Chapter Two
Socialist Health System Practices in Tanzania, 1967–1995

2.1 Introduction

The preceding chapter hinted at the roles played by the South-South Cooperation (SSC) in promoting the production and circulation of medical knowledge and experiences within the Southern world. This chapter broadens the discussion and adds knowledge to studies on Tanzanian socialism by examining the influence of the Southern solidarity agenda on the diffusion of Chinese-related health policies in Tanzania. It identifies health policies the government learnt from China and assesses their practicality in a young and low-income country. The chapter discloses that from 1966 to 1977, the Tanzanian Ministry of Health (MoH) sent medical delegates to study China's health system. It illuminates that the practice of free healthcare, the institutionalization of traditional medicine, rural healthcare and the banning of private health services by the Tanzanian government were informed by the delegates' knowledge learned from China. Nevertheless, the chapter shows that colonial continuities marked some policies adopted. The government manipulated both colonial and Chinese health policies to make them fit into its social, economic and political plans. However, the economic crisis of the 1980s, which coincided with liberalization policies, affected the sustainability of the adopted socialist health policies. The chapter builds upon the argument that the adoption of Chinese health policies not only signaled that Tanzania was evolving toward the east but also manifested the resolve of Southern countries to encounter their social challenges by sharing knowledge and experiences among themselves.

2.2 Tanzanian Socialism: Learning from China?

Before 1967, the Tanzanian government had no clear ideology but positioned itself as a non-aligned country with neither capitalist nor socialist commitments. However, from the mid-1960s, the government adopted several policies connected to socialism. It introduced the Arusha Declaration in January 1967, which was endorsed by the National Executive Council (NEC) of Tanganyika African National

https://doi.org/10.1515/9783112206881-002

Union (TANU), the ruling party, in February 1967.[1] To implement socialist policies, TANU laid down the principles of socialism in its constitution. It denounced class differentiation and postulated that all human beings were equal and had rights to dignity and respect. Endeavoring to ensure economic justice, TANU welcomed the government's effective control over the major means of production.[2] Definitely, the policies of TANU and the Arusha Declaration defined the government's social, economic and political path, which spearheaded two main principles, "socialism" and "self-reliance." Under socialism, the Declaration ought to eliminate the exploitation of "man by man" and consolidate the government's control of major means of production. According to the principle of self-reliance, the government was diffident to foreign grants, loans, private investments, and other forms of assistance, driving it into a dependent state. At the same time, it encouraged self-help schemes and local resources as primary agents of development.[3]

Socialism, loudly pronounced after the Arusha Declaration, draws its background from TANU's pamphlet drafted by President Julius Nyerere in 1962. Nyerere endeavored to make socialism TANU's ideology and socio-economic policy that would underpin the government's activity.[4] Indeed, at first, the ideology was about Nyerere's thoughts, and he wrote almost all the theoretical papers and books. Thus, it took time for officials at different administrative levels, party leaders and citizens to understand and implement the policy accordingly.[5] Characteristically, socialism, famously known as *Ujamaa* in Tanzania, was meant to be "Tanzanian socialism." Adopting the Kiswahili word *Ujamaa* deliberately aimed

1 C. G. Kahama, T. L. Maliyamkono and Stuart Wells, *The Challenge for Tanzania's Economy* (Dar es Salaam: Tanzania Publishing House, 1986), 31.

2 URT, *The Arusha Declaration and TANU's Policy on Socialism and Self-Reliance (Dar es Salaam: Publicity Section* 1967), 1; Priya Lal, "Maoism in Tanzania: Material Connections and Shared Imaginations," in *Mao's Little Red Book: A Global History*, ed. Alexander C. Cook (New York: Cambridge University Press, 2014), 98.

3 URT, *The Arusha Declaration and TANU's Policy on Socialism and Self-Reliance*, 1–4; also see Rune Skarstein and Samuel M. Wangwe, *Industrial Development in Tanzania: Some Critical Issues* (Uppsala: Scandinavian Institute of African Studies, 1986), 6.

4 Julius. K. Nyerere, *Ujamaa: Essays on Socialism* (Dar es Salaam: Oxford University Press, 1968), 8.

5 Maximillian Julius Chuhila, "'To Plan is to Choose:' Navigating Julius Nyerere's Economic and Political Thoughts, 1961–1980s," in *From African Peer Review Mechanisms to African Queer Review Mechanisms? Robert Mugabe, Empire and the Decolonisation of African Orifices*, ed. Artwell Nhemachane and Tapiwa V. Warikandwa (Bamenda: Langaa Research and Publishing CIG, 2019), 381; Priyal Lal, *African Socialism in Postcolonial Tanzania: Between the Village and the World* (New York: Cambridge University Press, 2015), 30; Idrian N. Resnick, *The Long Transition: Building Socialism in Tanzania* (London: Monthly Review Press, 1981), 82–87.

to root its meaning in traditional conceptions. Nyerere insisted that it used the African word "*Ujamaa*" to emphasize the adopted policy's Africanness. The literal meaning of *Ujamaa* was "family-hood." According to Nyerere, "socialism" meant the art of living and working together for communal benefits.[6] He added that Tanzanian socialism was based on the pre-colonial past with its unique design. In his words: "We are not importing a foreign ideology into Tanzania and trying to smother our distinct social patterns with it. We have deliberately decided to grow as a society out of our own roots, but in a particular direction and towards a particular kind of objective."[7] From Nyerere's words, Tanzanian socialism was founded on certain characteristics of a traditional social organization.

Thus, the socialist policy adopted in 1967 extended and modified traditional social relations to meet life challenges in the twentieth-century world. Drawing from traditional social living patterns, Nyerere aimed to create something unique from the prominent socialist architects.[8] Scholars contested Nyerere's claims that *Ujamaa* was distinct from other forms of socialism practiced in Asia and Europe. J. L. Kanywany underscores that nothing was purely African about *Ujamaa* besides its linguistic expression. In his view, many of the statements in the manifesto were taken from Asian and European socialist convenors.[9] I extend this claim by showing how Nyerere adopted several ideas and practices from Maoism.

Tanzanian socialism was arguably founded on the view that capitalism was undesirable for the economic, social and political development of Tanzania and Africa, as, for instance, seen in the fact that there were few indigenous capitalists in independent African countries to conceive and maintain a capitalist economy. Nyerere opposed reliance on foreign capitalists to develop a capitalist economy in Tanzania, arguing that they would threaten African countries' sovereignty through unbearable conditions.[10] Unfortunately, a full-blown socialist state was also unattainable to low-income African countries. However, Nyerere was intrigued by Maoism, which, unlike Marxism-Leninism, maintained that the peasantry possessed socialist consciousness

6 Julius K. Nyerere, *Nyerere on Socialism* (Dar es Salaam: Oxford University Press, 1969), 28; "Mwalimu Defines Socialism," *The Nationalist*, August 28, 1967, 1; Paul Bjerk, *Building a Peaceful Nation: Julius Nyerere and the Establishment of Sovereignty in Tanzania, 1960–1964* (New York: University of Rochester Press, 2015), 98.

7 Julius K. Nyerere, *Freedom and Unity/Uhuru na Umoja: A Selection from Writings and Speeches* 1952–1965 (Dar es Salaam: Oxford University Press, 1966), 28.

8 Nyerere, *Nyerere on Socialism*, 28.

9 J. L. Kanywany, "Theoretical Problems of Ujamaa," in *Re-Thinking the Arusha Declaration* ed. Jeannette Hartmann (Copenhagen: Axel Nielsen and Son A/S, 1991), 45.

10 Severine M. Rugumamu, *Lethal Aid: The Illusion of Socialism and Self-Reliance in Tanzania* (Trenton, NJ: Africa World Press, 1997), 122–123.

and so were the revolutionary vanguard in pre-industrial nations rather than proletariats.[11] Furthermore, Nyerere argued that socialism – unlike capitalism – had roots in traditional African social organization. Nyerere envisioned that African countries would maintain self-reliance and develop human equality and dignity for all people through socialism.[12]

At the same time, the Tanzanian socialist ideology adopted many of its ideas from China. On his first visit to China in 1965, Nyerere was impressed by several observations, including the Chinese people's commune system, self-reliance, and frugality.[13] Nyerere visited China for the second time in 1968 and postulated that he had "come to China to learn [. . .]. The last three days have confirmed my conviction that we have a lot to learn from China."[14] Nyerere perceived China's social, economic, and political policies as a perfect path to sustainable development, arguing that other Southern countries should learn from China.[15]

Notwithstanding its immature economy, the Chinese government adopted a socialist policy soon after the 1949 Revolution. Contrary to the view that a full-blown socialist nation could not exist in low-income countries, the policy practice in China showed promising results and gave courage to other countries to follow suit. In his third trip to China in April 1974, Nyerere reaffirmed that the practice of socialism in China had inspired his regime. He argued:

> Two things convince me that socialism can be built in Africa and that it is not a Utopian vision. For capitalism is ultimately incompatible with the real independence of African states. The second thing which encourages me is China. It is because it appears to me that, among the millions of unique individuals in this society, there has been created a spirit of working together for the good of the community and the country. China is providing an encouragement and an inspiration for younger and smaller nations which seek to build socialist societies.[16]

11 Maurice Meisner, "Leninism and Maoism: Some Populist Perspectives on Marxism-Leninism in China," *The China Quarterly*, no. 45 (Jan.-Mar. 1971): 18.

12 Julius K. Nyerere, *The Rational Choice, a Speech Delivered on his behalf by the First Vice President Aboud Jumbe in Khartoum in the 1970s*, 3.

13 "Fast Growing Sino-Tanzanian Friendship: China Hails President Nyerere's State Visit," *Peking Review*, February 26, 1965, 7; Sebastian Edwards, *Toxic Aid: Economic Collapse and Recovery in Tanzania* (Oxford: Oxford University Press, 2014), 75; Martin Bailey, "Tanzania and China," *African Affairs* 74, no. 294 (Jan. 1975): 41.

14 "President Nyerere's Speech at the Farewell Banquet he Gave in Peking on June 21," *Peking Review*, June 28, 1968, 8.

15 "President Nyerere's Speech at the Farewell Banquet he Gave in Peking on June 21," *Peking Review*, June 28, 1968, 8.

16 "President Nyerere Ends Visit to China," *Peking Review*, April 5, 1974, 7.

The preceding expositions testify that Tanzanian socialism adopted some Maoist practices. Nevertheless, Nyerere denied these allegations, underscoring that the policy was based on the needs of the people, not on Chinese philosophy.[17] He added that claims of copying the policies from Moscow and Beijing subscribe to the view that Africa, and in this case, Tanzania, lacked agency and had nothing to contribute to the world and that all good things came from elsewhere. However, Nyerere admitted that adopting some ideas from other places was not a sin, provided that the government learned and proceeded to think and not to copy.[18] In 1974, when Nyerere visited China, he underscored that learning from China did not mean he would implement its policies uncritically. He told Mao Zedong: "We shall not flatter you by trying to make an exact copy of what we see. But I hope we shall be good pupils who learn and then apply their lessons to their own situation."[19] In this regard, Nyerere did not limit himself to the Chinese. Instead, he learned policies from China and other socialist and non-socialist countries and molded them to fashion "socialism with Tanzanian characteristics."

Subsequent sections discuss how Tanzania and China faced similar health challenges at independence. Both countries encountered medical dependencies, unequal provision of health services between the haves and the have-nots, rural and urban areas, and other social disparities. These commonalities allowed for the practical exchange of knowledge and experiences.

2.3 Free Healthcare, 1967–1988

Under the German and British colonial governments in Tanganyika, health services to the indigenous population were not provided free of charge, as patients in all hospital grades were required to pay for the service. In some instances, the colonial governments offered free healthcare to deprived communities. In most cases, colonial healthcare services were extended to only a few areas, preferentially in the production zones, settlers' habitations, and a few business towns and cities. Worse still, the services were racially segregated, Europeans enjoying first-class healthcare, Indians, Arabs and colored people the second, and Africans the third.[20] Thus, the post-colonial Tanzanian government inherited a capitalist-oriented healthcare system characterized by an unequal distribution and provision of healthcare services.

17 "Nyerere's Stress on Self-reliance," *The Nationalist*, April 9–15, 1967.

18 Nyerere, *Freedom and Unity/Uhuru na Umoja*, 47–48.

19 "Chairman Mao Meets Nyerere," *Peking Review*, March 29, 1974, 9.

20 Kjell J. Havnevick, *et al.*, *Tanzania: Country Study and Norwegian Aid Review* (Moss: A/S Repro-Trykk, 1988), 15.

Nevertheless, it did not promptly undo colonial health policies. Instead, it made some adjustments to accommodate patients with low income. For example, in 1962, the government issued hospital fees for patients attending government hospitals. The costs varied depending on the grades of hospitals. Grade I outpatients were charged Tshs. 20 per day, while grade III outpatients paid Tshs. 2. The government offered free health services to outpatients in Grade IV hospitals.[21]

Costs for inpatient services varied depending on the status of the hospital and grade. For instance, grade I inpatients admitted to Princess Margaret (now Muhimbili), Mount Meru (Arusha), and Tanga hospitals were charged Tshs. 60 per day, while grade I inpatients admitted to all other hospitals paid Tshs. 50 per day. Similarly, grade II inpatients admitted to the same hospitals mentioned above paid Tshs. 35 per day, while grade II inpatients admitted to all other hospitals paid Tshs. 30 per day. Such variances were not noticed in grade III inpatients since they all paid Tshs. 6 per three days in all hospitals. As it was to outpatients, grade IV inpatients received free healthcare in all hospitals.[22] Additionally, half the standard fee was charged for children under the age of 14. When the child was an infant so young that it was considered desirable on medical grounds to admit the mother also, a single fee at adult rates was charged. The antenatal registration fee for attendance at grade I outpatient sessions was charged Tshs. 60. The mentioned fee covered all the outpatient examinations and investigations.[23] Generally, the 1962 health policy brought slight changes to the delivery of health services in Tanzania. It gave grade IV patients, both inpatients and outpatients, a chance to get free health services in public hospitals and sections. However, the policy retained health service grades and fees as introduced by the colonialists. Offering health services in grades maintained social inequalities between the haves and the have-nots, which was inconsistent with the socialist policies.

While on his first visit to China in February 1965, President Nyerere was impressed by China's healthcare policies and devised a socialist approach to healthcare. After Nyerere's visit, the MoH set plans to learn more about China's health system, which, after its Great Proletarian Cultural Revolution, had made significant strides to ensure equality in healthcare service provisions. Thus, from 1966 onwards, the Tanzanian government sent a delegation of medical doctors to

21 The schedule did not include Grade II hospitals as they were discontinued. More information is available in "Government Hospital Fees, a General Notice, July 1, 1962," TNA. Acc. No. 450, Ministry of Health, File No. HEM/20/14, Private Practice Policy.

22 "Government Hospital Fees, a General Notice, July 1, 1962," TNA. Acc. No. 450, Ministry of Health, File No. HEM/20/14, Private Practice Policy.

23 "Government Hospital Fees, a General Notice, July 1, 1962," TNA. Acc. No. 450, Ministry of Health, File No. HEM/20/14, Private Practice Policy.

China for a study tour. Several aspects of the Chinese health policy, including free healthcare, enthused the delegates. The MoH considered free healthcare essential and consistent with the government's socialist policies.[24] Subsequently, after the Arusha Declaration, the country's national health policies emphasized the need to provide equitable and sufficient health services to all citizens. The socialist government perceived hospital fees as illegitimate since they consolidated social disparities and restrained access to healthcare services for low-income communities. Therefore, under Tanzania's socialist health system, the government provided free inpatient and outpatient clinical services in all government health facilities.[25] The Free healthcare maintained access to essential health services, enabling the country to have a healthy community and a serviceable labor force needed for national development.

Undeniably, free healthcare was burdensome to the Tanzanian government, which had to allocate sufficient funds to purchase and distribute medicines and medical equipment. From 1970 to 74, the health sector's share in the total government expenditure ranged from 6 to 6.9%. Initially, the government could afford the costs because the population was relatively small, not more than 13 million people. Yet, the increase in population raised costs for free healthcare. For instance, spending for the health sector rose to more than 7% of the total government expenditure from 1975 to 77, following the increase in population from 13.171 million in 1970 to 16.498 million in 1977 (Table 1). From 1978 to 1989, the government budget records show that the soaring population, which increased from 15.976 million in 1975 to 22.611 million in 1987, overwhelmed the government's ability to afford free healthcare. Its spending on the health sector fell from 7.1% in 1975/76 to 4.0% in 1987/88 (Table 1). The annual increase in population raised government expenditure to an unbearable burden, leading to the official discontinuation of the service in 1988. Other factors which crippled the country's ability to afford free healthcare services include high debts, droughts, decreased donor funding, diseases, oil crises, and devaluations.[26]

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24 Xiaoping Fang, *Barefoot Doctors and Western Medicine in China* (New York: University of Rochester Press, 2012), 29; "Mambo yalivyo Uchina," *Nchi Yetu Tanzania*, December, 1966, 22–23; URT, *The Arusha Declaration and TANU's Policy on Socialism and Self-Reliance*, 1; Interview with Joseph W. Butiku, 9th July 2018, Posta-Dar es Salaam.

25 Havnevick, *et al*., *Tanzania: Country Study*, 168.

26 See, for instance, T. L. Maliyamkono and M. S. D. Bagachwa, *The Second Economy in Tanzania* (London: James Currey, 1990), 4; Deborah Fahy Bryceson, *Liberalizing Tanzania's Food Trade: Public and Private Faces of Urban Marketing Policy, 1939–1988* (Mkuki na Nyota Publishers, 1993), 8; Benno. J. Ndulu and Charles K. Mutalemwa, *Tanzania at the Turn of the Century: Background Papers and Statistics* (Washington DC: The World Bank, 2002), 12; Rwekaza Mkandala, "From Proud Defiance to Beggary: A Recipient's Tale," in *Agencies in Foreign Aid*: *Comparing China, Sweden and the United States in Tanzania,* ed. Goran Hyden & Rwekaza Mkandara (London: MacMillan, 1999), 5.

Table 1: Government health expenditure, 1970/71 to 1989/90.

Year	Health Expenditure Tshs. (Mill.)	Health Expenditure as % of Total Expenditure	Population (Mill.)
1970/71	152	6.2	13.171
1971/72	159	6.2	13.602
1972/73	207	6.5	14.047
1973/74	294	6.5	14.506
1974/75	426	6.9	14.980
1975/76	425	7.1	15.976
1976/77	561	7.1	15.976
1977/78	646	7.3	16.498
1978/79	688	5.3	17.036
1979/80	721	5.0	17.507
1980/81	815	5.5	18.080
1981/82	992	5.4	18.658
1982/83	983	5.1	19.255
1983/84	1171	5.4	19.871
1984/85	1329	4.8	20.506
1985/86	2446	6.2	21.162
1986/87	2213	4.2	21.874
1987/88	3074	4.0	22.611
1988/89	5509	5.0	23.1
1989/90	6532	4.6	272.2

Source: Modified from Lucian A. Msambichaka *et al*., *Economic Adjustment Policies and Health Care in Tanzania* (Dar es Salaam: Dar es Salaam University Press, 1994), 95.

Such a decline exacerbated maternal mortality rates and diminished the availability of drugs and medical equipment in government-owned hospitals.[27] The government's failure pulled the country towards traditional lending institutions such as the World Bank and International Monetary Fund (IMF), which, among other conditions, required the government to reduce spending in the social sector, including health. For instance, in 1987, the World Bank advocated greater reli-

27 Angwara D. Kiwara, "Health and Health Care in a Structurally Adjusting Tanzania," in *Development Challenges and Strategies for Tanzania: An Agenda for the 21st Century*, ed. Lucian A. Msambichaka, Humphrey P. B. Moshi and Fidelis P. Mtatifikolo (Dar es Salaam: Dar es Salaam University Press, 1994), 281–282.

ance on user charges, insurance mechanisms, the private sector and administrative decentralization policies to overcome the crisis.[28]

The increasing pressure from donor countries, the World Bank, and the IMF prompted the Tanzanian government to launch a cost-sharing policy, which began its trial in 1988, with every outpatient paying Tshs. 20 in a single attendance at any public health center. However, its implementation brought several challenges, such as mishandling the collected dues in hospitals since medical workers lacked practical knowledge of financial management. Furthermore, low-income communities complained that they could not afford the proposed fees. These and many other reasons prompted the government to drop the fee shortly afterwards, stating that further research and analysis were needed to implement the policy effectively.[29] However, joint research conducted by Tanzanian medical experts and the Britain Development Agency in 1990 affirmed that Tanzanians were ready for a cost-sharing program. The people's readiness was rooted in their determination to see improvements in the delivery of healthcare services, due to the government's inability to finance healthcare services following the 1980s economic shortfall.[30]

Implementation of the cost-sharing policy resumed in 1993 when the government reintroduced health service grades (I, II, III, IV), which redefined the quality of the services, costs, and kinds of prospective patients. Undoubtedly, the grades sustained the colonial and pre-socialist social disparities, whereby patients with high, middle, and low incomes received health services of varying quality. High-income patients afforded costs charged at grades I and II, which were relatively higher for more sophisticated health services. For instance, upon its commencement, patients attending grades I and II paid a consultation fee of Tshs. 500 at referral, 300 for regional and 150 for district hospitals. Furthermore, grade I patients paid a hospitalization fee of Tshs. 2,000 at referral, 1,500 at regional, and 1,000 at district hospitals per patient daily. While grade II patients paid Tshs. 1,000 for the referral, 750 for regional hospitals, and 500 for district hospitals. The government anticipated that patients who demanded grade I and II services

28 "Dr Y. Hemed, Source of Health Revenue from People who are Willing to Pay," MRC. Acc. No. 30, File No. M.10/5, Ulipiaji matibabu General, 1996–2006; Issa G. Shivji, "Liberalisation and the Crisis of Ideological Hegemony," in *Re-Thinking the Arusha Declaration*, ed. Jeannette Hartmann (Copenhagen: Axel Nielsen and Son A/S, 1991), 135.

29 JMT, Wizara ya Afya, *Hotuba ya Waziri wa Afya Mhe. Amrani H. Mayagila, MB. Kuhusu Makadirio ya Matumizi ya Fedha kwa Mwaka 1993/94*, 53.

30 JMT, Wizara ya Afya, *Hotuba ya Waziri wa Afya Mhe. Amrani H. Mayagila, MB. Kuhusu Makadirio ya Matumizi ya Fedha kwa Mwaka 1993/94*, 53; Phares G. M. Mujinja and Tausi M. Kida, *Implications of Health Sector Reforms in Tanzania: Policies, Indicators and Accessibility to Health Services* (Dar es Salaam: The Economic and Social Research Foundation (ESRF), 2014), 1.

would eagerly accept the cost-sharing policy; as a result, they were the first to be touched by the policy on July 1, 1993.[31]

In contrast, middle-income patients attended mainly grade III health services, where the quality of the services was moderate, consistent with their costs. Patients in this category paid consultation fees for Tshs. 300 for referrals, 200 for regional hospitals, and 100 for district hospitals. Unlike grades I and II, grade III patients paid once for the hospitalization regardless of the days. For instance, they paid Tshs. 500 in referrals, 300 for regional and 150 for district hospitals. The cost-sharing for this category was effective in the second phase, commencing on January 1, 1994. Admittedly, grades I, II, and III accommodated fewer Tanzanians, primarily businessmen, political elites and a few groups of formal and informal employees. Most Tanzanians with low incomes attended grade IV health services, which offered cheap but poor services. The services for this category were mostly executed through health centers and dispensaries. Unlike grades I, II, and III, the government gave grade IV beneficiaries and service providers time to prepare for the cost-sharing scheme.[32] It took until 1996 that the government, through the Community Health Fund (CHF), encouraged villagers and other non-civil servants to join the prepayment scheme voluntarily. The scheme aimed to reach about 85% of the population living in rural areas and others outside the formal employment sector. Under CHF, household members paid a fixed annual fee to access the primary level of health facilities.[33]

Moreover, in 1999, the Tanzanian government introduced the National Health Insurance Fund (NHIF) to provide its recipients with quality healthcare. The early beneficiaries of the scheme were civil servants and their dependents, but it has recently become open to private membership. Under the NHIF, employees in the public formal sector contributed 3% of their monthly salary, and their employers matched the same. NHIF covered health costs for the principal member, spouse, and legal dependents up to four under eighteen years old. The actual execution of the Insurance was released in 2001. The MoH assured NHIF members that they would receive sustainable healthcare in all public hospitals and some privately-

31 JMT, Wizara ya Afya, *Hotuba ya Waziri wa Afya Mhe. Amrani H. Mayagila, MB. Kuhusu Makadirio ya Matumizi ya Fedha kwa Mwaka 1993/94*, 54–55.

32 JMT, Wizara ya Afya, *Hotuba ya Waziri wa Afya Mhe. Amrani H. Mayagila, MB. Kuhusu Makadirio ya Matumizi ya Fedha kwa Mwaka 1993/94*, 54–55.

33 Peter Kamuzora and Lucy Gilson, "Factors Influencing Implementation of the Community Health Fund in Tanzania," *Health Policy and Planning* 22 (2007): 95; Gemini Mtei and Jo-Ann Mulligan, "Community Health Funds in Tanzania: A Literature Review," *Consortium for Research on Equitable Health Systems* (January 2007): 1.

run hospitals.[34] However, the membership turnout has been less promising. Up to September 2018, the NHIF had registered approximately 7%, while CHF covered about 25% of the Tanzanian population, accounting for 32% of the population covered by both NHIF and CHF. The government used two-thirds of the revenues to purchase medicines, medical equipment and other health-related expenditures. However, the funds collected could not cover the Ministry's health budget, forcing the government to keep financing the health sector from internal and external sources.[35]

Nevertheless, from the 1990s to the present, the government offered free health services to children of 0 to 5 years, pregnant women (clinic and delivery), elders of 60 years and above, and patients with contagious diseases such as HIV and AIDS, cancer, TB, leprosy and sickle-cell anemia, regardless of their ability to pay.[36] Notwithstanding a few categories of people, for whom the government waived their hospital fees, the introduction of cost-sharing buried equality in the delivery of health services since people with low income were unable to afford the prescribed costs. Many turned to traditional medicine and church hospitals, which charged lower fees.[37] Generally, cost-sharing transferred the responsibility of the socialist government to a third party, dismantling the socialist health system, which lasted over two decades in Tanzania.

2.4 Institutionalization of Traditional Tanzanian Medicine, 1968–1990

Before the coming of Europeans to Africa and Tanzania in particular, Africans depended entirely on local methods of diagnosis and treatment of diseases. Even after European missionaries and colonial governments came to the continent, most Africans continued to rely on traditional medicine because modern curative facilities were inadequate, and many Africans considered traditional therapy

34 JMT, Wizara ya Afya, *Hotuba ya Waziri wa Afya Mhe. Dk. Aaron D. Chiduo, MB. Kuhusu Makadirio ya Matumizi ya Fedha kwa Mwaka 2000/2001*, 7.

35 "Principal Secretary, Ministry of Health, Wananchi Kuchangia Huduma za Jamii, Afya, Muhtsari wa Mapendekezo ya Viwango na Maeneo ya Kuchangia, July 1, 1993," MRC. Acc. No. 30, File No. M.10/1/3, Medical Policy and Instructions General, 1990–2004; URT, *National Health Insurance Fund (NHIF), First Quarter Fact Sheet, September 2018*, 3–4; Selemani Mbuyita and Ahmed Makemba, "Equity in Health in Tanzania: Translating National Goals to District Realities," *EQUINET Discussion Paper*, no. 54 (Dec. 2007): 6.

36 MT, Wizara ya Afya, *Hotuba ya Waziri wa Afya Mhe. Dk. Aaron D. Chiduo, MB. Kuhusu Makadirio ya Matumizi ya Fedha kwa Mwaka 1999/2000*, 19.

37 Maliyamkono and Mason, *The Promise*, 456.

methods more effective.[38] Biomedical practices did not fully dismantle traditional healing systems in Tanzania and Africa. Instead, local healers integrated several elements of biomedical practices, such as injections, which seemed helpful in curing ailments.[39] German and British colonialists recognized traditional health practitioners as health service providers. However, their services were strictly controlled and sometimes restricted over witchcraft accusations.[40] During the German colonial era, traditional medicine was open to practitioners with certificates indicating their locations of practice and the illnesses they treated. Through the British Medical Practitioners and Dentists Ordinance of 1929, the British colonial government permitted traditional health practitioners to practice in their communities, subject to permission from respective traditional authorities.[41] However, the government, through the 1928 Witchcraft Ordinance, prohibited healing systems which involved the so-called witchcraft practices, such as divination, considering them a threat to the colonial administration.[42] Nevertheless, they allowed the practices of healing systems that mainly utilized medicinal herbs, through which they assigned colonial botanists to examine the efficacies of

38 The WHO defines traditional medicine as the total of the knowledge, skill and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness. It uses mainly medicinal plants, mineral substances, and animal parts and relies exclusively on traditional healers to provide healthcare. While herbalism is the most common practice, it relies on divination and spiritualism. See, WHO, WHO Global Report on Traditional and Complementary Medicine, 2019, 8; M. Fawzi Mohomoodally, "Traditional Medicine in Africa: An Appraisal of Ten Potent African Medicinal Plants," Evidence-Based Complementary and Alternative Medicine, (December 2013): 1–3; "Letter from Chief Medical Officer, February 12, 1969 to all Regional Medical Officers, Research in Indigenous Systems of Therapeutic and Traditional Medicine," MRC. Acc. No. 13, File No. HE.11/86, Private Medical and Dental Practitioners, 1954–1972.

39 Megan Vaughan, *Curing their Ills: Colonial Power and African Illness* (Cambridge: Polity Press, 1991), 24.

40 Z. H. Mbwambo, R. L. A. Mahunnah and E. J. Kayombo, "Traditional Health Practitioner and the Scientist: Bridging the Gap in Contemporary Health Research in Tanzania," *Tanzania Health Research Bulletin* 9, no. 2 (May 2007): 117.

41 Torunn Stangeland, Shivcharn S. Dhillion and Haavard Reksten, "Recognition and Development of Traditional Medicine in Tanzania," *Journal of Ethnopharmacology* 117 (2008): 294; Rogasian L. A. Mahunnah, Febronia C. Uiso and Edmund J. Kayombo, *Documentary of Traditional Medicine in Tanzania: A Traditional Medicine Resource Book* (Dar es Salaam: Dar es Salaam University Press, 2012), 45.

42 Simeon Mesaki, "Witchcraft and the Law in Tanzania," *International Journal of Sociology and Anthropology* 1, no. 8 (December 2009): 134; Stacey A. Langwick, *Bodies, Politics, and African Healing: The Matter of Maladies in Tanzania* (Bloomington, IL: Indiana University Press, 2011), 45–46.

herbal medicine used by local practitioners and recommend them for use in European pharmacology.[43] On the one hand, the colonial government controlled the practices of local healing systems for their ends. Still, on the other hand, the permission granted to local herbalists played a role in developing traditional medical knowledge during colonization, thus laying the ground for its flourishing during the post-colonial period.

Notwithstanding the practicality and acceptability of traditional medicine in the pre-colonial and during the colonial periods, the independent Tanzanian government did not promptly promote the practice of traditional medicine. It neither coordinated nor linked the activities of traditional health practitioners with organized health services.[44] However, after the Arusha Declaration of 1967, the government began to promote the use of traditional medicine to maintain its endurance amid the spread of biomedicine. The government encouraged local healing practices to rescue a health sector nearly overwhelmed by the country's soaring population and disease burden amid its drive to extend healthcare to all. Moreover, under the self-reliance policy, the government anticipated promoting the practice of traditional medicine to reduce dependence on biomedicine. More importantly, severe reliance on imported biomedicine seemed to bolster the wealth of countries of the Global North. Thus, the country's weak economy made biomedicines too expensive to import.[45]

The 1968 symposium on African Medicinal Plants, held in Senegal, attended by Tanzanian officials, exemplified the need to promote traditional African medicine. The attempts, however, were inspired by the Chinese model, which, from the mid-1950s and through its 1958 Great Leap Forward and the 1966 Great Proletarian Cultural Revolution, compelled experts to integrate traditional medicine with biomedicine into the healthcare system and erase non-scientific (old-fashioned) traditional Chinese medicine practices, such as belief in voodoo and sorcery.[46] The Chinese government established schools and colleges that offered traditional medicine students' teachings and training. In 1955, it institutionalized

43 Langwick, *Bodies, Politics, and African Healing*, 53.

44 Richard M. Titmuss, Brian Abel-Smith, George Macdonald, Arthur W. Williams, and Christopher H. Wood, *The Health Services of Tanganyika: A Report to the Government* (London: Pitman Medical Publishing, 1964), 72.

45 Mahunnah, Uiso and Kayombo, *Documentary of Traditional Medicine in Tanzania*, 18; Langwick, *Bodies, Politics, and African Healing*, 9–10.

46 For further details, see Chapter 3 in Kim Taylor, *Chinese Medicine in Early Communist China, 1945–63: A Medicine of Revolution* (New York: RoutledgeCurzon, 2005) 30–62; Chien Hsin-chung, "Chinese Medicine: Progress and Achievements," *Peking Review*, February 28, 1964, 18; John Iliffe, *East African Doctors: A History of the Modern Profession* (Cambridge: Cambridge University Press, 1998); Iliffe, 211.

traditional medicine and established the Academy of Traditional Chinese Medicine, currently called the China Academy of Chinese Medical Sciences (CACMS). The CACMS played a vital role in adding scientific value to traditional Chinese medicine through medical research and training.[47] Formally trained traditional health practitioners covered the needed medical personnel gap, reducing mortality and morbidity, raising life expectancy, and successfully eradicating the most troubling diseases in China.[48]

The Tanzanian government admired China's achievements over a short period and took several initiatives to learn from them. The 1966 delegation of the MoH recommended, among others, the institutionalization and use of traditional medicine in hospitals parallel to Western biomedicine. Lucy Lameck, also a delegate, was impressed with the use of traditional Chinese medicine parallel to biomedicine. She said: "I visited one hospital and saw many boxes full of medicinal herbs. I was further surprised to see patients prescribed to take traditional medicine in government dispensaries and hospitals."[49] The Chinese government pledged to boost traditional medicine knowledge to practitioners and researchers in Tanzania to ease its integration with biomedicine.[50]

The Chinese model prompted Tanzania's MoH to institutionalize and integrate traditional medicine with biomedicine. In 1968, the government legally recognized and began to move towards integrating traditional and biomedicine. The Medical Practitioners and Dentist Ordinance of 1968 recognized the existence of traditional health practitioners and their right to practice traditional medicine.[51] Yet, not all healers were legally allowed to practice their services. Instead, the government sustained the 1928 Witchcraft Ordinance and prohibited healers whose medical practices invoked supernatural powers. In such contexts, the gov-

47 "Taarifa Fupi ya Safari ya Jamhuri ya Watu wa China, 16–23 Julai 2006," NRC. Ministry of Health and Social Welfare, 14/7/01, File Ref. No. BC. 74/544/01, Technical Aid China 2005–2008, 7; Ling Yang, "Training Medical Workers," *Peking Review*, November 13, 1964, 23.

48 "Report on Visit of Ministry of Health Delegation to the People's Republic of China, September 1977," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China.

49 My translation from Kiswahili in "Mambo yalivyo Uchina," *Nchi Yetu Tanzania*, December 1966, 22–23.

50 "Mambo yalivyo Uchina," *Nchi Yetu Tanzania*, December, 1966, 22–23; also see China's commitment in "China's Obligation to Small Nations," *The Nationalist*, June 30, 1967, 8.

51 Traditional medicine practitioners in Tanzania comprise herbalists, ritualists, spiritualists, and midwives. See, for instance, Harald Kristian Heggenhougen, "Health Services: Official and Unofficial," in *Tanzania Crisis and Struggle for Survival*, ed. Jannik Boesen, Kjell J. Havnevik, Juhani Koponen, and Rie Odgaard (Uppsala: Scandinavian Institute of African Studies, 1986), 312; Vaughan, *Curing their Ills*, 60; URT, *Medical Practitioners and Dentists Ordinance (Amendment) Act, May 1968*.

ernment's legal system did not accept divination, perceiving it as chaotic and a threat to the nation's peace, security, and development.[52] These attempts imply that the Tanzanian government, like the British colonial government, endeavored to differentiate "witchcraft" practices from healing and magic.

The legal recognition of the local health system eased the establishment of the first National Union of Traditional Healers (UWATA) in 1971. The Union was a valuable forum for medical knowledge exchanges and cooperation among practitioners. Furthermore, through UWATA, the government monitored the activities of traditional health practitioners to enhance their effectiveness.[53] The government allowed practices of local healing systems prone to registering with the MoH at their respective district offices. Through their registration forms, healers recorded the places where they intended to work, the kinds of diseases they cured, and the commitment that their therapies did not involve so-called witchcraft.[54] The registration helped the government control their services and record its statistics.

Nevertheless, the recognition was negatively perceived by conventional doctors who mistrusted the ability and effectiveness of traditional health practitioners. Conventional doctors opposed the ministry's call for cooperation between traditional and conventional health practitioners.[55] The increasing mistrust between the two groups of health service providers was a challenge and an opportunity for the scientific development of traditional medicine. The ministry made several attempts to "modernize" the activities of traditional health practitioners through scientific research. In 1969, it launched research on traditional medicine that involved contacting famous local traditional African doctors and recording their methods of practice in accurate detail. The government research team also carried out a chemical analysis of herbs used in treatment by traditional health practitioners and conducted clinical trials for selected treatment methods.[56] The government's coordination of traditional medicine research was an emancipatory attempt, giving freedom to traditional health practitioners who had been offering

52 Mesaki, "Witchcraft and the Law in Tanzania," 132.

53 Mahunnah, Uiso and Kayombo, *Documentary of Traditional Medicine in Tanzania*, 7; Ann Beck, "The Traditional Healer in Tanzania," *A Journal of Opinion* 9, no. 3 (Autumn 1979): 4.

54 Langwick, *Bodies, Politics, and African Healing*, 39.

55 Mbwambo, Mahunnah and Kayombo, "Traditional Health Practitioner and the Scientist," 117; Elizabeth Karlin Feierman, "Alternative Medical Services in Rural Tanzania: A Physician's View," *Social Science Medicine* 15B (1981): 400.

56 "Letter from Chief Medical Officer, February 12, 1969, to all Regional Medical Officers, Research in Indigenous Systems of Therapeutic and Traditional Medicine," MRC. Acc. No. 13, File No. HE.11/86, Private Medical and Dental Practitioners, 1954–1972.

their services in the dark corners due to intimidation by religious leaders and government authorities.[57]

Initiatives in scientific research, institutionalization, and integration of traditional medicine with biomedicine made a breakthrough in 1974. During this period, the government launched a Traditional Medicine Research Unit (TMRU) at the University of Dar es Salaam's Faculty of Medicine of Muhimbili Medical College. The TMRU, which became an Institute of Traditional Medicine (ITM) in 1991, strived to put biomedically efficacious herbal medicines for use by conventional and traditional health practitioners.[58] It played a role in identifying useful health practices that could be adopted and *materia medica*, which could be modernized and developed into drugs for human use. Furthermore, the institute was determined to disentangle pre-colonial and colonial ways of communicating traditional medicinal knowledge, which mainly relied on informal training and inheritance, by establishing formal training for traditional medicine practitioners. Subsequently, it offered short and long training courses on traditional medicines to facilitate the improvement of knowledge, skills, and practice by various stakeholders in traditional medicine development and drug discovery.[59] These roles show that the institute internalized elements of biomedicine within its training, research and general practice, consistent with its endeavor of turning traditional medicine more scientific (Figure 1). Activities of the ITM and the whole institutionalization process leaned on herbal medicines compatible with scientific methods compared to other local healing systems that invoke supernatural powers.

From its inception, the institute conducted systematic studies and research on the plants suitable for making drugs for human use. The MoH anticipated that the research carried out by the institute would promote the development and use of traditional medicine as a substitute for imported drugs.[60] Besides medical research, the institute held scientific proof of medicines produced by traditional health practitioners to ensure their safety for human consumption and improve their practices, turning it into a credible scientific cure. The institute regularized

57 "Traditional Medicine: Will the Medicine Man Regain his Lost Honour?" *The Nationalist*, June 30, 1971, 4.

58 "Traditional Medicine Research Unit, Report from 1974–1982," TNA. Acc. 450, Ministry of Health, File. No. HEO.10/4A, Traditional Medicine Research Unit, 1979–83.

59 Interview with Rogasian L. A. Mahunnah, 21 July 2018, Tabata Kisiwani, Dar es Salaam; "Traditional Medicine Research Unit, Report from 1974–1982," TNA. Acc. 450, Ministry of Health, File. No. HEO.10/4A, Traditional Medicine Research Unit, 1979–83.

60 "Tenth Anniversary of Muhimbili Medical Centre," *Daily News*, August 3, 1987, 5; Interview with Professor Rogasian L. A. Mahunnah, July 21, 2018, Tabata Kisiwani, Dar es Salaam; Modest C. Kapingu, June 8, 2018, Institute of Traditional Medicine (ITM), Dar es Salaam.

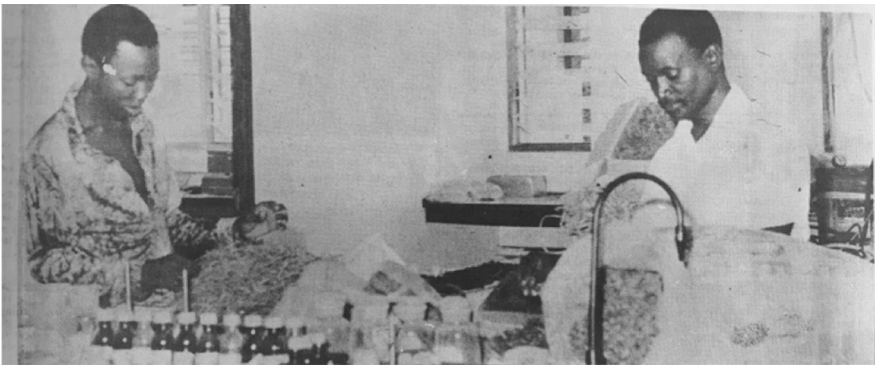

Figure 1: Phytopharmacological screening of various herbs at TMRU, 1985. Source: "Herbs Enter Conventional Medicine," *Sunday News*, July 28, 1985, 5 (printed with permission).

the activities of the practitioners without depriving them of their medical knowledge and social functions.[61]

The establishment of the TMRU eased the exchange of traditional medical knowledge between practitioners in China and Tanzania. On December 13, 1962, the two countries signed the Cultural Agreement, in which they agreed to exchange experiences in modern and traditional medicine.[62] However, it was not until the 1970s, after the Tanzanian government established TMRU, that the medical knowledge exchanges were realized. The exchange of practitioners and other medical stakeholders became a reality through the launch of the Sino-Tanzanian Joint Project on Traditional Medicine. Between 1974 and 1975, the joint research team collected samples of over 1,000 herbs used by traditional healers in Tanzania (Figure 2).[63] In 1977, traditional medicine researchers from ITM took over the research project and collected about 2,500 specimens of medicinal plants. Some specimens tested in the laboratory were efficacious, and researchers endorsed them for clinical trials.[64] In January 1983, the Faculty Board of Medicine and Senate of the University of Dar es Salaam approved further collaboration agreements

61 Morice Maunya, "Traditional Healers now in Mainstream Health Services," *Daily News*, February 28, 1991, 5; Beck, "The Traditional Healer in Tanzania," 4.

62 Read, for instance, Article 6 in URT, *Cultural Agreement Between the Government of the United Republic of Tanzania and the Government of the People's Republic of China, 1962*, 3.

63 Economic Commission for Africa, *Chemical Industry Development Programme: Report of the First ECA/UNIDO Chemical Industry Development Programme Mission, May-October 1978*, 113; Langwick, *Bodies, Politics, and African Healing*, 62.

64 "Amend your Laws on Medicine, Africa Told," *Daily News*, September 30, 1977, 3; also see "Tenth Anniversary of Muhimbili Medical Centre," *Daily News*, August 3, 1987, 5.

with training and research centers in China. These agreements, spanning six key areas, hold significant potential for the future of plant-derived pharmaceuticals in Tanzania. They included training and knowledge exchange on phytochemical and pharmacological screening of medicinal plants, production technology of plant-derived pharmaceuticals, and ethnobotanical and botanical garden preparations, deepening the Sino-Tanzanian traditional medicine knowledge exchange.[65]

In the 1980s, with the government's and donors' support, TMRU established botanical gardens in the Arusha, Tanga, Kilimanjaro, and Coastal regions. These gardens were among the initiatives and a strategic move to grow medicinal and aromatic plants to produce pharmaceuticals and cosmetics. The extensive cultivation of these plants was meticulously scheduled to ensure a steady supply of raw materials to the government-owned Keko Pharmaceutical Industries, which was expected to extract, distillate, and percolate the plants and finally produce medicines for human use.[66] However, the production of plant-derived pharmaceuticals ended in futility. TMRU failed to secure outlets for the products, presumably due to the non-existence of a clear-cut national policy on the production and utilization of plant-derived pharmaceuticals, collapsing the project in the 1990s.[67]

Besides the shortfalls, initiatives favoring the use of traditional medicine in parallel to Western biomedicine showed promising results. The ITM endorsed efficacious medicines for use in hospitals alongside modern medicine, and about seven types of herbal drugs were expected to be ready for use in hospitals by 1985.[68] Moreover, in 1990, the institute conducted research on traditional medicine capable of treating diabetes, malaria, asthma, ulcers, and HIV. Among the eight traditional medicines observed, one was found to control diabetes effec-

65 "Letter from the TMRU by E.N. Mshiu, Director of TMRU, to the Embassy of the United Republic of Tanzania in Beijing, China, dated 20 January 1983, titled Collaboration with Chinese Institution on Traditional Medicines Research," TNA. Acc. 450, Ministry of Health, File. No. HEO.10/4A, Traditional Medicine Research Unit, 1979–83.

66 "Ministry of Industries and Trade, Meeting on Plant Derived Pharmaceuticals Held at Keko Pharmaceutical Industries Limited 12th October 1984," TNA. Acc. 450, Ministry of Health, File. No. HEO.10/4A, Traditional Medicine Research Unit, 1979–83.

67 TNA. Acc. No. 638, Chemical Industries, File No. KPI/5, Keko Pharmaceutical Industries Ltd., 1991, Company Plan, 38.

68 The seven herbal drugs included *Azadirachta indica* – a popular herb locally known as *Mwarobaini* – used for treating malaria and fever, *calendula officinalis* with a potential for treating stomach pains, *cinchona succirubra* used for the preparation of quinine and chloroquine drugs for malaria cases, *cynara scolymas* for containing blood vein problems, *digitalis lanata* for heart ailments, *saponaria officinalis* and *tagets patula* for treating blindness, see "Herbs Enter Conventional Medicine," *Sunday News*, July 28, 1985, 5; "Local Herbs Usable in Hospitals," *Daily News*, March 21, 1987, 3; Langwick, *Bodies, Politics, and African Healing*, 62.

Figure 2: Ibrahim Mapembe (first left), a Tanzanian traditional healer, explains to Chinese doctors how he treats patients and the herbs he uses for treatment (1975). Source: "Traditional Healers and 'Health for All,'" *Sunday News*, February 19, 1984, 8 (printed with permission).

tively, while others were found to cure chronic malaria and ulcers.[69] Surely, achievements reached by the ITM brought hope and relief as the availability of more local medicine would ease the burden on the government, which spent a considerable amount of foreign currency to import drugs. Above all, the discovered local medicines were significant in curbing the dominance of biomedicine in healthcare and, therefore, a promising step toward self-reliance.

From 1974 to 1990, the MoH vigorously coordinated and gave prominence to the ITM's activities and services over traditional health practitioners' services. Such a context created the impression that the government had abandoned the practitioners and disvalued their services. It further generated numerous complaints from traditional health practitioners, who demanded more support and consideration from the MoH.[70] Fortunately, in February 1991, the MoH considered their demands and took several initiatives to coordinate their activities.

69 JMT, Wizara ya Afya, *Hotuba ya Waziri wa Afya Mhe. Prof. Philemon M. Sarungi, MB. Kuhusu Makadirio ya Matumizi ya Fedha kwa Mwaka 1992/93*, 40; Interview with Febronia C. Uiso and Edmund J. Kayombo, June 8, 2018, Institute of Traditional Medicine (ITM), Dar es Salaam.
70 Interview with Edmund J. Kayombo, June 8, 2018, Institute of Traditional Medicine (ITM).

Among other things, it formally included traditional healers into its mainstream health services. The Minister for Health, Professor Philemon Sarungi, said: "I am here to announce to you [traditional medicine practitioners] that you are now a fully recognized sector, and my Ministry is now working to chart out guidelines and policies under which your activities would be coordinated nation-wide."[71] Before the official recognition, traditional practitioners worked individually, and the MoH did not effectively coordinate the services offered with the rigor needed to prevent and heal diseases. Since the 1990s, the government made more tangible attempts to promote the use of traditional medicine parallel to biomedicine. The ITM owed to the support it received from the Chinese government. In 1991, the Minister for Health acknowledged the support and affirmed that Tanzania was making headway on her research in traditional medicine because of the assistance it received from the Chinese government.[72]

The institutionalization of traditional medicine pleased many Tanzanians who trusted traditional medicine more than biomedicine. The available research illuminates that many patients went to hospitals or clinics as a last resort after traditional medicine had failed. Additionally, about 60% of the urban population and over 80% of the rural population in Tanzania rely on traditional medicine. Moreover, traditional health practitioners in Tanzania enjoyed a much more agreeable ratio of patients they attended to than biomedical doctors. The ratio of traditional health practitioners was 1:500 patients while that of biomedical doctors was 1:25,000 by 2012.[73] These glimpses imply that traditional medicine contributed significantly to the development of primary healthcare in Tanzania. They further demonstrate that the effective use of traditional medicine was vital for developing local medical knowledge, a key factor to attaining medical self-sufficiency.

2.5 Rural Healthcare, 1969–1980

At the time of its independence, rural healthcare services in Tanzania faced significant challenges. The 1964 Titmuss report showed that there were two to three trained doctors for every 100,000 people in rural areas by 1963. The report recommended that the post-colonial government prioritize staffing rural health centers to fight diseases effectively, curb rural-urban migration, and hasten agricultural

71 Maunya, "Traditional Healers now in Mainstream Health Services," 5.
72 "Sarungi Praises Chinese," *Daily News*, September 7, 1991, 3.
73 Mahunnah, Uiso and Kayombo, *Documentary of Traditional Medicine in Tanzania*, 8.

production, which was the backbone of the country's economy.[74] However, it was not until the Arusha Declaration of 1967 that the Tanzanian government took the rural healthcare agenda seriously, entrenching it in the concept of "socialism and rural development."[75] Its rural healthcare policy mirrored that of China, which took serious measures to improve rural healthcare services after the start of the Great Proletarian Cultural Revolution in 1966. Following the Revolution, crowds of urban medical and health workers nationwide were sent to rural areas to deliver medical care to peasants and workers. For instance, by 1973, the Chinese Ministry of Public Health reallocated more than 100,000 medical workers to rural areas.[76] Similarly, at independence, Tanzania had more than 90% of rural dwellers who depended on agricultural activities for survival. The government noticed that investing in rural healthcare was crucial for improving the lives of rural communities and the country. Consequently, Tanzania's economic destiny depended heavily on peasants, the primary food and cash crop producers. To promote peasants' production, the government, among others, extended health services to their vicinity.[77] Rural health services, therefore, constituted a crucial investment consistent with Nyerere's commitment to socialism and rural development and his bio-political endeavor. The state anticipated that people would produce more if they were energetic and healthier.

The Tanzanian government approached the rural healthcare program through a three-tier structure of personnel and facilities, consisting of village health posts, dispensaries, and health centers. It considered villages to be the basic unit of the healthcare system. Thus, it placed prime importance on village healthcare. Nevertheless, the delivery of healthcare in rural areas was challenging. The main hurdles were rooted in the structure of the villages themselves. Rural communities were scattered, and the voluntary concentration of scattered homesteads, administered in 1963 by the Rural Settlement Commission, was not progressing well. Up to 1965, only about 3,400 families resided in the newly established villages.[78] Despite such noticed failure, the government found it necessary for people to live in organized settlements to facilitate rural development. Nyerere argued: "We shall not be able to use

74 See, for instance, Chapter 5 in Titmuss, Abel-Smith, Macdonald, Williams, and Wood, *The Health Services of Tanganyika*, 106–107.

75 Resnick, *The Long Transition*, 192.

76 Zhou Xun, *The People's Health: Health Intervention and Delivery in Mao's China, 1949–1983* (Chicago: McGrill-Queen's University Press, 2020), 192–193; Xiaoping, *Barefoot Doctors*, 37; Wu, "For Workers, Peasants and Soldiers," 10.

77 Wilson Kaigarula, "Taking Health Services to the People," *Daily News*, March 6, 1979, 4.

78 Idriss S. Kikula, *Policy Implications on Environment: The Case of Villagization in Tanzania* (Dar es Salaam: Dar es Salaam University Press, 1997), 21.

tractors; we shall not be able to build hospitals or have clean drinking water; it will be quite impossible to start small village industries without a rural population living in villages."[79] The government perceived villagization as the only feasible means of reaching economic and social development.

Bringing together previously scattered communities heightened after the Arusha Declaration, where, through the Cooperative Societies Act of 1968, the government encouraged the registration of the newly established settlements as *Ujamaa* villages. Such attempts persuaded some communities to relocate to established villages, reaching approximately 300,000 people in about 650 villages by 1969. However, the pace was below the government's expectations. Thus, through the President Circular No. 1 of 1969 and the Presidential Decree of 1973, resettlement became compulsory, while the government applied both coercive and persuasive means to make sure that all families resided in *Ujamaa* villages by the end of 1976.[80] These attempts increased the pace of communities residing in the established *Ujamaa* villages. Up to 1983, about 35% of the rural population lived in established *Ujamaa* or developed villages where the government extended its health services.[81] Coercive measures led to a violent confrontation between villagers and the campaign teams in several places in the country. Such confrontation prompted numerous critics from human rights defenders and scholars who claimed that the campaign led to dehumanization and the declining rural economy throughout the 1970s.[82] Despite the odds, the villagization campaign was an essential means of putting communities together to facilitate the provision of social services. This view implies that the campaign brought hardships and opportunities to the rural communities.

The government development plans were structured according to the rural healthcare program. For example, the Second Five Year Development Plan stressed preventive health services through the agency of rural health centers. The government anticipated establishing health centers throughout the country. It aimed to attain the ratio of one health center to every 50,000 people. With this

79 Kikula, *Policy Implications on Environment*, 14.

80 Kikula, *Policy Implications on Environment*, 22; URT, *Second Five-Year Plan for Economic and Social Development July 1, 1969–June 30, 1974, Volume I: General Analysis, 1969*.

81 "World Drug Market Manual, November 19, 1982," TNA. Acc. No. 450, Ministry of Health, File No. HE/H/30/7A, Primary Health Care.

82 Read, for instance, Maxmillian J. Chuhila, "Agrarian Change and Rural Transformation in Tanzania: Ismani, circa 1940–2010," *UTAFITI* 14, no. 1 (2019): 13; Andrew Coulson, *Tanzania a Political Economy* (New York: Oxford University Press, 1982), 168–176; also see James C. Scott, *Seeing Like a State* (London: Yale University Press, 1998), 223–261; Yusufu Q. Lawi, "Tanzania's Operation Vijiji and Local Ecological Consciousness: The Case of Eastern Iraqwland, 1974–1976," *The Journal of African History* 48, no. 1 (2007): 73.

target, the government needed to establish 240 health centers to meet the demands of the whole country. Besides supervising dispensaries in their respective areas, health centers organized preventive campaigns, such as nutrition education, environmental sanitation, maternal and child health services and immunization.[83] Under the Second Plan, the government further proposed establishing enough rural dispensaries as it endeavored to reach a ratio of a single dispensary to every 10,000 people. The government achieved its target by increasing development capital in the health sector from 2.2% allocated in the First Five Year Development Plan to 8% in the Second Five Year Development Plan.[84] The government plans were realistic since the budget for the Ministry of Health increased from Tshs. 8,538,000 in the 1971/72 financial year to Tshs. 14,198,000 in 1973/74. While in 1971, there were about 87 rural health centers, by the end of 1973, the number of centers increased to 135. Likewise, the number of dispensaries rose from 1,445 in 1971 to 1,594 in 1973.[85]

Furthermore, in the 1977/78 financial year, the government allocated Tshs. 15,800,000 to complete new rural health centers and dispensaries in different regions of Tanzania. The allocated funds were additional to Tshs. 18,590,000, spent in the 1976/77 financial year for the same purpose. The government's target was to establish at least 10 to 15 rural health centers and 40 to 50 dispensaries annually.[86] The 1970s and 80s were economically challenging periods for the Tanzanian government. The country experienced droughts, the oil crisis and a war fought with Uganda; thus, it spent much on purchasing imported foodstuffs, oil, and weapons. Despite the mentioned challenges, the government was devoted to improving health services, particularly in rural areas. Subsequently, it directed more funds to rural healthcare. Table 2 shows that between 1971 and 1980, the government's shares in rural health services rose from 20% to 42%. The government's commitment to allocating more funds for rural healthcare aimed to meet deliberations by its Second Five Year Development Plan, where it anticipated to establish about 80 rural health centers in various districts of Tanzania.[87] Despite

83 URT, *Second Five-Year Plan for Economic and Social Development, July 1, 1969–June 30, 1974, Volume II: The Programmes, 1969*, 101.

84 URT, *Second Five-Year Plan for Economic and Social Development, July 1, 1969–June 30, 1974, Volume I: General Analysis, 1969*, 162–164.

85 Julius Nyerere, *President's Report to the TANU Conference, September 1973*, 16.

86 "Big Cash Set Aside for Rural Health," *Daily News*, July 13, 1977, 1.

87 "Letter from the Office of Chief Medical Officer, Ministry of Health and Social Welfare, June 30, 1971, to all Regional Medical Officers, Rural Health Centres 1969/74," TNA. Acc. No. 450, Ministry of Health, File, No. HEH/41/4, Rural Health Centres, Ulanga District; Dominicus and Akamatsu, "Health Policy and Implementation in Tanzania," 199; Gerardus Maria van Etten, *Rural Health Development in Tanzania: A Case-Study of Medical Sociology in a Developing Country* (Assen: Van Gorcum, 1976), 43–44.

the evidence that the government allocated considerable funds for rural healthcare, the actual implementation of the program needed more funds, medicines, medical equipment, and personnel, which were not adequately available. Such inadequacies curtailed the sound achievements of the project.

Table 2: Budget allocation ratio between rural and urban healthcare.

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

Source: Created by the author based on data from Dominicus and Akamatsu, "Health Policy and Implementation in Tanzania," 199.

The establishment of the rural health posts and dispensaries went hand in hand with the staffing program. At independence, most rural health posts in Tanzania lacked trained medical personnel. Such a situation, too, existed in China. At liberation, China had only about 20,000 doctors trained in Western medical schools who mostly worked in urban areas. Its villagers depended mainly on traditional Chinese medicine practitioners.[88] After the Revolution, Chairman Mao strategized to improve health facilities throughout the country while prioritizing rural areas where most people lived. With the engagement of Mao's regime, it took about three years to implement a rural healthcare policy where staff and facilities in rural areas were improved, inspiring other countries of the Global South, such as Tanzania, to follow suit.[89]

Borrowing a leaf from China, the Tanzanian government established the Village Health Care Scheme in 1969. The scheme, famously known as the "First Aid-Kit Scheme," was run by Village Medical Helpers (VMHs) and aimed to provide healthcare to villages without health centers since the colonial era. Through village health posts, the scheme intended to obviate the need for people to travel more than 20 to 30 miles to seek health services. Moreover, village health posts anticipated a considerable reduction in the number of outpatients attending for

88 Chien, "Chinese Medicine: Progress and Achievements," 18.

89 "Report on a visit of Ministry of Health delegation to the People's Republic of China, September 1977," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China.

comparatively trivial ailments at regional and district hospitals. It further aimed to get enough health practitioners to address village health challenges. Through the scheme, the government aimed to have at least two VMHs (one male and a female) in each village. Local administrations employed VMHs who worked for their respective ethnic groups or belonged to the same ethnic group as the area in which they were to be employed. By 1974, the government had trained 2,218 VMHs, who were working in villages throughout the country.[90] Generally, VMHs supplemented long-trained medical staff who were fewer in number to cater to the needs of the government.

The name "village medical helpers" was analogous to the British colonial "tribal dressers" of 1925 and the Chinese "barefoot doctors" (*chìjiǎo yīshēng*) of 1965 in structure and practice.[91] Findings from the present study show that the Tanzanian government utilized both experiences it learned from the British and the Chinese. The delegates from MoH sent to China for a study tour learned that the Chinese government improved its healthcare services by providing short-term training programs to lower medical cadres, enabling the country to record 4,000,000 barefoot doctors up to 1977.[92] Chinese achievements in staffing rural health centers were, therefore, admired and adopted by the Tanzanian government.

The VMHs scheme trained lower medical personnel. The training was elementary and chiefly confined to treating common local diseases. District medical officers (DMOs) were responsible for executing the training program.[93] The

90 "WHO, National Health Planning in Tanzania: Report on a Mission, August 1, 1973–April 28, 1974," WHOA, File No. TAN/SHS/002, 1972–1974-SHS/NHP, National Health Planning, 8; "Letter from the Principal Secretary, Ministry of Health, August 25, 1977, to all District Executive Directors of Tanzania, Mpango wa Huduma za Afya Vijijini," NRC. RAS-DOM 9/5/06, File Ref. No. M. 10/19 Medical Including Health Village Dispensaries, 1965–1982; Christopher Magola, "Accent on Rural Health," *Daily News*, December 4, 1982, 6; also see Kaigarula, "Taking Health Services to the People," 4.

91 The British tribal dressers scheme was initially introduced by the British Director of Medical and Sanitary Services, Dr J. O. Shircore, in 1925. The scheme trained mainly lower medical personnel assigned to address common local diseases in their respective villages. The term "barefoot doctors" came from Southern farmers who often worked barefoot in the rice paddy fields. The government recruited a lower medical cadre from a group of youths who received minimal training in treating minor illnesses, immunization, environmental sanitation, and other preventive services. See Xiaoping, *Barefoot Doctors,* 31.

92 "Mambo yalivyo Uchina," *Nchi Yetu Tanzania*, December 1966, 22–23; "Report on a visit of Ministry of Health delegation to the People's Republic of China, September 1977," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China.

93 "Letter from the Principal Secretary, Ministry of Health, August 25, 1977, to all District Executive Directors of Tanzania, Mpango wa Huduma za Afya Vijijini," NRC. RAS-DOM 9/5/06, File Ref. No. M. 10/19 Medical Including Health Village Dispensaries, 1965–1982.

course lasted a minimum of three months. The training sessions were held in their respective districts and regional hospitals. Training for VMHs included lectures on basic anatomy and general medicine subjects, mother and child welfare, the village government's political structure, health posts management, environmental sanitation, food and nutrition, and knowledge of undesirable customs and beliefs that had a bearing on village health.[94] The government expected that trainees would be able to deal effectively with the average assortment of rural sick and would do a certain amount of treatment of minor ailments, render first aid, and act as collecting agents for the hospitals.[95] Furthermore, VMHs had to provide minimal preventive and curative services to the villages without a dispensary or health center and connect their respective villages to the official chain of referrals if more skilled services other than simple village-based ones were required. The government smoothed the effective delivery of health services to the trainees by equipping them with first-aid kits containing drugs for common health cases such as malaria, diarrhea, and other tropical diseases. They also received basic medical equipment, including a complete delivery kit, a scalpel with a blade, scissors, a dressing, forceps, a gallipot, and a kidney dish.[96]

Like the British tribal dressers and China's barefoot doctors, the selection of the VMHs involved local administration, which was their primary employer. However, the post-colonial Tanzanian government improved the selection process by training village leaders regarding rural healthcare and their roles as employers of the VMHs. The village leaders consulted villagers and recommended four names (two males and two females). Eligible persons were required to be permanent residents in the village, liked and respected by all, married or owned a durable house and farm in the village, married and living together with a spouse, aged between 25 and 45 years, and a diligent member of the Tanganyika African National Union (TANU).[97] Additionally, applicants were required to hold a minimum standard of primary education. Primary school graduates with suffi-

94 "Letter from District Medical Officer of Mbozi District to the Regional Medical Officer, January 2, 1971, Village Helper Course," MRC. Acc. No. 13, File No. HE.11/1, Rural Medical Aids General, 1971–1980; Christopher Magola, "Programme Brings Health Care to Rural Folk's Door," *Daily News*, March 5, 1987, 4; Magola, "Programme Brings Health Care to Rural Folk's Door," 4.

95 Magola, "Programme Brings Health Care to Rural Folk's Door," 4.

96 "Letter from the Office of the Principal Secretary, May 19, 1983, to the Programme Officer, UNICEF, First Aid Kits for Village Health Workers," TNA. Acc. No. 450, Ministry of Health, File No. HE/H/30/7A, Primary Health Care.

97 "F. D. E. Mtango, Helena Restrepo, K. G. M. M. Alberti, O. Dale Williams, S. Dodu, Tanzanian Integrated Non-Communicable Diseases Prevention and Control Studies, Report of a Review of Activities, Geneva, Switzerland, August 17–19, 1983," TNA. Acc. No. 450, Ministry of Health, File No. HE/H/30/7A, Primary Health Care.

cient knowledge and ability to read and write well in Kiswahili and a working knowledge of English were considered a priority. To commit VMHs to the service, the government demanded that they fill in agreement forms, committing them to serve the village for at least five years after completing their training.[98]

Most of the criteria used by the post-colonial Tanzanian government to admit eligible candidates for the VMHs program resembled those used by the British colonial government. Similarly, the criteria resembled and differed from those used to select barefoot doctors in China. For instance, the Chinese government considered trainees with secondary school certificates. Such a qualification allowed trainees to advance their medical education and get promoted to village medical doctors. In the 1980s, when the scheme collapsed, some barefoot doctors went for further training and became village medical doctors.[99] The selection of secondary school graduates would not work in colonial and post-colonial periods in Tanzania since there were few secondary school graduates.[100] As a result, the British recruitment system, which the post-colonial Tanzanian government embraced, limited further training to VMHs and left them jobless after the program's decline.

Like the British tribal dressers, the VMHs scheme acquainted trainees with notions of biomedicine. Such a training system contrasted with that in which the Chinese prepared trainees in both biomedicine and traditional Chinese medicine. The Chinese training system aligned with the Maoist policies, which stressed integrating biomedicine and traditional medicine in healthcare.[101] Archival records show that before the opening up of dressing stations in colonial Tanganyika, biomedicine was prevalent in only a few towns.[102] Therefore, dressing stations

98 Magola, "Programme Brings Health Care to Rural Folk's Door," 4; for the British Tribal Dressers, see "Letter by the Director of Medical Services to the Provincial Commissioner of the Southern Highlands Province, Mbeya, January 3, 1937," TNA. Acc. No. 450 Ministry of Health, File No. 209/1, Instructions for Tribal Dressers; "F. D. E. Mtango, Helena Restrepo, K. G. M. M. Alberti, O. Dale Williams, S. Dodu, Tanzanian Integrated Non-Communicable Diseases Prevention and Control Studies, Report of a Review of Activities, Geneva, Switzerland, August 17–19, 1983," TNA. Acc. No. 450, Ministry of Health, File No. HE/H/30/7A, Primary Health Care.

99 Daqing Zhang and Paul Unschuld, "China's Barefoot Doctor: Past, Present, and Future," *The Lancet* 372, (November 29, 2008): 1866.

100 More details about Tanzania's education situation read Kahama, Maliyamkono and Wells, *The Challenge for Tanzania's Economy*, 23.

101 Xiaoping Fang, "Changing Narratives and Persisting Tensions: Conflicts Between Chinese and Western Medicine and Professional Profiles in Chinese Films and Literature, 1949–2009," *Medical History* 63, no. 4 (2019): 463.

102 "Organisation of Rural Medical Work in the Western Province," TNA. Acc. No. 450, Ministry of Health, File No. 209/7, Tribal Dressing Stations and Government Rural Dispensaries-Tabora District.

played a vital role in popularizing biomedicine in the interior of Tanganyika. Similarly, the negligence in training VMHs in traditional Tanzanian medicine played a role in popularizing biomedicine in rural areas.

The post-colonial Tanzanian government was dedicated to promoting preventive healthcare. Under its First Five-Year Development Plan of 1964 to 1969, the government prioritized preventive and curative measures. It realized that many health challenges were preventable, prompting its stress on vaccination and health education. Accordingly, the MoH circulated knowledge on the significance of wearing shoes, digging and using latrines, and paying proper attention to nutrition and cleanliness.[103] Thus, VMHs were effectively used to transmit preventive knowledge to villagers, consistent with the Chinese scheme, which also circulated preventive medical education through barefoot doctors.[104]

The British tribal dressers and the Chinese barefoot doctors worked in simple health units erected by villagers with minimal government assistance.[105] Likewise, through its district and village officers, the post-colonial Tanzanian government organized villagers to establish simple buildings and used them as village health posts. The Presidential Circular No. 2 of 1968 subjected all minor community development projects such as schools, dispensaries, community centers, teachers' houses and the like to a "self-help scheme." The government supported self-help projects with technical advice, roofing materials, pipes, and other forms of capital assistance.[106] At the same time, the village community furnished village health posts with simple facilities such as a table and chairs. Moreover, village governments covered travel costs for the helpers to enable them to travel to health centers and collect drugs and equipment. Additionally, the village governments exempted the helpers from other village development activities, such as

103 "Budget Speech by Minister for Health, June 1965," TNA. Acc. No. 589, Orodha ya Majalada ya Mtu Binafsi, Bhoke Munanka, File No. BMC. 10/03, Speeches of Ministers and Junior Ministers, 6.

104 Zhang and Unschuld, "China's Barefoot Doctor," 1866; "F. D. E. Mtango, Helena Restrepo, K. G. M. M. Alberti, O. Dale Williams, S. Dodu, Tanzanian Integrated Non-Communicable Diseases Prevention and Control Studies, Report of a Review of Activities, Geneva, Switzerland, 17–19 August 1983," TNA. Acc. No. 450, Ministry of Health, File No. HE/H/30/7A, Primary Health Care.

105 "An Inspection Report by Sd. B. A. Coghlan, Medical Officer, Musoma to the Director of Medical Services, of February 21, 1935," TNA. Acc. No. 450 Ministry of Health, File No. 209/1, Instructions for Tribal Dressers, Revised Edition; "Report on a Visit of Ministry of Health delegation to the People's Republic of China, September 1977," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China.

106 "The State House, Presidential Circular No. 2 of 1968, Self-Help Schemes, August 24, 1968," TNA. Acc. No. 593, Orodha ya Majalada Idara ya Habari, File No. IS/P/120/59, Distribution of Press Releases, 1963–1970.

road construction, cultivating *Ujamaa* farms and the like, to enable them to deliver medical services effectively.[107]

VMHs received monthly allowances from their respective village government councils, similar to the British tribal dressers and Chinese barefoot doctors. In China, for instance, barefoot doctors were paid by the people whom they served. In some places, barefoot doctors received a peasant's share, just like other peasants working on farms, while in other provinces, the residents of each commune paid one to two yuan per year as an allowance for the doctors. Thus, patients received clinical care free of charge. Under this system, China had two groups of medical workers: the ones who were paid by the government and those who were paid by communes, which reduced the central government's expenditure and enhanced people's access to healthcare.[108] Though details showing the monthly allowances received by VMHs are missing, village governments were obligated to enforce fee collection and indeed saw to it.[109]

Investments in rural healthcare required both political will and financial ability. Political elites in Tanzania were determined to see the rural healthcare scheme succeed. However, the country's ill economic situation was the main hindrance. The Tanzanian government requested and received support from different donors to address the financial deficit. Although China influenced the Tanzanian government to establish a village healthcare scheme, funding did not flow from China in significant amounts. Instead, the scheme was backed by the Basel Foundation for Aid to Developing Countries and other traditional donors of the Global North. The Basel Foundation provided 1,000,000 Swiss francs for the construction of buildings and the Rural Aid Centre (RAC) equipment at Ifakara in 1961. It also donated 200,000 francs annually to run the course and to develop and maintain the center.[110] The RAC trained low medical cadres, such as rural medical aids and assistant medical officers. However, following the government's needs for VMHs, it adjusted its training to meet the demand.[111] The United Nations

107 "Letter from the Head of the Department, Mvumi Hospital to Village Chairmen and Chair Health Committee, Mpango Kuhusu Wahudumiaji wa Afya Vijijini (Village Medical Helpers)," November 2, 1977," NRC. RAS-DOM 9/5/06, File Ref. No. M. 10/19 Medical Including Health Village Dispensaries, 1965–1982.

108 "Report on a visit of Ministry of Health delegation to the People's Republic of China, September 1977," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China.

109 Magola, "Programme Brings Health Care to Rural Folk's Door," 4.

110 Rudolf Geigy, "Rural Medical Training at Ifakara: Swiss Help to Tanzania," *The Lancet* 285, Issue, 7400 (June 26, 1965): 1385–1386.

111 Lucas Meier, "Striving for Excellence at the Margins: Science, Decolonization, and the History of the Swiss Tropical and Public Health Institute (Swiss TPH) in (Post-) Colonial Africa, 1943–2000" (PhD diss., University of Basel, 2012), 171.

International Children's Emergency Fund (UNICEF) and the Swedish International Development Cooperation Agency (SIDA) also sponsored the program. The Swedish government, for instance, signed an agreement in May 1973, committing to donate 35 million Swedish kronor to Tanzania's disposal to support the development of rural health services during the fiscal years 1972/73 to 1976/77.[112] Furthermore, village medical helpers received bicycles, medicines and medical equipment from the central government, but provided by UNICEF as grants.[113] Bicycles helped them to reach many rural patients on time.

Despite the order from Health Minister Ally Hassan Mwinyi in 1972, directing medical graduates to work in rural dispensaries, unfavorable living and working conditions dissuaded many candidates.[114] Therefore, up to 1977, VMHs dominated healthcare delivery in rural health posts, while most medical graduates worked in towns and cities. This context created the impression that medical staff with short training were destined for rural areas, while qualified medical doctors were assigned to towns and cities.[115] In September 1977, the Minister for Health, Leader Stirling, issued another order to force medical graduates to work in rural areas for some years before they apply for re-allocation to towns and cities.[116] Subsequently, many doctors were relocated to rural areas in response to the Ministry's order (Table 3). The Ministry's decisions were consistent with the recommendations made by delegates from the MoH who went to China for a study tour. The delegates realized that by 1965, the Chinese government mobilized thousands of Chinese doctors from towns and cities and reallocated them to rural areas to prevent diseases, treat people, and transmit preventive health education to rural communities. These delegates recommended that the government improve living and working environments to convince medical graduates to work in rural health facilities.[117]

112 "Rural Health Programme, Terms of Reference for Review, 1976–77," NRC. RAS-DOM 9/5/06, File Ref. No. M. 10/19 Medical Including Health Village Dispensaries, 1965–1982.

113 "UNICEF, Plan of Operations for Development of Public Health Services (DPHS) in the United Republic of Tanzania, Interim Addendum for Development of Basic Health Services, July, 1991," WHOA, File No. TANZANIA/UNICEF-5, 1968–1972-SHS, Development of Public Health Services; "Letter from the Principal Secretary, Ministry of Health, August 26, 1976 to Development Directors, Mtawanyo wa Kwanza kwa Wahudumiaji wa Afya Vijijini," NRC. RAS-DOM 9/5/06, File Ref. No. M. 10/19 Medical Including Health Village Dispensaries, 1965–1982.

114 "Madaktari wafike pia Vijijini," *Uhuru*, July 15, 1972, 1; Heggenhougen, "Health Services: Official and Unofficial," 310.

115 Interview with Gallus Namangaya Abedi, June 6, 2018, Posta-Dar es Salaam.

116 "Doctors to Work in Rural Areas," *Daily News*, September 30, 1977, 5; also see Kaigarula, "Taking Health Services to the People," 4.

117 "Report on a visit of Ministry of Health delegation to the People's Republic of China, September 1977," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China.

Table 3: Distribution of medical workers between urban and rural areas.

Year	1972	1976	1978	1980
Doctors				
Urban	418	487	513	598
Rural	216	399	479	547
Nurses				
Urban	2606	2760	2868	3570
Rural	1653	2060	3322	4705
Medical Auxiliaries (MAs* & RMAs*)				
Urban	208	456	624	910
Rural	605	1363	2166	2800

Source: Modified from Heggenhougen, "Health Services: Official and Unofficial," 310.

** MAs stands for Medical Assistants and RMAs for Rural Medical Aids.

The government's decision to force medical graduates to work in rural areas was intended to level the unequal distribution of medical workers in rural and urban areas, as shown in Table 3. From the colonial to the post-colonial periods, urban dwellers, who constituted less than 10% of the population, enjoyed a more sophisticated healthcare service. At the same time, the remaining majority endured inadequate health services with short-term trained medical personnel.[118] Before government efforts to prioritize rural healthcare, the national health system was structured like a pyramid, with well-equipped hospitals, research centers, specialist doctors, and auxiliary medical facilities in big cities. At the bottom, however, several districts, each with district hospitals and health centers, lacked basic facilities. Consequently, achieving equitable healthcare required the MoH's commitment to reconsidering how its limited resources could better serve rural areas.

Despite its merits, the VMH scheme faced several problems, such as inadequate funding from local authorities (employers), which threatened its survival. Some village governments did not provide monthly allowances and other incentives to VMHs. The lack of allowances and incentives influenced some VMHs to seek potential jobs in towns. The 1988 MoH evaluation report shows that about

118 Kaigarula, "Taking Health Services to the People," 4.

12% of VMHs left their jobs.[119] Moreover, village health posts lacked adequate medicines and medical equipment, especially from the end of the 1970s and 1980s when the economic crisis severely hit the country.[120] Additionally, some rural communities mistrust the health services offered by VMHs. Gallus Namangaya Abedi asserts that some villagers were worried when they were approached by a helper dressed in trousers and a shirt rather than the crisp white coats worn by doctors. Similarly, they were shunned and isolated from the learned medical staff, who perceived them as incompetent cadres, discouraging VMHs' healthcare delivery.[121] Consequently, from the 1980s and 90s, the VMHs scheme lost its relevance since it lacked effective management and community support. Like China's barefoot doctors, the cost-sharing policy, which emerged in the 1990s, buried the VMHs scheme in Tanzania. The free healthcare services provided by VMHs declined. Thus, a few remaining VMHs turned to other professions.[122]

The rural healthcare scheme became the cornerstone of the international Primary Health Care (PHC) conference held at Alma-Ata (Almaty), Kazakhstan, in September 1978. The conference made a declaration to meet the health needs of people worldwide. The declaration identified VMHs as one of the foundational cornerstones of having a comprehensive PHC, a program that would be a global strategy for achieving "Health For All" by 2000.[123] Tanzania was in an advantageous position since, even before the Alma-Ata conference, it had already in place a well-structured healthcare system from the grassroots level for more than a decade. With such initiatives, the WHO commended the country for having one of the most thoughtfully designed health systems based on human equality and the foundations of justice.[124] The "Health For All" agenda aligned with Tanzania's so-

119 "PHC Coordinating Section, Ministry of Health, A Briefing on PHC Programme for the Italian Delegation Visiting Tanzania, October 15, 1983," TNA. Acc. No. 450, Ministry of Health, File No. HE/H/30/7A, Primary Health Care; JMT, Wizara ya Afya, *Hotuba ya Waziri wa Afya Mhe. Prof. Phillemon M. Sarungi, MB. Kuhusu Makadirio ya Matumizi ya Fedha kwa Mwaka 1991/92*, 17.

120 Michele Barry and Frank Bia, "Socialist Health Care in Tanzania: A View from Kilimanjaro Christian Medical Centre," *Annals of International Medicine* 104, no. 3 (1986): 438; Heggenhougen, "Health Services: Official and Unofficial," 311.

121 Interview with Gallus Namangaya Abedi, June 6, 2018, Posta-Dar es Salaam; "E. J. I. Kato, Assessment of Village Health Workers' Diagnostic and Treatment Capabilities in Selected Villages in Maswa District, Tanzania, Faculty of Medicine, University of Dar es Salaam, February 28, 1983," TNA. Acc. No. 450, Ministry of Health, File No. HE/H/30/7A, Primary Health Care, 3.

122 For barefoot doctors, read Zhang and Unschuld, "China's Barefoot Doctor," 1866; for cost-sharing policy in Tanzania, read JMT, Wizara ya Afya, *Hotuba ya Waziri wa Afya Mhe. Amrani H. Mayagila, MB. Kuhusu Makadirio ya Matumizi ya Fedha kwa Mwaka 1993/94*, 54–55.

123 WHO, *Primary Health Care: Report of the International Conference on Primary Health Care, Alma-Ata, USSR, September 6–12, 1978*, 61–62.

124 Rose Kalemera, "Well Done Tanzania, Says WHO Chief," *Daily News*, July 27, 1987, 1.

cialist policies adopted during the Arusha Declaration of 1967 and the ruling party's ideology of 1971. Socialist principles spearheaded the equality of all individuals and the preservation of life and health, which were also included in the Alma-Ata declaration. The PHC program, which the MoH implemented after the Alma-Ata conference, incorporated more than 2000 VMHs working throughout the country.[125] The preceding assertions imply that the Tanzanian government practiced the "Health For All" agenda before the 1978 conference. Nevertheless, after the Alma-Ata conference, it reviewed and updated its healthcare delivery system to conform to the PHC.

2.6 Banning Private Health Services Practice, 1977–1992

Although the Tanzanian government vowed to maintain equality among its citizens in accordance with socialist ideology, it retained the 1958 private practice policy endorsed by the British colonial government. The policy left room for the private domiciliary practice, consulting practice and special procedures.[126] Under private domiciliary practices, a patient could attend government-owned or private health centers. The policy allowed people and organizations to own and practice private hospitals. There were a few private health service centers during the British colonial period, but their number exploded after independence. For instance, by 1973, there were about 32 private health centers in Dar es Salaam alone, many owned by Tanzanians, Indians and the British. Private institutions were also established in the up-country areas and were mainly owned by Indians, Tanzanians, Italians, British, Kenyans, Australians, Pakistanis, and Swiss.[127] Thus, private health services functioned in parallel with government-owned hospitals. Above all, while the number of health facilities under private practitioners was lower than that of institutions provided by the government, their doctors accounted for almost half of the total number of doctors in the country (Table 4). For instance, in 1961, there were 419 registered doctors in the country, of whom

125 "J. A. S. Mahalu, Primary Health Implementation in Tanzania," TNA. Acc. No. 450, Ministry of Health, File No. HE/H/30/7A, Primary Health Care: International Conference on Primary Health Care, Declaration of Alma-Ata, Alma-Ata, USSR, 6–12 September 1978; "Applied Village Health Worker Research and Evaluation Project in Tanzania, September 1983," TNA. Acc. No. 450, Ministry of Health, File No. HE/H/30/7A, Primary Health Care.

126 "Medical Department, Private Practice secular of 1958," TNA. Acc. No. 450, Ministry of Health, File No. HEM/20/14, Private Practice Policy.

127 "List of Private Practitioners in Tanzania-Mainland," TNA. Acc. No. 450, Ministry of Health, File No. HEM/20/14, Private Practice Policy.

about 239 were in government service, while 180 were in private practice.[128] This context indicates that patients attending private health services would likely to receive more effective healthcare than those who attended government services.

Private practitioners spread primarily in towns and cities, widening the gap in medical services between urban and rural dwellers. People in urban areas enjoyed efficient health services from the government and private practitioners. Since profit maximization was the determining factor in establishing private practices, towns and cities were preferred over rural areas. Private practices paid high wages to their medical workers, attracting more medical graduates. In 1973, a medical officer started at TShs.1,840 a month and could not earn more than TShs.3,200, far below parastatal and private salaries or the incomes of less-qualified senior officers elsewhere in government. By 1973, nearly 50 Tanzanian Asian doctors had left government service and often the country, while several senior African doctors were moving to private practice.[129] Amon Nsekela and Aloysius Nhonoli write that out of 30 dentists, only ten worked in government or volunteer agencies.[130]

The survival of private practitioners under the socialist regime was uncertain. In the 1970s, the Tanzanian government realized private practitioners were inconsistent with its socialist ideology. Therefore, in 1977, the parliamentary procedures for banning the practice of private health services were tabled. Recommendations made by delegates of medical workers who went to China for a study tour backed the ban agenda. The delegates learned that under socialist policies, the Chinese government had prohibited private practitioners.[131] The recommendations were an eye-opener to political elites as they realized that ten years after Tanzania had opted for socialism, one professional field was yet to be effectively touched by the country's socialist endeavors to eradicate exploitation in its many and varied ramifications. Before the ban, private medical practitioners in Tanzania enjoyed a heaven of their own, notwithstanding complaints that they highly exploited low-income patients.[132]

128 Amon J. Nsekela and Aloysius M. Nhonoli, *The Development of Health Services and Society in Mainland Tanzania: A Historical Overview-Tumetoka Mbali* (Dar es Salaam: East African Literature Bureau, 1976), 79.

129 Iliffe, *East African Doctors,* 2004.

130 Nsekela and Nhonoli, *The Development of Health Services and Society in Mainland Tanzania*, 80.

131 "Report on a visit of Ministry of Health delegation to the People's Republic of China, September 1977," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China.

132 R. Mwinyimbegu, "Private Hospitals Must Go Now," *Daily News*, January 19, 1977, 6.

Before the ban, politicians and ordinary citizens demanded the outlawing of private health services in Tanzania. Socialist allies wanted private health institutions to be closed to allow the government to practice fully socialist policies.[133] While supporters of socialism demanded the closure of private health practitioners, other citizens argued against it, maintaining that private health services were vital since they gave patients the freedom to choose where to get adequate health services. They further backed the fact that the services offered by private health practitioners were effective and quicker compared to public health services. The other point opposing the ban was that the government had inadequate health service centers; thus, banning private services would complicate healthcare delivery. In this view, the government had to promote the further establishment of private health services by local and foreign investors, instead of banning them.[134] Surely, the government health centers were overcrowded and provided inadequate services due to an acute shortage of medical personnel and limited resources. Yet, conflicting views from pro-socialism and anti-socialism groups were inevitable, given that the ban came at the height of Cold War politics.

Notwithstanding the contribution of private health services and the people's divergent opinions over their presence, the government considered it necessary to ban their practices to attain equality in service delivery and fulfil the "Health For All" agenda. Theoretically, the idea was revolutionary because it was premised on providing free medical services to all Tanzanians. Allies of socialism accused private hospitals of delivering health services to a particular class of people who could afford the expenses. They further alleged that the owners of private hospitals persuaded well-trained doctors working in public hospitals to retire prematurely and join their hospitals with the promise of higher salaries.[135] Furthermore, the government claimed that private medical practitioners were more concerned with making money than providing better services to patients. The Minister for Health cautioned: "It is not good that anybody should make [a] private profit out of human suffering."[136] The government suspected public medical staff members of stealing medicines and selling them to private hospitals and apothecaries.[137] The government anticipated that outlawing private hospitals would eventually address the shortcomings. President Nyerere endorsed the ban on private health practices, regularly maintaining that health was not an appro-

133 Mwinyimbegu, "Private Hospitals Must Go Now," 6.

134 K. K. Asher, "Unnecessary Hardship," *Daily News*, January 13, 1977, 7; also see Jeremiah Mwakasonda, "Are all Private Doctors Qualified?" *Daily News*, January 13, 1977, 7.

135 Johnhanes Ndossi, "Jumping Over a Stick, Landing on a Snake!" *Daily News*, January 13, 1977, 7.

136 Quoted in Iliffe, *East African Doctors*, 209.

137 Jeremiah Mwakasonda, "Are all Private Doctors Qualified?" *Daily News*, January 13, 1977, 7.

priate sector for profit-making and that private hospitals were inconsistent with his regime's socialist policies.[138] Thus, learning from the Chinese government and pressure from political elites and ordinary citizens influenced the ban on private health practices.

The long-standing outcry to end the practice of private health services was resolved in 1977 with the government signing the Private Hospital (Regulation) Act. Under the Act, the Tanzanian government made it illegal for any individual or organization to manage or cause to be managed by any private hospital except on behalf of an approved organization.[139] Up to 1977, more than 20% of doctors worked in the private health sector. Thus, restricting the operation of private health services was, from one perspective, the government's initiative to bring more doctors to the public health sector. After the closure of private health centers, the government convinced medical workers from the private sector to join the national health service and pledged to buy all medical equipment and related facilities used by the expelled hospitals.[140]

Nevertheless, the ban did not touch some private health centers owned by non-profit Non-Governmental Organizations (NGOs), mostly under religious institutions. Retaining them was not only the concern of political elites but also of the ordinary citizens. The government supported non-profit health practitioners since they charged relatively low fees and sometimes offered free healthcare to low-income families. Non-profit health practitioners charged low fees since they received most of their medicines and medical equipment as aid.[141] Yet, not all private practitioners under NGOs got approval certificates to operate. Under the 1977 Act, the MoH stipulated criteria for the approval of organizations to run private health services. According to the Act, religious and non-religious organizations were eligible for approval if they had as objects the advancement of religion, or they were established for the promotion of the welfare of workers and peasants, or they were engaged in the advancement of any other public purpose.[142]

The Minister for Health had the mandate to disapprove or cancel approval certificates of any organization which engaged or intended to engage in the man-

138 URT, *The Address Given to the National Conference of Chama cha Mapinduzi by the Chairman, Ndugu Julius. K. Nyerere, on 20th October, 1982 at Diamond Jubilee Hall, Dar es Salaam*, 27.

139 "URT, The Private Hospitals (Regulation) Act of 1977," MwRC, File No. M.10/1, Medical and Health, Medical Policy and Instructions, 1.

140 "World Drug Market Manual, November 19, 1982," TNA. Acc. No. 450, Ministry of Health, File No. HE/H/30/7A, Primary Health Care.

141 Mwinyimbegu, "Private Hospitals Must Go Now," 6.

142 "URT, The Private Hospitals (Regulation) Act of 1977," MwRC, File No. M.10/1, Medical and Health, Medical Policy and Instructions, 1.

agement of private health services to make a profit or promote the economic interests of the organization's members.[143] Generally, from 1977 to 1991, the government strictly prohibited the management of private health centers without a special approval certificate from the MoH. Any person who managed unregistered private health services was guilty of an offence and was liable on conviction to a fine not exceeding Tshs. 50,000 or to imprisonment for a term not exceeding three years, or to both fine and imprisonment.[144]

Despite the ban, several private health institutions remained, supplementing government health services. The 1992 World Bank statistics indicate that by 1988, NGOs owned approximately 96 hospitals, while government hospitals amounted to 74. However, the government outnumbered NGOs in health centers and dispensaries. Statistics show that it had 266 health centers and 2,205 dispensaries by 1988, while NGOs owned 11 health centers and about 730 dispensaries in the same period (Table 4).[145]

However, the ban on private health services did not survive liberalization. The 1986 structural adjustment programs (SAPs), which the Tanzanian government signed with the IMF, forced the government to allow private investment in economic and social sectors. From 1986 on, several internal and external campaigns demanded the resumption of private health services in Tanzania. For example, the Medical Association of Tanzania (MAT) tirelessly lobbied the government to allow the operation of private health practitioners.[146] Eventually, in 1991, the government resumed the operation of private health services following the passing of the Private Hospitals (Regulation) (Amendment) Act. Under this Act, the government allowed qualified medical practitioners and dentists to manage private health facilities with the approval of the MoH.[147] The lifting of the embargo led to a boom in private health services in Tanzania. For example, up to 1995, there were more than 300 private clinics and hospitals in Dar es Salaam. Above all, many private apothecaries extended to different parts of the country.[148]

143 "URT, The Private Hospitals (Regulation) Act of 1977," MwRC, File No. M.10/1, Medical and Health, Medical Policy and Instructions, 2.

144 "URT, The Private Hospitals (Regulation) Act of 1977," MwRC, File No. M.10/1, Medical and Health, Medical Policy and Instructions, 3.

145 World Bank Report, *Tanzania AIDS Assessment and Planning Study*, June 1992, 7.

146 Interview with Joseph W. Butiku, July 9, 2018, Posta-Dar es Salaam.

147 URT, *The Private Hospitals (Regulations) (Amendments) Act, 1991*, 1.

148 Iliffe, *East African Doctors*, 218.

Table 4: Total health facilities by region and management, 1988.

SN.	Region	Hospitals		Health Centres		Dispensaries	
		Govt	NGOs	Govt	NGOs	Govt	NGOs
1	Tanga	5	7	15	---	136	67
2	Coast	4	2	11	---	90	44
3	Morogoro	4	7	15	1	131	52
4	Lindi	4	3	12	---	88	12
5	Iringa	5	8	16	---	91	50
6	Ruvuma	2	5	13	---	93	36
7	Kilimanjaro	5	8	13	4	93	42
8	Arusha	6	6	11	---	115	65
9	Dodoma	5	1	16	1	148	24
10	Mara	3	4	11	---	92	31
11	Rukwa	2	1	11	1	73	15
12	Singida	2	4	12	---	75	46
13	Tabora	4	3	10	1	84	22
14	Kigoma	3	2	10	---	94	26
15	Mbeya	4	6	17	---	149	37
16	Mtwara	3	2	13	---	99	9
17	Mwanza	4	7	26	---	204	34
18	Kagera	1	10	12	---	132	15
19	Shinyanga	4	2	19	---	137	30
20	Dar es Salaam	4	8	3	3	81	73
Totals		**74**	**96**	**266**	**11**	**2205**	**730**

Source: World Bank Report, *Tanzania AIDS Assessment*, 1992, 7.

2.7 Conclusion

This chapter attempted to draw out some of the ways in which Chinese health policies inspired health policy developments in post-colonial Tanzania. The discussions showed that between 1966 and 1977, the MoH sent delegations of medical experts to study China's health system. Recommendations made by these envoys reinforced the government's decisions to practice a free healthcare policy, institutionalize traditional medicine, promote rural healthcare, and ban private health service practices. The government, however, did not copy the policies uncritically. Instead, the policies were learnt and applied based on the country's economic and social situation. To some extent, the post-colonial government molded some colonial health practices to conform to the socialist path. Inspired by China's parallel endeavor to pursue a distinct socialist path, Tanzanian authorities adopted socialist health policies and bolstered their relationship with China. As the exam-

ple of health policies shows, China's influence was not limited to direct transfers of resources and knowledge. Instead, the country also served as an inspiration "from the South" in less direct ways. This chapter has foregrounded the understanding of other means of China's medical assistance to Tanzania, which are the subject of the subsequent chapters.