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Maternal Healthcare and Health Policy Planning in Tanzania, 1961–1970s

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Abstract

The period immediately after independence in Tanzania was marked by intense planning for the country's development. Part of this planning involved the healthcare system and was aimed at addressing the grave dangers posed by life-threatening diseases. Improvements in healthcare included the expansion of medical facilities and staff. The government identified maternal health as vital in revamping public health. It understood that the well-being of mothers and children was fundamental for the prosperity of the newly founded state. The focus, however, was on rudimentary health provisions. This article examines health policy planning in Tanzania immediately after independence. Using examples from maternal health, it argues that healthcare planning after independence was still largely shaped by the measures developed under colonial rule despite the optimism about a sovereign future. This was mainly because the problems and plans that had arisen during colonialism remained in existence after independence. The article uses archival, oral and secondary sources to show how attempts to shift health policies were hindered by poor planning, lack of funds, inadequate staff, gender relations and the choice between healthcare and other needs. It examines how the newly independent government negotiated the quest for better healthcare, especially maternal health.

Keywords: development; future making; healthcare; maternal health; social policy; planning; postcolonial; Tanzania; welfare

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Résumé

Immédiatement après son indépendance, la Tanzanie a été marquée par une intense réorganisation du pays vers un avenir meilleur. Ce changement concernait en partie le système de santé et visait à répondre aux graves dangers posés par les maladies mortelles. Pour améliorer la santé, l'expansion des établissements sanitaires et celle du personnel étaient incluses. Le gouvernement a déterminé la santé maternelle comme essentiel pour la réorganisation de la santé publique. Il avait compris que le bien-être des mères et des enfants était fondamental pour la prospérité de l'État nouvellement fondé. Toutefois, l'accent a été mis sur des dispositions sanitaires rudimentaires. Cet article étudie la planification de la politique de santé en Tanzanie immédiatement après l'indépendance. À l'aide d'exemples tirés de la santé maternelle, il soutient que, malgré l'optimisme quant à un avenir souverain, la planification des soins médicaux après l'indépendance a encore été largement façonnée par les mesures développées sous le régime colonial à cause des problèmes et projets qui avaient vu le jour pendant la période coloniale et qui se sont poursuivis après l'indépendance. L'article s'appuie sur des archives, des sources orales et secondaires pour montrer comment les tentatives de réorientation des politiques de santé ont été entravées par une mauvaise planification, un manque de fonds, un personnel non qualifié, des relations hommes-femmes et le choix entre la santé et d'autres besoins. Il examine comment le nouveau gouvernement indépendant négociait à la recherche de meilleurs systèmes de santé, en particulier la santé maternelle.

Mots-clés : développement ; construction de l'avenir ; santé ; santé maternelle ; politique sociale ; planification ; postcolonial ; Tanzanie ; bien-être

Introduction

On 9 December 1961, Tanzania attained independence. Like many African nations that experienced colonialism, the optimism for a better future was high. The imagined future went beyond political independence to encompass economic autonomy and social progress, including a focus on good health for the population. At the time, there was rampant infant and maternal mortality, disease and malnutrition, leading to low life expectancy and productivity. Therefore, planning for better health, though difficult, was necessary to achieve an auspicious future for the nation (Green 2007:1). However, for many African countries, planning for healthcare after independence inevitably reflected colonial plans and strategies (Malowany 1997:236; Ombongi 2011:353). Until the 1960s, when most African states became independent, healthcare policy planning was still relatively nascent.

Only a few historical studies have focused on health, and those that do mainly concentrate on colonial controversies, missionary medical works and neoliberal policies (Beck 1970; Meredeth 1977; Hunt 1988; Vaughan 1991; Kanogo 2005; Crozier 2007; Masebo 2010; Jennings 2016; Dreier 2015). Most of these studies posit that during the late nineteenth century European colonial 'civilising mission' to Africa, the health of Africans was never a priority. The immediate focus of Europeans was the occupation and exploitation of the territories. However, on arrival in Africa, Europeans were presented with hurdles to their goal of exploiting the acquired territory. One such obstacle was tropical diseases. This hurdle necessitated the formulation of policies to manage or counter this danger.

In East Africa, malaria and trypanosomiasis were major concerns. The limitations of existing medical facilities, personnel and equipment were enormous and forced the existing medical practitioners to perform tasks beyond their competencies (Beck 1970:2; Ngonyani 2018:5). In addition, healthcare had developed slowly, driven largely by its subservient role in colonial capitalist interests in Africa, principally in supplying enough healthy labour for plantation agriculture. The need for healthy and consistent labour in agriculture and infrastructure building was among the many reasons workers' health later became a concern of the colonial government. Furthermore, in the first decades of the twentieth century, the colonial government had to face the challenge of a low birth rate and declining population, both at home and in Africa (Vögele 2010:131; Lindner 2014:214; Davin 1978:11). A shrinking population was alarming to the colonial government because agriculture was the backbone of many economies and '… without black labour, our colony would never be able to send to Europe the wealth buried in [*Africa's*] soil' (italics added) (Hunt 1988:405).

This phase of colonialism coincided with the twentieth-century concept of the welfare state, a period when European states were evolving into guardians of social welfare. The idea was soon exported to the colonies within the framework of what has been described as 'colonial developmentalism'. This followed the enactment of the British Colonial and Welfare Act, in 1929, which matured to encompass colonial developmentalism (Zeleza 1997:218). From the mid-1930s, social policy became a major preoccupation of 'modern' governments. This concern was fast-tracked by the two world wars when the state emerged as the sole structured entity capable of restoring order to social policy. A series of legislation and economic distribution subsequently gave value to social policy interventions (Pekarová 2017:104; Ombongi 2011:355). Equally forceful in enhancing the value of social

policy were trade unions and social reformers, who demanded that the state take responsibility for welfare (Midgley and Livermore 2009:28). By the late 1930s, welfare, social policies and the state had become inseparable and concern for welfare became a symbol of advanced capitalist societies (Malpass 2005:3).

The interwar period was problematic because of the economic recession that came after World War I. Significant resources were committed to the war effort, which had disrupted economic progress. Nevertheless, the war highlighted the importance of the question of well-being. According to Anne Beck, this period in Africa forced a new focus on 'native interests' (Beck 1970:2). The colonial governments started health campaigns to teach hygiene and went on to build more hospitals in the colonies, in addition to the existing mission hospitals that handled disease and injuries, among other health problems. After World War II, colonial governments increased funding for the expansion of health facilities in Africa. Although this had the appearance of helping the colonies grow, it was mostly about Britain finding ways to survive tough times during the war and cope with the ascendancy of the USA (Zeleza 1997:223).

The study of African medicine and its convergence with Western medicine leading to conflict, hybridity or medical pluralism has been a subject of inquiry by many scholars. However, the research on health policies and planning in East Africa has not received commensurate attention, except perhaps for a few studies (Achola 2000, 2005, 2006; Ombongi 2011), which concentrate more on the urban setting in colonial and postcolonial Nairobi, Kenya. For the case of Tanzania, most studies focus on health in the colonial period and where they veer away from this, they examine health policies in the context of Ujamaa or in neoliberal times, thus largely ignoring the early post-independence period. Yet, understanding policymaking in these early years is crucial because the period was the spindle upon which development was anchored and from which a change of policy was later imagined or developed. In focusing on the first decades of independence, this article seeks to add to this broader discussion on health as a social policy issue. Using Tanzania as a case study,[1] I show that despite the overarching intentions for the future in many states, historical events informed social policy plans.

Although the historical, ecological and environmental conditions of East African countries are similar, the case of Tanzania remains unique for several reasons. First, its colonial history and status as a trust territory of the League of Nations and later as a mandate of the United Nations largely influenced internal developments. Second, since the political economy and

social organisation of a country are key determinants of its health planning (Feierman 1985:73; Keita 2007:13), the decision to adopt socialism in Tanzania as early as 1962, and the dominance of the Tanganyika African National Union (TANU) party reflected on the development path of Tanzania. In contrast, Uganda and Kenya were more oriented to the capitalist West. Third, the ratio of land mass to the population is a major consideration in planning, and the vastness of Tanzania is a feature that dominates this argument.

Using data from oral interviews, archival sources, government reports and secondary sources, the article shows that planning for health was challenging for the state, thereby necessitating the incorporation of support from voluntary agencies, 'friendly' nations and international actors. Overlaying this support was the inescapable embrace of traditional therapies. Using examples from maternal health, I demonstrate how colonialism and strategies by TANU influenced policy planning in independent Tanzania.

The article has three main sections. The first traces the transfer of medical knowledge and policies to Tanzania under colonialism framed in the guise of the 'civilising mission'. The second section describes the health situation immediately after independence, focusing on the role of TANU and the need for better health in the context of meagre resources. Section three studies the example of maternal healthcare to further illuminate the application of the policies discussed in sections one and two.

The Transfer of Western Medicine to Colonial Tanzania: An Overview

Africans had knowledge of health and healing as they practised traditional medicine before colonial governments and missionaries introduced Western medicine on the continent. For Tanzania, it was the Germans who conceived the colonial political administration, economic production and social amenities that revolved around health matters. The first hospital in what was then Tanganyika was opened by the Church Missionary Society (CMS) in Mamboya in Kilosa, Morogoro, in 1877, but it was in 1888 that the German administration started what Titmus *et al* termed as properly organised medical services (Titmuss *et al*. 1964:1).

The CMS was followed by other Protestant and Catholic mission societies, mainly from Germany and, later, Britain. Missionaries regarded the provision of medical services as insurance for the relevance of their services to the colonial government and Africans (Jennings 2016:153). Despite initial resistance to medical interventions from missionaries in

certain regions, the practice of Western medicine grew and was embraced by communities, even if reluctantly, especially during epidemics. However, this did not eradicate the use of different African traditional therapies. Studies have documented the practice of medical pluralism in Africa, where different therapies were 'complementary rather than competing' (Feierman 1985:73; Malowany 1997:24; Keita 2007; Tilley 2011:181). The competition narrative, perhaps, was a creation of the missionaries to demonstrate the hegemony of their medicine. But in fact, African medicine was still widely used and, indeed, the competition narrative demonstrated that African medicine had some 'life dynamism' (Keita 2007:33). Moreover, what was termed 'Western medicine' was not uniform; it varied depending on the country of origin (Crozier 2007:4).

However, in the politics of civilisation, African traditional medicine was relegated to the bottom as unscientific, less effective, ungodly and primitive (Ranger 1981; Feierman 1985). This perspective was further entrenched after the arrival of European colonialism coincided with a period of outbreaks of human and animal diseases that were previously unknown to Africans; the known remedies for dealing with them were ineffective because of the policies imposed by the colonisers (Giblin 1996:128). Africans were forced to seek help from the Europeans on how to treat these 'new' ailments. Western medicine came in handy here. Rather than using it to treat only these new ailments, the bearers of this medicine, namely the missionaries and colonial officials, deployed it primarily as a tool for engaging with Africans to convince them of the value and superiority of their civilisations. Certainly, European interests had to be 'protected politically and medically' (Nhonoli and Nsekela 1976:7). Although this was interpreted as a win for Western medicine, studies have shown that it simply joined the array of different therapies Africa adopted for different diseases (Feierman 1985; Malowany 1977).

It is not surprising that among the first group of German colonial officials to come to Tanzania were five fully qualified medical doctors and fifteen orderlies (Titmuss *et al.* 1964:2; Nhonoli and Nsekela 1976:8), who set up the first medical department on 1 April 1891. However, the medical services rendered by this department were hierarchical. Priority was given to the military men, then German merchants, and lastly, African soldiers (Nhonoli and Nsekela 1976:8). At this point, most other Africans were not included in the government's health plans. Instead, they were mainly attended by the missionaries, a service that continued well into the twentieth century. Military hospitals in Dar es Salaam, Lindi, Kilwa, Pangani, Mikindani and Mtwara, among other towns, offered services based on race and status; the hospitals cared foremost for Europeans.

Maternity services were generally left to the missionary sisters and were not a concern of the government until the population question came to the fore[2] (Lindner 2014:215).

In 1894, the German parliament approved the construction of the Ocean Road Hospital to serve grade one patients (Europeans). Consequently, a twenty-five-bed hospital was built that remained exclusively for European use until 1961. In the capital city and many other rural areas, no hospital was constructed for Africans, purportedly because of a lack of funds. Nonetheless, the German Chief Medical Officer, Becker, approached Sewa Haji Paroo, a wealthy Indian philanthropist, who agreed to fund the building of a hospital to serve the non-European population (Tanganyika Ministry of Health 1960:1). On April 15, 1892, Sewa Haji donated 12,400 rupees on condition that the hospital would bear his name (Nhonoli and Nsekela 1976:9). The hospital was opened in 1897 and operated for more than sixty-seven years, until the official opening of Princess Margaret Hospital (later renamed Muhimbili) in 1960. German rule in Tanzania ended abruptly after the end of World War I.

After World War I, the British took over Tanganyika from the Germans. At the time, civilian medicine was in 'a neglected state' (Titmuss et al. 1964:4). Just as the Germans did, the army took over the medical sector. It was only in 1923 that British civil medical research was established (Beck 1970:2). In 1924, the Principal Medical Officer, Dr Shircore, noted that much needed to be done in rural Tanzania. The government responded by trying to develop health facilities and Africanising medical workers by training Africans as wound dressers (Tanganyika Annual Report of the Medical Department 1960:2). However, this did not bear much fruit. In any case, this 'investment' was not considered beneficial to the capitalist interests that drove the colonial state, which manifested in investments concentrated in more 'productive' areas. As Maghan Keita argues, the provision of health went hand in hand with anticipated economic benefits (Keita 2007:49). Thus, the areas that were labelled 'unproductive' were left out of such investment and remained largely undeveloped.

By the 1940s, the demand for medical services was increasing, especially for mother and child health (MCH). Plans for the expansion of the MCH section, for instance, became very visible by 1944. This visibility was driven by a constellation of factors. For a start, demand continued to rise even as a lack of resources and inflation restricted the expansion of MCH facilities. In Dar es Salaam, the facilities were provided in temporary buildings that were mostly unsuitable (TNA/ACC450/108 1944)[3]. Thus, while many scholars have argued that health centres were concentrated in urban areas, this did

not always mean better services. As argued below, it was clear that the urban poor were also subjected to substandard public health services at the time. In the rural areas, medical services and maternity in particular depended largely on missionaries and traditional midwives.

By 1949, the situation regarding health services was dire, leading the Chief Medical Advisor of the Colonial Office, Dr Pridie, to describe them as being '… below the minimum standard of efficiency' (Titmuss *et al.* 1964:18). Even so, funding remained the main excuse to stall investment in public health services. The 1957 approval by the Legislative Council for the 'Plan for the Development of Medical Services in Tanganyika', for instance, was adopted subject to availability of funds (Tanganyika Annual Report of the Medical Department 1957:1). The notion of 'availability of funds' is illustrative of how a capitalist logic played a crucial role in determining priorities in health planning (Zeleza 1997:223). The irony is that while the public health sector was developing so slowly, the attitude of Africans towards Western medicine was changing very quickly. By 1958, institutionalised maternity services had become so popular that the government was unable to keep up with the demand (Tanganyika Annual Report of the Medical Department 1958:15). Yet, strangely, in the same year the hiring of staff was suspended because of a lack of funds (Tanganyika Ministry of Health 1958:1). The report by the Principal Secretary in the Ministry of Health in 1959 showed that the demand for health had 'reached embarrassing proportions' (Tanganyika Ministry of Health 1959:1). Clearly, health was not a priority to the colonial government. Most women, especially in rural areas, sought the services of traditional midwives.[4]

The Health Situation in Tanzania After Independence

The Commencement of Health Planning in the 1960s

The 1960s saw several African countries break from the yoke of political colonialism. For Tanzania, this happened in 1961 and was followed by intensive planning. It was a time of redefining the future and charting the way forward for the newly independent nation. With Julius Nyerere as its leader, Tanzania identified the priority of fighting against poverty, ignorance and disease (Nyerere 1973:15). Health had now officially obtained national attention. This was also in line with the World Health Organization (WHO) principles as set out in the WHO Constitution adopted in July 1946, where health was outlined as a key concern (WHO 1946). For Tanzania, planning for health was understood as a project of self-determination. To Nyerere, self-determination meant freedom, and being disease-free was an integral

part of this freedom (Nyerere 1973:58). For him and his ruling party, TANU, this was an opportunity to provide to the masses of Tanzania what colonialism had denied them. But was the same intent reflected in planning and implementation?

Apart from the speeches that politicians delivered at rallies, the government had to follow a laid-out plan. In the early years of independence, health policy was included in a three-year plan which was followed by a series of quinquennium plans (Development Plan 1961–64; First Development Plan 1964–69; Second Development Plan 1969–74). Another document that was key for the health sector was the Titmuss Report (Titmuss *et al*. 1964), which recorded the medical situation as discussed below. The plan for the period 1961–1963 was prepared just before independence was officially granted in December 1961. It was based on the information received through surveys conducted by the World Bank. Thus, from the start, Tanzania's planning operations emanated from the perspective of 'outsiders'. This was not unique to Tanzania. For many African states, independence was not a spontaneous moment but rather an orchestrated transition into a colonial dispensation in which institutions like the World Bank would play a critical role.

About GBP 24 million was allocated to the development plan of 1961–1963 (Development Plan 1961:13). But between the competing needs of the time, only 4 per cent (approximately GBP 954,000) of the whole budget was allocated to the health and labour sectors. Thus, the Ministry of Health and Labour received the smallest allocation, compared to 24 per cent and 13.7 per cent allocated to the agriculture and education ministries respectively (Development Plan 1961:13).

The planning of the health sector in the early years of independence was not as optimistic on paper, either. Indeed, in the broad objectives of this plan, health was conspicuously missing and was mentioned only in the analyses of the health department. The underlying theme for the 1961–63 plan was 'laying the foundation for future growth', which was largely based on developing agriculture, education and infrastructure. Just as in the colonial era, emphasis was placed on economic development, and health provision was meaningful only if it facilitated economic gain. It is also worth noting that a substantial amount of the GBP 24 million for the 1961–1963 plan was to be funded through loans and grants (Development Plan 1961:10). This dependency increased in the subsequent years such that the government could not sustain its expenditure, despite the clarion call of self-reliance that started as early as 1962 (Nyerere 1965:22).

Notwithstanding the difficulties of funding highlighted above, there was a notable increase in patients in medical facilities managed by both the government and voluntary agencies (Tanganyika Ministry of Health 1963:18). However, this was not a reflection of the whole country. Some parts of rural Tanzania, where majority of the people lived, had no access to health services (Meredeth 1977:24). Many rural areas continued to rely on voluntary agencies such as missions, even after independence. Most of the available medical services—largely curative at the time—were located in urban areas. Even so, the services were 'scattered, partial and uncoordinated' (Gish 1975:8).

In 1961, there were only 1,236 dispensaries, 25 health centres, 204 antenatal clinics and 195 child health clinics in Tanzania (Ngonyani, 2018:5). These were not enough given the vastness of the country and the size of its population, estimated at 11 million. The first step was to address the distribution of health facilities, with an emphasis on the rural areas. The government aimed to have a hospital of not less than 200 beds capacity per district by 1969 (First Development Plan 1964:69). However, it was later noted that although building hospitals would not cater for the needs of the majority, dispensaries and rural health centres (RHCs) would. This mirrored the efforts of the Principal Medical Officer, Dr Shircore, who as early as 1924 identified the rural dispensary system as the panacea for rural health issues (Beck 1970:148).

The basic role of the RHCs and dispensaries was to offer first aid and MCH services. They also remained centres of health campaigns, as in colonial times. Thus, many RHCs and dispensaries were built. In Ifakara, for instance, the Kibaoni dispensary was built, although it was overshadowed by St Francis Hospital, which was one of the big hospitals not only in Kilombero District, but in Tanzania as a whole. In places such as Kidatu, the Kilombero Sugar Company had its own hospital as early as 1960. This demonstrates the role of voluntary agencies and NGOs in the provision of medical care.

Beyond the challenge of facilities, the number of trained African medics was still low. According to Gish, the existing chain of dispensaries was 'ill-equipped and manned by staff who were only capable of dispensing pharmaceutical palliatives, when these were available' (Gish 1975:8). The problem of inadequate medical staff was enormous. For a population of slightly above 11 million, there were 400 doctors, only 178 of whom worked for the government at independence (Titmuss *et al.* 1964:29). Worse still, out of the 400, only eighteen were of Tanzanian origin (Nhonoli

and Nsekela 1976:1). The scarcity trickled down to other medical workers, including Medical Assistants (MAs), Assistant Medical Officers (AMOs), Rural Medical Aides (RMAs) and midwives. In 1961, there were only thirty-two AMOs, although this number increased to 105 in 1967. The only options for health in the country were to continue to rely on expatriate medical staff or substantially increase the training of new local staff.

The use of expatriates was a direct contradiction of the logic of decolonisation and had been highly condemned by the nationalist movements during the struggle for independence (Ayoade 1988:106). It was even more problematic because most expatriates, especially the British, opted to go back to Britain in 1963, attracted by the compensation scheme offered by their government (Tanganyika Ministry of Health 1963:3). Thus, there was a massive exit through the retirement of senior staff and resignations. Furthermore, within the existing local medical staff, excessive drunkenness and stealing, leading to dismissal, were reported (TNA/ACC 450/HE 1424/6 1973; Ngurumo 1964b:4).

In addition, most qualified health workers went overseas for further studies or to Dar es Salaam for an upgrade course in the new medical school that was opened in July 1963 (Tanganyika Ministry of Health 1962:2). Perhaps the government allowed medics to go abroad for further studies because of the many opportunities that were offered through scholarships by various governments, especially the United Kingdom, Japan and, later, China (Ngurumo 1965b:2; TNA/HE/1674/5 1962; TNA/HE/A/90/16 1977; TNA/HEA/90/5 1962). To overcome the shortage of medical staff, Tanzania had to devise a plan to train healthcare personnel locally.

Training medical staff in Tanzania

The establishment of the Dar es Salaam Medical School (DMS) in 1963 marked a significant step towards training medical personnel in Tanzania, intending to reduce the reliance on overseas institutions and Makerere University in Uganda, which by then was under the umbrella of the University of East Africa (Illife 1998; Kithinji 2012). However, training medical staff was not easy in Tanzania. First, the number of tutors was insufficient for the task. Also, too few individuals were interested in or qualified to pursue medical courses. The problem of getting qualified people for training was inherited from the colonial education policies that had relegated Africans to the lowest level of education, ostensibly to help them acquire 'practical' skills, which meant that most did not get past the basic level of education. In this racialised form of education, Europeans and Asians were automatically

groomed for higher education; its gendered character meant that African women were largely left out (Mbilinyi 1979:238; Kahama, Maliyamkono and Wells 1986:22).

Nevertheless, the addition of the DMS was a boost to government facilities since most of the already existing centres were run by voluntary agencies. For instance, two RHCs with training goals were opened in 1961—one in Ifakara, under Professor Geigy from Switzerland, and the other in Bukoba, with aid from Scandinavian countries (Tanganyika Ministry of Health 1962:2). Just as in the colonial days, when voluntary foreign agencies played an important role in providing health services, so it remained the case that the central government in independent Tanzania could not be the sole provider of health services.

One of the goals of the DMS was to produce a 'multipurpose' nurse who was to be trained for three years to replace the three-year training of a hospital nurse and the two-year training of a health nurse (Titmuss et al. 1964:29).[5] It was also expected that in the last six months of the training, the female students would get midwifery training. In 1968, DMS was integrated to form what became the Faculty of Medicine at the University of Dar es Salaam.

To enrol in the university medical course, the entry requirement was a complete secondary school level education. This enabled the student to join a five-year course followed by one year of pre-registration medical employment. The full cost of training a medical doctor was USD 40,000, which was too expensive compared to USD 2,500 and USD 2,000 for the medical assistant and the rural medical aide respectively (Gish 1975:12). Hence the government preferred to train at lower grades and then upgrade later. The qualification for a medical assistant took eleven years of basic schooling plus three years of medical training; the AMOs were trained as medical assistants, and after four years of work experience received eighteen months of upgrading courses. However, in practice, the AMO took on the work of a graduate doctor and was the only 'known doctor to the people in the rural areas' (Gish 1975:13).

Upgrading was the only feasible solution for staffing because such courses were cheaper and consumed less time. At Ifakara, many retired health workers were a product of upgrading, which remained an important feature in Tanzania's health sector.[6] Yet, the question of the quality of local training arose because the government had lowered the entry requirements to get more people to train as medical workers (Tanganyika Ministry of Health 1962:2). At the time, but also until as late as 1975, most doctors in Tanzania were still trained outside the country whereas medical auxiliaries

were trained locally. This continued to exacerbate the dualism in the hierarchy of the medical personnel and medical disciplines in Africa, where doctors who were trained abroad were seen as better than the lower cadres of nurses, midwives and medical assistants, most of whom were trained locally (Keita 2007:23).

In rural Tanzania, staffing was problematic because the 'best' doctors were located in the cities where they were better paid and got the opportunity to practice what they were taught in 'modern' medicine. This unequal distribution of medics remained a problem that worsened even as the government of Tanzania tried to resolve it. In 1977, the government restricted private medical services, which not only led to further deterioration in service delivery but also to brain drain (Illife 1998; Bech *et al.* 2013). Throughout this period, and in the policies initiated around health matters, the ruling party, TANU, played a central role in shaping decision-making.

TANU and the Structure of the Health Services in the Early Years of Independence

Despite the slow start, the government health division had programmes and made visible progress that partly followed the recommendations of the Titmuss Report (Titmuss *et al.* 1964).[7] The report gave an overview of the situation of the health sector and made recommendations and projections for the future. It was termed 'the most valuable document' for the medical planning committee (Tanganyika Ministry of Health 1963:1). The report came out the same year as the first development plan of 1964. Unlike the 1961–1963 plan, which was based on World Bank surveys, there was optimism in the 1964 plan as the first 'homegrown' plan. Therefore, it was expected to tackle the issues in the country better from an 'insider' perspective. Some of the proposals of the Titmuss report, especially the emphasis on rural health, were incorporated into the 1964 plan. Thus, the overall thrust for the health division became the extension of medical services to the rural areas and a concentration more on preventive healthcare than curative measures. This move was adopted and given agency by TANU.

TANU officials were important agents in harmonising the functioning of government, which operated at two levels—the central or national level, and the local or regional level. However, all the policies were made by the central government and trickled down to the local level. According to Titmuss, the difference between the central and the local government was very thin, 'geographical rather than functionality' (Titmuss *et al.*

1964:68). The relationship between the two levels was not comprehensive, especially on the part of the voluntary agencies, most of which worked in the rural areas.

For the medical sector, the organisation was structurally not different from the colonial hierarchy. At the top of the hierarchy was the health minister, followed by the chief medical officer (CMO), deputy chief medical officer, three principal medical officers, the principal matron and the chief health inspector, in that order (Tanganyika Ministry of Health 1962:1). These echelons were based in Dar es Salaam, and by 1964, some members of TANU were complaining about the concentration of amenities and industries in the city (Ngurumo 1964:1).

Ironically, despite the call for a unitary system after independence, decentralisation of some functions was practical but problematic. Maghan Keita provides a two-fold explanation for decentralisation in the case of Senegal. On the one hand, the local government was given the recognition that was characteristic of principles of democracy and modernity, but on the other hand, decentralisation seemed like an abdication of responsibility by the central government (Keita 2007:161). This was the case in many African states. In Tanzania, health provision was decentralised from the regional level, but policymaking was not.

At the regional level, the regional medical officer (RMO) acted on behalf of the CMO. Under the RMO were the district medical officers, representing each of the districts (Titmuss *et al.* 1964:34). Under this hierarchy were the medical practitioners divided into four categories: university graduate medical doctors, AMOs, medical assistants and RMAs. Just as in the colonial period, medical services were still organised on a provincial basis, with the state as the controller (Ombongi 2010:355). The only change of policy in 1961 was that provincial and RMOs were assigned medical duties on top of their administrative roles (Tanganyika Ministry of Health and Labour 1961:1). In addition to addressing the problem of staffing, the move was to keep the administrators acquainted with the medical issues that their provinces were facing.

Policymaking in the newly independent country was centred around TANU and its chairperson, Julius Nyerere. Therefore, the professional medical hierarchy discussed above was interwoven in the party politics of the TANU. TANU was visible at all the stages of health policymaking, such as agenda setting, priority setting, appraisal, implementation, monitoring and evaluation, and policy maintenance or termination (Milevska-Kostova *et al.* 2013:4). Thus, policymaking and political decisions were inseparable (Milevska-Kostova *et al.* 2013:4). Starting a new health facility was a

political decision. While responding to a question in Parliament in 1973, the minister of health told the House that if a decision was made to have two health centres in a district, then it was the role of the leaders to decide the location of the facilities (TNA/HE/1674/5). Request for licences to practise, even for traditional healers, was done through TANU branch leaders (TNA/HET/120/15). Any medical officer who wanted to upgrade to another level had to write a letter through the TANU branch leader (Ngurumo 1965b; TNA/HE/A/90/16 1977), and being a TANU member was an added advantage, though it was never made an official policy.[8]

There were pros and cons of TANU being the only party in policymaking. It was common for doctors to receive orders from TANU leaders, which often led to conflicts. There is evidence of meetings called to restore order between non-medical workers—mainly TANU leaders—and medical doctors, with the latter blaming the former for behaving 'as if they were above the law' (TNA/HQ/1.30/21/11/1975). In some cases, medical workers were obliged to leave their duties to attend to TANU activities. For instance, doctors would be ordered by TANU leaders to travel to the villages to help the sick; and a TANU branch chairman orders the same doctor to stop his work and join *maandamano*.[9] Thus, the relationship between social policy and the welfare state was evidently inseparable (Aravacik 2018:103).

From the TANU party leader to the village head, there was an elaborate hierarchical system of how things were to run. TANU members were active in popularising health policies and the construction of dispensaries (TNA/HQ/1.30/21/111975). The TANU Youth League offered labour in the construction of dispensaries.[10] TANU leaders went around the villages announcing the dates for immunisations and important meetings with *Bwana afya*.[11] One interviewee added that being a member of TANU was a silent consideration for jobs and positions.[12] Members of the public would complain to TANU leaders about poor services in hospitals. When the challenge was beyond the local TANU leaders, it was taken to a higher authority. In 1973, for instance, TANU men wrote to the minister complaining of the lack of medicine in dispensaries and the laxity of doctors (TNA/HEA/150/2/411 1973). Some of these challenges were occasioned by poor pay for doctors, leading to a lack of motivation (Illife 1998; Bech *et al.* 2013:63).

However, TANU faced challenges in the process of implementing health policies because there were other pressing problems to be tackled, such as building the economy through agriculture and improvements in education. Indeed, after the 1967 implementation of *Ujamaa*, more schools than dispensaries were built, and working on *shamba la Kijiji* and *Mfumaki*[13] was emphasised. These areas seemed to have been the major preoccupation of the

TANU government. Problems such as a lack of finances, a rapidly growing population, inflation and ever-rising economic demands, necessitating upward revision of salaries and wages to an already strained sector, were apparent (Bech *et al.* 2013). What did this mean to particular medical departments? It was even more problematic to address the specificities of departments within the health sector, as shown in the maternal health policies below.

Planning Maternal Health in the Early Years of Independence

After independence, the government of Tanzania considered MCH vital in addressing public health and other maladies that could be prevented at or before birth. There was the need to address maternal mortality, which according to the Annual Report stood at 232 (Tanganyika Ministry of Health 1962:26); infant mortality was at 140 per 1,000 live births in 1961 (Titmuss *et al.* 1964:59; Macrotrends n.d.). Yet, it is possible that the numbers were higher because of the challenge of record-keeping at the time. It was assumed that the solution would be found by encouraging mothers to attend health facilities for delivery and follow-up.

From 1961 to 1964, the medical reports from the health division reported increased demand for MCH every year. In the 137 antenatal and 190 child health clinics available countrywide in 1961, 60,000 mothers and 54,000 children were attended to. In the same year, 67,000 women sought maternity services compared to 23,000 in 1951; still, only 17 per cent of the deliveries were handled by trained staff (Titmuss *et al.* 1964:37). This meant that many of the births occurred at home because the clinic was not always better than home delivery. Lack of water, the presence of male medical staff, and the mixing of the sick and the pregnant also made some people stay away from the clinic (Titmuss *et al.* 1964:68; Kanogo 2005:171). For others, like Zuhura,[14] home delivery was a choice they made because it was holistic: '*Nyumbani ulikuwa unapata mtoto, unatibiwa na dawa za kienyeji na pia mtoto anapewa dawa ili asipate kilala*'[15] (at home, the mother and the baby were treated with traditional medicine to prevent diseases). The government wanted every woman to be attended to in a medical facility, but, as already noted, medical facilities and staffing were a problem. This explains why, despite the government's wishes, delivery at a health facility was not understood as official policy.

The delivery of babies was the most common service provided at dispensaries and RHCs in rural areas. Yet, most of these dispensaries did not have a maternity section. Only a few of the 'normal' beds were set aside for maternity cases. Even in established hospitals, the maternity section

was under-resourced. The policy was that out of one hundred beds in a general hospital, sixty were meant for short-stay admission, fourteen for patients with mental illnesses, fourteen for tuberculosis patients, five for infectious diseases and seven for obstetrics (Titmuss *et al.* 1964:43). It was not clear what informed this policy. Still, seven beds for a section that was described as the 'busiest' meant that overcrowding in the maternity ward was inevitable. In such a situation, some maternity wards became a breeding ground for contamination and infections.

By 1961, the total number of beds in all health facilities was 7,028, of which only 462 were obstetric beds (Titmuss *et al.* 1964:45). Worse still, of the 462 beds, 369 were in regional and district hospitals, which were located in urban areas (Tanganyika Ministry of Health and Labour 1961:1). These numbers portray how bad the situation was in the rural areas. It can correctly be argued that delivery was certainly viewed as just a 'normal' procedure until there was a complication that demanded a visit to a medical facility.

The neglect of maternal health was partly because the medical field and the policymaking arena were male-dominated and thus underappreciated. For this reason, in rural areas, most births were attended to at home either by traditional midwives or traditional birth attendants (TBA). Most of the people lived in rural areas, but medical services there were still rudimentary, illustrative of a colonial legacy that reproduced capitalist tendencies. The policy was that the central government should not establish a dispensary where the local government had one already. In addition, the government was to hand over dispensaries to the local authorities to maintain or administer them (Tanganyika Ministry of Health 1963:31). This meant that most rural areas received less in terms of medical development.

The lack of facilities was exacerbated by the problem of staffing. By 1963, it was clear that the Tanzanian health sector needed auxiliary maternity staff, who were easier and cheaper to train. It was assumed that auxiliary staff would be retained in the villages because most graduate doctors were based in urban areas. One of the government interventions was to lower entry requirements for some courses, to be upgraded later (Tanganyika Ministry of Health 1963:1). The most important auxiliary medical staff who significantly impacted maternal health were the village midwives, village medical helpers (VHM) and the MCH aides (Gish 1975:12). Having attained seven years of primary schooling, a VMH was selected by fellow villagers or through the church to undergo six months of training at a district hospital after which they would work in the villages in collaboration with the nearby RHC.

Collaborating with the RHC and dispensaries was a way of getting medical services closer to homes. However, there was disagreement on who to train: on the one hand, young women were more suitable for the job, but on the other hand, it was not socially acceptable for them to perform the delivery and maternity duties. This is because, initially, Africans believed that midwifery was meant for not just any female but a woman whith had moral standing in society, preferably married and a mother herself. This resonates with Thomas Lynn's' 'Politics of the Womb', where the notion of being 'biologically able but not socially consecrated' is well articulated (Lynn 2003:10). Although training girls straight from school was the easiest and perhaps the most successful way, the government also resorted to training older women who would be accepted by their fellow villagers (Tanganyika Ministry of Health 1963:33). This was a replica of the dilemma of the missionaries in the colonial days: when they wanted to train young as opposed to old women, they were believed to be propagating bad delivery and child-rearing techniques, as well as 'satanic' habits (Bruchhausen 2003:105).

Secondly, many young women did not have the prerequisite qualifications, as a result of the gendered character of the education system, in which sending only boys to school was preferred. Moreover, young women who had the qualifications would train but later quit their jobs for other reasons, including marriage. After all, taking care of the home, husband, and children was a more socially expected and accepted trajectory of life. Those who continued working had to look for health facilities where their husbands had been posted. In Ifakara, nearly every retired female health worker I spoke with answered the question, 'When did you come to Ifakara?' by saying, 'I followed my husband after he was posted here'.[16]

Though the government embarked on training older women, attending home deliveries proved difficult because of poor transportation and communication networks. Further, it was never easy to get these older women to train. Perhaps this was seen as interfering with the duties of the traditional midwives. In some areas, like Iringa, training village midwives was abandoned as early as 1962, partly because there were no available women to train (Tanganyika Ministry of Health 1962:32). In addition, there were not many trained village midwives, and they first had to handle the demands of the health facilities before domestic services (Tanganyika Ministry of Health and Labour 1961:5).

In addition, midwifery was a no-go zone for men, a facsimile of the situation in colonial times (Kanogo 2005:171). Machado shows that African women in Dar es Salaam refused to attend clinics and decided to give birth

at home, however 'life-threatening' it was, if the delivery was going to be managed by a man. The newspaper read, '*Wanawake hawataki kupekuliwa na wanaume*' (Women do not want to be inspected by men) (Machado 1950:12). Therefore, to cover the demand for MCH, each of the regions in Tanzania was to have an MCH aide school offering eighteen months of training to selected women whose qualification was a primary school certificate. After the training, MCH aides were posted in dispensaries and RHCs (Gish 1975:13). According to Titmuss *et al.* (1964), the demand for MCH services contributed to the growth of RHCs. However, the relationship between the RHCs and the demand for MCH was symbiotic, such that the availability of these centres also attracted women to seek services. Otherwise, long distances were a major hindrance to accessing a medical facility, with some women having to walk almost 26 kilometres (16 miles) to access MCH services (Tanganyika Ministry of Health 1963:2; Gish and Walker 1978).

To keep up with the demand, many RHCs and dispensaries were built. However, because the construction of the facilities was done in haste, ostensibly to supply every village, quality was compromised in the process. Most of these dispensaries and health centres did not have staff, drugs and equipment. Also, the expansion went hand in hand with the construction of big zonal and regional hospitals. These were capital-intensive projects that led to excessive borrowing. The reliance on external experts, loans and grants (The Standard 1966a:1, 5), particularly for MCH, was immense, and although it seemed as though the benefits were free of cost, they resulted in debts (Ayoade 1988:104). Secondly, these big hospitals were erected in urban areas, even though, according to Nyerere, Tanzania was 'aiming at the village while the others were aiming at the moon' (Nyerere 1973:5). The construction of these hospitals meant that the government was still concentrating on a curative rather than a preventive health system (Segall 1972).

The inequities described above explain why the RHCs and dispensaries had to do most of the MCH work in the rural areas. The role of the midwives in these facilities was to organise postnatal, antenatal and family planning, nutritional education and school health and the health of children below the age of five. Some of these procedures involved vaccination. With the help of UNICEF, child vaccination procedures were carried out against whooping cough, diphtheria and tetanus (Tanganyika Ministry of Health and Labour 1961:9). Though vaccination was recorded as popular and already accepted, there were cases where mothers refused to have their children vaccinated, and worse still, others did not complete the required dose, leading

to wastage (Tanganyika Ministry of Health and Labour 1961:10). In addition, the availability and efficacy of vaccines was dependent on storage, which was lacking. Only a few hospitals and health centres had kerosene refrigerators, which were difficult to maintain and broke down easily.[17] This was characteristic of many former colonies, including francophone regions like Senegal (Keita 2007) and Belgian Congo (Hunt 1988). Even basic equipment in MCH kits, such as syringes, weighing scales, sterilisers, blood pressure pumps and needles, were not readily available, and, in most cases, the facilities relied on aid (Hart 1978:7).

The policy of handling more complicated maternal health cases was not friendly. A case too complex for an RHC was referred to the nearby district hospital and then the regional hospital, after which the case would be taken to Dar es Salaam. The nature of the case, which was often treated as an emergency, did not allow for such bureaucracy, given the major infrastructural problems that existed. There were no ambulances in the rural areas, except for the few Land Rovers that were part of the UNICEF aid given to support mobile clinics (Tanganyika Ministry of Health and Labour 1961:12). The use of mobile clinics for MCH was problematic: there were too few vehicles, fuel was lacking, the poor roads led to constant breakdown (Ngurumo 1965:3) and, in some cases, women in labour were carried on bicycles (Stirling 1977:92). Retired nurses in Ifakara also recalled having to trek long hours to the villages but these mobile clinics could not reach everyone.[18]

In addition, the MCH programme was poorly planned, such that clinic sessions for mothers, for child immunisation, for sick mothers, for sick children and for family planning were all held on different days, which made it difficult for mothers to attend. Even a woman who was not employed could not keep up with these trips, not to mention pregnant women, working women and rural women who had farming or other work to do (Hart 1978:8). This necessitated a harmonisation of these services by 1978.

In the villages, TANU, as already noted, was active in popularising health policies. For instance, TANU women advocated for better hygiene, childcare and nutritional practices through music and clubs (Titmuss *et al.* 1964:53; Geiger 1997:65).[19] Women organised themselves into groups, primarily according to regions. In Morogoro, for instance, women carried out different activities, such as farming, tailoring, knitting, reading, writing and artwork, such as mat-making (Geoghegan 1965:38). A particular group of women in Kilosa, Morogoro, met three times a week to discuss matters concerning womenfolk, hygiene and agriculture (The

Standard, 17 January 1966:19). At these meetings, women were taught how to take care of the family and young children. These meetings were given a boost by the emphasis on primary healthcare, through campaigns such as *Mtu ni Afya* (Man is Health) and *Chakula ni Uhai* (Food is life) in the 1970s (Budd 1978:46). In these campaigns, TANU leaders became campaign group leaders. Budd states that these campaigns would not have succeeded without the Party, pointing out that the main reason previous campaigns failed was because they were disconnected from TANU's politics (Budd 1978:28).

In these meetings, however, colonial policies and medical missionary practices continued. For example, there was the 'president's bounty' for any woman who gave birth to triplets (NRC,[20] M.15/530 1966; *The Standard* 27 January 1966:2). In colonial days, this was referred to as the 'Governor's Bounty' (NRC, M.1/15/46 1960). The reason for the bounty in Tanzania is not clear, but, as in other parts of the continent, such rewards were meant to discourage the taboo and killing of twins or triplets. After independence, the bounty may have been used to popularise the presidency. TANU remained at the centre with its political education department, playing a key role in publicising both political and other matters to the society.

In this way, the overall acceptance of policies was also influenced by social, economic, environmental and political factors. Events and subsequent societal changes played a significant role in shaping social policies. For instance, periodic famines in certain parts of Tanzania affected nutrition in those regions. This highlighted the importance of providing nutritional education to mothers, addressing not only food availability but also social and cultural practices. Additionally, even in regions with abundant food, like Kilombero in the Rufiji Basin, malnutrition remained prevalent because of traditional customs that restricted women from consuming protein-rich foods (Ngurumo 1970:2). Lack of nutritional knowledge led to the continued consumption of less nutritious staples, such as cassava and rice (Meredeth 1977:23).

It was noted in the Rufiji Basin report that consumption of goat or chicken occurred only on special occasions because these animals were usually kept for sale (MOH 1960:3). The report added that people were also not fond of eating eggs or drinking milk. Furthermore, vegetables like green leaves and pumpkins were not popular, and fruits – mostly mangoes or oranges – were eaten only in their season. Mothers did not have enough milk to breastfeed their babies, causing them to feed their infants with porridge on the second day after birth (MOH 1960:12). Therefore, health education was deemed necessary. However, the approaches were

similar to those of colonial times. Mama Maria Nyerere, the first lady, initiated a programme of giving powdered milk to women and their children (The Standard 23 February 1966:3). The initiative also aimed to educate parents on proper child upbringing, expanding MCH facilities and launching campaigns against diseases that posed a significant threat to MCH (Titmuss *et al*. 1964:79).

Health education was intensified, and as early as 1963, a standardised health education teaching kit was put together (Tanganyika Ministry of Health 1963:31). The teaching kit included visual aids, charts, posters, leaflets and scripts for broadcasting health programmes. In addition, seminars for government and private organisations were held. There was also a radio broadcast, dubbed 'Freedom from Hunger Week', in 1963 (Tanganyika Ministry of Health and Labour 1961:5). Similar approaches continued in the 1970s, with campaigns such as *Mtu ni Afya* (Budd 1978). In this campaign, the ministries of agriculture, health and education collaborated to promote better nutrition. Various seminars were held, including international cooperation with FAO and UNICEF to present a series of national nutrition seminars (Tanganyika Ministry of Health 1961:5), the UNICEF seminar on the problems of obstetrics and the newborn, and the Sixth International Nutrition Congress in Edinburgh in 1963 (Tanganyika Ministry of Health 1961:6). The main concern was to reduce maternal and infant mortality and educate people on better health and nutritional practices, mainly preventive. However, after the seminars, implementation was problematic because Tanzania's economy could not support an overhaul of the system from curative to preventive.

Were MCH services better in urban areas such as Dar es Salaam, Arusha and Tanga? In 1961, Sewa Haji Hospital was closed after the completion of the 230-bed third ward block at Muhimbili. However, the Muhimbili maternity section had only fifty beds and forty-two baby cots. The 1961 Annual Report of the Health Division shows that there were ten deliveries per day in this facility, excluding abortions (Tanganyika Ministry of Health and Labour 1961:31). Even though a separate obstetrics section was opened at Muhimbili, it could not handle all the maternity cases. For instance, matters to do with infertility were considered not to be urgent and were put on the waiting list, which is said to have 'lengthened rapidly' (Tanganyika Ministry of Health and Labour 1961:31). As a result, Ocean Road Hospital was mandated to cater for maternity cases. All the general beds were replaced with maternity beds, and by 1961, Ocean Road Hospital had 116 maternity beds (Tanganyika Ministry of Health 1961:1). By 1962, this capacity was increased to 122. However, the pressure was still too great and, therefore,

mothers who had normal deliveries were discharged within twenty-four hours to create space for others, a situation which was worsened by the shortage of staff.

Thus, maternal health conditions in the urban areas were not any better, especially for the poor. Despite the increase in services and the recorded decrease in maternal and infant mortality, as per the statistics, the situation was challenging. The government could not handle all medical matters alone, and so voluntary agencies were brought in. Even if the government had 'planned' to disregard the services of voluntary agencies by replacing them with government facilities, it soon realised that this was impossible. The government changed its strategy by cooperating with the voluntary agencies and giving them either grants or staff. It requested certain voluntary agencies to turn their hospitals into designated district hospitals (DDH), which many voluntary agencies did. The problem was that there was no formal cooperation between the government and voluntary agencies (Jennings 2016:207), a problem that had started in the colonial days, making it difficult to coordinate MCH and other services in the postcolonial era.

Conclusion

The article has discussed how the process of making and implementing policies is a complex venture influenced by a constellation of factors. In the early years of Tanzania's independence, the pressure and triumph of independence were quickly tested through the making and implementation of policies. In the health sector, Tanzania inherited a health system that mimicked and retained elements of colonial policy. In the bid to improve, healthcare policy planning encountered stormy realities. Colonial policies continued, and policymaking remained difficult. By the mid-1960s, despite the progress that had been made, the health sector was still challenged by, among other things, inflation, a rising population and a weak economy. Tanzania continued with the colonial model that largely emphasised modernisation, which often led to dependency and underdevelopment.

The development plan of 1961–1963 reflected the principles of the World Bank. The questions of sovereignty and self-reliance were glaring as early as 1962 because, on many occasions, Tanzania had to retain expatriates for technical and managerial support. Maternal health was no exception. Coupled with a lack of equipment and medical facilities, medical pluralism was practised in that most women sought help from traditional midwives. However, the government embarked on an expansionist policy to build hospitals, RHCs and dispensaries. Unfortunately, this led to financial strain, overreliance on foreign aid, and excessive borrowing.

TANU was at the centre of policymaking and implementation. With TANU women and the Youth League, maternal and health policies were popularised among the masses. However, being the only ruling party, the TANU government had no watchdog, and so policy flaws were inevitable. The medical sector, though expanded, faced many challenges. Indeed, as in many other countries in Africa, postcolonial medical plans and challenges were indicative of the colonial agenda.

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Notes

1. Though the term Tanzania is used, the article is concerned with only the mainland and the name Tanganyika is used where necessary.
2. The population question was the fear that the world's population was on the decline. In Africa, this concern was a real problem in the first decades of the twentieth century, when the population was decimated by wars of conquest, diseases and injuries.
3. TNA as used in the references stands for Tanzania National Archives in Dar es Salaam.
4. Interview, Zuhura Said, 21.9.2023, Lipangalala, Ifakara.
5. Interview, Margaret Kindasi, 25.9.2023, Kibaoni, Ifakara.
6. Oral interviews with Margaret Kindasi, who upgraded from a certificate in nursing assistant to diploma, 25.9.2023, Kibaoni, Ifakara; Leah Mpombo, who upgraded from MCHA to Public Health Aide, then later to a Diploma in Nursing, 25.9.2023, Uwanja wa Ndege, Ifakara; Dr Eliasante Mchomvu, who progressed from Clinical Officer to AMO; interviewed 23.9.2023, Viwanja sitini, Ifakara.
7. In July 1961, Prof. Titmuss, a welfare expert in Britain, was requested by the then Minister of Health in Tanganyika, Mr Bryceson, to review of the medical services in Tanganyika. With his team, Titmuss compiled a report called 'The Health Services of Tanganyika', or simply 'The Titmuss Report'.
8. Interview, George Mwambeta, 19.9.2023, Viwanja Sitini, Ifakara.
9. In this context, it loosely translates to demonstrations, meaning party activities but not protests.

10. Interview with Ephrasia Melowi, 27.9.2023), Ephrasia Melowi interviewed on 2.10.2023, Kidatu.
11. *Bwana Afya* and *Bi Afya* (male and female) were auxiliary health officers, mostly working among the people in preventive health.
12. Interviewee A, 19.9.2023, Viwanja Sitini, Ifakara.
13. *Shamba la Kijiji* (communal land); *Mfumaki* means Mfuko wa Maendeleo ya Kijiji (Village Development Fund).
14. Interview, Zuhura Said, 21.9.2023, Lipangalala, Ifakara.
15. What Zuhura meant was that home delivery accommodated African culture. The belief was that a husband may look for another partner during the period of seclusion after birth which would result in the baby contracting *kilala*. *Kilala* was a condition that led to delayed milestones. Administration of k*ilala* was the reason why many women continued to seek the services of traditional midwives because such rituals were prohibited in hospitals. (For further details on this subject, including other rituals and the role of age in traditional midwifery, please see a forthcoming paper, "Change and Continuity in the Concept of Seniority in Midwifery in Kilombero, Tanzania" by Veronica Kimani and Ulrike Lindner, currently under review by the *Nordic Journal of African Studies.)*
16. Interviews with Leah Mpombo, 25.9.2023, Uwanja wa Ndege, Ifakara, and Christina Isakwisa, 20.9.2023, Viwanja sitini, Ifakara.
17. Interview, Margaret Kindasi, 25.9.2023, Kibaoni, Ifakara.
18. Interview, Christina Isakwisa, 20.9.2023, Viwanja sitini, Ifakara.
19. FGD with Theresia Tamayamali, Zuhura Said, Alice Fande, Hamisi Kulengama, 21.9.2023, Lipangalala, Ifakara.
20. NRC is the National Record Centre in Dodoma.

References

Achola M.A., 2000, Preventive Health and Colonial African Urban Policies in Nairobi, *African Urban Quarterly*. Nairobi: University of Nairobi.

Achola, M.A., 2005, Public Health Policy in an Urban Setting: The Case of Maternal and Child Welfare in the First Ten Years of Moi's Rule', *Proceedings of African Health and Illness Conference at the University of Texas in Austin, USA.* Nairobi: University of Nairobi.

Achola M.A., 2006, Public Health Policy in Kenya: The Case of Nairobi Maternal and Child Health, in Falola, T. and Heaton, M. eds., *Endangered Bodies: Women, Children and Health in Africa.* Trenton, NJ: Africa World Press, pp. 237–248.

African Institute for Economic Development and Planning (IDEP), 1968, *United Republic of Tanganyika and Zanzibar: First Five-Year Plan for Economic and Social Development, 1st July 1964 to 30th June 1969*, Vol 1. Dar es Salaam: Government Printer. https://repository.uneca.org/ds2/stream/#/documents/edc7a7ff-51f3-5725-bc32-beb3d345a89e/page/1

Anderson, J., 1970, *The Struggle for the School: The Interaction of Missionary, Colonial Government and the Nationalist Enterprise in the Development of Formal Education in Kenya.* Nairobi: Longman.

Aravacik, E.D., 2018, Social Policy and the Welfare State, in Açıkgöz, B., *Public and Economic Finance*, Intech Open. DOI: 10.5772/intechopen.82372.

Ayoade, J.A.A., 1988, State Without Citizen: An Emerging African Phenomenon, in Rothchild, D. and Chazan, N., eds. *The Precarious Balance: The State and Society in Africa*. New York: Routledge, pp. 100–118.

Bech, M.M, Lawi, Y.Q, Massay D.A. and Rekdal O.B., 2013, Changing Policies and Their Influence on Government Health Workers in Tanzania, 1967–2009: Perspectives from Rural Mbulu District, *The International Journal of African Historical Studies*, Vol. 46, No. 1, pp. 61–103.

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

Bruchhausen, W., 2003, Practising Hygiene and Fighting the Natives Diseases: Public and Child Health in German East Africa and Tanganyika Territory, 1900–1960, *DYNAMIS*, Vol. 23, pp. 85–113.

Budd, H.L., 1978, *Mtu Ni Afya ('Man is Health'): Tanzania's Health Campaign*. Washington DC: Agency for International Development.

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

Crozier, A., 2007, *Practising Colonial Medicine: The Colonial Medical Service in British East Africa*. London: Bloomsbury Publishing Plc.

Davin, A., 1978, Imperialism and Motherhood. *History Workshop*, Spring, No. 5, pp. 9–65.

Dreier, M., 2015, Health, Welfare and Development in Rural Africa: Catholic Medical Mission and Configuration of Development in Ulanga, Tanzania, 1920–1970. PhD dissertation: University of Basel.

Etten, G.M.V., 1976, *Rural Health Development in Tanzania*. Assen: Van Gorcum & Comp. B.V.

Geiger, S., 1997, *TANU Women: Gender and Culture in the Making of Tanganyikan Nationalism*, *1955-1965*, Portsmouth: Heinemann.

Giblin, J.L., 1996, The Precolonial Politics of Disease Control In the Lowlands of North-eastern Tanzania, in Maddox, G., Giblin, J. and Kimambo, I., eds. *Custodians of the Land Ecology & Culture in the History of Tanzania*. London: James Currey.

Gish, O., 1975, The Way Forward, *Journal of World Health* 6. https://iris.who.int/bitstream/handle/10665/272473/WH-1975-Apr-p8-13-eng.pdf?sequence=1

Gish, O. and Walker, G., 1978, Alternative Forms of Transport and their Use in the Health Sector of Developing Countries, *International Journal of Health Services*, Vol. 8, No. 4, pp. 633–651.

Green, A., 2007, *An Introduction to Health Planning for Developing Health Systems.* Oxford: Oxford University Press.

Hart, Dr., 1978, MCH Nutrition: Tackling the Malnutrition Problem in the Ministry of Health, *Lishe: Tanzania Food and Nutrition Journal*, Vol. 2, No. 4.

Hunt, N.R., 1988, 'Le Bébé En Brousse': European Women, African Birth Spacing and Colonial Intervention in Breast Feeding in the Belgian Congo, *The International Journal of African Historical Studies*, Vol. 21, No. 3, pp. 401–32.

Illife, J., 1998, *East African Doctors: A History of the Modern Profession*. Cambridge: Cambridge University Press.

Jennings, M., 2016, Cooperation and Competition: Missions, the Colonial State and Constructing a Healthy System in Colonial Tanganyika, in Greenwood, A. ed., *Beyond the State: The Colonial Medical Service in British Africa.* Manchester: Manchester University Press pp. 153–73.

Kahama, G., Maliyamkono T.L. and Wells, S. 1986, *The Challenge for Tanzania's Economy.* London: James Currey Ltd.

Kanogo, T., 2005, *African Womanhood in Colonial Kenya 1900–50*. Oxford: James Currey Ltd.

Keita, M., 2007, *A Political Economy of Healthcare in Senegal.* Leiden: Koninklijke Brill NV.

Kimani, V., 2015, The Transformation of Circumcision and Masculinity Among the Agikuyu of Kiambu, 1945–2008. Master's thesis: Kenyatta University.

Kithinji, M.W., 2012, An Imperial Enterprise: The Making And Breaking of the University of East Africa, 1949–1969, *Canadian Journal of African Studies / Revue Canadienne des Études Africaines*, Vol. 46, No. 2, pp. 195–214.

Lindner, U., 2014, The Transfer of European Social Policy Concepts to Tropical Africa, 1900–50: The Example of Maternal and Child Welfare, *Journal of Global History*, Vol. 9, No. 2, pp. 208–31. DOI:10.1017/S1740022814000047.

Lynn, T.M., 2003, *Politics of the Womb: Women, Reproduction, and the State in Kenya*, Oakland, CA: University of California Press.

Machado, R., 1950, Hatutakumbali Wanaume Clinic, *ZUHRA Newspaper*, 23 September, p. 10.

Macrotrends, n.d. Tanzania Infant Mortality Rate 1950–2024. https://www.macrotrends.net/countries/TZA/tanzania/infant-mortality-rate Accessed 25.8.2023.

Malowany, M., 1997, Medical Pluralism: Disease, Health and Healing on the Coast of Kenya, 1840–1940. PhD thesis: McGill University.

Malpass, P., 2005, *Housing and the Welfare State: The Development of Housing Policy in Britain*, New York: Palgrave Macmillan.

Mandela, N., 1994, *Long Walk to Freedom: The Autobiography of Nelson Mandela*. London: Abacus.

Masebo, O., 2010, Society, State, and Infant Welfare: Negotiating Medical Interventions in Colonial Tanzania, 1920–1950. PhD thesis: University of Minnesota.

Mbilinyi, M.J., 1979, African Education During British Colonial Period, 1919–1961, in Kaniki, M.H.Y. ed., 1980, *Tanzania Under Colonial Rule*, Harlow: Longman, p. viii.

Meredeth, T., 1977, The Impact of Colonialism on Health and Health Services in Tanzania, *International Journal of Health Services*, Vol. 7, No. 1, pp. 8–30.

Midgley, J. and Livermore, M., 2009, Introduction: Social Policy and Social Welfare, in Midgley, J. and Livermore, M. eds. A *Handbook of Social Policy: Introduction*. 2nd ed. New York: Sage.

Milevska-Kostova, N., Stikova, E. and Donev, D., 2008, Health Policy Analysis and Development, in Kovacic, L. and Zaletel Kragelj, L. eds. *Management in Health Care Practice*, Lage: Hans Jacobs Publishing, pp. 147–63.

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

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

Ngurumo (Swahili Newspaper), 4 Desemba 1964, Mbunge Adai Viwanda Visiwekwe Dar Pekee Yake.

Ngurumo, 2 February 1965a, Ajali Barabarani.

Ngurumo, 15 Machi 1965b, Mtanzania Asomea Meno Eastmont Hospital.

Ngurumo, 8 Januari 1970, Kina Mama Kilosa Waendelea.

Nhonoli, A.M. and Nsekela A.J., 1976, *Health Services and Society in Mainland Tanzania: A Historical Overview 'Tumetoka Mbali'.* Dar es Salaam: EALB.

NRC, M.1/15/46 1960 Letter from DC Kisarawe to the PC Morogoro 20th September 1960, Wazaramo Triplets.

NRC, M.15/530 1966 Letter from the Administrative sec to the Area Secretary Mahenge 19th July 1966. (RE: President's Bounty for Triplets).

Nyerere J., 1965, Hotuba Ya Rais, Mwalimu Julius K. Nyerere Katika Mbunge Tuesday 8 June 1965, Kuhusu Siasa ya Serikali.

Nyerere, J., 1973, *Freedom and Development: A Selection of Writings and Speeches, 1963– 1978.* Dar es Salaam: Oxford University Press.

Ombongi, K., 2011, The Historical Interface Between the State and Medical Science in Africa, in Geissler, P. and Molyneux, C., eds. *Evidence, Ethos and Experiment: the Anthropology and History of Medical Research in Africa*, New York: Berghahn Books, pp. 353–371.

Pekarová, D., 2017, Health Policy as a Specific Area of Social Policy, *Challenges of the Future*, Vol. 2, pp. 102–20.

Ranger, T., 1981, Godly Medicine: The Ambiguities of Medical Mission in Southeast Tanzania, 1900–1945, *Social Science and Medicine*. Part B: Medical Anthropology, Vol. 15, No. 3, pp. 261–277.

Segall, M., 1972, The Politics of Health in Tanzania, *The Standard*, 21 March.

Stirling, L., 1977, *Tanzanian Doctor*. London: C. Hurst and Company.

Tanganyika, Medical Department, 1959, *Annual Report: Report on Health Services 1959,* Prepared by the Principal Secretary Ministry of Health. Dar es Salaam: Government Printer.

Tanganyika, Ministry of Health, 1957, *Annual Report of the Medical Department*, vol 1, 1957. Dar es Salaam: Government Printer.

Tanganyika, Ministry of Health, 1958, *Annual Report of the Medical Department,* Vol 1, 1958. Dar es Salaam: Government Printer.

Tanganyika, Ministry of Health and Labour, 1960, *Annual Report of the Health Division, 1960,* Vol. 1, Prepared by the Chief Medical Officer. Dar es Salaam: Government Printer.

Tanganyika, Ministry of Health and Labour, 1961, *Annual Report of the Health Division 1961*, Vol 1. Prepared by the Chief Medical Officer. Dar es Salaam: Government Printer.

Tanganyika, Ministry of Health and Labour, 1961, *Annual Report of the Health Division 1961*, Vol II (Statistics). Prepared by the Chief Medical Officer. Dar es Salaam: Government Printer.

Tanganyika, Ministry of Health, 1962*, Annual Report of the Health Division 1962*, Vol II (Statistics), Prepared by the Chief Medical Officer. Dar es Salaam: Government Printer.

Tanganyika, Ministry of Health, 1963*, Annual Report of the Health Division, 1963,* Vol 1. Prepared by the Chief Medical Officer. Annual Report. Dar es Salaam: Government Printer.

Tanganyika, 1961, *Development Plan for Tanganyika 1961/62–1963/64*. Dar es Salaam: Government Printer.

The Standard, 7 January 1966a Loan in Yen from Japan to Tanzania.

The Standard, 7 January 1966b, Five-Year Development Plan Held Up.

The Standard, 19 January 1966, Kilosa Completes 10,000 Pounds Projects.

The Standard, 17 January 1966, Women's Role Is Vital.

The Standard, 27 January 1966, Kilosa Sisal Worker's Wife Has Triplets.

The Standard, 23 February 1966, Mrs Nyerere Sees Free Milk Scheme.

Tignor, R.L., 1976, *The Colonial Transformation of Kenya: The Kamba, Kikuyu and Maasai from 1900 to 1939.* Princeton, NJ: Princeton University Press.

Tilley, H., 2011, Africa as a Living Laboratory: Empire, Development and the Problem of Scientific Knowledge 1870–1950. Chicago, IL: University of Chicago Press.

Titmuss, R.M., Abel-Smith, B., Macdonald, G., Williams, A. W. and Wood, C. H., 1964, *The Health Services of Tanganyika: A Report to the Government.* London: Pitman Medical Publishing Co. Ltd.

TNA/ACC450/108, 1944, Dar es Salaam Maternity and Child Welfare Clinic, Tanzania National Archives.

TNA/ACC450/HE 1424/6, 1973, Dar es Salaam Maternity and Child Welfare Clinic.

TNA/HE 1674/5, 1962, Technical Assistance U.K. Tanzania National Archives.

TNA/HEA/150/2/411, 1974, Mkutano Baina ya Wazzee wa TANU wa DSM na WAZIRI WA Afya.

TNA/HEA/90/5, 1977, Application for Further Studies in Medicine Course. Tanzania National Archives.

TNA/HEA/90/16, 1977, Technical Assistance Japan. Tanzania National Archives.

TNA/HQ/1.30/21/11, 2.9.1975, TANU5 (Tanzania National Archives).

United Republic of Tanzania, First Five-Year Plan for Economic and Social Development, 1st July 1964 to 30th June 1969 Vol 1.

United Republic of Tanzania, Second Five-Year Plan for Economic and Social Development, 1st July 1969 to 30th June 1974 Vol 1.

Vaughan, M., 1991, *Curing Their Ills: Colonial Power and African Illness*. Redwood City, CA: Stanford University Press.

Vögele, J., 2010, 'Has All That Has Been Done Lately For Infants Failed?' 1911, Infant Mortality and Infant Welfare in Early-Twentieth Century Germany, *Annales de Démographie Historique*, Vol 2, pp. 131–146.

World Health Organization (WHO) Constitution, 1946. https://www.who.int/about/governance/constitution

Zeleza, P.T., 1997, *Manufacturing African Studies and Crises*. Dakar: CODESRIA.