road network was inadequate.<sup>1128</sup> The Mlimba Health Centre provides an example of how the Chinese assisted the Ifakara Health Centre in transporting heavy materials via the TAZARA.<sup>1129</sup> By 1976, over 90 per cent of the population was living in the villages. The presence of Chinese workers and the subsequent opening of the railway led to an increase in agricultural work in Kilombero, resulting in a growing population that had a direct impact on health needs and the response by providers.<sup>1130</sup> The Chinese working on the TAZARA also provided health services. In Mang'ula, near the train station, there was a health centre managed by Chinese doctors who offered services not only to railway employees but also to the general public.<sup>1131</sup> Perhaps due to its proximity to other health facilities, such as St. Francis Hospital in Ifakara, the dispensary at Msolwa Ujamaa, and the Sonjo and Kilombero Sugar Company Hospital in Kidatu, the largest railway hospital was built in the Mbeya region, which falls beyond the scope of this study.<sup>1132</sup>

In the Kilombero Valley, the TAZARA also led to a transformation in the transportation of agricultural produce.<sup>1133</sup> On the one hand, enhanced transportation encouraged people to change to cash crop production over food crops, which also had a negative impact on nutrition. The assumption was that cash crop would improve the living standards of the people. However, this was not the case, as Tanzania's agricultural produce did not fetch a substantial amount of money in the global market. This was a double loss: of revenue and food crop.

TAZARA also led to the movement of people to Kilombero for economic and political reasons. The connection between Zambia and Tanzania was a response to the South African apartheid regime and the Unilateral Declaration of Independence (UDI) government in Zimbabwe, as noted above. The construction of TAZARA was thus intended to free Zambia from the influence of Southern African colonial politics. At the time, South Africa, Zimbabwe, and Mozambique were still under colonial rule. Tanzania's commitment to the railway marked a significant step towards the calls for the liberation of the African continent. However, in such

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<sup>1128</sup> Interview with Margaret Kindasi at Kibaoni, Ifakara, September 25, 2025.

<sup>1129</sup> TNA ACC 450 HEH/41/4 'Rural Health Centres-Ulangu. Rekodi Ya Mazungumzo Kuhusu Ujenzi Wa Mlimba Kati Ya E. Hausser, Shayo Na Manumbu TAZARA'; see section 5.3.3 above on the Swiss reliance on TAZARA for transportation of materials for the construction of Mlimba Health Centre and the frustrations of Mr Heusser.

<sup>1130</sup> Interview with Mtendaji wa Kijiji, at Msolwa *Ujamaa*, September 30, 2023.

<sup>1131</sup> Interviewee F at Msolwa *Ujamaa* on September 30, 2023.

<sup>1132</sup> Mentioned during the Interviews at Ifakara with Interviewee A at Viwanja Sitini, on September 20, 2023.

<sup>1133</sup> Monson, *Africa's Freedom Railway*.

a politically heated environment and amid the Cold War, there was a fear that the railway construction would be sabotaged. Vandalism was reported in many sections.<sup>1134</sup> To provide security to the railway, people were encouraged to set up their villages along the railway. With people living near the railway, it was hoped that vandalism would be brought under control. Encouraging people near the railways led to the construction of many villages along the TAZARA, particularly in the Kilombero area. Moreover, the railway workers opted to remain in the Kilombero area and formed villages, a move that the government greatly welcomed.<sup>1135</sup> Therefore, many of the workers employed by the railway chose to settle in Kilombero after the project was completed. The population increase was a justification for the need for healthcare facilities.

The other level at which Kilombero interacted with the Chinese medical help was through the CMT. The CMTs were viewed as a solution to the shortage of medical personnel. As noted in Chapter Three, the scarcity of doctors in post-independence Tanzania was a problem inherited from colonial times. Ten years after independence, the situation had not improved due to the inadequate ratio of medical workers to the burgeoning population. In 1972, for instance, there were 556 doctors, just about 150 more than after independence. Out of the 536, those in government were 333, 101 worked with religious organisations and 122 in private practice. The doctor-patient ratio was 1:25,000. This shortage was also exacerbated by brain drain. An estimated 300 doctors, mainly of European and Asian origin, had left the country since 1961.<sup>1136</sup> This movement might have been occasioned by unfavourable conditions for doctors after the Arusha Declaration.<sup>1137</sup> With such conditions, CMTs were taken with utmost importance. In 1971, a group of 46 doctors, comprising 14 teams, arrived, followed by another group of 11 teams in 1972.<sup>1138</sup> These doctors went to different regions. The table below lists the doctors sent to the Morogoro region in 1972 (see Table 17).

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<sup>1134</sup> TNA. TZR/C/86/5/82 'Letter from General Manager, TAZARA to the Regional Commissioner Iringa. Security of the Railway', September 2, 1976; TNA, CT.20/8/58 'Mkuu wa Wilaya Njombe kwa Mkuu wa Mkoa Iringa. Taarifa ya Usalama wa Reli', June 5, 1986; TNA, CT.8/51 'Mkurugenzi wa Maendeleo kwa Katibu Mtendaji wa TANU. Ulinzi wa Reli ya Uhuru', Oktoba 1976; TNA, CP.60/2. 'Kaimu Mkurugenzi wa Maendeleo Mkoa Iringa kwa Mkuu wa Wilaya Njombe. Ukaguzi wa Reli kutoka Mpakani wa Morogoro/Iringa/na Iringa Mbeya', Mai 1986,

<sup>1135</sup> Rebecca et al., 'The Role of the State and Foreign Capital in Agricultural Commercialisation: The Case of Sugarcane Outgrowers in Kilombero District, Tanzania. Working Paper 106', 6.

<sup>1136</sup> Bundesarchiv Bern, 'E200.83 (B) 001.32 Uebereinkommen Über Diplomarische Und Kansularische Beziehungen', n.d,

<sup>1137</sup> See Margum Bech *et al*, 'Changing Policies and Their Influence on Government Health Workers in Tanzania, 1967-2009: Perspectives from Rural Mbulu District', *The International Journal of African Historical Studies*, no. 46(1) (2013): 61–103.

<sup>1138</sup> 'TNA/HEA/90/5/493 Technical Health Assistance China.

Region	Name of Doctor	Speciality
Morogoro	Hsu Chuan	Physician /Group leader
	Hsu Jen-Huai	Surgeon
	Chang Min	Gynaecology and Obstetrics
	Liu Shu-chiao	ENT
	Yu Hsiu-Lu	Anaesthetic
	Yung Yung	Chinese acupuncture
	Yang Jsum-Yum	Interpreter

Table 17: A CMT to Morogoro on 26th September 1972.

Source: Extracted from the list of Chinese Doctors in 'TNA/HEA/90/5/493 Technical Health Assistance China.

According to oral accounts, the people in the Kilombero Valley received assistance from Chinese medical personnel. However, there was a mixed experience concerning Chinese medical help. While some villagers commented on the help and having experienced the doctors, others were quick to note that the Chinese were present but isolated. It appears that the influx of Chinese in the Kilombero Valley meant that most of the villagers could not differentiate between those involved in railway and other infrastructural works and the CMTs. However, the presence of the Chinese in the 1970s and 1980s was vividly remembered by the majority. They remembered the holistic approach of the Chinese medical aid, which had both direct and indirect impacts on MCH, traditional medicine, immunisation and family planning.

### 5.5.1 Change of Attitude Towards Traditional Medicine

Informed by socialist principles that sought to unify economic, social, and political dimensions into a comprehensive and interconnected system, the Chinese health model exhibited a holistic nature. In Tanzania, a similar trend was reflected in the *Ujamaa* way of life. The Chinese were actively involved in the village life, especially at Msolwa *Ujamaa* Village. The emergence of Msolwa *Ujamaa* as the best-organised and productive *Ujamaa* village was partly attributed to the help they received from the Chinese. The Chinese trained the village on better agricultural practices and provided access to water and medical services (see Chapter 4 on *Ujamaa*).

The general acceptance of the Chinese medical approach was based on the fact that the Chinese philosophy also resonated with the African culture. Li Chen et al. provide the Chinese concept of *Zuoyenzi* (sitting month), which meant that a mother had to sit inside for one month without going out.<sup>1139</sup> Although the timing of when the woman had to rest after delivery varied from

<sup>1139</sup> Chen et al, 'Coverage, Quality of and Barriers to Postnatal Care in Rural Hebel, China: A Mixed Method Study'.

one community to another,<sup>1140</sup> the understanding was that a new mother needed rest and care. Additionally, the Chinese did not condemn the use of traditional medicine; instead, as shown in the preceding chapters, traditional medicine played a crucial role in birth rituals. While the missionaries opposed such traditions, Mao believed that traditional Chinese medicine was beneficial and should be integrated into biomedicine.<sup>1141</sup> Therefore, the attitude of the Chinese doctors towards traditional medicine in Tanzania differed from that portrayed by the missionaries during the colonial era.

In 1968, Traditional medicine was recognised as part of the therapies in Tanzania. In 1971, UWATA (*Umoja wa Waganga wa Tanzania*)<sup>1142</sup> was formed. The formation of UWATA was a positive development towards traditional medical societies, as a similar organisation had been denied registration by the government in 1962.<sup>1143</sup> UWATA members registered with the government, detailing their roles, workplaces, and the types of diseases they have treated. It is the existence of UWATA that led to the formation of other traditional health practitioners' bodies, such as *Chama cha Waganga na Wakunga wa Tiba Asilia Tanzania* (CHAWATIATA).<sup>1144</sup> One of the interviewees, Amina, is a long-time member of CHAWATIATA, as a traditional midwife and healer based in Mang'ula B. She boasts that she has handled issues that doctors have been unable to handle concerning infertility. While this was difficult to substantiate, some people confirmed her sentiments. Amina noted that they were required by law to be registered and to practice within the bounds of the law as part of the government's policy of integrating biomedicine and traditional medicine.

Such integration was further reinforced by the WHO's support for conventional medicine in the 1970s. WHO supported the use of traditional medicine as an ally to biomedicine.<sup>1145</sup> Traditional medicine emphasised the social aspects of healing. The social component of medicine was crucial to the people of the Kilombero Valley, whose use of traditional medicine was deeply intertwined with their belief system. This attitude resonated with the Chinese belief in the hand of god and the role of religion in healing, in contrast to biomedicine, which focused solely on the mortal body. Michael Jennings explains that the concentration of biomedicine on the body was a concept rooted in the modernity brought about by the Enlightenment and the Scientific

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<sup>1140</sup> Musie et al, 'African Indigenous Beliefs and Practices during Pregnancy Birth and After Birth'.

<sup>1141</sup> Xun, *The People's Health: Health Interventions and Delivery in Mao's China, 1949-1983*.

<sup>1142</sup> The National union of traditional healers and midwives.

<sup>1143</sup> 'Serikali Yakataa Chama Cha Waganga', *Mwafrika*, Agosti 1963.

<sup>1144</sup> CHAWATIATA means the Association of Traditional Healers and Midwives of Tanzania.

<sup>1145</sup> *Primary Health Care: Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978. Jointly Sponsored by the World Health Organization and the United Nations Children's Fund.*

Revolution.<sup>1146</sup> However, in ‘traditional Africa, healing practices are underpinned by differing cultural social understanding of the cause and nature of illness and by what might be perhaps perceived as a more holistic definition of what constitutes ‘good health’ and ‘normality’.<sup>1147</sup>

The Chinese and African understanding of medicine, therefore, encompasses aspects of inclusivity that extend beyond the body.<sup>1148</sup> Perry notes that these traditions were portrayed during the COVID crisis in 2020 when China built two health facilities, namely Fire God Mt. Hospital and Thunder God Mt. Hospital, after the two gods that unite the Chinese people, similar to Mao’s call to sweep the ox demons and snake gods during the mass campaigns in the 1950s.<sup>1149</sup> Though the CMTs did not practice spiritualism, they did not condemn the ATM as the missionaries did during the colonial period, which was propagated in the postcolonial era. The embrace of traditional medicine by the populace resonated with African concepts of medicine, particularly the belief in the healing properties of herbs.<sup>1150</sup> The integration and the push for biomedicine integration with traditional medicine have been criticised as biopiracy and bioprospecting.<sup>1151</sup> Still, it offered a distinct perspective on the social aspect of medicine, contrasting with the Cartesian approach.<sup>1152</sup> The challenge, as I argued elsewhere, is that the Tanzanian government, heeding the call by the WHO, concentrated on herbs and ignored other forms of traditional medicine.<sup>1153</sup>

The colonial attitudes about the inefficacy and inferiority of traditional medicine were still held. The government of Tanzania adopted the colonial 1928 witchcraft ordinance that prohibited healers from invoking the supernatural.<sup>1154</sup> Indeed, members of UWATA had to declare that in their practice, they were not to use witchcraft. Tanzania’s attitude to traditional medicine continued to emphasise the use of herbs. The Tanzanian state’s selective embrace of herbalism

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<sup>1146</sup> Michael Jennings, ‘Chinese Medicine and Medical Pluralism in Dar Es Salaam. Globalisation or Glocalisation?’, *International Relations* 19, no. 4 (2005): 459.

<sup>1147</sup> Jilek-Aall, *Call Mama Doctor: African Notes of a Young Woman Doctor*; Jennings, ‘Chinese Medicine and Medical Pluralism in Dar Es Salaam. Globalisation or Glocalisation?’, 459.

<sup>1148</sup> African idea of health was holistic including the environment and the spiritual, while the biomedicine as presented by the Europeans followed the dualistic nature on the cartesian model of health. for more on this see Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception* (Routledge, 1973); Paul Rabinow and Rose Nikolas, ‘The Birth of Social Medicine’, in *Selection from the Essential Work of Foucault, 1954-1984* (New Press, 2003).

<sup>1149</sup> Perry, ‘Public Health, National Strength and Regime Legitimacy: China’s Patriotic Health Campaign.’, 18.

<sup>1150</sup> Veronica Kimani, ‘Nurturing Traditional Midwifery and Medicine: The Entangled Path of Health Integration in Post-Independence Kilombero, Tanzania’, *Zamani: A Journal of African Historical Studies*. 1, no. 1 (2024), <https://doi.org/10.56279/ZJAHS1118>.

<sup>1151</sup> Cori Hayden, *When Nature Goes Public: The Making and Unmaking of Bioprospecting in Mexico* (Princeton University Press, 2003); Dutfield Graham, *Intellectual Property, Biogenetic Resources and Traditional Knowledge*. London: Earthscan, 2004. (Earthscan, 2004).

<sup>1152</sup> Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*.

<sup>1153</sup> Veronica Kimani, ‘Nurturing Traditional Midwifery and Medicine’ 191.

<sup>1154</sup> Lorne Larson, ‘Witchcraft Eradication Sequences among the People of the Ulanga (Mahenge) District, Tanzania.’, 1975; Kifyasi, ‘Neither a Saviour nor Exploiter: A Historical Study of China’s Medical Assistance in Post-Colonial Tanzania’, 87.

reflects the enduring influence of colonial and external models that privilege certain forms of knowledge while sidelining others. By adopting travelling ideas, whether biomedical or Chinese, without fully engaging with the holistic and spiritual dimensions of African therapeutic medicine, the government reproduced a narrow vision of tradition. This uncritical adoption of external frameworks risks marginalising local epistemologies and reinforces a hierarchy that places imported models above indigenous ones, the very ones they claimed to serve.

### **5.5.2 Bringing Vaccination Production Closer Home**

While immunisation in Tanzania was introduced and supported by the West through UNICEF, as shown below, the efforts to reduce dependency on the Global North were supported by China. As noted above, the Chinese established the Mabibo Vaccine Institute (MVI) and Keko Pharmaceutical Industries (KPI) in Dar es Salaam. These companies played a significant role in the production of BCG, a vaccine for TB prevention, which was produced at the MVI. MVI and KPI were instrumental between 1971 and 1980 in delivering vaccines and medicines that were used locally.<sup>1155</sup> It was seen as revolutionary for Tanzania to have reached a certain level of ‘self-sufficiency’.

Raw materials, technology and the technical know-how, however, were sourced from China. Moreover, the Tanzanian auxiliary level borrowed significantly from the Chinese township level, both in terms of structure and practice. In China, maternal and child health, which included immunisation, ANC and postnatal care, was handled at the township level.<sup>1156</sup> The same organisational approach was used in Tanzania, where auxiliary health workers primarily handled MCH. However, in the early 1980s, pharmaceutical firms experienced a decline due to limited resources, the availability of vaccines through global networks, and shifts in national health policies.<sup>1157</sup>

### **5.5.3 China’s Family Planning Policies and the Indirect Impact on Tanzania**

Population control was a key theme in the Chinese medical system. China, India, and Japan started the population campaigns as early as the 1930s by encouraging people to have fewer children, legislating the use of contraceptives, and funding related research.<sup>1158</sup> A large population was believed to be detrimental to a nation’s progress, especially in terms of the

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<sup>1155</sup> TNA, ACC 450, HEA/90/5 ‘Chinese Medical Assistance to Tanzania’; Kifyasi, ‘Neither a Saviour nor Exploiter: A Historical Study of China’s Medical Assistance in Post-Colonial Tanzania’, 221.

<sup>1156</sup> Chen et al., ‘Coverage, Quality of and Barriers to Postnatal Care in Rural Hebei, China: A Mixed Method Study’

<sup>1157</sup> Sadock, ‘Prevention Is Better Than Cure’: Smallpox Vaccination in Postcolonial Tanzania, 1961-1980.’

<sup>1158</sup> Packard, *A History of Global Health*, 186.

relationship between the number of people and available food. In the Malthusian understanding, population increased geometrically while food supplies increased arithmetically, which automatically compromised the socioeconomic development of any nation.<sup>1159</sup> In China, it was observed in 1975 that grain production increased by 72 per cent from 156.9 million tons to 270 million tons, while population increased by 100 per cent from around 400-583 million to 800-900 million in the same period.<sup>1160</sup>

China's entry into the United Nations General Assembly (UNGA) positioned it as a model for the Global South.<sup>1161</sup> The position of China was further strengthened by the prevailing geopolitics of the time. Therefore, China served as a model for other countries, allowing it to exert its influence directly or indirectly. Population control in China was an urgent agenda. By 1979, China's population control had taken a new trend with the socialist government actively involved in matters of population control. The population control pill was made available for free. The use of IUDs, condoms, and spermicidal jellies was advocated.<sup>1162</sup> The Chinese emphasised family planning to reduce poverty and famine. Family planning was also seen as emancipatory for women.<sup>1163</sup> In the same year, the one-child policy was enacted, and in September, it was legislated as law. Abortion was legalised as a method of contraception if conventional family planning failed.<sup>1164</sup> Getting married at a later age was advocated, and the public discourse had little to do with overemphasis on sex. A lot of written materials have been written on family planning, not only in China but also in other countries.<sup>1165</sup>

Initially, economists and demographers argued that improvements in living standards, such as those experienced in the West during the Industrial and Scientific Revolutions, would be spread to the Global South, leading to a reduction in birth rates among its inhabitants.<sup>1166</sup> The assumption was that medicine had led to increased life expectancy, and the discovery of machines meant that there was no need to rely on human labour, hence a low birth rate. In Tanzania, the advancement in medicine and machines, however, did not translate into a reduced birth rate as was expected. Packard adds that the reduced food supplies led to alternative ways of thinking about the relationship with demography. The most propagated alternative was the

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<sup>1159</sup> Packard, *A History of Global Health*, 181.

<sup>1160</sup> Liu (1978) and Chesneau (1979) as cited by Dobson, 'Health Care in China After Mao', 49.

<sup>1161</sup> Xun, *The People's Health: Health Interventions and Delivery in Mao's China, 1949-1983*.

<sup>1162</sup> Dobson, 'Health Care in China After Mao', 49.

<sup>1163</sup> Sidel and Sidel Ruth, 'Healthcare Delivery System of the People's Republic of China', 7.

<sup>1164</sup> Ashan, 'Chinese Medical Cooperation in Africa'; Dobson, 'Health Care in China After Mao'.

<sup>1165</sup> 'Chinas's Birth Planning Campaign Leads to Major Birth-rate Decline in Shanghai, Nation's Largest City', *International Family Planning Digest*, June 1976; 'Improved Public Health Tied to Family Planning', *International Family Planning Digest 2*, no. 2 (June 1976); 'Restrictive Laws, Policies Hamper Family Planning', *International Family Planning Digest*, June 1976.

<sup>1166</sup> Packard, *A History of Global Health*, 186.

use of contraceptives.<sup>1167</sup> The use of contraceptives was popularised from the 1950s, which was later related to the rights and emancipation of women. However, many nations, especially in the West, did not directly address the population question; instead, they entrusted the task to NGOs. Similarly, in the Global South, there was scepticism that population control was an imperialist propaganda to reduce their population.<sup>1168</sup> In addition, the Catholic Church was strongly opposed to population control.<sup>1169</sup>

The opposition did not deter population control narratives. Between 1960 and 1970, the need to control the world's population became a matter of global interest. The UN became instrumental in propagating family-planning acceptability. In 1974, the UN held its first conference on population in Bucharest, which defined family planning as a means of helping couples or individuals decide the number and spacing of their children.<sup>1170</sup> In the same year, the government of Tanzania took over the responsibility of providing family planning, which was organised through health education on parenthood, counselling, provision of contraceptives, and management of infertility.<sup>1171</sup> Ten years later, the second UN conference on the same topic was held in Mexico City in August 1984, and working together with the International Planned Parenthood Federation (IPPF), it was agreed that everyone, including adolescents, had a right to family-planning services.<sup>1172</sup> Lack of family planning was identified as one of the challenges to proper parenting and child upbringing.

Contrary to China, in Tanzania population control was not a publicly accepted discourse in the 1960s and 1980s. Additionally, unlike China that adopted strict limits on family size., Tanzania took a more flexible approach, emphasising education, access to contraceptives, and integration into broader health initiatives rather than use of forced policy. The socio-cultural and religious orientation of Tanzania required a soft approach. As noted in Chapter 3, women in the Kilombero Valley relied on traditional midwives' family-planning approaches such as the use of the kanga and snail-shell method to inhibit conception, as well as abstinence and long period

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<sup>1167</sup> Packard, *A History of Global Health*, 183.

<sup>1168</sup> Robert M. Park, 'Not Better Lives, Just Fewer People: The Ideology of Population Control', *International Journal of Health Services* 4, no. 4 (1974): 691–700; Packard, *A History of Global Health*, 187; Ellis Patrick and Jesse Olszynko-Gryn, 'Communicating Overpopulation to a Global Audience: Disney's Family Planning (1968)', *Journal of Global History* 19, no. 3 (2024): 439–62, <https://doi.org/10.1017/S1740022824000068>.

<sup>1169</sup> Packard, *A History of Global Health*; Patrick and Olszynko-Gryn, 'Communicating Overpopulation to a Global Audience: Disney's Family Planning (1968).'

<sup>1170</sup> 'World Population Conference, August 19-30 1974, Bucharest, Romania', 1974, <https://www.un.org/en/conferences/population/bucharest1974>.

<sup>1171</sup> Staatarchiv Basel-Stadt (StABS), '940 HI (1) I Tanzania Maternal and Child Health Programme' (1976).

<sup>1172</sup> 'International Conference on Population, 6-14 August 1984, Mexico City.', 1984, <https://www.un.org/en/conferences/population/mexico1984>.

of breast feeding.<sup>1173</sup> Although having a large family was considered admirable by both men and women, some circumstances led women to plan their families. Traditionally, conceiving while still breastfeeding was taboo and frowned upon. There were many ways of avoiding conceiving, especially abstinence on the side of the woman, because the man was technically allowed to be polygamous or have sexual contacts outside the confines of the marriage. Rituals such as *kilala* were used to put caveats on the extent to which such an arrangement was allowed.<sup>1174</sup>

The topic of modern population control techniques was, however, not easily embraced in Tanzania. Socio-cultural, religious, economic and political factors were at play. Amid a deteriorating economy, the Tanzanian government struggled to deliver the services promised after independence. As a result, birth control was necessary to allow only the number of children a family could adequately support. Even though the state was not so explicit about birth control, there was a need for control. Still, the national mood, spirit and culture on the concept of family planning was against artificial methods, at least for the majority of people. As described in Chapter 4, birth control through traditional and natural methods was preferred over the ‘modern and artificial’ ones, often seen as dangerous. However, it was apparent that the consequences of unplanned births usually led to limited access to quality education, nutrition, and healthcare. These impacts were not just at the national level but also at the local level, even at the village level, often transforming many homes into a site of domestic tension and perpetuating a cycle of poverty and violence, which eventually permeated to define the state of the nation. Nationally, the government could only influence from behind the scenes. Otherwise, the president and top political leaders avoided the topic or still categorically stated that the government had no plans to control the number of children that a family could have. Up to 1989, during a three-day seminar on demography with religious leaders, CCM chair Julius Nyerere clarified that there was no government plan to impose birth control.<sup>1175</sup> The seminar gathered religious perspectives on population issues. Most religious leaders opposed population control, arguing that it interfered with God’s work (*kazi ya Mungu*), and, therefore, it was viewed more as a personal choice, not a state policy. President Ali Hassan Mwinyi encouraged Muslim leaders to consult the Qur’an on the matter. While the government prioritised political

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<sup>1173</sup> Women in Ifakara, Focus Group Discussion at Lipangalala, September 21, 2023.

<sup>1174</sup> Women in Ifakara, ‘Focus Group Discussion at Lipangalala’, September 21, 2023.

<sup>1175</sup> Hassan Mwadini, ‘Mwalimu Aiambia Semina Ya Idadi Ya Watu: Hakuna Mpango Wa Kutunga Sheria Ya Kudhibity Uzazi.’, *Uhuru*, Februari 28, 1989.

legitimacy by respecting religious views, it ultimately emphasised the importance of family planning for maternal health.<sup>1176</sup>

In the Kilombero Valley, children were viewed by many communities as a divine blessing and a valuable labour resource in an agricultural economy. The children were also seen as a source of social security for the parents in old age, leading to a general reluctance towards the practice of family planning. Additionally, family planning was seen as an attack on men's virility.<sup>1177</sup> A woman seeking to be free from constant childbearing was a reason enough to have problems with the in-laws and the husband because they had now been contaminated with 'modern ideas'.<sup>1178</sup> Therefore, the government retained a reserved role; no government would want to jeopardise its legitimacy on matters that were unpopular with the masses.

From the archival records, however, there were written records from China on the topic of family planning in Tanzania. However, there was no evidence that the Chinese CMTs or other medical workers directly addressed population control. This does not imply that family-planning campaigns were absent; instead, they occurred in more indirect forms. Like many Western governments, Tanzania left the issue to NGOs, private organisations and TANU-affiliated bodies such as UWT, and UMATI.<sup>1179</sup>

In Tanzania, the national policy of *Ujamaa* called for accelerated economic growth. At the time, women's engagement with work outside the home became a reason for embracing family planning. Through UWT, TANU emphasised family education to sensitise people to the need to have a manageable family. Just as in the Chinese model, the development that was envisioned in Tanzania through *Ujamaa* needed to be interpreted in the context of eradicating poverty, and the number of children in a family was as significant as the number of people in a country at a given time. Apart from the traditional methods of contraceptives provided by the midwives, the use of artificial family-planning methods in Tanzania started with *Chama cha Uzazi na Malezi Bora* (UMATI) in 1959.<sup>1180</sup>

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<sup>1176</sup> Mwadini, 'Mwalimu Aiambia Semina Ya Idadi Ya Watu: Hakuna Mpango Wa Kutunga Sheria Ya Kudhibiti Uzazi.', 'Mwalimu Aiambia Semina ya Idadi ya Watu'.

<sup>1177</sup> Women in Ifakara, 'Focus Group Discussion at Lipangalala', September 21, 2023.

<sup>1178</sup> Dumont and Mottin, *Stranglehold in Africa*.

<sup>1179</sup> 'CCM Library. CCM: Sera ya Malezi ya Taifa kwa Watoto na Vijana Tanzania', Dodoma 1987.

<sup>1180</sup> UWT, 'Umoja wa Wanawake wa Tanganyika (UWT). Taarifa ya Mwaka 1975' (1975); 'Umati', <https://umati.or.tz/about-us/>. accessed on May 10, 2025.

UMATI encouraged women to use biomedical practices for birth control. However, in a society that was still strongly connected to culture and religion, it was not easy. As noted above, the government carefully navigated the issue by having policies worked towards finding a middle ground for the uptake of family planning services in clinics and through UMATI. For instance, the policy that a doctor could only help a woman to use family planning with the permission of the husband was introduced.<sup>1181</sup> However, men who were largely excluded from family-planning matters both in the biomedical and traditional arena were not easily incorporated. The incorporation of men was problematically seen from two angles; on the one hand, the long absence of men in matters reproduction was a major setback to the MCH section and the overall government policy. On the other hand, it was seen as a perpetual control of the woman's body.

UWT became largely involved in the emancipation of reproductive health. By putting UWT to take the lead, it was publicly seen as a women's issue rather than a political or a global issue. Statements such as '*wanawake waruhusiwe wapange uzazi wao*'<sup>1182</sup> (women to be allowed to freely family plan) were often seen in the newspapers and UWT documents. This resonates with the emergence of human right activists in the West who saw population control as advantageous to women. Margaret Sangers, the American sex activist and a nurse remains a notable figure in the notion that birth-control pill was emancipatory and important to the reproductive rights of women.<sup>1183</sup> Therefore, the question of population control was transformed from a political, economic issue to a women's right agenda. There was a shift from focusing on population control from a national economic angle, to focusing on women's health, rights bodies, and privacy.

The change of family-planning understanding was important to the general attitude and response by women as it was portrayed as being beyond the control of the state to more of a personal choice. Therefore, through continued campaigns and health education, women started to embrace family-planning services provided by UMATI. In Tanzania at large, 'artificial' ways of family planning were primarily conducted by women in the urban areas,<sup>1184</sup> while the traditional methods from a traditional midwife or prolonged breastfeeding were taken by rural women, only to space accordingly, but not as a way of controlling the number of children.<sup>1185</sup> While these broader trends in family planning were evident across Tanzania, the situation in

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<sup>1181</sup> Oral Interview with Christina Isakwisa, Posta Ifakara, September 20, 2023.

<sup>1182</sup> CCM Library 'Sera Ya Wanawake Katika Maendeleo Tanzania'.

<sup>1183</sup> Carole R McCann, *Birth Control Politics in the United States, 1916–1945*. (Cornell University Press, 1994).

<sup>1184</sup> Callaci, *Street Archives and City Life: Popular Intellectuals in Postcolonial Tanzania (Radical Perspectives)*.

<sup>1185</sup> Interview with Zuhura Hassan, a traditional midwife at Lipangalala, September 21, 2023

Kilombero presents a unique context. Traditional methods were prevalent, but the presence of Catholic missionaries, Chinese workers at TAZARA establishments, CMTs, and cultural dynamics were also significantly shaping the transnational influence.

The Catholic Church influence was notable. Internationally, the Church has maintained its stance against artificial family planning.<sup>1186</sup> The Church blamed the IPPF for supporting contraception for everyone, whether married or not. The Church was also not supportive of artificial family planning for it advocated for the use of natural family-planning methods. In Kilombero, for instance, the Catholic Church running the St. Francis Hospital, Ifakara, did not provide family-planning pills except to ‘those who were really in need’.<sup>1187</sup> These were women whose bodies were at risk due to pregnancy and childbirth. However, even in such a case, this medication could only be given by the Swiss head midwife.<sup>1188</sup> Although family planning was largely treated as a private matter, it was shaped by conflicting philosophies among the state, the Church, African traditional cultures, and subtle Chinese influence. Through UMATI, the government promoted family planning as essential for both women’s well-being and national development. In contrast, African traditional beliefs regarded having many children as a divine blessing, while the Catholic Church maintained a conservative stance on matters related to health, reproduction, and God’s creation

The controversies surrounding family planning were not a unique to Tanzania. It was a worldwide issue that caught the attention of the UN and even evolved beyond the question of whether to use or not, to the question of who was morally allowed to contraceptives. Neither the Church nor African values supported sex before marriage, and therefore, the unmarried did not need to access contraceptives in the official view. This shows that there was a transformation in the way contraceptives were viewed in the 1960s. More women had started opening up to the idea of use of contraceptive as a right and beneficial to their health and that of a child. In Tanzania, the history of a family is also fascinating because UMATI could not give contraceptives to unmarried women until 1975, thanks to UWT campaigns.<sup>1189</sup> By the 1980s, the issue of family planning was still highly contested, but not totally rejected. According to a study conducted in Morogoro in the late 1980s, various family-planning methods were employed (see Figure 27 below). Only 11% of the women in Tanzania used the methods provided by the government and other agencies.

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<sup>1186</sup> Packard, *A History of Global Health*, 187.

<sup>1187</sup> Interview with a retired nurse at Posta Ifakara, September 22, 2023.

<sup>1188</sup> ‘CCM Library Dodoma, Education of Youth in Sexuality: The Plans for your Children’ (Benedictine publication Ndanda-Peramiho, 1986).

<sup>1189</sup> ‘Pay Maternity Leave for All Says UWT’, *Sunday News*, August 8, 1971; UWT, ‘Umoja wa Wanawake wa Tanganyika (UWT). Taarifa ya Mwaka 1975’.

While the people were sceptical about the contraceptives provided by the government, the government was equally doubtful of the traditional herbs that women used as contraceptives. MCHAs were implored to promote the use of artificial contraceptives, partly due to suspicions that traditional herbal methods led to infertility. However, I found no scientific evidence to substantiate these claims, nor was it clear whether such concerns were grounded in fact or served as a form of propaganda. District Medical Officers (DMOs) were responsible for ensuring that every health auxiliary or MCHA was competent in providing contraceptives. These were to work as agents and propagators of artificial contraceptives. The challenge, however, was a lack of follow-up by the community health workers, not involving men in MCH matters, and different actors who had different views on the topic, such as the ruling party CCM, UMATI, religious organisations, other voluntary agencies and the citizens.<sup>1190</sup>

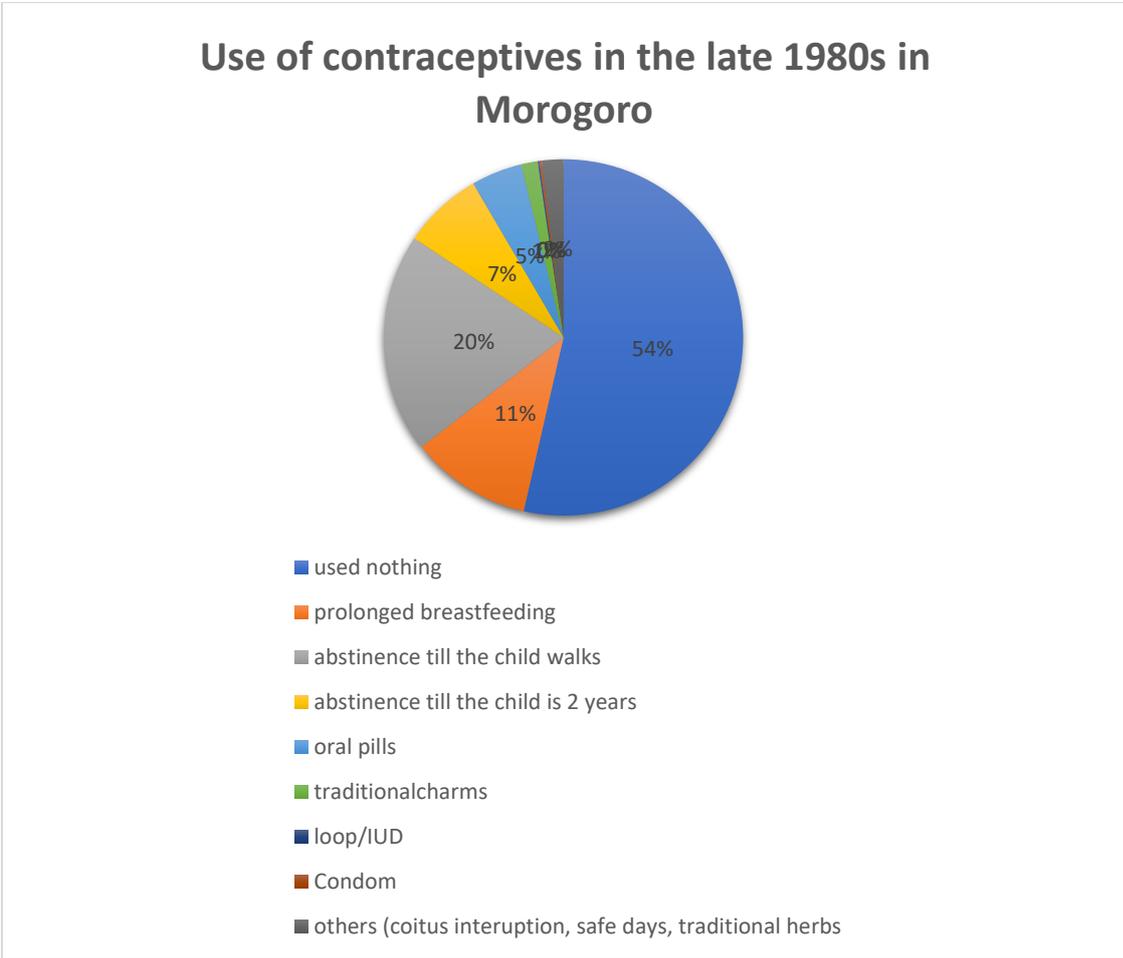


Figure 27: The use of Contraceptives in the late 1980s in Morogoro. Source: data from Staatarchiv Basel PA940d H1, Tanzania and maternal health systems.

<sup>1190</sup> 'CCM Library, Hotuba ya Waziri wa Afya na Ustawi wa Jamii Katika Mbunge 1988', 1988.

By the end of the 1980s, there were calls to unpack the meaning of MCH because it was said to leave men and women beyond childbearing age out of the activities of the clinic.<sup>1191</sup> Men were encouraged to accompany their spouses to the clinic for family planning.<sup>1192</sup> By the 1980s, family planning in Kilombero had gained some acceptance, which can be attributed to the immense help from USAID. Influence from the USA, China and Europe on the need to control the population was reflected in many African countries, with some of these countries pegging their foreign policy on the acceptance of birth-control programmes.<sup>1193</sup>

The foregoing discussion illustrates that family planning was a key health policy that complemented preventive health and was closely related to government economic planning. Recognising the importance of population numbers as a crucial determining factor, the government of Tanzania had to be indirectly or directly involved in family-planning initiatives. Population concerns have been a global agenda item since the early 20th century, originating from metropolitan anxieties about declining populations that extended to the colonies.<sup>1194</sup> However, in postcolonial Tanzania, the concern shifted to managing a burgeoning population, which, if left unchecked, could disrupt government health planning and policy-making. Transnational relations influenced Tanzania's birth-control trends. China's control of the population was a good example for Tanzania to learn from, albeit with different socio-cultural inclinations. This suggests that there are limitations to ideas that travel; they may be embraced, but only up to a specific point. While family planning was officially introduced by UMATI in 1959, it was not until 1975 that family planning was introduced as part of the MCHA training.<sup>1195</sup>

Thus, the period from 1961 to the 1980s presents two decades of active Chinese medical assistance in Tanzania. China invested in many ways, including sending doctors through the CMTs and the construction of plants in Dar es Salaam. Additionally, infrastructural development, notably the TAZARA, impacted health access in the Kilombero region, as well as easing the transportation of medical equipment, drugs, and personnel from the capital. Chinese involvement in the villages, such as Msolwa *Ujamaa*, left them not only with

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<sup>1191</sup> 'Sera ya Wanawake katika Maendeleo Tanzania', 29.

<sup>1192</sup> Staatsarchiv Basel-Stadt, Lucy Gilson and Martin Serikiaeli Alilo, 'PA 940d Maternal Care in Primary Level Health Units with Some Aspects of Childcare: Experience from Morogoro' (25 June 1991), 26.

<sup>1193</sup> Packard, *A History of Global Health*, 206.

<sup>1194</sup> Bruchhausen Walter, 'Practising Hygiene and Fighting the Natives' Diseases. Public and Child Health in German East Africa and Tanganyika Territory, 1900-1960', *DYNAMIS*. 23 (2003): 85-113; Jörg Vögele, 'Has All That Has Been Done Lately for Infants Failed?' 1911, Infant Mortality and Infant Welfare in Early Twentieth-Century Germany', *Annales de Démographie Historique*, no. 2 (January 2010): 131-46; Ulrike Lindner, 'The Transfer of European Social Policy Concepts to Tropical Africa, 1900-50: The Example of Maternal and Child Welfare', *Journal of Global History* 9, no. 2 (2014): 208-31, <https://doi.org/doi:10.1017/S1740022814000047>.

<sup>1195</sup> Chagula and Tarimo, 'Meeting the Basic health Needs in Tanzania', 155.

agricultural knowledge but also access to medical care through the dispensaries started by the Chinese. Indirectly, China's involvement was also indirect, especially in matters concerning family planning.

However, to what extent they performed is a question that suggests they left more memories than legacies, as their medical involvement with the people was short-lived. In terms of training, the barefoot doctor concept did not gain traction. From the organisation, the doctors were to be in Tanzania for two years, during which they would relocate to various villages and regions following a rotational system within the two-year operation period. While they would be able to solve some medical problems, as was witnessed,<sup>1196</sup> the movement from one place to another meant that they did not have enough time to establish a lasting presence in one place, as was the case with the missionaries during the pre-colonial period. Secondly, in China, Tanzanian students were not sent to study Chinese medicine. They studied Western medicine for only one semester, supplemented by a brief introduction to Chinese traditional medicine, acupuncture, and orthopaedics. The reduction in years of training led to China-trained doctors being perceived as inferior compared to those trained elsewhere. In Tanzania, the Medical Council of Tanzania refused to recognise them as doctors, while others were demoted to administrative jobs when they refused to go for an upgrade. This discouraged people from Chinese-based scholarships and education.<sup>1197</sup>

Importantly, just as with the Swiss medical help, Chinese medical help also had its interests, especially Chinese admission to the UN, after which there was a decline in medical aid to Tanzania, or it came with more demands that proved expensive to Tanzania. In 1972, during the farewell party of the CMT whose term had ended, Dr Wang, the lead Doctor, asked if more doctors would be required in the future. When the answer was given in the affirmative, he said that they would want to provide not more than 10 teams.<sup>1198</sup> This showed that sending CMTs to African countries was no longer important to China.<sup>1199</sup>

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<sup>1196</sup> Witness wrote a letter requesting the CMT to Bukoba after his health problem was attended as recorded in TNA, Chinese technical Assistance.

<sup>1197</sup> Kifyasi, 'Neither a Saviour nor Exploiter: A Historical Study of China's Medical Assistance in Post-Colonial Tanzania', 136.

<sup>1198</sup> 'TNA/HEA/90/5/493 Technical Health Assistance China-A Record of the Meeting with the Chinese Medical Team Head on February 5, 1972'.

<sup>1199</sup> After 1980, CMT became expensive to maintain with Tanzania required to use more money to maintain and support the doctors in Tanzania as well treating them to expensive gateways in national parks which led to the question of 'socialist brotherhood.' Later, Chinese medicine was described as a business. For more on these see Kifyasi, 'Neither a Saviour nor Exploiter: A Historical Study of China's Medical Assistance in Post-Colonial Tanzania'; Hsu, 'Medicine as Business: Chinese Medicine in Tanzania.'; Monson, 'Liberating Labour? Constructing Anti-Hegemony on the TAZARA Railway in Tanzania 1965-1976'.

## 5.5 Summary

The medical assistance provided by China and Switzerland in Tanzania presents a revealing contrast in both form and underlying philosophy. On the one hand, Swiss aid, rooted in a capitalist and missionary tradition, was characterised by long-term engagement with an emphasis on humanitarianism, public health, institutional capacity-building, and the advancement of scientific and technological knowledge. Chinese support, on the other hand, was framed within a socialist ethos and typically delivered as short-term interventions under the banner of friendship and solidarity. Owing to its history of colonial subjugation and public health challenges, China was often perceived as more attuned to Tanzania's developmental realities, especially after the 1967 Arusha Declaration. Therefore, between 1960 and the 1980s, Tanzania was often perceived as a benchmark from which to provide alternatives to futuristic governance and development trajectories following the crises that many African states experienced after independence.<sup>1200</sup>

Nyerere was seen as a hero, and therefore, he was able to attract the attention of many donors and international actors. The involvement of donors and international experts in Tanzania's medical landscape was often marked by complex dynamics, including asymmetrical power relations, competing priorities, and hidden agendas that extended beyond purely humanitarian concerns. Health planning in Tanzania was deeply influenced by external actors, making it an inherently political and economic process. However, the presence of multiple stakeholders did not necessarily lead to effective outcomes. As Frederick Cooper aptly observed, 'it was a matter of universal concern, but fragmented responsibility'.<sup>1201</sup> The dynamics of international cooperation, whether through aid, loans, or technical assistance, were often contentious and fraught with challenges. As discussed in the foregoing chapter, many development projects were closely tied to donor involvement. International collaboration was largely experimental, particularly in the case of medical interventions. For example, the utterance by Rudolf Geigy referring to Ifakara as 'Bush' was too telling, and despite the differing ideological and strategic orientations, a critical question persists: what interests ultimately drove these engagements, and how did they shape the trajectory of Tanzania's health-policy planning?

While Tanzania benefited from these transnational actors, the analysis provided in this chapter shows that the latter were the biggest beneficiaries. Without the CMTs, it would have been hard

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<sup>1200</sup> Roger Nord, Yuri Sobolev, David Dunn, Alejandro Hajdenberg, Niko Hobdari, Samar Maziad, and Stéphane Roudet, Tanzania, *The story of an African Transition*. Washington DC: International Monetary Fund (IMF), 2009.

<sup>1201</sup> Cooper, 'Writing the History of Development'.

for China to negotiate its space in the UN. The Swiss medical aid on the other hand, had lasting impacts on the medical landscape in Tanzania that are still very alive in Kilombero Valley today, over a century later.<sup>1202</sup> In the celebration of the 40 years of existence in Ifakara, Bishop Maranta asked, ‘What would Ifakara be today without the mission?—a question to which he answered, ‘still an insignificant fishing village...now from a fishing village of 1911 to a commercial and transportation centre’.<sup>1203</sup> Bishop Maranta’s statement reflects a one-sided colonial gaze that downplays the role of indigenous systems, knowledge, and potential. It assumed that Ifakara had no inherent value or capacity for transformation without the Swiss intervention. This perspective risks erasing local agency and the contributions of Tanzanian actors, both before and alongside the mission. The statement by the Bishop also relegated Ifakara and the people of Tanzania as the only beneficiaries, while ignoring the experiments conducted at the Kilombero government and their implications for the Swiss government, pharmaceutical companies, and the career progression of Prof. Geigy and other scientists in the Global North. Louise Jilek-Aall narrates her experiences with traditional medicine men and the struggles with epilepsy in Mahenge. In one instance, she narrated how a medicine man shared his secrets by giving her the bark of a tree that he claimed could heal epilepsy. Jilek-Aal sent the bark for pharmacological tests in Switzerland, where it was proven to have anticonvulsive properties in animal tests.<sup>1204</sup> Later, a professor of Pharmacology in Zurich told Jilek-Aal that the sample was too small for further experiments and that she was interested in returning to Africa to gather more, all expenses to be paid by the pharmaceutical company. Jilek-Aal was apprehensive, but she agreed and was assisted by the medicine man and the people of Mahenge in collecting barks in the forest, which were then shipped to Europe. Unfortunately, the experiment was discontinued because it proved ‘uneconomical’ to the pharmaceutical company.

Tanzania did not achieve the desired level of self-sufficiency with the help of these actors; instead, a dependency syndrome towards medical assistance developed, such that some functions could not operate without external assistance. This reflects what Meghan Keita describes as ‘manipulation by assistance’.<sup>1205</sup> Such foreign aid contributed to the creation of a dualised healthcare system, exacerbating disparities between the rich and the poor, as well as

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<sup>1202</sup> ‘Switzerland–Tanzania: A Century of Shared History’, *The Citizen Newspaper*, November 25, 2021, <https://www.thecitizen.co.tz/tanzania/supplement/switzerland-tanzania-a-century-of-shared-history-3631236>.

<sup>1203</sup> MDA *Die Schweizer Kapuziner in Africa*, ‘Mitteilungen Aus Den Missionen Dar Es Salaam and Seychellen. Jahresbericht 1921-1941’.

<sup>1204</sup> Louise Jilek-Aall, *Call Mama Doctor: African Notes of a Young Woman Doctor* (London: George Allen and Unwin LTD, 1980), 200.

<sup>1205</sup> Maghan, *A Political Economy of Health Care in Senegal*.

between urban and rural populations, the same challenges the government wanted to eradicate. For instance, it was often challenging to send CMTs to impoverished regions where there was no accommodation or transportation for the doctors, yet, these were areas that needed the services the most.<sup>1206</sup> Cooperation with multinational actors reinforced existing economic and social divisions, particularly between the urban industrial workforce and the rural agricultural workforce. Moreover, Tanzania's reliance on foreign assistance was perceived as a sign of weakness and dependency. Aid from China and Switzerland, for instance, included medical supplies and equipment that, once imported, often fell into disrepair due to the lack of local maintenance capabilities. This supports the fact that foreign aid was not as unconditional as it may have seemed; instead, it came with implicit conditions and long-term dependencies.

Nevertheless, Tanzania derived significant benefits from this aid and, at times, successfully navigated the political dynamics by asserting its agency, as demonstrated by the transfer of the Ifakara Health Institute to government control in 1978. Controlling the institute was the postcolonial government's way of localising transnational health interventions. In the area of maternal health, such dynamics were equally evident, where imported models of care, including family planning and insistence on institutional deliveries, were adapted or contested by local actors. Travelling theory helps us understand how these global health ideas were not simply imposed, but were reinterpreted within Tanzanian contexts, shaped by historical, political, and economic realities on the ground, as well as cultural and gendered aspects at the local level, as in the case of the Kilombero Valley.

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<sup>1206</sup> 'TNA/HEA/90/5/493 Technical Health Assistance China-A Record of the Meeting with the Chinese Medical Team Head on February 5, 1972'.

## CHAPTER 6:

### CONCLUSION: TOWARDS A HYBRID FUTURE OF HEALTH

In early 2025, I returned to Kilombero Valley for a follow-up fieldwork that I had begun in 2022 and continued into 2023, with intermittent periods away from the field during which I conducted archival research. I arrived in one of the villages in Mahenge, and there I encountered the news of a cholera outbreak. Later that week, I went back to Ifakara, 72 kilometres away. I visited a traditional midwife whom I had previously met in 2023. This time, I found her attending to a young woman who had brought her 7-month-old baby due to delayed milestones and persistent crying at night. In the midwife's diagnostic process, she inquired whether the mother had taken the child to the hospital. Upon hearing that she had taken the baby for biomedical checks, the midwife informed the mother that the child required a ritual treatment. Still, the ritual could not commence immediately until a boy, whose presence was essential for the ritual, was available. At the time, the boy was at school, so the mother and child were told to return later in the day.

Later that night in the town centre, the air was filled with the loud shouts of a street vendor selling various types of '*dawa ya mbu*' (which loosely translates to mosquito repellents). Malaria continues to pose a serious health threat. These three scenarios prompted me to question whether these are the kind of 'health futures' the post-independence government had envisioned to create when it committed to a modern, state-led health system aimed at reaching all Tanzanians in 1961. Such scenes serve as a reminder that, despite the ambitious health policies of the post-independence era and decades of international aid, access to reliable, equitable, and culturally resonant healthcare remains uneven, and health challenges and tensions persist in the present-day health landscape.

It is these tensions between past promises and unfolding realities that informed this study's central concern: how health futures have been historically imagined, planned, and shaped in Tanzania. Framed through the concept of future-making, the study traced the post-independence health-policy planning between 1961 and 1980. In pursuit of a healthier future, post-independence health policies in Tanzania were positioned as instruments for shaping and planning imagined futures. In doing so, the study has shown that these imagined health futures were neither linear nor purely technocratic, but rather shaped by hybrid practices that blended local knowledge systems with external models. The lens of hybridity demonstrated how traditional midwifery, herbal medicine, and modern biomedical systems coexisted and were negotiated. Drawing from postcolonial theory and the notion of travelling models, the study

further demonstrated that health planning in Tanzania was deeply influenced by the global circulation of ideas and aid, yet constantly reinterpreted through local contexts. At the same time, a political economy perspective revealed the material constraints, such as funding shortages, personnel gaps, and donor dependencies, that limited the implementation of ambitious health goals. Together, these frameworks offered a nuanced understanding of how health futures were imagined, adapted, and contested in Tanzania between 1961 and the 1980s.

The first two decades after independence were the ‘take-off’ period, very crucial in the formation of the newly independent state. Tanzania’s plans were initially stipulated in the 1961/1963 and the 1964-1969 development plans. Other plans were drawn in the 1970s, all aimed at a long-term plan extending up to 1980. Through these plans, Tanzania increased the number of medical practitioners and health facilities. However, challenges such as shortages in health personnel, infrastructure, and funding were present, and the rapid population growth further undermined some of the initial gains. In line with the arguments of Jennifer Whyte, Alice Comi, and Luigi Mosca, this study has demonstrated that future-making in Tanzania in 1961 was about ‘possibilities and probabilities’.<sup>1207</sup> Operating at the level of possibilities and probabilities complicated both the formulation and implementation of health policies.

With TANU, both the ruling party and the central actor in policy processes, policymaking increasingly became a political exercise shaped as much by ideological goals as by practical realities. While policy-making is not devoid of politics, excessive interference is also detrimental to the entire process. At the time under study, TANU, as the only party, decided and adopted uniform national strategies, many of which were later reversed, abandoned, or transformed when their shortcomings became apparent. The overpoliticisation of policy-making introduced a level of unpredictability, as decisions could easily be swayed by changing political agendas rather than being grounded in long-term planning. Some of the plans were only publicly announced, as was the case with the preventive versus curative health system, but never followed through to actualisation, which was determined by the political class.

While there was a notable increase in the number of health facilities and workers, the government’s health sector still suffered from many inadequacies. In the case of MCH, women continued to consult traditional midwives, while the government had assumed that increased health facilities would wean women off consulting the traditional midwives. However, the study characterises future-making as an uncertain, challenging, and often non-linear process, aligning with Theo Aalders and Detlef Müller-Mahn’s assertion that future-making constitutes ‘hard

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<sup>1207</sup> Jennifer Whyte et al., ‘Making Futures That Matter: Future Making, Online Working and Organizing Remotely’, *Organisation and Theory* 3, no. 1 (forthcoming), <https://doi.org/10.1177/26317877211069138>.

work'.<sup>1208</sup> Tanzania's quest for a healthy future demonstrates that future-making was not a one-time affair but a long, often rugged, process. Through policymaking and implementation, future-making involves competing needs and multiple actors. The health planning process was structured in a way that maternal health was just one of the many needs within the health sector. The competing needs led to disagreement over policies, as planning for one sector of the economy was not isolated from others, making the whole process layered and complex. Additionally, it was a simplistic assumption to assume that traditional health practitioners would be rendered useless by the availability of biomedical facilities. Future-making therefore proved to be 'pluralistic, radically open, and therefore contested',<sup>1209</sup> characterised by an open space, uncertainty, and unknown outcomes. The ideological change towards *Ujamaa* in 1967 is illustrative of the government's struggles in the first six years of independence.

Using maternal health as a case study, the research demonstrates that health policy in postcolonial Tanzania was both temporally and spatially constructed. Temporally, policymakers and international actors operated with overlapping yet sometimes conflicting horizons, balancing immediate post-independence needs with longer-term visions of a modern health system. Spatially, the reach of maternal health initiatives was uneven, often concentrated in urban or more accessible regions. At the same time, rural areas, such as Kilombero Valley, remained peripheral to the envisioned future of healthcare. Such regions continued to rely on voluntary agencies and transnational actors, as shown by the medical aid from Switzerland and China. These transnational connections were intended to improve the health sector; however, in most cases, they proved to be interventionist policies that not only did not transform the health sector as envisioned, but were also fundamentally grounded in hidden interests, scientific experimentation or achieving political ends as shown. Therefore, not much was changed on the ground. For example, just as Mao Zedong criticised the Ministry of Health in China for concentrating on urban problems in 1965,<sup>1210</sup> Tanzanian national policy continued to prioritise urban health.<sup>1211</sup> These dynamics illustrate how visions of progress were not universally applied or experienced, but somewhat shaped by shifting timelines, uneven geographies, and the complex interplay between global health agendas and local realities. It also demonstrated that donor aid is not a panacea for local health challenges, as donor countries themselves faced medical and economic difficulties at home.

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<sup>1208</sup> Aalders and Müller-Mahn, 'The Hard Work of Future-Making: Alienated Futures, Invisible Labour and Liberation'.

<sup>1209</sup> Ian Scoones, *Navigating Uncertainty: Radical Rethinking for a Turbulent World*. (Polity Press, 2024).

<sup>1210</sup> Sidel and Sidel Ruth, 'Healthcare Delivery System of the People's Republic of China'.

<sup>1211</sup> Heggenhougen et al., *Community Health Workers: Tanzanian Experience*.

Tanzania's post-independence health-policy planning, therefore, did not chart a straight path toward a fixed future. Health planning was a dynamic process shaped by shifting expectations, competing temporalities, spatial inequalities, and the influence of diverse actors. Rather than a singular vision, what emerged was a moving target, an evolving negotiation between global health agendas and national ambitions. Yet this very fluidity would have been used to enable a more inclusive approach that embraced a hybrid or synchronised medical system, deliberately integrating biomedical frameworks with local and indigenous knowledge systems. In Kilombero Valley, where traditional midwives and healers coexist with formal healthcare, such reconciliation was not only possible but also essential. However, the National Health Policy in Tanzania positioned traditional medicine as subordinate to biomedicine.

Planning for the future of health should recognise and legitimise the plurality of healing practices, rather than seeking to replace them. However, when efforts were made to engage with traditional medicine, they were narrowly focused on herbal remedies, aligning more with global interests, particularly those of the WHO in the 1970s, than with the broader realities of local health practices. This continued the colonial legacy of Western medicine's hegemony. Ian Scoones notes that, 'there are many examples of diverse intellectual and cultural traditions...It is perhaps a peculiar anomaly that...Western visions of modernity have ignored or suppressed uncertainty in the pursuit of a particularly narrow vision of "innovation" and "development"'.<sup>1212</sup> Examining health policy planning in Tanzania, the postcolonial state has, unfortunately, perpetuated this anomaly.

The postcolonial Tanzania health plans, therefore, often reflected the colonial high modernist strategy.<sup>1213</sup> This strategy aimed to disregard traditional medical knowledge and impose biomedicine as the sole best therapy, rather than an alternative or complement to local knowledge. The postcolonial state inherited the goal of 'civilising' the people from its colonial predecessor.<sup>1214</sup> Giving an example of *Ujamaa*, Scotts adds that it paid no attention to local knowledge, a notion that the traditional midwives in Kilombero reiterated.<sup>1215</sup> The government saw 'modern' health as the one in which women accessed maternal health services through hospitals or clinics. As a result, attempts by traditional health practitioners to modernise their practices struggled to gain recognition, reflecting on the challenges of top-down solutions, based on the assumption that the state inherently knew what was best for the population.

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<sup>1212</sup> Scoones, *Navigating Uncertainty: Radical Rethinking for a Turbulent World.*, 3.

<sup>1213</sup> Scott, *Seeing Like a State: How Certain Schemes to Improve the Human Condition Have Failed*, 3.

<sup>1214</sup> Scott, *Seeing Like a State: How Certain Schemes to Improve the Human Condition Have Failed*, 220.

<sup>1215</sup> 'Interviewee B (a Traditional Midwife), at Lipangalala, Ifakara', September 21, 2023.

Postcolonial health-policy planning in Tanzania was therefore primarily geared towards establishing a modern health system, which was interpreted as being mainly biomedicine-based. However, Tanzania would have significantly benefited from a more inclusive and hybrid approach, one that meaningfully engages local communities, national institutions, and transnational actors. While there was an attempt at hybridisation during the era of *Ujamaa*, challenges were witnessed. Village life, communal living and the calls for self-reliance brought hope for access to healthcare and water. *Ujamaa* sought to geographically consolidate populations to facilitate the government's provision of services. It was believed that *Ujamaa* would help combat the three enemies mentioned in the president's independence speech. However, the *Ujamaa* policy was seen as a failure and has been described as an 'experiment'.<sup>1216</sup>

The state at the centre of health planning and provision engineered many plans but often prioritised consolidating political legitimacy and securing international partnerships with external donor agencies, particularly through missionaries and later the WHO, UNICEF, IMF, and the WB.<sup>1217</sup> Health planning, therefore, became a negotiated space where diverse interests, ideologies, and practices intersected. Indeed, Kuhlmann et al. note that policy making and implementation are influenced by external factors, including political parties, interest groups, and bureaucratic agencies.<sup>1218</sup> In many cases, the people were ignored or came at the bottom of the hierarchy of health actors. The lack of deliberate integration between people and local knowledge, as well as external expertise, meant that the very people the policy aimed to benefit remained marginal in the decision-making process. A better nexus between these actors could have fostered a more effective and responsive health system.

Ultimately, this thesis posits hybridity as a generative force in postcolonial health governance, as demonstrated through Tanzania's Kilombero region, where the blending of local practices, state-sponsored medical interventions, and transnational influences shapes more equitable health futures. It shows how the present health plans and struggles reflect the past. Maternal health in Tanzania, for instance, is yet to achieve the goals that the Safe Motherhood Initiative (1987), the Millennium Development Goals (MDGs), or the Sustainable Development Goals had for MCH. The findings of this study challenge simplistic narratives of development success or failure and call for historically informed, context-sensitive approaches to health policy today.

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<sup>1216</sup> Freyhold, *Ujamaa Villages: Analysis of a Social Experiment*.

<sup>1217</sup> Kjell, *Tanzania The Limit to Development from Above.*, 19.

<sup>1218</sup> Kuhlmann et al., 'How Social Policy Travels: A Refined Model of Diffusion'.

Nevertheless, there is no absolute failure in policy planning and implementation.<sup>1219</sup> Even in cases of failure, projects were often viewed as well-meaning initiatives, despite many of their shortcomings being foreseeable.

By tracing maternal health and health-policy planning in postcolonial Tanzania, this study contributes to the broader histories of health in Africa, extending beyond the colonial era into the postcolonial state-making period. It offers a historical analysis of national health planning that engages with donor agendas, North–South, and South–South cooperation, and the broader frameworks of political economy and postcolonial studies. Ultimately, the story of maternal health in Tanzania is not only about the past; it is a reminder that colonial legacies, political and donor interests, continually shape the ‘futures’ for health. While improvements in health infrastructure and access have occurred, critical questions remain about the sustainability and equity of state-provided healthcare in the face of persistent structural inequalities and external influence. This study highlights that Tanzania’s health futures are being shaped by the policy frameworks established today. By reflecting on the postcolonial history of maternal health and planning, we are reminded that historical trajectories continue to inform—and in many ways determine—how health systems evolve.

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Allan McConnell, ‘What Is Policy Failure? A Primer to Help Navigate the Maze.’, *Public Policy and Administration* 30, nos 3–4 (2015): 221–42; Lindner, ‘Introduction: Failed Futures? (Post)-Colonial Planning and Future-Making in Tanzania’.

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Theresia Tamayamali, Lipangalala, September 21, 2023

Dr. Elisante Mchomvu, Galilaya, September 23, 2023

Dr Eliniache John, Mbasia Mlimani, September 24, 2023

Zuhura Said Hamisi, Lipangalala, September 21, 2023

Alice Fande, Lipangalala, September 21, 2023

Hamisi Kulengama, Lipangalala, September 21, 2023

Mzee George Mwambeta, Viwanja Sitini, September 20, 2023

Jisbert Aloyce Mchangeledi, Mang'ula, September 28, 2023

Margret Kindindi, St Francis Hospital Canteen, February 5, 2025

Ephrasia Melowi, Kidatu, October 2, 2023

Margret Naftali Kindasi, Kibaoni, September 25, 2023

Grace Nakuyoa at Kidatu, October 1, 2023

Mwalimu, Kidatu, October 2, 2023

Christina Isakwisa, Viwanja Sitini, Ifakara, September 20, 2023

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<sup>1220</sup> Luoneko Kaduma assisted me in conducting interviews during my fieldwork in Ifakara.

Binti Sambiliana at Mangula, September 28, 2023

Amina Omari Mangula, September 30, 2023

Father Luanda Vitalis at Tobora, Mahenge, February 6, 2025

Salum Ramadhan Mtunga, Mangula, September 28, 2023

Mtendaji wa Kijiji, at Msolwa *Ujamaa*, September 30, 2023

William Sudi, Msolwa Ujamaa, September 30, 2023

Interviewee F at Msolwa Ujamaa, September 30, 2023

Interviewee A (a retired Nurse), Viwanja Sitini, Ifakara, September 20, 2023.

Interviewee D (resident of Ifakara), September 25, 2023.

Interviewee B (a Traditional midwife), at Lipangalala, Ifakara, 21 September 2023.

Members of the Clergy, Kwirowa, February 7, 2025

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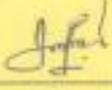
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## APPENDICES

### A. Research Permit

UNITED REPUBLIC OF TANZANIA	
MINISTRY OF EDUCATION, SCIENCE AND TECHNOLOGY	
TANZANIA COMMISSION FOR SCIENCE AND TECHNOLOGY	
	
	
<b>RESEARCH PERMIT</b>	
Permit No.	2022- 1010-NA-2022-093
Date issued	07 <sup>th</sup> December, 2022
Researcher's Name	Veronica Kimani
Nationality	Kenyan
Research Title	A History of Maternal Health and Policy Planning in Post-Colonial Tanzania, 1961 to 1980
Research Area(s)	Morogoro
Validity	From: 07 <sup>th</sup> December, 2022 to 05 <sup>th</sup> December, 2023
Contacts of local collaborator (with affiliated institution)	Dr. Musa Sadock, Department of History, University of Dar es Salaam P. O. Box 35050, Dar es Salaam, Tanzania Sadock.musa@udsm.ac.tz; <a href="mailto:musasadock478@gmail.com">musasadock478@gmail.com</a> +255754898751
 PROGRAM OFFICER	 FOR: DIRECTOR GENERAL
<b>IMPORTANT REQUIREMENTS</b>	
<ul style="list-style-type: none"><li>• A PI who wishes to continue with a research beyond the expiry date of the research permit should write to COSTECH two months before the operational permit's expiry date, to request for an extension or renewal of the permit.</li><li>• Research permit that involves collecting human, plant or animal materials / data that will be exported outside Tanzania must submit a signed Material Transfer Agreement (MTA), Data Transfer Agreement (DTA) between Tanzania host institution and the foreign counterpart. The MTA/DTA will indicate terms for collecting, storing/managing, transporting, disposal or returning of the materials/DATA to Tanzania after the closure of the research project.</li><li>• Any patent or intellectual property and royalty emanating from any research approved by the National Research Clearance Committee (NRCC) shall be owned as stipulated in the research proposals and in accordance with the IP policy of the respective research institutions.</li><li>• All researchers are required to report to a Regional Administrative Secretary (RAS) of the study area and present the introduction letter and activity schedule (plan) prior starting any research activity.</li><li>• All researchers are required to submit semi-annual, annual and final reports and all relevant publications made after completion of the research.</li><li>• All communications should be addressed to COSTECH Director General through <a href="mailto:clearance@costech.or.tz">clearance@costech.or.tz</a>; <a href="mailto:dg@costech.or.tz">dg@costech.or.tz</a> or +255 (022) 2700749; +255 (022) 2771358. Terms and conditions of the permit are found at <a href="http://www.costech.or.tz">www.costech.or.tz</a></li></ul>	
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