Changing Policies and Their Influence on Government Health Workers in Tanzania, 1967–2009: Perspectives from Rural Mbulu District*

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Tanzania has experienced fundamental policy shifts during the last forty to fifty years. This included experimentation with reforms based on socialism and neoliberalism, and involved powerful actors. Julius K. Nyerere, president of Tanzania from 1964 to 1985, was the most influential individual with his development model "African Socialism" or *Ujamaa*. In addition to the Tanzanian government, the World Bank, the International Monetary Fund (IMF), and multi- and bi-lateral donor agencies have played prominent roles in the formation of Tanzanian policies.

The public health services have been one of the main targets for policy and structural reforms, and staff on the ground have had to cope with new measures under changing regimes. Historian Ann Beck, who did extensive research on the development of biomedical services in East Africa from colonial times until 1970,[1] argued that "[s]ome of the problems ... which later caused much frustration and harassment to the medical officers in the twentieth century were present at the very beginning ... of the British medical services in East Africa [the 1890s] ... Money was scarce ... [and] the actual working conditions did not resemble the utopian plans."[2] The history of African biomedical doctors in East Africa was published in the collective biography *East African Doctors: A History of the Modern Profession* after extensive research by historian John

* The work was carried out by Bech as part of the research project "Strengthening Human Resources for Health: A Study of Health Worker Availability and Performance in Tanzania" (project number 171822/S50), funded by Program for Global Health and Vaccination Research (GLOBVAC), Research Council of Norway. Bech and Rekdal conceived the idea of this article; Lawi provided a deeper understanding of the history of Tanzania and Mbulu District; and Massay assisted Bech in collecting and analyzing the oral and written material. All co-authors contributed to the article. We thank the interviewed health workers for their time and openness; archives and libraries in Tanzania for giving access to their collections; and field assistants from Mbulu District, without whose help the work would not have succeeded: Loema Tluway for assistance in interviews of retired health workers, and Marcell K.A. Amri for transcription and translation of recorded material. The research group "Global Health: Ethics, Economics and Culture," University of Bergen, provided useful comments on an early draft.

[1] Ann Beck, *A History of the British Medical Administration of East Africa, 1900–1950* (Cambridge: Harvard University Press, 1970); *Medicine and Society in Tanganyika 1890–1930: A Historical Inquiry* (Philadelphia: The American Philosophical Society, 1977); *Medicine, Tradition, and Development in Kenya and Tanzania, 1920–1970* (Waltham, MA: Crossroads Press, 1981).

[2] The services started in Uganda. See Beck, *A History of the British Medical Administration*, 8–9.

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Iliffe. He argued that "professions and the state are in large measure symbiotic" and that "the *weakening* of the state in the face of population growth, economic crisis, [and] commersialisation, ... damaged the power and status of East African doctors after independence."[3] In an ethnographic study in 2008 of a district hospital outside Arusha town, the anthropologist Noelle Sullivan discussed the development of the Tanzanian health sector from colonial times, and the hospital from 1968, until the present.[4] When arguing that "an overarching continuity in the history of biomedical institutions and professions in Tanzania has been the considerable gap between ideals outlined in policy and the realities of daily practice" and the interdependence between medical professionals and the state, Sullivan followed up on the reflections made by Beck and Iliffe.[5]

Tanzanian government health worker perspectives were prominent in Iliffe's and Sullivan's research. However, based on scarce written contemporary sources Iliffe found it "hard to assess" doctors'—predominantly male and urban based—reactions to the socialist regime from 1967. He argued that few were dedicated and more were ambivalent. He also argued that protest and strikes by doctors from 1990 until 1992 accelerated change. Iliffe's study ended in 1997, when the health system was still in the adjustment process to neoliberalism.[6] Interviewees in Sullivan's study had negative memories of the socialist period. However, the earliest work experience was from 1977. Sullivan argued that the hospital workers' performance as professionals was undermined due to lack of resources until the late 1990s, when implementation of the health sector reform improved the hospital infrastructure considerably.[7]

This article explores the public health services in Tanzania mainland from 1967 to 2009 from a health worker perspective in order to further examine these issues.[8] We address the questions as to how shifting policies influenced government health workers in their daily work and how they perceived and responded to the policies. Retrospective views from rural Mbulu District challenged perceptions in Iliffe's and Sullivan's studies on some major policies and reforms that influenced government health workers. Interviewees in this study perceived the working conditions in the 1970s and after 2000 as better in

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[3] John Iliffe, *East African Doctors: A History of the Modern Profession* (Cambridge, UK: Cambridge University Press, 1998), 3, 5, 1–6. Iliffe showed how the recruitment and training of Africans in the biomedical field started in the 1870s, their struggle for education and recognition, doctors' role in the development of medical systems in Uganda, Kenya, and Tanzania after independence, and also East African doctors' responses to the AIDS epidemic and their important contribution to research and control of AIDS.

[4] Noelle Sullivan, "Negotiating Abundance and Scarcity: Health Sector Reform, Development Aid, and Biomedical Practice in a Tanzanian Hospital" (Ph.D. thesis, University of Florida, 2011), 69–142, 176–244. A main focus of her study was interaction and interconnection within the hospital and between the hospital and local, national, and global forces from the 1990s. Ibid., 28–51.

[5] Ibid., 70, 37, 107–109. Sullivan did not refer to Beck, but quoted Iliffe.

[6] Iliffe, *East African Doctors*, 208, 218–19.

[7] Sullivan interviewed fifteen health workers. See Sullivan, "Negotiating Abundance and Scarcity," 116–17, 109–42.

[8] "Health worker" includes the internationally qualified medical doctors and nurses, as well as the large group of paramedics in the Tanzanian health system.

comparison to other periods during the years 1967-2009. This is probably due to the implementation of policies during both periods aiming at providing health services to the majority of the population. The interviewees identified the years until 1978 as the only time in their working careers when they could live on government salary; an important indication only briefly mentioned by Sullivan.[9] The decade identified by the interviewees as the worst period in their working careers, the late 1980s until the late 1990s, constitutes a major part of this article. Government health workers in Mbulu District and all over Tanzania felt abandoned and powerless in their appalling local work places, lacking essential drugs, equipment, and personnel. This could be connected to the financial crisis after the socialist era combined with neoliberalist austerity measures from 1986, which drained the Tanzanian public health sector of financial and human resources. An option taken by some of the health workers in Mbulu District and elsewhere was to leave the government service. Retrenchments and a hiring freeze from 1993 to 2001 strained remaining health workers. This measure and its implications were not discussed by Iliffe and Sullivan, and have not received sufficient attention in other research. Even though liberalization gradually opened up the society, health workers in Mbulu District and most other parts of Tanzania had no influence on decision makers based in the far away Dar es Salaam city. We argue that the top-down experiments undertaken by development experts and politicians on the national and global arena during the socialist period (1967–1985) and the neoliberalist period (1986 to the present) had both intended and unintended outcomes. While some of the policies pursued during both periods provided Tanzanian government health workers with acceptable working conditions, others resulted in unacceptable working conditions with long term negative consequences for the Tanzanian public health sector. We also argue that there were some differences in the health workers' experiences depending on the geographical location and size of the facilities in which they worked.

This study adds to Iliffe's and Sullivan's research some new dimensions from female and male employees in the Tanzanian government health services. The historical experiences of the government health workers in this study provide more background understanding to some of the present challenges in the public health sector in Tanzania, discussed within the growing research on human resources for health.[10] The study further

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[9] "Salaries prior to the 1980s were adequate to support families." No source was provided. See Sullivan, "Negotiating Abundance and Scarcity," 266.

[10] This study is part of an interdisciplinary research project including both quantitative and qualitative methods. The government health worker perspective has particularly been included in these three articles: Nils G. Songstad, Ole B. Rekdal, Deodatus A. Massay, and Astrid Blystad, "Perceived Unfairness in Working Conditions: The Case of Public Health Services in Tanzania," *BMC Health Services Research* 11, 34 (2011); Ottar Mæstad and Aziza Mwisongo, "Informal Payments and the Quality of Health Care: Mechanisms Revealed by Tanzanian Health Workers," *Health Policy* 99 (2011), 107–115; Michael A. Munga, Nils G. Songstad, Astrid Blystad, and Ottar Mæstad, "The Decentralisation-Centralisation Dilemma: Recruitment and Distribution of Health Workers in Remote Districts of Tanzania," *BMC International Health and Human Rights* 9, 9 (2009).

contributes, though to a limited extent, to existing literature about the history of biomedical services in Tanzania.[11]

Few Tanzanian government health workers have written about their own experiences.[12] In order to capture health workers' perspectives this article largely relies on oral narratives, collected mainly in rural Mbulu District during fieldwork in Tanzania over a period of thirteen months extending from 2006 to 2009.[13] Mbulu District is located in north central Tanzania, in the highlands to the west of the East African Rift Valley, about 250 kilometres southwest of Arusha town. The district was part of Arusha Region until 2002 when it was included in the newly established Manyara Region.[14] The district's multiethnic population primarily depends on peasant farming and livestock keeping. According to Mbulu District Council, in 2009 the population estimate was 307,620 with an annual growth rate of 3.8 percent[15];while the district had twenty dispensaries, one rural health center and one hospital run by the government with a total health work force of 271.[16]

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[11] See the above mentioned literature by Beck, and David F. Clyde, "History of the Medical Services of Tanganyika" (Dar es Salaam: Government Printer, 1962); Amon J. Nsekela and Aloysius M. Nhonoli, *The Development of Health Services and Society in Mainland Tanzania* (Nairobi: East African Literature Bureau, 1976); the chapter about transfer of biomedicine from Europe to Tanzania 1860–2000, in Walter Bruchhausen, *Medizin zwischen den Welten: Geschichte und Gegenwart des medizinischen Pluralismus im südöstlichen Tansania* (Göttingen: V&R unipress, Bonn University Press, 2006), 39–140. Another contribution was Helmut Goergen, Walter Bruchhausen, and Kirsten Kuelker, eds., "The History of Health Care in Tanzania: An Exhibition on the Development of the Health Sector in More than 100 Years" (Dar es Salaam, German Agency for Technical Cooperation (GTZ) and National Museum of Tanzania, 2001).

[12] The rare attempts include a book by a health officer and co-authors. See Babuel A. Lyimo, Per Bergsjø, and Knut-Inge Klepp, *From Smallpox to AIDS: Public Health Services at Grassroots Levels in Tanzania (1955–1995)* (Bergen: Center for International Health, University of Bergen, 2001). Another contribution was an abstract by a pediatrician to the Medical Association of Tanzania (MAT). See V. P. Kimati, "The Effect of Welfare of Medical Officers on Quality of Health Care in Tanzania" (MAT 36th Annual General Meeting and Scientific Conference, Program and Abstracts, Dar es Salaam 19–21 September 2001).

[13] The research project had ethical clearance from the National Institute for Medical Research (NIMR) in Tanzania (NIMR/HQ/r.8a/Vol. IX/433); and Bech had research permits from the Commission for Science and Technology (COSTECH) (2006–69), and introduction letters from Manyara Region and Mbulu District.

[14] United Republic of Tanzania (hereafter Tanzania), "Manyara Region: Socio-Economic Profile" (2nd ed., Dar es Salaam, National Bureau of Statistics and Manyara Regional Commissioner's Office, 2005), 1.

[15] Tanzania, "Comprehensive Council Health Plan for the Year 2009/2010" (Mbulu, Mbulu District Council, 2009), 1.

[16] In addition the district had seven dispensaries, two rural health centers and one hospital that were non-governmental. The most common diagnoses of in and out patients in Mbulu District in 2008 were malaria, pneumonia, respiratory tract infections, diarrheal and gastroenteritis diseases, and tuberculosis. See ibid., 4, 13–15.

Twenty-seven government health workers (fifteen female and twelve male) representing ten staff categories were interviewed in Mbulu District.[17] Eight of them were retired at the time of interviews (aged 60–75). The interviewees had long work experiences in the government health service: one since 1952, six since the 1960s, eight since the 1970s, and twelve since the 1980s; and had experience from three different levels within the Tanzanian public health system: dispensaries, rural health centers and district hospitals. A few had also worked for voluntary agencies and private dispensaries, clinics, and pharmacies. Also included among interviewees were three retired male medical doctors with work experience from the Ministry of Health, and national, regional and district hospitals, as well as health education institutions; and one retired female nurse in a higher position within the nursing education sub-sector at the national level. The interviews, done individually or in groups in Swahili or English, were recorded, transcribed/translated. Most of the interviewees wanted anonymity, and therefore all were treated anonymously. The oral narratives are discussed in relation to the broader context of the Tanzanian sociopolitical setting. In the analysis we also include information gathered from newspaper articles, documents from the Tanzanian government and external actors, and academic literature.

Changing Policies: From Socialism to Neoliberalism

The Tanzania mainland, known in colonial times as Tanganyika Territory, became independent in December 1961. The Tanganyika African National Union (TANU), led by Nyerere, peacefully took over the Territory's governance from the British.[18] In his independence message to TANU, Nyerere declared disease as one of the major challenges of the new nation: "Poverty, ignorance, and disease must be overcome before we can really establish in this country the sort of society we have been dreaming of. These obstacles are not small ones, they are more difficult to overcome than any alien government."[19]

The biomedical services, introduced by the Europeans, had been expanded and improved during the seventy years of colonial administration.[20] However, the beginning of

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[17] Medical doctor (1), assistant medical officer (2), clinical officer (5), health officer (1), nurse tutor (1), nursing officer (5), nurse midwife (2), nurse (4), maternal and child health aide (1), and medical attendant (5). Some of these staff categories are no longer in official use. To secure anonymity, an interviewee in a higher position is called "health worker in a senior position" throughout the paper.

[18] The mainland was part of the German protectorate or colony "Deutsch-Ostafrika" from 1885; officially under the German government from 1891 until the end of the First World War when the British took control. The British ruled Tanganyika Territory as a mandate area under the League of Nations from 1922, and from 1947 to 1961 under a trusteeship agreement with the United Nations. See John Iliffe, *A Modern History of Tanganyika* (Cambridge: Cambridge University Press, 1979), 88–91, 97–98, 246–47, 430, 576.

[19] Julius K. Nyerere, *Freedom and Unity Uhuru na Umoja: A Selection from Writings and Speeches 1952–65* (1966; reprint, Dar es Salaam: Oxford University Press, 1970), 139.

[20] Clyde, "History of the Medical Services"; Richard M. Titmuss, Brian Abel-Smith, George Macdonald, Arthur W. Williams, and Cristopher H. Wood, *The Health Services of Tanganyika: A Report to the Government* (London: Pitman Medical Publishing Company, 1964), 1–32; Nsekela and Nhonoli, *The Development of Health Services*, 5–74; Beck, *Medicine, Tradition, and Development*, 1–35; Bruchhausen, *Medizin zwischen den Welten*, 57–123.

social improvements for the general population started as late as 1956.[21] The main concern of the colonial system had been the Europeans and the few African and Asian civil servants in urban areas, and African male workers in colonial production.[22] The central government mainly provided hospital services, while local native authorities were responsible for rural dispensaries and the building of health centers that started in 1958. Christian missions (categorized as voluntary agencies from 1961) were a major provider of hospital and dispensary services in rural areas, where the majority of the population lived.[23]

At independence only twelve of about 400 registered doctors in Tanganyika were African, and several training programs were started to increase the number of African medical staff.[24] Thus, the Tanganyika government inherited from the British a neglected educational system, an underdeveloped health sector, and a critical shortage of African health workers.[25] In the period from January to December 1962, when Nyerere resigned as prime minister to become president of TANU and later president of the Republic of Tanganyika, more Africans were given senior posts in the civil service. In the Ministry of Health in 1965, thirty medical officers were Tanzanian citizens, sixty-two were expatriates, and thirty-five posts were vacant.[26]

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[21] Titmuss, et al., *The Health Services of Tanganyika*, 23–24; Nsekela and Nhonoli, *The Development of Health Services*, 121; Beck, *Medicine, Tradition, and Development*, 14.

[22] Gerardus M. van Etten, *Rural Health Development in Tanzania: A Case-Study of Medical Sociology in a Developing Country* (Assen, Netherlands: Van Gorcum, 1976), 16–38; Meredeth Turshen, "The Impact of Colonialism on Health and Health Services in Tanzania," *International Journal of Health Services* 7, 1 (1977), 26–30; *The Political Ecology of Disease in Tanzania* (New Brunswick, N.J.: Rutgers University Press, 1984), 149–52; Douglas E. Ferguson, "The Political Economy of Health and Medicine in Colonial Tanganyika," in Martin H.Y. Kaniki, ed., *Tanzania Under Colonial Rule* (London: Longman, 1980), 307–43.

[23] Some missions received grants from the central government. See Tanganyika Territory, "Annual Report of the Medical Department 1958" (Dar es Salaam: Government Printer, 1959), 1: 1–2, 20, 23, 36–37, 44. In 1961, fifty-two hospitals and twenty-one dispensaries were governmental, while forty-seven hospitals and 239 dispensaries belonged to voluntary agencies; local authorities were responsible for twenty-two health centers and 715 dispensaries; industrial or occupational health provided 1,659 beds for patients. The population estimate was 9.2 million. See Tanganyika Territory, "Annual Report of the Health Division 1961" (Dar es Salaam: Government Printer, 1963), 2: 12–15, 22–24; Timotheus W.J. Schulpen, *Integration of Church and Government Medical Services in Tanzania: Effects at District Level* (Nairobi: African Medical and Research Foundation, 1975), 58–61.

[24] In 1961, there were also five African intern doctors in government service. See Titmuss, et al., *The Health Services of Tanganyika*, 30, 180; Julius K. Nyerere, *Freedom and Development Uhuru na Maendeleo: A Selection from Writings and Speeches 1968–1973* (Dar es Salaam: Oxford University Press, 1973), 293; Oscar Gish, *Planning the Health Sector: The Tanzanian Experience* (1975; 2nd ed., London: Croom Helm, 1978), 20–21; Nsekela and Nhonoli, *The Development of Health Services*, 71–95; Iliffe, *East African Doctors*, 119, 127–28.

[25] Nyerere acknowledged in Clyde's foreword in 1962 that there was a medical service at independence, "due in no small measure to the medical workers of earlier years." See Clyde, "History of the Medical Services," i.

[26] Cranford Pratt, *The Critical Phase in Tanzania, 1945–1968: Nyerere and the Emergence of a Socialist Strategy* (Cambridge: Cambridge University Press, 1976), 105–26, 131.

In April 1964 Tanganyika and Zanzibar joined to form a union and Nyerere became the first president of the United Republic of Tanzania. By 1965 Tanzania was a one-party state.[27] National five-year development plans guided the activities of all sectors, including health, until 1981.[28] Since Zanzibar retained relative autonomy for matters concerning internal affairs, the union government's policies on health mainly applied to the mainland. An invited team of British medical planners, led by Richard M. Titmuss, warned the policy makers in their 1964 report that "[i]f a health plan for Tanganyika is to progress beyond the stage of ideas and ideals it must be firmly based on the realities of economics and population."[29]

Socialism: 1967–1985

An official policy shift came in 1967 with the announcement of the Arusha Declaration and the adoption of "Socialism and Self-reliance." Nyerere argued that European socialism—a result of the agrarian and the industrial revolutions—was not applicable to Africa, where people traditionally had lived in "tribal socialism" devoid of a capitalist class struggle. Nyerere believed that "African Socialism," *Ujamaa* (familyhood), would be attained by persuading the dispersed population to move together in villages and work collectively to increase agricultural production and thus improve their livelihoods. It was further envisaged that the government would provide basic social services to such village communities.[30] Villagization campaigns were implemented to resettle people.[31]

The socialist policy was based on the philosophy of central state planning. The government took control of the major means of production and nationalized institutions; the civil service and parastatals (state corporations) were expanded. The state-party tried to regulate all aspects of society, from price control to the media. In 1977 TANU merged with the Afro-Shirazi Party (ASP), the ruling party in Zanzibar, and formed *Chama Cha Mapinduzi* (CCM), "Party of the Revolution."[32] To strengthen rural planning and

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[27] For Nyerere's arguments for a democratic one-party system, see Nyerere, *Freedom and Unity*, 195–203.

[28] United Republic of Tanganyika and Zanzibar (hereafter Tanganyika and Zanzibar), "Tanganyika Five-Year Plan for Economic and Social Development 1st July, 1964–30th June, 1969" (Dar es Salaam: Government Printer, 1964), 1: 68–72, 2: 118–22; Tanzania, "Tanzania Second Five-Year Plan for Economic and Social Development 1st July, 1969–30th June, 1974" (Dar es Salaam: Government Printer, 1969), 1: 162–175; 2: 101–10; "Third Five Year Plan for Economic and Social Development 1st July 1976–30th June 1981" (Dar es Salaam: Government Printer, 1977), 1: 89–93, 107–108.

[29] Titmuss, et al., *The Health Services of Tanganyika*, 31–32.

[30] Nyerere, *Freedom and Unity*, 162–71; *Freedom and Socialism Uhuru na Ujamaa: A Selection from Writings and Speeches 1965–1967* (Dar es Salaam: Oxford University Press, 1968), 231–50, 337–66, 385–409.

[31] A voluntary campaign was initiated from 1967. According to Coulson and Lawi, a compulsory campaign 1973–1976 was carried out by force throughout the country. See Andrew Coulson, *Tanzania: A Political Economy* (Oxford: Clarendon Press, 1982), 235–62; Yusufu Q. Lawi, "Tanzania's Operation Vijiji and Local Ecological Consciousness: The Case of Eastern Iraqwland, 1974–1976," *Journal of African History* 48, 1 (2007), 71–75.

[32] Pratt, *The Critical Phase*, 237–38; Coulson, *Tanzania*, 176–331.

administration, local authorities were dissolved in 1972 and power was given to regions.[33] However, in 1982 local government authorities (district and urban) were re-established.[34]

Tanzania was striving to be self-reliant, as described in the Arusha Declaration: "The four prerequisites of development are ... (i) People; (ii) Land; (iii) Good Policies; (iv) Good Leadership."[35] At the same time Nyerere welcomed capital and skilled people from abroad. The main focus of development was on agriculture, small industry, and education.[36] Nyerere's ideas were embraced by socialist regimes and by many development economists; and African countries that relied on state control of the economy were supported financially by the World Bank and aid donors.[37] Between 1967 and 1973 the estimated Tanzanian annual growth of Gross Domestic Product (GDP) per capita averaged 1.8 percent.[38]

The overall health policy for socialist Tanzania was discussed at the TANU conference in September 1971, where the party directed that health services, along with water and education in the rural areas, should receive priority in future national development plans. Preventive health services and training of rural health cadres were emphasized. It was determined that medical care should, in general, be provided free of charge to the people.[39] Private health services were restricted from 1977.[40] The total

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[33] Tanzania, "The Decentralisation of Government Administration (Interim Provisions) Act, 1972 (Act No. 27/1972)," acts available at Parliament of Tanzania website, www.parliament.go.tz; Nyerere, *Freedom and Development*, 344–50. McKinsey and Company from New York had been commissioned in 1971 to assist the Tanzanian government. See Nsekela and Nhonoli, *The Development of Health Services*, 107; Coulson, *Tanzania*, 255.

[34] Tanzania, "The Decentralization of Government Administration (Interim Provisions) (Amendment) Act, 1982 (Act No. 12/1982)."

[35] Nyerere, *Freedom and Socialism*, 243.

[36] Ibid., 242–47, 267–90, 315–26.

[37] World Bank, *Adjustment in Africa: Reforms, Results, and the Road Ahead* (New York: Oxford University Press, 1994), 20–21; Mike Stevens, "Public Expenditure and Civil Service Reform in Tanzania," in David L. Lindauer and Barbara Nunberg, eds., *Rehabilitating Government: Pay and Employment Reform in Africa* (Washington D.C.: The World Bank, 1994), 62–63. World Bank publications and documents available at, www.worldbank.org.

[38] World Bank, "Economic Memorandum on Tanzania" (Report No. 1567-TA, Washington D.C., World Bank, 1977), 5.

[39] Tanzania, "Hotuba ya Mh. Waziri Ali Mwinyi katika Bunge—Julai 1972. Siasa na Makadirio ya Matumizi ya Fedha kwa Mwaka 1972/73" (Budget Speech by the Minister for Health, Hon. A.H. Mwinyi, MP, for the Year 1972/73) (Dar es Salaam, Wizara ya Afya [Ministry of Health], 1972), para. 5–9, 29; "Evaluation of the Health Sector 1979" (Dar es Salaam, Ministry of Health, 1980), 9–10. Preventive medicine, health centers, and training of staff for rural areas had been recommended in the 1964 Titmuss report and the 1964 and 1969 five-year plans. See Titmuss, et al., *The Health Services of Tanganyika*, 222–32; Tanganyika and Zanzibar, "Tanganyika Five-Year Plan," 1: 68–71; 2: 118–22; Tanzania, "Tanzania Second Five-Year Plan," 1: 162–172; 2: 101–103.

government expenditure on health increased from 5.2 percent of the total government expenditure in 1970/71 to a high of 8.9 percent in 1973/74, but then dropped to 5.6 percent in 1978/79.[41]

In 1973 and 1975 TANU organized major public adult education campaigns on prevention of common diseases, *Mtu ni Afya* ("Man is Health"), and nutrition, *Chakula ni Uhai* ("Food is Life"), reaching out to the rural areas where the majority of the population lived.[42] With the emphasis on rural health, Tanzania was one of the countries inspiring the World Health Organization's (WHO) primary health care Declaration of Alma-Ata in 1978, which had the explicit overall goal of achieving health for all by the year 2000.[43] Tanzania implemented WHO's Primary Health Care (PHC) concept in 1983.[44]

Tanzania's economy stagnated from the late 1970s due to a number of factors: the international oil crisis in 1973 and 1979, the break-up of the East African Community in 1977, the war with Uganda during 1978/79, and decline in agricultural production and export as a result of droughts, floods, and the villagization policy. The budgetary deficit increased and Tanzania tried self-made recovery programs: the National Economic Survival Program (1981–1982) and the Structural Adjustment Program (1982–1985).[45]

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[40] Non-profit health services run by an approved organization, such as religious, could continue to charge small patient fees. See Tanzania, "The Private Hospitals (Regulation) Act, 1977 (Act No. 6/1977)." Some private health institutions were exempted and their fees fixed by the government. A list could be found in *Daily News* 31 March 1978, "78 Clinics Close Down Today" (Dar es Salaam).

[41] Tanzania, "Evaluation of the Health Sector 1979," 30–31.

[42] W.K. Chagula and E. Tarimo, "Meeting Basic Health Needs in Tanzania," in Kenneth W. Newell, ed., *Health by the People* (Geneva: World Health Organization, 1975), 155. In 1967, 93.6 percent of the population lived in rural areas. See Tanzania, "Tanzania Census, 25th August–4th September, 2002: Analytical Report" (Dar es Salaam, National Bureau of Statistics, 2006), 10: 9, available at National Bureau of Statistics website, www.nsb.go.tz

[43] Kenneth W. Newell, "Introduction" and "Health by the People," in Newell, ed., *Health by the People*, ix–xii, 191–202; Chagula and Tarimo, "Meeting Basic Health Needs," 145–68; WHO, "Declaration of Alma-Ata" (Alma-Ata, USSR, International Conference on Primary Health Care, 1978), available at WHO web page, http://www.who.int/topics/primary_health_care/en; T. Kue Young, "Socialist Development and Primary Health Care: The Case of Tanzania," *Human Organization* 45, 2 (1986), 128; Kris Heggenhougen, Patrick Vaughan, Eustace P.Y. Muhondwa, and J. Rutabanzibwa-Ngaiza, *Community Health Workers: The Tanzanian Experience* (Oxford: Oxford University Press, 1987), 1; Bruchhausen, *Medizin zwischen den Welten*, 132–33; Priscilla Wald, *Contagious: Cultures, Carriers and the Outbreak Narrative* (Durham, NC: Duke University Press, 2008), 266.

[44] Tanzania, "Guidelines for the Implementation of the Primary Health Care Programme in Tanzania" (Dar es Salaam, Ministry of Health, 1983).

[45] Knut E. Svendsen, "The Creation of Macroeconomic Imbalances and a Structural Crisis," in Jannik Boesen, Kjell J. Havnevik, Juhani Koponen and Rie Odgaard, eds., *Tanzania: Crisis and Struggle for Survival* (Uppsala: Scandinavian Institute of African Studies, 1986), 59–78; Howard Stein, "Economic Policy and the IMF in Tanzania: Conditionality, Conflict, and Convergence," in Horace Campbell and Howard Stein, eds., *Tanzania and the IMF: The Dynamics of Liberalization* (Boulder, CO: Westview, 1992), 59–69; Kjell J. Havnevik, *Tanzania: The Limits to Development From Above* (Uppsala: Nordiska Afrikainstitutet, 1993), 46–62.

The economy was in crisis and the estimated GDP per capita average annual growth rate was -1.7 percent between 1981 and 1986.[46] Nyerere's socialist regime was gradually losing political legitimacy and donor support in the face of these hardships. In 1985 Nyerere stepped down as president, but continued as CCM chairman until 1990.[47]

Neoliberalism: 1986–Present

When the bilateral donors stopped supporting the "socialist experiment," the Tanzanian government had no choice but to gradually accept the principles of economic liberalization to secure loans from the World Bank and IMF. Ali H. Mwinyi, who assumed the presidency after Nyerere in 1985, opened the way for liberalization. The neoliberalist policy was based on the capitalist philosophy of free markets.

The World Bank and IMF advocated structural adjustment programs with monetary and austerity measures as the only way forward for Sub-Saharan Africa.[48] After several years of negotiations with IMF, Tanzania signed an agreement in August 1986 to implement structural adjustments. The aim of the Economic Recovery Program (1986–1989) was devaluation of the overvalued currency, removal of food and input subsidies, liberalizing price control, raising of interest rates, reduction in government expenditure, and privatization. The second phase, Economic and Social Action Program (1989–1992), would continue to reduce state control over the economy and also focus more on the deteriorated social sectors.[49] Both programs were supported by aid donors.[50] In an effort to ensure a stable macroeconomic environment, IMF followed up with the Enhanced Structural Adjustment Facility (1995–1999).[51] The estimated average annual GDP per

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[46] World Bank, *Adjustment in Africa*, 243.

[47] Issa G. Shivji, "Introduction: The Transformation of the State and the Working People," in Issa G. Shivji, ed., *The State and the Working People in Tanzania* (Dakar: Council for the Development of Social Science Research in Africa (CODESRIA), 1986), 1–15; Havnevik, *Tanzania: The Limits to Development*, 60–62.

[48] World Bank, *Accelerated Development in Sub-Saharan Africa: An Agenda for Action* (Washington, D.C.: World Bank, 1981), 1–8, 127–28; *World Development Report 1983* (New York: Oxford University Press, 1983), 41–73.

[49] Stein, "Economic Policy and the IMF," 59–75; Havnevik, *Tanzania: The Limits to Development*, 23, 59–60, 290–99.

[50] For discussions of "stakeholders" in the Tanzanian health sector from the 1990s, see Innocent A.J. Semali, "Understanding Stakeholders' Roles in Health Sector Reform Process in Tanzania: The Case of Decentralizing the Immunization Program" (Ph.D. thesis, University of Basel, 2003), 63–93, University of Basel web page, http://edoc.unibas.ch/diss/DissB_6803; Sullivan, "Negotiating Abundance and Scarcity," 143–75.

[51] World Bank and Tanzania, *Tanzania at the Turn of the Century: Background Papers and Statistics* (Washington, D.C.: World Bank, 2002), 15; Tanzania, "Tanzania Assistance Strategy: Tanzania Country Profile" (Dar es Salaam: Government Printer, 2003), 1: 7.

capita growth was 0.4 percent between 1988 and 1993, and 0.1 percent between 1993 and 1998.[52]

Parts of the socialist system existed parallel to the structural adjustment approach for many years. For example it took time to privatize parastals and the state tried to control the independent press emerging in the early 1990s. Nonetheless, during a CCM meeting in Zanzibar in 1991 the Arusha Declaration was replaced with what was unofficially called the "Zanzibar Declaration."[53] Officially a new course for the Tanzanian economy and society, reflecting neoliberalist ideas, was set in the document "The Tanzania Development Vision 2025" completed in 1999.[54] The Tanzanian government was reluctant to join the "democratic experiment" in Africa, which was part of the World Bank conditionality of "Good Governance."[55] In 1992 Tanzania announced a multi-party system to be implemented in 1995.[56] CCM won the election, with Benjamin W. Mkapa as new president.

A Civil Service Reform Program was implemented in Tanzania in 1993.[57] According to the World Bank "[t]he public sector lies at the core of the stagnation and decline in growth in Africa" and "fundamental reform of the public sector is needed to reverse the economic decline."[58] The aim was to reduce the number of civil servants and make those who remained more efficient. In Tanzania the reform involved removal of "ghost workers," retrenchments, and a public employment freeze from 1993 to 2001.[59]

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[52] Robert J. Utz, "A Decade of Reforms, Macroeconomic Stability, and Economic Growth," in Robert J. Utz, ed., *Sustaining and Sharing Economic Growth in Tanzania* (Washington, D.C.: World Bank, 2008), 21.

[53] Aili M. Tripp, *Changing the Rules: The Politics of Liberalization and the Urban Informal Economy in Tanzania* (Berkeley: University of California Press, 1997), 90–91, 103–104, 171; Issa G. Shivji, *Let the People Speak: Tanzania Down the Road to Neo-Liberalism* (Dakar: CODESRIA, 2006), 9.

[54] Tanzania, "The Tanzania Development Vision 2025" (Dar es Salaam, Planning Commission, 1999), available at Tanzania Online website, www.tzonline.org

[55] Michael Bratton and Nicolas van de Walle, *Democratic Experiments in Africa: Regime Transitions in Comparative Perspective* (1997; reprint, Cambridge: Cambridge University Press, 1998), 120. World Bank, *Sub-Saharan Africa: From Crisis to Sustainable Growth* (Washington, D.C.: World Bank, 1989), xii, 1–6, 60–62.

[56] Nyerere supported multi-partyism. See *Daily News*, 21 January 1992, "NEC Proposes Multi-party System"; 19 February 1992, "'Time for Multi-party System.' Father of Nation Urges Ample Time before Elections."

[57] For background information about the reform, see Fidelis P. Mtatifikolo, "Reforms in Systems of Governance: The Case of Civil Service Reforms in Tanzania," in Lucian A. Msambichaka, Humphrey P.B. Moshi and Fidelis P. Mtatifikolo, eds., *Development Challenges and Strategies for Tanzania: An Agenda for the 21st Century* (Dar es Salaam: Dar es Salaam University Press, 1994), 59–88.

[58] World Bank, *Adjustment in Africa*, 99–100.

[59] Stevens, "Public Expenditure and Civil Service Reform," 72; IMF, "Policy Framework Paper—Tanzania: Enhanced Structural Adjustment Facility Policy Framework Paper for 1998/99–2000/01," IMF web page, http://www.imf.org/external/np/pfp/1999/tanzania/taztab.htm; International Labour Organization (ILO), Tanzania, and UNDP, *Investment for Poverty Reducing Employment in Tanzania* (Dar es Salaam:

Changes in the Tanzanian health sector were signalled in the 1990 "National Health Policy" document. The government acknowledged private health services and announced that the people had to contribute to paying for public services.[60] Profit-oriented health care was officially allowed again in 1991.[61] User fees were first introduced in some government hospitals in 1993 as part of a cost-sharing program.[62] Following a 1993 World Bank report on health, Tanzania in 1994 reviewed health policies in "Proposals for Health Sector Reform," where the government redefined its role from dominant provider to facilitator.[63] Total government expenditure on health averaged 4.7 percent of total government expenditure between 1986 and 1991, 6.4 percent between 1992 and 1995, dropped to 3.7 percent for 1996 and 1997, while the estimates for 1998 and 1999 were 6.5 percent. [64]

The Tanzanian economy began to improve in 2000, during Mkapa's second term as president (2000–2005). CCM continued as the ruling party after the 2005 election with Jakaya M. Kikwete as president. The estimated average annual GDP per capita growth rate was 4.2 percent between 2000 and 2009.[65] Tanzania still depended on loans and development aid and was monitored by the external "stakeholders" through Poverty Reduction Strategy Papers from 2000.[66]

ILO, Jobs for Africa Program, 2002), 25, 200, 203–204; Christoph Kurowski, Kasper Wyss, Salim Abdulla, N'Diekhor Yémadji, and Anne Mills, "Human Resources for Health: Requirements and Availability in the Context of Scaling-Up Priority Interventions in Low-Income Countries. Case Studies from Tanzania and Chad" (World Bank, 2003), 17; Anna Dominick and Christoph Kurowski, "Human Resources for Health—An Appraisal of the Status Quo in Tanzania Mainland (Working Paper, World Bank, 2005), 14. "Ghost workers" were salary recipients who actually did not work.

[60] Tanzania, "National Health Policy" (Dar es Salaam, Ministry of Health, 1990), 17, 32, 38, available at, www.tzonline.org

[61] Tanzania, "The Private Hospitals (Regulations) (Amendment) Act, 1991 (Act No. 26/1991)."

[62] World Bank, *Tanzania: Social Sector Review* (Washington, D.C.: World Bank, 1999), xvii, 117–18.

[63] World Bank, *World Development Report 1993: Investing in Health* (Oxford: Oxford University Press, 1993); *Better Health in Africa: Experience and Lessons Learned* (Washington, D.C.: World Bank, 1994); Tanzania, "Proposals for Health Sector Reform" (Dar es Salaam, Ministry of Health, 1994), iii, vi. It was followed up with a strategic health plan. See Tanzania, "Strategic Health Plan 1995–1998" (Dar es Salaam, Health Sector Reform Group, Ministry of Health, 1995). For a discussion of health sector reforms in Tanzania 1924-1993, see Semali, "Understanding Stakeholders' Roles," 33–62.

[64] World Bank and Tanzania, *Tanzania at the Turn of the Century: Background Papers*, 305.

[65] World Bank, *Africa Development Indicators 2011* (Washington, D.C.: World Bank, 2011), 7.

[66] World Bank, *New Paths to Social Development: Community and Global Networks in Action* (Washington D.C., World Bank, 2000), iii–iv; "Simplified Implementation Completion Report Tanzania Second Poverty Reduction Support Credit and Grant" (Report No. 33594, Washington D.C.: World Bank, 2005); World Bank and Tanzania, *Tanzania at the Turn of the Century: From Reforms to Sustained Growth and Poverty Reduction* (Washington, D.C.: World Bank, 2001); Tanzania, "Poverty Reduction Strategy Paper (PRSP)" (Dar es Salaam: Government Printer, 2000); "Poverty Reduction Strategy Paper. Progress Report 2000/01" (Dar es Salaam: Tanzania, 2001); "National Strategy for Growth and Reduction of Poverty (NSGRP)" (Dar es Salaam, Vice President's Office, 2005). PRSP and NSGRP document available at, www.tzonline.org

The second stage of the civil service reform was launched in 2000 as the Public Service Reform Programme (PSRP).[67] The aim of the PSRP was to "[e]stablish [an] efficient and motivated civil service" and together with the Local Government Reform Program should "improve the quality of, and access to, public services provided through or facilitated by local government authorities."[68] That the state should invest in decentralized basic social services was in accordance with a World Bank report from 1997.[69]

In the health sector, the "Second Health Sector Strategic Plan (HSSP) (July 2003–June 2008)" aimed at "provision of quality health service"[70]; while the focus of the "Health Sector Strategic Plan III July 2009–June 2015" was "partnership for delivering the Millennium Development Goals."[71] The general government expenditure on health increased from 9.1 percent of total government expenditure in 2000 to 18 percent in 2008.[72]

Political Experiments

Several scholars have described the socialist policies in Tanzania as "experiments." The historian John Lonsdale called the 1967 Arusha Declaration a "socialist experiment." He discussed whether it was compatible with the experiment of implementing the one-party democracy initiated in 1965.[73] The sociologist Michaela von Freyhold analysed the "social experiment" of *Ujamaa* villages in Tanzania[74]; and the legal scholar Issa G. Shivji argued that "experiments were made with such forms as villagisation and so-called decentralisation"[75]; while the historian Yusufu Q. Lawi described the last villagization campaign, *Operation Vijiji* (1973–1976), as "one of the greatest social experiments in postcolonial Africa."[76] The political scientist Roger Yeager assessed the socialist period in

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[67] Tanzania, *Public Service Reform Programme 2000–2011* (Dar es Salaam: Mkuki na Nyota Publishers, 2001).

[68] IMF, "Policy Framework Paper—Tanzania."

[69] World Bank, *World Development Report 1997: The State in a Changing World* (New York: Oxford University Press, 1997), 1–5, 12–15, 120–22, 162–63.

[70] The Health Sector Program of Work (1999–2002) had focused on reform of the overall systems, and a Sector Wide Approach (SWAp) should coordinate domestic and foreign funding. See Tanzania, "Second Health Sector Strategic Plan (HSSP) (July 2003–June2008) 'Reforms Towards Delivering Quality Health Services and Client Satisfaction'" (Dar es Salaam, Ministry of Health, 2003), 1, 51.

[71] Tanzania, "Health Sector Strategic Plan III July 2009–June 2015 'Partnership for Delivering the MDGs'" (Dar es Salaam, Ministry of Health, 2009), i. Recent documents available at Ministry of Health website, www.moh.go.tz

[72] WHO, *World Health Statistics 2011* (Geneva: WHO, 2011), 134. WHO publications and documents available at, www.who.int

[73] John Lonsdale, "The Tanzanian Experiment," *African Affairs* 67, 269 (1968), 332.

[74] Michaela von Freyhold, *Ujamaa Villages in Tanzania: Analysis of a Social Experiment* (London: Heinemann, 1979).

[75] Shivji, "Introduction: The Transformation of the State," 8.

[76] Lawi, "Tanzania's Operation Vijiji," 69.

a book titled *Tanzania: An African Experiment*.[77] Also Iliffe in *East African Doctors* named his chapter on Tanzania "Tanzania: Doctors and a Socialist Experiment."[78]

When describing neoliberalist policies as "experiments," several scholars have included Tanzania as an example. The economists Thandika Mkandawire and Charles C. Soludo in their African perspective on structural adjustment found it "remarkable to observe how Africa, over the decades, has been the pawn of international interests experimenting with development models."[79] In the article "An Argentinisation of Tanzania?" Shivji described "[t]he rise and fall of the neo-liberal experiment in Argentina" by the World Bank, IMF and the U.S. Treasury (the so-called "Washington Consensus").[80] Regarding health services, the political scientist Meredeth Turshen argued in 1999: "Given the already frightfully high rates of mortality and morbidity in Africa and the past record of World Bank policy failures, the large-scale experiments in privatization now being undertaken cannot be justified."[81] Rick Rowden, international relations specialist, followed up in 2009 when he discussed developing and transition economies and what he called "[t]he disastrous consequences of the thirty-year neoliberal policy experiment conducted on the healthcare systems."[82]

The sociologist Tony Waters described Tanzania as an "experimental laboratory" from 1890 to the present: "As a poor but politically attractive backwater Tanzania has served as the experimental laboratory for a succession of development policies based on the plantation agriculture of mercantile colonialism (1890–1950s), neoclassical development ideologies (1961–67), *ujamaa* socialism (1967–85), and, again, neoclassical development ideology (1985 to date)."[83] That development models and policies have been directed "from above" or "top-down" in Tanzania has been discussed by several scholars, such as the economist Kjell J. Havnevik and the political scientist Göran Hydén.[84]

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[77] Rodger Yeager, *Tanzania: An African Experiment* (Boulder, CO: Westview Press, 1982), 109–14.

[78] Iliffe, *East African Doctors*, 200.

[79] Thandika Mkandawire and Charles C. Soludo, *Our Continent, Our Future: African Perspectives on Structural Adjustment* (Dakar: CODESRIA, 1998), 37, 53, 61–62, 71–72, 80.

[80] Issa G. Shivji, "An Argentinisation of Tanzania?" *Pambazuka News* 204 (2005), *Pambazuka News* web page, http://pambazuka.org/en/category/comment/27917.

[81] Meredeth Turshen, *Privatizing Health Services in Africa* (New Brunswick, NJ: Rutgers University Press, 1999), xi, 16, 20, 41–43, 50, 65, 73–74, 98, 129.

[82] Rick Rowden, *The Deadly Ideas of Neoliberalism: How the IMF Has Undermined Public Health and the Fight against AIDS* (London: Zed Books, 2009), 153, 156–58.

[83] Tony Waters, "The Persistence of Subsistence and the Limits to Development Studies: The Challenge of Tanzania," *Africa* 70, 4 (2000), 636. Waters discussed why development experiments in Tanzania have failed. He argued that the majority of Tanzanians, the peasants, lived in a local subsistence economy not depending on the global system of world capitalism advocated by the Tanzanian government and development partners.

[84] Havnevik, *Tanzania: The Limits to Development From Above*; Göran Hydén, "Top-Down Democratization in Tanzania," *Journal of Democracy* 10, 4 (1999), 142–55.

Government Health Workers under Socialism

All interviewed government health workers in Mbulu District were well informed about President Nyerere and his socialist policies; the Arusha Declaration, *Ujamaa*, the nationalization of the economy, political campaigns, and party slogans. However, the level of international advice and assistance was less known.

An Optimistic Beginning

Several government health workers in Mbulu District in retrospect spoke favourably about the socialist policies. A retired clinical officer started his training in the early 1970s after completing secondary school: "my primary interest was to join the medical field ... [and] I took the RMA [rural medical aide] course." Thereafter he worked as a RMA during the *Ujamaa* movement: "I did participate in moving people to those new settlements as villages. I was on a district health service team in 1975. The objective was very good because when people live close together it is easier to provide services.... So that really brought positive changes in the health service."[85] A retired female nurse midwife talked about the new health institutions: "Dispensaries were constructed, and also health centres."[86] Mbulu was one of the districts where the planned expansion of rural health centers were met during the financial year 1973/74 in Endabash and 1974/75 in Dongobesh.[87]

Whereas Beck called the socialist health scheme in Tanzania "with all its shortcomings ... daring in suggesting the construction of an egalitarian health system in a

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[85] 14.GHMD (interviewee no.) .A0060 (recording no.), Mbulu District, 18 December 2008. In the 1970s Tanzania had the following medical staff: RMAs needed primary school (7 years) and 3 years course; medical assistants (MA) had secondary school (11 years) and 3 years course; assistant medical officers (AMO) often were MAs with work experience, and 18 months upgrading course. AMOs were officially titled doctors. Medical doctors (MD), called medical officers, had full secondary school (13 years), 5 years university education, plus 1-year internship. From 1974 "mature" candidates could sit for university entrance exam and obtain a MD degree. See Gish, *Planning the Health Sector*, 76; Young, "Socialist Development," 130–31.

[86] 2.GHMD.30089, Mbulu District 30 November 2007. In the 1970s Tanzanian nursing staff consisted of these categories: nursing attendant with primary school and local training, village midwife with primary school and 1 year local training; in 1972/73 a maternal and child health (MCH) aide cadre was created requiring primary education and 18 months local training course; B nurse had primary school, 3 years course, plus 4th year midwifery (B midwife); A nurse had secondary school (11 years), 3 years course, plus 4th year midwifery (A midwife). Nurse tutors had an additional 18 months course. See Gish, *Planning the Health Sector*, 73, 93–96; Young, "Socialist Development," 130–31.

[87] Tanzania, "Hotuba ya Mh. Waziri Ali Mwinyi katika Bunge—Julai 1974. Siasa na Makadirio ya Matumizi ya Fedha ya Wizara kwa Mwaka 1974/75," (Speech by the Minister for Health, Hon. A.H. Mwinyi, for the Financial Year 1974/75) (Dar es Salaam, Wizara ya Afya, 1974), para. 28; "Hotuba ya Ndugu Ali Mwinyi, Waziri wa Afya katika Bunge—Juni, 1975. Siasa na Makadirio ya Matumizi ya Fedha ya Wizara kwa Mwaka 1975/76" (Speech by the Minister for Health, Ndugu A. H. Mwinyi, MP for the Financial Year 1975/76) (Dar es Salaam, Wizara ya Afya, 1975), para. 41–42. The 1975 budget speech referred to Kitete health center, Mbulu District. It should be Dongobesh. In 1978, two health centers existed in Mbulu District: Endabash and Dongobesh. See Tanzania, "Inventory of Health Facilities 1978. 01 Arusha Region" (Dar es Salaam, Ministry of Health, 1979), 19, 63. Endabash is now in Karatu District, Arusha Region.

poor country"[88]; others assessed the development of the rural health system in Tanzania as unique and impressive.[89] Between 1971 and 1978 the relative government expenditure on the rural health sector increased from 20 to 40 percent.[90] Later statistical evidence showed great improvements in public health in Tanzania since independence in 1961. There was a rise in life expectancy from 35 years in 1964 to 52 years in 1984, and a reduction in infant mortality rate from 215 per 1,000 in 1961 to 105 per 1,000 in 1987.[91] This could indirectly be seen as related to the expansion of rural health services.[92] However, the social scientist Eustace P.Y. Muhondwa, who made reference to annual budget speeches by the ministers of health between 1973 and 1981, pointed out that more than 70 percent of the development budget was based on foreign aid contributions.[93]

For government health workers in Mbulu District it was of less importance where the funding came from, as long as the working conditions were seen as acceptable. A nursing officer described the situation when she started as a nurse in the early 1970s: "medicines were available and there were sufficient working tools and equipment."[94] A male medical attendant elaborated: "In the [19]70s the situation was good. In those days medicines were issued for free,... and we treated our people for free.... the patients were even given food three times a day."[95] Public criticism of inadequate drugs and equipment in newspapers in the early 1970s was according to Iliffe "encouraged by party intellectuals as ammunition against doctors believed to oppose the socialization of medicine."[96]

The salary for government health workers was seen as adequate during the early socialist period. A retired health worker in a former senior position in Mbulu District actually expressed high satisfaction with his starting salary: "I could build a house ... I could furnish my house. And I had some surplus in the bank at the end of the year ... after some two years I had a wife ... That was until [19]78 ... thereafter the [government] salary

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[88] Beck, *Medicine, Tradition, and Development*, 44.

[89] Van Etten, *Rural Health Development*, 99–100; Gish, *Planning the Health Sector*, 209–10; Urban Jonsson, "Ideological Framework and Health Development in Tanzania 1961–2000," *Social Science and Medicine* 22, 7 (1986), 746–47; Harald K. Heggenhougen, "Health Services: Official and Unofficial," in Boesen, et al., eds., *Tanzania*, 310–11, 316.

[90] Heggenhougen et al., *Community Health Workers*, 27.

[91] Tanzania, "National Health Policy," 5.

[92] Heggenhougen, "Health Services," 311; Heggenhougen et al., *Community Health Workers*, 27–28.

[93] Muhondwa argued that the aid dependency was contrary to the objective of self-reliance of the Arusha Declaration. See Eustace P.Y. Muhondwa, "The Role and Impact of Foreign Aid in Tanzania's Health Development," in Michael R. Reich and Eiji Marui, eds., *International Cooperation for Health: Problems, Prospects, and Priorities* (Dover, MA: Auburn House Publishing Company, 1989), 179–82.

[94] 13.GHMD.30079, Mbulu District, 22 November 2007.

[95] 18.GHMD.30068, Mbulu District, 14 April 2007. A medical attendant could have on the job training; or a certificate in laboratory, pharmacy, or dentistry requiring primary education and 2 years course. In the 1970s staff with such education were considered paramedics. See Gish, *Planning the Health Sector*, 96–97.

[96] Iliffe, *East African Doctors*, 203.

was no longer [sufficient] to survive on."[97] Other interviewees also emphasized comfort with pay. For example a female nursing officer said: "It [net salary per month] was 108 shillings and 25 cents [as a nursing attendant in 1971].... I managed well because everything in those days was very cheap."[98] A clinical officer, at that time called medical assistant, mentioned his salary in 1976: "that 800 shillings [net salary per month] was enough for everything."[99] This view was supported by two retired medical doctors who began their careers in other districts in Tanzania in the mid 1970s. One of them explained: "Mid [19]70s to late [19]70s, that was the only time in my life when [government] salary was adequate."[100] Iliffe referred to some doctors' discontent with socialist pay, based on scarce newspaper articles.[101] The retrospective views of the few doctors in this study give another perception.

Valerian P. Kimati, who served as a district medical officer from 1965 to 1970, was satisfied with the working situation.[102] Kimati thought the "medical officers were well motivated" and their services were of good quality, even after they lost their intramural private practice.[103] Some of the African doctors took over posts from doctors of Asian origin who left the government and socialist Tanzania.[104] Iliffe argued that "[d]octors entered Tanzania's socialist period divided in their minds and sympathies."[105]

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[97] 3.GHMD.30035, Mbulu District, 29 March 2007. According to Pratt, since 1967 a class of politicians and civil servants had emerged in Tanzania with "vastly higher" incomes than ordinary citizens. See Pratt, *The Critical Phase*, 221. Before 1972 the annual inflation never exceeded 8 percent. Prices increased substantially from 1974. However, Coulson argued that civil servants were "better off" than the average Tanzanian in both rural and urban areas during the 1970s. The ratio between top and bottom salary was narrowed. Coulson claimed that at the same time senior civil servants were promoted to higher salary scales, and fringe benefits increased. See Coulson, *Tanzania*, 195, 198, 203.

[98] 11.GHMD.30066, Mbulu District, 13 April 2007. The gross salary for nursing attendants in 1971 was 120–180 shillings per month. See Tanzania, "Staff Circular No. 2 of 1970," in, "Staff Circulars 1957–1970" (Dar es Salaam: Government Printer/Civil Service Department, undated), 504, 509.

[99] 19.GHMD.B0050, Mbulu District, 26 August 2008. The gross starting salary for medical assistants in 1976 was 1,035 shillings per month. See Tanzania, "Waraka wa Watumishi wa Serikali Na. 4 wa 1974" (Staff Circular No. 4 of 1974), in, "Staff Circulars 1971–1995" (Dar es Salaam: Government Printer, undated), 168.

[100] 4.GHN.30145, Dar es Salaam, 24 October 2008.

[101] Iliffe, *East African Doctors*, 204.

[102] Kimati, "The Effect of Welfare of Medical Officers," unpaginated; P.M. Barnes, "Obituaries: Dr Valerian Pius Kimati FRCP Edin," Royal College of Physicians of Edinburgh web page, http://www.rcpe.ac.uk/publications/obituaries/2005/kimati.php.

[103] Kimati, "The Effect of Welfare of Medical Officers." From 1962 doctors had lost their extramural practice to work privately off duty. From 1969 intramural practice, private consultation for fixed fees as part of the government post, was abolished. See Nsekela and Nhonoli, *The Development of Health Services*, 99–100.

[104] By 1973 almost fifty Asian doctors were gone. The exodus of doctors from the government accelerated in 1975. See Nsekela and Nhonoli, *The Development of Health Services*, 101–103; Iliffe, *East African Doctors*, 209. Also qualified nurses, probably of Asian origin, left Aga Khan Hospital in Dar es Salaam to work abroad in the early 1970s. See *Sunday News*, 2 April 1972, "Hospital Matrons Encounter

The socialist health system depended on a motivated staff. In his budget speech of July 1972, Minister of Health Ali H. Mwinyi had recognized the important role of health workers in the expansion of rural health services in Tanzania: "Our success will depend in the first place upon the morale and dedicated work of all the staff who man our health services."[106] In a survey by the sociologist Gerardus M. van Etten during the years 1969 to 1972 in Mwanza Region, 37 medical assistant students, 87 rural medical aids students, and 37 graduated rural medical aides were asked of their motivation towards a medical career. Two main motives were given; to help people and nation building, as exemplified in this statement: "'I decided to become a medical worker in order to help all other citizens in fighting against one of the three enemies of Tanzania—disease.'" "A good salary" was ranked lowest. The nation-building factor was explained as a result of mobilization of the population after the Arusha Declaration. However, the follow-up of that motivation in the training situation and working environment was seen as lacking.[107]

Critical Views

Several government health workers in Mbulu District in retrospect questioned the socialist policies. A nursing officer mentioned the deteriorating work ethics in the 1970s: "probably it [the morale] started to deteriorate from that time when they talked a lot about human rights ... some took this situation as if it was a personal right, while it was meant for everyone."[108] The "human rights" she was referring to were TANU's party guidelines issued in 1971, *Mwongozo*.[109] According to Hyden the document "signalled the end of capitalist forms of management in Tanzania." The intension was to get the labor force committed to socialism. Instead the managers' power to discipline the workers was reduced and the "[m]anagement of the public sector was, if not paralysed, at least considerably weakened after *Mwongozo*."[110]

Numerous and Tough Complaints," in Vincent van Amelsvoort, *Medical Anthropology in African Newspapers: An Annotated Facsimile Edition from the Third World* (Nijmegen: Anthropological Publications, 1976), 92–93.

[105] Iliffe, *East African Doctors*, 204.

[106] Tanzania, "Budget Speech ... 1972/73," para. 58.

[107] According to van Etten, students lacked knowledge about socialist health policies emphasizing preventive medicine and rural health services. Students, often with urban background, focused on what had highest status (curative medicine) and had negative and patronizing attitudes towards rural people and their use of traditional healers and medicine. See Van Etten, *Rural Health Development*, 112–113, 105–44.

[108] 13.GHMD.30079, Mbulu District, 22 November 2007. In Sullivan's study a female ward attendant mentioned the poor management and working moral from the time when she started in 1978 and through the 1980s. See Sullivan, "Negotiating Abundance and Scarcity," 122.

[109] TANU, "Mwongozo wa TANU, 1971" (Dar es Salaam: The Union, 1971); T.A.N.U. Guidelines, 1971 (Dar es Salaam: Government Printer, 1971).

[110] Goran Hyden, *Beyond Ujamaa in Tanzania. Underdevelopment and an Uncaptured Peasantry* (Berkeley: University of California Press, 1980), 156, 165.

A retired health worker in a former senior position in Mbulu District, who was a nurse midwife in the 1970s, was critical of the socialist rhetoric, which in her opinion inspired corruption:

> Corruption started with the politics of the Arusha Declaration.... there was the word *ndugu* [brother, comrade] in politics.... Everybody was equal ... even the president of the country was *ndugu* ... [and] everything was equal, even matters regarding salaries.... To be fair it was as though it strengthened the people, it made them a little happier.... But then people began to have negative feelings.... Later it truly became *ndugunisation* [nepotism]. Everybody who had a higher position looked after his relatives and gave them employment and promotion.[111]

The *ndugu,* or brotherhood concept in official use in Tanzania from 1975, was discussed by political scientist Michael Okema. He argued that it was used to create a separation from the harsh authority and fearful obedience of the colonial past, but also to distinguish friends from enemies of the socialist regime. Okema pointed to several dangers: corruption, inefficiency, indifference, and lack of necessary authority and discipline.[112]

Another retired health worker in a former senior position in Mbulu District criticized decentralization. He said: "decentralisation was from [19]72 to [19]83.... Apart from causing a lot of bureaucracy it didn't achieve anything."[113] Health Officer Babuel A. Lyimo found it more difficult to perform his duties after the Arusha Declaration and the villagization campaigns. He witnessed health assistants abandoning their professions for good party posts in the newly established *Ujamaa* villages. The political emphasis was on agricultural development and in the context of "party supremacy," health workers who argued their concerns for public health issues risked being "accused of sabotaging the party." Lyimo favored large public health campaigns, but he claimed their outcomes were short lived due to lack of follow-up.[114]

Doctors, the highest ranked health cadre, were most affected by the socialist egalitarian policies. A retired senior official within the Ministry of Health, who had been practicing as a medical doctor after the Arusha Declaration, remained with the government even though he was critical of party policies:

> We [doctors] had to sign a declaration....[115] We were sort of cowardly hiding behind these [active TANU/CCM members] and pretending to be

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[111] 25.GHMD.30132, Mbulu District, 11 March 2008.

[112] Michael Okema, *Political Culture in Tanzania* (Lewiston, N.Y.: Edwin Mellen Press, 1996), 36–46.

[113] 3.GHMD.30035, Mbulu District 29 March 2007. For a discussion of the confusing decentralized bureaucracy in the health sector, see Lucy Gilson, Peter Kilima, and Marcel Tanner, "Local Government Decentralization and the Health Sector in Tanzania," *Public Administration and Development* 14 (1994), 455–61.

[114] Lyimo served as a health officer from district to ministerial level, 1958–1989; and worked for an AIDS research project after his retirement. See Lyimo et al., *From Smallpox to AIDS*, 9, 55, 122, 126–27.

[115] Government employees of higher ranks had to sign a declaration of party membership, and a leadership code. See Tanzania, "Staff Circular No. 2 of 1968. The Arusha Declaration. The Leadership and

> participating. But we really had our own ideas ... There were a lot of resources for political campaigns ... They were very good campaigns, but then the practical application was not [there]. And of course I wouldn't have said this then, because I would probably have been locked up. So you just opted for the best.[116]

This attitude corresponded with other sources discussed by the political scientist Aili M. Tripp. Any open criticism of the Arusha Declaration was crushed, and therefore people did not feel free to voice their opinions.[117]

Iliffe pointed out that the small number of Tanzanian doctors prevented them from having influence on health-related policies. Their participation in public debates was also limited. Iliffe gave one example of a surgeon in Muhimbili in Dar es Salaam, the national consultant and referral hospital, who shared his views in a newspaper. Philip Hiza was quoted in *Daily News* 2 July 1973: "Doctors are frustrated not necessarily because of low salaries or absence of fringe benefits,... but they are more frustrated professionally when they cannot discharge their skills to the full to benefit the patient." Doctors' salaries were restrained; health service conditions were deteriorating and the public blamed doctors.[118]

Kimati explained how the newly appointed local elitist party officials were better paid and had higher status in society than a medical doctor. From his perspective the prohibition of private practice in 1977 "put the nail in the coffin" for Tanzanian doctors.[119] The man behind the 1977 regulation was Leader Stirling, a retired mission doctor and a member of the Tanzanian parliament for seventeen years. He was appointed by Nyerere to be minister of health from 1975.[120] Iliffe argued that "[a] proportion [of Tanzanian doctors] ... were committed to the socialist programme." ... "More doctors probably viewed socialist medicine with ambivalence, respecting its concern for social justice but misliking the sacrifices it claimed to justify."[121]

Government Employees," in, "The Staff Circulars 1957–1970," 443–48. It was meant to discourage leaders from taking advantage of their positions. For discussions, see Pratt, *The Critical Phase*, 237–40; Leonard P. Shaidi, "The Leadership Code and Corruption," in Jeannette Hartmann, ed., *Re-thinking the Arusha Declaration* (Copenhagen: Center for Development Research, 1991), 125–31; Tripp, *Changing the Rules*, 171–89.

[116] 1.GHN.30149, Dar es Salaam, 31 August 2009.

[117] Tripp, *Changing the Rules*, 173–75.

[118] Iliffe, *East African Doctors*, 200, 204.

[119] Kimati, "The Effect of Welfare of Medical Officers." Kimati had postgraduate training in the United Kingdom 1970–1972 and 1980–1982. From 1972 he was a researcher in Muhimbili, from 1979 as the first Tanzanian professor of pediatrics. Kimati was president of the Medical Association of Tanzania, 1978–1980. See Barnes, "Obituaries: Dr Valerian Pius Kimati FRCP Edin."

[120] Iliffe, *East African Doctors*, 209–210; Leader Stirling, *Tanzanian Doctor* (London: Hurst, 1977), 122, 133, 135. Stirling became a Tanzanian citizen in 1961. Apart from the epilogue, where Sterling wrote about the time when he became minister of health, the book was that of a British doctor in mission service.

[121] Iliffe, *East African Doctors*, 208.

The Beginning of the End of Socialism: The 1978/79 Ugandan War

Many interviewed government health workers in Mbulu District described the Ugandan war as a landmark in Tanzanian history. It was seen as an explanation for the increasing problems in the country. The Tanzanian government played a major role in removing Uganda's dictator Idi Amin from power, but Tanzania had to bear financial costs of the war alone.[122] A retired male health worker in a former senior position stated: "a lot of money was injected into the war, and so things became expensive ... That was the beginning of the problems in the country.... I was not very much affected because I had a district level position with allowances in addition to my salary....[123] But with other people [in non-managerial positions] it was very difficult."[124] A majority had a gloomy memory of the situation after the war. This was explicit in testimonies such as the following from a female nursing officer: "I can't think of words to explain the living conditions of those difficult days ... after the Idi Amin war ... there was no soap and sugar."[125] A male health worker in a senior position, who at that time was in a training college, elaborated: "We just survived. It was really difficult; if you ask any Tanzanian..., just after the 1979 war.... Our president announced an eighteen months' difficult period. But ... it lasted eighteen years instead of eighteen months!"[126]

A Tanzanian national health sector evaluation conducted in 1979 identified the major constraints then being experienced as: shortage of trained health personnel, transport, equipment and drugs. "Lack of motivation" among health workers was also seen as "a significant factor." The study showed that around 60 percent of the 8,200 villages had no health facility.[127] In such villages, the community was obliged to select one or two persons to be trained for three to six months as village health workers at a hospital or health center. Since the ad hoc training was insufficient and the salary was left to the communities, a number of these auxiliary health personnel eventually abandoned their work.[128]

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[122] Coulson, *Tanzania*, 310–11.

[123] Transport allowances and some other allowances had been there since colonial times for civil service officers. See Tanzania, "Staff Circulars 1957–1970"; "Staff Circulars 1971–1995."

[124] 3.GHMD.30035, Mbulu District, 29 March 2007.

[125] 21.GHMD.30077, Mbulu District, 20 November 2007. According to Shivji, ordinary Tanzanians experienced "enormous scarcities" during the early 1980s. He claimed smugglers, "big shots," and other "quick money makers had 'golden times.'" The government took actions against people, but not against "big shots" in the party or the state. See Issa G. Shivji, "The Politics of Liberalization in Tanzania: The Crisis of Ideological Hegemony," in Campbell and Stein, eds., *Tanzania and the IMF*, 51–52.

[126] 23.GHMD.30072, Mbulu District, 16 April 2007. Other interviewees also mentioned the eighteen months turning into eighteen years of hardship. Interestingly health workers in Sullivan's study did not refer to the war when in retrospect describing their difficult working situation at the time. Sullivan mentioned the war in connection with economic decline in a previous section of her thesis. See Sullivan, "Negotiating Abundance and Scarcity," 103, 118–24.

[127] Tanzania, "Evaluation of the Health Sector 1979," 14, 183.

[128] The first community health worker scheme started in 1969. See Heggenhougen et al., *Community Health Workers*, 1, 38–43.

Lyimo, who at that time was the regional health officer of Arusha, welcomed the Primary Health Care implementation in 1983.[129] However, Lyimo referred to several major problems. Transport was one obstacle as cars and roads were in extremely bad conditions and petrol was scarce. Also some district administrators opposed the PHC. He mentioned that the district development director of Mbulu District refused to let the two most vital staff members, the medical officer and health officer, attend the awareness seminar. Lyimo concluded: "The programme took off in Arusha under very severe financial and logistical problems. The Ministry of Health and the region could not rectify most of the problems; hence the progress was below standard."[130] A national PHC review in 1984 had identified the same problems with financial constraints, poor planning and management, and inadequate transport.[131]

Tanzania had an acute shortage of drugs in the early 1980s. Assistant Chief Medical Officer S.P. Dyauli in the Ministry of Health recognized that "[t]he over 15,000 health workers all over the country found themselves unable to deliver the services. They became demoralized." WHO's Essential Drug Program (EDP) was introduced in rural dispensaries and health centers from 1984 with financial aid from Denmark. One of the challenges was that the standardized kits did not take local disease patterns into account.[132] There were insufficient supplies of needed drugs, as explained by a female nursing officer in Mbulu District working as a nurse midwife in a rural health center: "We used to get something called 'EDP Kit.' Everybody took medicines and stocked some—those who were ill and those who were not ill—knowing that came the tenth [of the month] there was not a tablet left."[133] However, the EDP kits gave relief to the government health services at the rural primary-level.[134] A World Bank mission to Tanzania in the period 1987–1989 observed:

> Shortages of both drugs and staff were most acute in the district and regional hospitals. This reflects Tanzania's unusual degree of success in implementing a primary-level and rurally-oriented health care strategy, as well as the effectiveness of the Essential Drugs Program ... However, it

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[129] Tanzania, "Guidelines for the Implementation."

[130] Lyimo et al., *From Smallpox to AIDS*, 139–40.

[131] Tanzania, "Joint PHC Review Tanzania 1984" (Dar es Salaam: Ministry of Health and WHO, 1984), 2–17, Annexes Table 12.

[132] S.P. Dyauli, "Experiences of Implementing the EDP in Tanzania 1983–1986" (WHO, Proceedings of the Workshop on the Essential Drugs Concept and the Role of Medical Schools in Its Dissemination, Dar es Salaam 11–18 December 1986, Action Program on Essential Drugs and Vaccines, DAP/87.6, 1987), 9–10.

[133] 21.GHMD.30077, Mbulu District, 20 November 2007.

[134] Hilbrand Haak and Hans V. Hogerzeil, "Essential Drugs for Ration Kits in Developing Countries," *Health Policy and Planning* 10, 1 (1995), 40–49; Anna K. Tibaijuka, "Trends and Issues in Health Service Delivery under Economic Adjustment," in Anna K. Tibaijuka, ed., *The Social Services Crisis of the 1990's: Strategies for Sustainable Systems in Tanzania* (Aldershot, UK: Ashgate, 1998), 144.

> also points to the ... relative inattention to the urban population's need for adequate primary health care.[135]

Urbanization increased and Iliffe regarded Dar es Salaam and other towns as "[t]he chief victims of rural-focused health policy."[136] On the other hand, there were more hospitals in towns, providing another source of income for government doctors than their colleagues in rural areas. Kimati claimed "many government doctors 'in mass' spent a lot of time clandestinely in private hospital to the detriment of their services in government units, their place of employment."[137] For Tripp, doctors who would "moonlight" from work in a government hospital was only one example of how the socialist controlled economy forced people in Dar es Salaam to operate in an illegal commercial market.[138]

According to Iliffe, the poor quality of government health services "stimulated public complaints" during the 1970s and 1980s.[139] As a result, a presidential commission was appointed in 1983 to look into the level of performance in Muhimbili hospital in Dar es Salaam, a parastatal institution since 1977. The committee found several shortcomings: financial constraints, lack of efficiency, poor discipline among workers, poor supervision, and "lack of political education and maturity."[140] One of the symptoms described was "rudeness and harsh language when communicating with patients."[141] Also the crisis-hit economy could not sustain the increasing demands for health services by the growing Tanzanian population that almost doubled from 12.3 million in 1967 to 23.1 million in 1988.[142]

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[135] Regions visited: Dar es Salaam, Morogoro, Iringa, Mbeya, Rukwa. See World Bank, "Tanzania: Population, Health and Nutrition Sector Review" (Report No. 7495–TA, Washington D.C., World Bank, 1989), 65, 76.

[136] Iliffe, *East African Doctors*, 207. In contrast, Pat Caplan argued that the 1980s "was the period in which state intervention in education and health had made a considerable difference to people's lives" on rural Mafia Island, Coast Region. There life got harder during the 1990s. See Pat Caplan, "Between Socialism & Neo-Liberalism: Mafia Island, Tanzania, 1965–2004," *Review of African Political Economy* 34, 114 (2007), 683–84.

[137] Kimati claimed "moonlighting" happened 1973–1982. See Kimati, "The Effect of Welfare of Medical Officers." In 1982 Kimati was appointed to UNICEF. He returned to Tanzania after his retirement in 1996. See Barnes, "Obituaries: Dr Valerian Pius Kimati FRCP Edin."

[138] According to Tripp, and also Joe L.P. Lugalla, "moonlighting" continued after 1982. See Tripp, *Changing the Rules*, 1–5, 138, 162–63; Joe L.P. Lugalla, "The Impact of Structural Adjustment Policies on Women's and Children's Health in Tanzania," *Review of African Political Economy* 22, 63 (1995), 45. The same article was printed in Kris H. Heggenhougen and Joe L.P. Lugalla, eds., *Social Change and Health in Tanzania* (Dar es Salaam: Dar es Salaam University Press, 2005), 243–56.

[139] Iliffe, *East African Doctors*, 207.

[140] Tanzania, "A Report on Muhimbili Medical Centre: Analysis of the Problems of the Centre and Suggested Solutions" (Dar es Salaam, Prepared by the Special Committee, 1983), 53, 1, 5–6, 35–54.

[141] Ibid., 52.

[142] Tanzania, "Tanzania Census ... 2002," 10: 2.

The words of a female nurse in Mbulu District could summarize what appeared to be the view of many workers about the socialist period: "The policy of the Arusha Declaration had good aims, because all property was meant to be in public hands. The supervision for proper implementation was not that good. It finally turned out to be a failure as it seemed to benefit only a few rather than the majority."[143]

Government health workers in Tanzania had divided views of the socialist policies. Interviewees in Mbulu District, and other sources, described optimism before the Ugandan war in 1978/79; a time of mass mobilization, expansion of rural health services, acceptable working conditions, and adequate salaries. However, there was also criticism of the socialist regime undermining health management and supervision, and inspiring indifference and corruption. Some doctors and nurses, mostly of Asian origin, left socialist Tanzania. Doctors found it increasingly difficult to work in a system restraining their salaries and private practice in a declining state economy. Also the working conditions in the government health services were deteriorating; apparently slower in rural than urban areas. By the mid 1980s it had become clear that the "socialist experiment," which had been supported by donor agencies, was not financially sustainable.

Government Health Workers under Neoliberalism

All interviewed government health workers in Mbulu District were well informed about the policy change to privatization after Nyerere had stepped down as president in 1985 and some of the reforms during the presidencies of Mwinyi (1985–1995), Mkapa (1995–2005), and Kikwete (2005–). However, most of them did not know about the structural adjustments of the World Bank and IMF, or the word neoliberalism.

A Decade of Despair: Late 1980s until Late 1990s

All interviewees in Mbulu District saw their situation deteriorating severely from the late 1980s. Even though products were available in shops after President Mwinyi—nicknamed *Mzee Ruksa* ("all is permitted")—had liberalized the economy, government health workers found they did not have the purchasing power.[144] A female nursing officer formulated the frustration among workers: "The government servants were forgotten.... That money—[President] Mwinyi's money—was like peanuts. Even if you had a lot of it, it was of no value.... children selling charcoal had a better life than a civil servant."[145] The reduction of

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[143] 20.GHMD.30079, Mbulu District, 22 November 2007.

[144] Shivji, *Let the People Speak*, 8; Todd Sanders, "Save our Skins: Structural Adjustment, Morality and the Occult in Tanzania," in Henrietta L. Moore and Todd Sanders, eds., *Magical Interpretations, Material Realities: Modernity, Witchcraft and the Occult in Postcolonial Africa* (London: Routledge, 2001), 164. *Mzee Ruksa* literally meant the man who abundantly allowed "things" to take their course. Shops in towns had filled up with expensive consumer goods since the 1984 so-called "own-funded import scheme." Shivji claimed import of goods was financed by smuggling of gold, trophies, etc. He called the post-IMF liberalization economy of Tanzania "the *matapeli* economy" ("the economy of the con men"); a term used to describe "people who make a fast buck by wit, tricks, fraud, and forgery." See Shivji, "The Politics of Liberalization," 52–53.

[145] 21.GHMD.30077, Mbulu District 20 November 2007. The annual inflation rate in the late 1980s was around 30 percent. It had fluctuated between 26–36 percent since 1980. See World Bank, "Tanzania the Challenge of Reforms: Growth, Income and Welfare" (Report No 14982-TA, World Bank, 1996), 2: 61.

Sub-Saharan African official wage rates was seen by the World Bank as "a brutal but necessary adjustment." In Tanzania real wages by the late 1980s were less than half of the level in 1980.[146] According to the social scientists Benson A. Bana and Suleiman S. A. Ngware "[t]his situation had adverse effects, especially for the ethics, morale and motivation of staff in the Public Service. The macro-economic crisis led to a macro-public service crisis."[147]

Government servants were forced to engage in side activities to make ends meet, as explained by a male health worker in a senior position in Mbulu District: "You had to do something. You had to embark yourself in *shamba* [farm] work,... doing nasty business ... It was really difficult for a worker in Tanzania to survive."[148] A female doctor interviewed by Tripp in Dar es Salaam in 1987 expressed her frustration: "When I studied to be a doctor, I never thought I'd learn so much about chickens or end up doing so many other things." Tripp cited *Daily News*, 29 July 1987, where a member of parliament, Doctor Zainab A. Gama, said "it was an open secret that some doctors were working with private clinics and hospitals on a part-time basis ..." while "[o]thers engaged in poultry projects so as to augment their 'meager' salaries."[149]

Salary was not the only issue. The working environment for government health personnel was frustrating. A female nursing officer in Mbulu District Hospital stated: "The situation was bad. You were attending a patient and you thought of ways of treating her/him and you did not know how; there were ... no medicines, there was absolutely nothing.... Maybe we lost some [patients died] because of the circumstances."[150] Health workers in Sullivan's study in retrospect voiced similar distress about being unable to treat patients in their government health institution outside Arusha town.[151] The medical doctor and health worker educator Sidney Ndeki described the administrative struggles of providing free medical services within austerity measures faced by District Medical Officer E. Nashara in rural Kiteto, Arusha Region, in an article in 1989: "[Dr Nashara] is in a frustrating situation ... unable to provide ... people ... in dire need of his services ... as he would like to, because material and human resources are limited or lacking altogether. The result is a poor service about which public complaints are abundant."[152]

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[146] World Bank, *Sub-Saharan Africa*, 29, 35. For more information about Tanzania, see World Bank, "Tanzania: Public Expenditure Review" (Report No. 7559-TA, Washington D.C., World Bank, 1989).

[147] Benson A. Bana and Suleiman S.A. Ngware, "Reforming the Public Service: The Tanzanian Experience," in Kithinji Kiragu and Gelase Mutahaba, eds., *Public Service Reform in Eastern and Southern Africa: Issues and Challenges* (Dar es Salaam: Mkuki na Nyota Publishers, 2006), 201.

[148] 23.GHMD.30072, Mbulu District, 16 April 2007.

[149] Tripp, *Changing the Rules*, 162–63.

[150] 13.GHMD.30079, Mbulu District, 22 November 2007.

[151] Sullivan, "Negotiating Abundance and Scarcity," 119–20.

[152] Ndeki proposed affordable technological innovations to reduce running costs. However, that required capital investments forbidden under the economic recovery program. See Sidney Ndeki, "Money for Health," *World Health* (May 1989), 11–13.

A *Daily News* reporter visiting a Dar es Salaam City Council clinic in 1988, wrote: "Amtulabhai clinic, once rated among the best in the country, is in a mess." Matron Beatrice Ojike explained there had been no water in taps and toilets since 1982; she showed the reporter broken doors, windows, and chairs, and concluded: "we are now working under duress to the point that we have stopped conducting services to mothers."[153] Muhondwa referred to observations in health centers, clinics, and dispensaries in different places in Tanzania showing "impersonal and perfunctory performance of health care activities" due to lack of equipment and supplies.[154] In 1989, Minister of Health Aaron Chiduo reported to the parliament that during the last years the government could only manage to pay 10 percent of the required import of drugs and equipment. The government was dependent on development aid.[155]

A British medical doctor, who returned to Tanzania in 1989 after having worked there in 1968 to 1969 and 1975 to 1977, made this observation: "Going from an inner-London district general hospital that had been subjected to 10 years of 'efficiency saving' under Thatcherism, I was struck with the fact that the problems my Tanzanian colleagues faced were far beyond anything I could have coped with."[156] The president of the Medical Association of Tanzania (MAT), Philemon Sarungi, was quoted in *Daily News* from MAT's annual scientific and general meeting in Dar es Salaam in 1990, saying: "The present medical equipment in nearly all hospitals in Tanzania is 30 years old ... This is a source of a lot of discouragement to our medical staff who have to carry out their duties under a lot of frustration."[157]

Sarungi was appointed minister of health in 1991, and was in charge of launching a revised "Primary Health Care Strategy," in which foreword he wrote that the Ministry of Health was committed to "[m]otivation of frontline health workers in PHC through supervision, provision of supplies/equipments, provision of incentives and provision of training programmes that aspire to improve and update their performance, skills etc."[158]

However, all interviewees in Mbulu District felt their working situation worsening during the 1990s and services were of a low standard. A male health worker in a senior position explained: "Patients called it [Mbulu District Hospital] a guest house because they

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[153] "Dar Clinic Falling Apart?" *Daily News*, 17 March 1988.

[154] Muhondwa also linked poor performance to inadequate salaries. See Eustace P.Y. Muhondwa, "Declining Quality of Health Care: Is Supervision the Anti-Dote?" *TPHA Forum* (Tanzania Public Health Association) 1, 1 (1991), 2.

[155] Tanzania, "Hotuba ya Waziri wa Afya Mh. Dr. A.D. Chiduo, MB. Kuhusu Makadirio ya Matumizi ya Fedha kwa Mwaka 1989/90" [Budget Speech by the Minister of Health, Hon. Dr. A.D. Chiduo, MP, for the Year 1989/90] (Dar es Salaam, Wizara ya Afya, 1989), 28, 41; "Govt Shelves Decision on 20/- Patient Fees," *Daily News*, 20 July 1989.

[156] John S. Yudkin, "Tanzania: Still Optimistic After All These Years?" *Lancet* 353, 9163 (1999), 1520.

[157] "Obsolete Equipment. Doctors' Knowledge Rotting—Sarungi," *Daily News*, 22 September 1990.

[158] Tanzania, "Primary Health Care Strategy" (Dar es Salaam, Ministry of Health and DANIDA, 1992), ii–iii; Iliffe, *East African Doctors*, 217.

came here just to sleep. They had to get prescribed medicines from outside [from private pharmacies]."[159] A female nursing officer added: "When women came to give birth, you told them: 'Go to Haydom!' [Lutheran hospital, Mbulu District, about 80 km away from Mbulu town]. [160] A retired male clinical officer gave an example of the many manifestations of the crisis:

> There was a child who was given a transfer from the hospital [in Mbulu] to Tlawi [Roman Catholic Health Centre in nearby village], and was waiting for the bus. And there, the child got very dehydrated and he collapsed and died ... if those drips were available it is possible we could have saved that child's life.... It was the year 1993, I remember.... You were given a clinic without medicines—what were you to do?[161]

Health workers in Sullivan's study also described hardship at the time in their health facility outside Arusha town.[162] In a study by the geographer John S. Benson of rural and urban health facilities in Arusha and Arumeru districts in 1993 "lack of supplies and things that would make their life easier" frustrated health personnel the most.[163]

Social scientists Brian Abel-Smith and Pankaj Rawal did a study for the Tanzanian government in 1991. They found the public health sector had the following "[s]ymptoms of under-financing": foreign aid reliance for drugs to rural areas, under-provision of drugs in hospitals and urban areas, lack of repair and replacement of equipment and vehicles, neglected maintenance of buildings, a fall in real wages encouraging demands of "gifts" from patients, shortage of staff, and a non-functional information system.[164] In 1994 the Ministry of Health recognized that "underfunding at all levels of health services ... has led

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[159] 12.GHMD.30077, Mbulu District, 20 November 2007. An assessment of forty government dispensaries and four health centers, and fourteen Roman Catholic dispensaries in Morogoro Region in 1991 found serious weaknesses. Shortages of drugs and equipment were most often cited by staff as a problem, and it undermined curative services in government facilities. See Lucy Gilson, Henry Kitange, and Thomas Teuscher, "Assessment of Process Quality in Tanzanian Primary Care," *Health Policy* 26 (1993), 133; L. Gilson, M. Magomi, and E. Mkangaa, "The Structural Quality of Tanzanian Primary Health Facilities," *Bulletin of the World Health Organization* 73, 1 (1995), 106, 108–109.

[160] 21.GHMD.30077, Mbulu District, 20 November 2007.

[161] 14.GHMD.A0060, Mbulu District, 18 December 2008.

[162] The facility was upgraded from a health center to a district hospital in 1989. See Sullivan, "Negotiating Abundance and Scarcity," 133–34.

[163] Benson interviewed staff in fourteen government facilities (11 rural, 3 urban) and fifteen facilities with religious (Christian or Muslim) affiliation (7 rural, 8 urban). He had hardly any quotes from health workers. Benson had a chapter about the history of health services in Tanzania with focus on Arusha and Arumeru districts, and also an overview of the development of training programs for medical personnel. See John S. Benson, "Primary Health Care Options in Tanzania: The Case of Arusha and Arumeru Districts" (Ph.D. thesis, University of Minnesota, 1996), 310, 49–176, 298–314, 344, 349–50.

[164] Brian Abel-Smith and Pankaj Rawal, "Health Sector Financing Study for the Government of Tanzania. Report on the Potentiality for Cost Sharing. First Report: User Charges," (Overseas Development Agency, London, 1992), 1–2, Annex I, 7; "Can the Poor Afford 'Free' Health Services? A Case Study of Tanzania," *Health Policy and Planning* 7, 4 (1992), 330.

to shortage of drugs and supplies; deterioration of physical structures and low staff morale."[165] A retired senior official in the Ministry of Health claimed the health services had deteriorated so much in ten years that it was almost a work from scratch when the World Bank and donors started to support health sector programs again during the 1990s.[166]

The hardship continued for government health workers in Tanzania. A retired male health worker in a former senior position in Mbulu District described the situation: "between [19]93 to [19]99; [that] was a very difficult period.... we had no drugs at all in the health services. The community was complaining.... We had a doctor in the hospital who could not do any operations, who could not treat any patients ... The tools ... are the most important incentive. If you don't have working tools, you can not work."[167] Dr. Petronila Ngiloi presented a similar view at the MAT annual general meeting and scientific conference in Dar es Salaam in 1997; as quoted in the *Guardian* newspaper:

> A doctor would be struggling to help a patient by using alternative equipment other than the professionally recommended one because it is not available. Who is therefore to blame if the worst happened?... Medical professionals have had to work under hostile circumstances since the start of the economic crisis in the late 1970s, but members of the public hold them responsible for accidental deaths or undesirable situations.[168]

Sullivan argued that health workers' performance as professionals in a district hospital outside Arusha town was undermined due to lack of infrastructure, supplies, and human resources that lasted until 1999.[169]

Reduction of staff was included in the structural adjustment measures.[170] A number of interviewees in Mbulu District were critical about the retrenchments of their paramedical colleagues, who had acquired some skills and covered some professional gaps. A nurse complained about the worsening maternity situation in the late 1990s when four staff members in her health center were retrenched: "Because the village midwife was doing delivery [services]."[171] According to a health worker in a senior position there was a shortage of 60 percent nurses, and a shortage in all cadres, except attendants in Mbulu District during the 1990s. He commented: "They retrenched a lot of staff from the medical field.... they were actually trying to economise ... later they found that we had very few

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[165] Tanzania, "Proposals for Health Sector Reform," viii.

[166] 1.GHN, Dar es Salaam, 4 December 2006. Not recorded, notes approved by informant.

[167] 3.GHMD.30035, Mbulu District, 29 March 2007.

[168] "Doctors Blame Poor Facilities for Deaths," *Guardian*, 25 September 1997 (Dar es Salaam).

[169] Sullivan, "Negotiating Abundance and Scarcity," 133–37.

[170] Between 1993–1995 the number of government employees was reduced by 102,814 workers, or 28 percent; due to slow economic growth, reforms, retrenchments, and employment freeze. See Tanzania, "Hali ya Uchumi wa Taifa katika Mwaka 1995" [Economic Survey 1995] (Dar es Salaam, Tume ya Mipango [Planning Commission], 1996), 88–90; ILO, *Investment for Poverty Reducing Employment*, 204.

[171] 7.GHMD.30135, Mbulu District, 19 March 2008.

health workers. That was a big mistake they did, to retrench."[172] A female nurse in Mbulu District elaborated about the staffing situation: "The government did stop new recruitment;... [and] there were those retrenched, those who retired and those who died."[173] A nurse in Muhimbili in Dar es Salaam complained to a *Guardian* newspaper reporter about the retrenchment of 400 employees in 1997, and even though there was a shortage of personnel in many departments there was no employment of new staff.[174] In 1996 and 1997 the government even suspended employment of graduate medical doctors because of financial constraints; despite a huge demand for doctors in many regions.[175] A male assistant medical officer in Mbulu District called it "a brain in the drain" not to employ graduate doctors.

The strategy of reducing staff in the civil service during the 1990s did not lead to the intended efficiency among government health workers. A nursing officer in Mbulu District expressed her frustration: "The government did not care. Because they saw that even when they left one health worker, that person worked, and gave services ... It came to a point that I said: 'I do what I can, what I cannot, I just leave.'"[176] A female nurse elaborated: "[a] government health worker was doing double duty ... in a situation of poverty ... Instead of bringing achievements [improved pay, moral, and performance] it had a negative impact."[177] The medical doctor and health policy specialist Christoph Kurowski estimated that the total number of Tanzanian health staff declined from approximately 67,000 in 1994/1995 to 54,000 in 2001/2002.[178] At the same time the population had grown from 23.1 million in 1988 to 34.4 million in 2002.[179] An external evaluation of the Tanzanian health sector 1999–2006 found that retrenchments of paramedical staff combined with employment freeze of qualified health workers "actually resulted in lower efficiency."[180]

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[172] 9.GHMD.30142, Mbulu District, 3 March 2008.

[173] 20.GHMD.30079, Mbulu District, 22 November 2007.

[174] "MMC Workers Protest Against Cancellation of Overtime Pay," *Guardian*, 11 March 1998.

[175] "Qualified Doctors Jobless," *Observer*, 2 February 1997 (Dar es Salaam); "Ministry Sorting Out Doctors' Employment," *Guardian* 8 February 1997; "Health Ministry to Rescue Stranded Doctors," *Sunday Observer*, 9 February 1997.

[176] 21.GHMD.30077, Mbulu District, 20 November 2007. In Sullivan's study one nurse administrator in the hospital mentioned that "employment had been completely stopped" in connection with big staff shortage and heavy workloads. Sullivan only referred to suspension of new employments in the civil service from July 1997, based on *Daily News*, 3 December 1997. See Sullivan, "Negotiating Abundance and Scarcity," 134, 156.

[177] 22.GHMD.30079, Mbulu District, 22 November 2007.

[178] Of these, an estimated 64.5 percent worked in the public sector, 21.6 percent in voluntary agency institutions, and 13.9 percent in private institutions in 2001/2002. See Kurowski et al., "Human Resources for Health," 26.

[179] Tanzania, "Tanzania Census ... 2002," 10: 2.

[180] COWI, Goss Gilroy Inc., and Epos Health Consultants, "Joint External Evaluation of the Health Sector in Tanzania, 1999–2006" (Copenhagen, Ministry of Foreign Affairs of Denmark, 2007), 78.

The difficult working environment opened up for indifference and abuse on the part of health personnel. Some interviewees in Mbulu District talked openly about poor treatment of patients because of constraints. A female nurse gave an example from the maternity ward: "Maybe you were struggling to save a woman's life, when another PPH patient [post partum haemorrhage; bleeding just after giving birth] was asking for your attention. Instead of replying politely and saying 'wait a little' ..., you rebuked her and answered her rudely. In a state of being overwhelmed with work, it often happened like that."[181] A Singida regional workshop for medical personnel in 1998 observed that "poor health services at government hospitals, health centers and dispensaries are chiefly caused by understaffing and misconduct by a few members of staff."[182] According to the deputy minister for health, between 1995 and 2001 fifteen doctors and eight nurses were penalized for "violating medical ethics and procedures" including "negligence leading to deaths of patients especially in maternity and operation theatres."[183] In 1996 a medical doctor was suspended from practice for twelve months after a woman died in the maternity ward of the government hospital where he was supposed to be on duty, while in fact he was attending patients in his own private hospital. The legal scholar John A. Harrington implied the "phenomenon of abandonment" started in Tanzania after the liberalization of the health sector.[184]

Corruption, too, was growing in the government health service. A female nursing officer in Mbulu District noted: "I don't know when it [corruption] started ... Except when I was in college in the year [19]88, that was when people spoke about it."[185] This corresponded with an observation made by Illife, that "[c]orruption ... was relatively rare in Tanzania until the later 1980s."[186] A retired health worker in a former senior position in Mbulu District accused party officials in CCM for leading the way in corruption. She said: "People renamed CCM: *Chukua chako mapema!* ["Take what is yours as soon as possible!"]"[187] The political scientist Horace Campbell referred to the renaming of CCM as one expression of popular cynicism toward attempts to politically mobilize society at a time when adjustment measures burdened the broad masses of the population while bypassing the ruling class.[188] Anthropologist Joe L.P. Lugalla argued that the gap between salary and cost of living "bred corruption in the medical sector" and he claimed that

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[181] 26.GHMD.30079, Mbulu District, 22 November 2007.

[182] "Understaffing Cause of Poor Services," *Daily News*, 19 January 1998.

[183] "Doctors Penalised for Cheating," *Daily News*, 13 February 2002.

[184] John A. Harrington, "Between the State and Civil Society: Medical Discipline in Tanzania," *Journal of Modern African Studies* 37, 2 (1999), 231–32.

[185] 21.GHMD.30078, Mbulu District, 21 November 2007.

[186] Iliffe, *East African Doctors*, 207–208.

[187] 25.GHMD.30132, Mbulu District, 11 March 2008.

[188] Horace Campbell, "The Politics of Demobilization in Tanzania: Beyond Nationalism," in Campbell and Stein, eds., *Tanzania and the IMF*, 101.

"[k]ickbacks have become the medium of exchange for medical attention."[189] A presidential commission led by Judge Joseph S. Warioba (a former prime minister and first vice-president) found in 1996 that the health sector was one of the most corrupt of the public services.[190] The impression was confirmed in an investigation of corruption in 2001 by the Economic and Social Research Foundation (ESRF) and the Front Against Corrupt Elements in Tanzania (FACEIT).[191]

Retired President Nyerere commented on the situation in Tanzania when interviewed by the *New Internationalist* in 1999. He referred to a meeting held at the World Bank in Washington D.C. the previous year:

> At the World Bank the first question they asked me was 'how did you fail?' I responded that we took over a country with 85 per cent of its adult population illiterate. The British ruled us for 43 years. When they left, there were 2 trained engineers and 12 doctors.... When I stepped down there was 91-per-cent literacy and nearly every child was in school. We trained thousands of engineers and doctors and teachers. In 1988 Tanzania's per-capita income was $280. Now, in 1998, it is $140. So I asked the World Bank people what went wrong. Because for the last ten years Tanzania has been signing on the dotted line and doing everything the IMF and the World Bank wanted. Enrolment in school has plummeted to 63 per cent and conditions in health and other social services have deteriorated. I asked them again: 'what went wrong?' These people just sat there looking at me. Then they asked what could they do? I told them have some humility. Humility—they are so arrogant![192]

For the majority of the Tanzanian people the neoliberalist structural adjustments could be seen as another experiment forced on them with harsh consequences. The words of a female nursing officer in Mbulu District could express the opinion of government health workers about the decade from the late 1980s to the late 1990s: "The situation resulted in poor services to patients.... [and] the health workers despaired."[193]

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[189] Lugalla, "The Impact of Structural Adjustment Policies," 45. See also Kris H. Heggenhougen and Joe L.P. Lugalla, "How Should Tanzania Improve People's Health?" in Heggenhougen and Lugalla, eds., *Social Change and Health*, 293–94.

[190] Tanzania, "Report on the Commission on Corruption" (Dar es Salaam, Presidential Commission of Inquiry Against Corruption, 1996), 2: 440–50.

[191] ESRF and FACEIT, "The State of Corruption in Tanzania. Annual Report 2002" (Dar es Salaam, ESRF and FACEIT, 2002), xi, 45.

[192] Ikaweba Bunting, "The heart of Africa," *New Internationalist* 1, 309 (1999), *New Internationalist* web page, http://www.newint.org/features/1999/01/01/anticolonialism. Stein argued that in the 1980s Nyerere and other Tanzanian politicians publicly were against the World Bank and the IMF, while privately they embraced liberalization "to ensure the hegemony of the state and the bureaucratic class." The state could blame IMF and the World Bank for future failures. See Stein, "Economic Policy and the IMF," 81. However, it was possible that Nyerere in 1998 did have good reasons to criticize the World Bank for bringing more suffering to Tanzanians.

[193] 13.GHMD.30079, Mbulu District, 22 November 2007.

Protest from Government Health Workers

Most government health personnel in Tanzania seemed to struggle silently in their local communities about how to offer services to the patients and how to secure a livelihood for themselves and their families. For many, the options to structural adjustment policies and reforms were limited to poultry keeping, running a small shop; or even unethical transactions. One survival option that could also be seen as a way of showing protest was to quit. A male health worker in a senior position in Mbulu District talked about the colleagues who left their government posts from the late 1980s: "Highly qualified personnel absconded to private or religious institutions, or even to other countries, and some left the profession altogether.... If he was a doctor he went and did business. If she was a nurse she went and did ... farming.... or [even] ... went to the mines and sold gems."[194] Another male health worker in a senior position elaborated about the "brain drain": "Two DMOs [district medical officers] who were here [in Mbulu] ..., they are working in Botswana now.... Even nurses ... I know about two, three nurses who are out of Tanzania."[195]

Tanzanian medical doctors and registered nurses held internationally recognized qualifications. In rural Mbulu District there was only one government medical doctor, the DMO; and during some years an assistant medical officer acted as DMO. In urban areas with more medical doctors, the number of those who left the country was higher. An interviewee in this study explained why he left Dar es Salaam to work in a neighboring country in the early 1990s: "Hard, hard! ... First of all there was financial discipline.... I opted not to come back. So I sort of defected and looked for greener pasture."[196] The social scientist Angwara D. Kiwara claimed that close to 26 percent of government doctors, or 170 physicians, left Tanzania between the mid and late 1980s; the legal scholar Leonard Shaidi referred to what he called "reliable sources" for a "brain drain" of 196 Tanzanian medical doctors to neighboring countries between 1984 and 1989; while Iliffe cited Hubert Kairuki, the owner of a private hospital in Dar es Salaam, who was quoted in *Daily News* 9 October 1991 to have claimed that some 200 doctors were working abroad.[197] The primary sources were unknown. However, the different sources were consistent and were confirmed by a retired senior official in the Ministry of Health in an interview.[198] The "brain drain" continued during the 1990s. According to the Organization for Economic Co-operation and Development (OECD), Tanzania was among the top ten countries with highest expatriation rates for doctors, since 55.3 percent of Tanzanian

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[194] 12.GHMD.30077, Mbulu District, 20 November 2007.

[195] 23.GHMD.30072, Mbulu District, 16 April 2007.

[196] 3.GHN.30129, Dar es Salaam, 29 February 2008.

[197] Angwara D. Kiwara, "Health and Health Care in a Structurally Adjusting Tanzania," in Msambichaka et al., *Development Challenges and Strategies for Tanzania*, 282; Shaidi, "The Leadership Code and Corruption," 128; Iliffe, *East African Doctors*, 215, 217–18.

[198] 1.GHN.30149, Dar es Salaam, 31 August 2009.

medical doctors (1,018 doctors) were working abroad around the year 2000. The expatriation rate for Tanzanian nurses was 6.8 percent (970 nurses).[199]

Associations for medical and health cadres had their headquarters in Dar es Salaam. The Medical Association of Tanzania was the most powerful.[200] According to Tripp, MAT was leading the movement for privatization of the health sector.[201] Iliffe cited *Daily News* 18 September 1986 where the president of MAT, Sarungi, "called on the government to re-examine the 'non-economic' and 'impractical' ban on private practice." The government agreed to reopen the issue one year later.[202] However, the bill of allowing private practice was not passed before 1991.[203] Iliffe claimed "[p]rofessional ethics had suffered during the 1980s" and "[d]octors' morale was low." He argued that what threatened the medical profession was the inability of the state to preserve a free public health service, offer acceptable working conditions, pay living wages, and protect doctors' privileges.[204]

Iliffe found it likely that the increasing number of Tanzanian doctors "was sufficient to give the profession a substantial collective influence."[205] At a meeting in Muhimbili in May 1990 doctors grieved to President Mwinyi about poor treatment by Ministry of Health officials, lack of promotions, and low salary. One of them, Mafwili, said that "doctors were finding it hard to feed their families." Another, Kahamba, suggested a range of allowances, such as "hardship, on-call, [and] professional risk." President Mwinyi "agreed that they had problems" and he said "the Government will try to 'sweeten' the jobs by adding more incentives."[206] Not only doctors, but also nurses in Muhimbili, the national consultant and referral hospital, were able to draw the attention of top politicians and the media and to take advantage of that opportunity. A few days later *Daily News* reported from the international nurses' day in May 1990, that nurses staged a play for Minister of Health Charles Kabeho to demonstrate how the lack of protective gear made nurses vulnerable to diseases such as cholera, tuberculosis, and HIV. The newspaper heading was: "Nurses Press for Better Conditions."[207] In June 1990, Kabeho announced to parliament allowances to doctors, nurses, and paramedical staff as an incentive.[208]

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[199] Jean-Christophe Dumont and Pascal Zurn, "Immigrant Health Workers in OECD Countries in the Broader Context of Highly Skilled Migration," in OECD, *International Migration Outlook* (Paris: Sopemi, 2007), 3: 212–15, available at OECD website, www.oecd.org.

[200] MAT was formed in 1965 after dissolving the Tanganyika Medical Association from 1962. See MAT website, www.mat-tz.org.

[201] Tripp, *Changing the Rules*, 162.

[202] Iliffe, *East African Doctors*, 217, 210.

[203] Tanzania, "The Private Hospitals (Regulations) (Amendment) Act, 1991."

[204] Iliffe, *East African Doctors*, 217, 5.

[205] Ibid., 219.

[206] "Mwinyi Unveils Incentives for Docs," *Daily News*, 9 May 1990.

[207] *Daily News*, 14 May 1990, "Nurses Press for Better Conditions."

[208] "Minister Unveils Incentive Package for Medical Staff," Ibid., 29 June 1990"; Iliffe, *East African Doctors*, 218–19. A process of including allowances in the salary started from 1995. "Special skill" and

Also in Muhimbili go-slows, stoppages and strikes were used as a peaceful weapon several times to show dissatisfaction. According to Iliffe, citing newspapers, during the years 1990 to 1992 junior doctors protested against financial grievances. Those who went on strike over unpaid allowances in January 1992 were sacked and some were removed from Muhimbili by police. After general protests by most workers at Muhimbili the junior doctors were pardoned and reinstated in their positions. Iliffe claimed "[t]he sequence of strikes ... accelerated change within the health system."[209] In Lugalla's opinion the police harassment led to "[g]rowing hostility between the state and health personnel [that] worsened the delivery of health services."[210] This did not keep doctors and other health workers from protesting. Again in 1996, 1997, and 1998 doctors in Muhimbili went on go-slows or strikes to protest against difficult working conditions: poor funding, lack of supplies, and delay of salaries.[211] In 1998, interns in Muhimbili also went on strike demanding better living conditions on the hospital campus.[212] Improvements in the public health sector from around 2000 seemed to calm down the staff for some years. However, during 2005 several hundred health workers, led by intern doctors in Muhimbili, went on go-slows and strikes three times. Initially the interns protested against cuts in allowances. The interns were joined by senior doctors demanding better pay and work conditions. The protests spread to regional referral hospitals in other parts of Tanzania. The government responded by sacking the striking staff in Muhimbili. Later they were pardoned and reinstated.[213] The strikes eventually led to general salary increases for all health workers in Tanzania.[214]

"topping-up" were two of the allowances included in the salary. It was announced that the government considered including all allowances in later salary scales. In 1995 the starting salary increased for a nurse (with diploma) from 16,015 to 29,310 shillings, for a clinical officer from 15,595 to 28,580 shillings, and for a medical doctor from 20,605 to 41,950 shillings. See Tanzania, "Waraka wa Watumishi wa Serikali Na. 2 wa 1995" [Staff Circular No. 2 of 1995], in, "Staff Circulars 1971–1995," 719, 722, 709–33. The annual inflation rate in the early 1990s fluctuated between 22 percent and 36 percent. See World Bank, "Tanzania the Challenge of Reforms," 2: 61.

[209] Iliffe, *East African Doctors*, 218.

[210] Lugalla, "The Impact of Structural Adjustment Policies," 45; Heggenhougen and Lugalla, "How Should Tanzania Improve People's Health?" 295.

[211] *Guardian*: 18 October 1996, "Doctors Strike"; 22 October 1997, "Patients Die at Muhimbili Because of Strike?"; 26 November 1997, "Muhimbili Workers Threaten Work Stoppage"; 11 March 1998, "MMC Workers Protest Against Cancellation of Overtime Pay." *Daily News*, 4 April 1998, "Muhimbili Workers Put Off Strike."

[212] *Guardian*, 16 February 1998, "Interns' Go-Slow Paralyses Muhimbili Services"; *Daily News*, 20 February 1998, "MMC Interns End Strike on Condition."

[213] *Guardian*: 23 February 2005, "Chaos as Interns' Go-Slow Paralyses Muhimbili Hospital"; 4 March 2005, "Interns End Boycott at Mbeya Hospital." *Daily News*, 17 June 2005, "Striking Muhimbili Interns Told to Go Back to Work." *Guardian*: 21 June 2005, "Now MNH Doctors Join Interns' Strike"; 25 June 2005, "We'll Pay You, PM Promises Medics"; 18 November 2005, "Muhimbili Doctors on Strike Again"; 22 November 2005, "Govt Raises Doctors' Salaries"; 24 November 2005, "Striking Doctors Sacked"; 22 December 2005, "Sacked MNH Doctors Plead for Forgiveness." *Daily News*, 11 January 2006, "Govt Pardons 224 Medics." International Confederation of Free Trade Unions (ICFTU), "Internationally

Liberalization of the Tanzanian society made it easier to voice dissatisfaction. A retired medical doctor in the Ministry of Health explained: "Before people [leaders and administrators] could do anything, almost, as long as you were in the party you were strong. But those—community, the media, multi party—those are the things which have affected us a long way. And it's very different. Now people can [even] talk about the president."[215] The anthropologist Nils G. Songstad also referred to the rapid increase in use of mobile phones as a quick way of spreading information. In a study from Mbulu District during the period 2007–2009 they found that health workers extensively used the "[i]ncreased opportunities to express dissatisfaction" with their employer, the government.[216] However, the vocal complaints remained within the local work places. That was also revealed in Sullivan's study of a district hospital outside Arusha town.[217] As observed by Sullivan, "location ... mattered."[218] Health workers—in particular doctors—in Muhimbili hospital in Dar es Salaam had the best chance to reach decision makers.

Glimpses of Optimism After 2000

Most government health workers interviewed in Mbulu District agreed that after 2000 the working conditions started to improve. A few credited President Mkapa (1995–2005) for bringing back an element of state control and take measures to strengthen government institutions, like this female nursing officer: "Mkapa set things right so that at least we had medicines,... and respect for the civil servants was restored."[219] A female nurse emphasized the financial aspect: "changes were brought about by increased budgets or income from the government.... if you are given satisfactory financial support you can bring about the required changes"[220]; while another female nurse referred to the staffing

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Recognised Core Labour Standards in Tanzania" (Report for WTO General Council Review of Trade Policies of Tanzania, Geneva, 25–28 October 2006), 4, available at ICFTU website, www.icftu.org.

[214] Songstad et al., "Perceived Unfairness in Working Conditions," 3.

[215] 4.GHN.30145, Dar es Salaam 24 October 2008.

[216] Songstad et al., "Perceived Unfairness in Working Conditions," 12–13.

[217] Sullivan showed how the hierarchical structures within a local hospital prevented workers from bringing complaints, and also new ideas, further to national (Ministry of Health) and global actors (donors and development partners). See Sullivan, "Negotiating Abundance and Scarcity," 59–60, 260–78, 424–25.

[218] Ibid., 109–110, 181–82, 187–89. Sullivan connected the hospital location and funding from the 1990s.

[219] 21.GHMD.30077, Mbulu District, 20 November 2007. The World Bank allowed the state to take an active role again. See World Bank, *World Development Report 1997*, 4, 14, 162. A team of scholars found limited outcomes "in the direction of broad based and sustainable development" during Mkapa's presidency. See Kjell Havnevik, "Postscript: Tanzania in Transition—Summary and Trends 2005–2010," in Kjell Havnevik and Aida C. Isinika, eds., *Tanzania in Transition: From Nyerere to Mkapa* (Dar es Salaam: Mkuki na Nyota Publishers, 2010), 274.

[220] 26.GHMD.30079, Mbulu District, 22 November 2007. Only members of the Council Health Management Team seemed to be aware that donor agencies also were main financial providers to the district health sector budget in Mbulu. From July 2001 donors were more unwilling to assist with donations for development and recurrent work since they were contributing to a basket fund. See Tanzania, "Council Comprehensive Health Plan for the Year 2002" (Mbulu, Mbulu District Council, 2002), viii–x, 3.

situation: "in 2002 several nurses were posted here and we were relieved. That was the time we started feeling the improvement and changes."[221]

According to the district medical officer, the new reforms in the public service and the local government were implemented in Mbulu District from 2001. The Council Health Services Board, Health Facilities Governing Committees, and Community Health Fund were operating from September 2002.[222] Members of the Council Health Management Team were relieved when their responsibilities were defined. A male member commented: "Before that time,... you just sat in the office as if you had nothing to do. You had no power."[223] A female nurse mentioned another change: "Suppose we do something wrong; there is that committee from the community... So our health services are much improved because of these policies."[224] Sullivan found the same optimism among staff in a district hospital outside Arusha town, where the reforms were implemented from 1999.[225]

Some interviewees in Mbulu District expressed concern about patients' abilities to pay after the introduction of user fees for government health services. However, a majority were in favour of the Community Health Fund, which at that time was managed locally to finance immediate priorities of the health facility, as expressed by a female nursing officer:

> The scheme of contributing towards the provision of health service has moved us from where we were stuck in the past to the present situation; where at least the community would see the importance of this scheme, since things [medicine and equipment] are now available. And we [health workers] are careful as we know that the patients have also contributed to the expenses of the services.[226]

Similar accounts were given by hospital workers in Sullivan's study.[227]

The reforms led to increased workshop and seminar activities.[228] Health workers in Mbulu District considered workshop packages as personal incentives to make them remain

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[221] 22.GHMD.30079, Mbulu District 22 November 2007.

[222] Tanzania, "Comprehensive Council Health Plan for the Year 2008/2009" (Mbulu, Mbulu District Council, 2008), 13; The Community Health Fund had been tested in other districts of Tanzania from 1996 to 1998. See World Bank, *Tanzania: Social Sector Review*, xvii, 117–19.

[223] 9.GHMD.30046, Mbulu District, 1 April 2007.

[224] 7.GHMD.30135, Mbulu District, 19 March 2008.

[225] Due to delay in funding from the government, hospital staff from 1999 contributed from their own salaries to build a new x-ray building completed by 2001. This gave the workers a special pride and optimism. See Sullivan, "Negotiating Abundance and Scarcity," 116, 129–33, 180, 190.

[226] 13.GHMD.30079, Mbulu District, 22 November 2007.

[227] Sullivan, "Negotiating Abundance and Scarcity," 185–87.

[228] Workshops and seminars had been there for many years. In 1986, in connection with government cost cutting measures, Prime Minister and First Vice-President Warioba commented to journalists that some people were "professionals at attending and organising seminars," which were "accompanied with parties and other things that ignored the fact that we are a poor country." See *Daily News*, 7 May 1986, "'No Need for Referendum.'"

with the government. This was acknowledged by a male interviewee in a senior position: "it is one of the incentives. If you pick a health worker from the ward and say: 'You are going for a seminar!' She will really become happy ... because she is getting extra money.... in addition to the knowledge and skills that she will use to serve her patients."[229] The income from attending workshops and seminars were also seen as important by government health workers in Sullivan's study.[230] The anthropologist Maia Green has described the workshop system and how per diems and allowances provided considerable additional income for Tanzanians.[231] A retired medical doctor in the Ministry of Health raised some questions about the workshop phenomenon:

> It was WHO,... DANIDA; ... the government can hardly do any workshops.... You have to train people.... It doesn't have to be workshops, but it is the workshop style because its incentive, it's money.... And when they [the health workers] come back [to their workplace]; one thing which we didn't do is follow-up. We didn't know whether it was working; and it's a lot of money which goes into training.[232]

The medical doctor Stefan Hanson was one of those who has criticized the donor community's system of giving incentive for health workers through invitation to workshops, instead of doing necessary daily routine work in their respective health facilities.[233] Sullivan showed how donor-funded workshops created conflicts within a hospital with workers accusing the administration of corruption and favoritism, having a negative influence on the working moral.[234] There is evidence that the donor-sponsored workshop culture led to more corruption, with fictive seminar dates and inflated prices.[235]

Despite optimism among some government health workers in Mbulu District about the latest reforms, other interviewees expressed fatigue. This was not surprising after having experienced two decades of ever-worsening working conditions from the late 1970s until the late 1990s. Statistics from Mbulu District, as shown in Figure 1, revealed that a majority (59.8 percent) of the 249 staff members in the year 2007 had a work experience that went back to the socialist (31.7 percent) or neoliberalist structural adjustment (28.1 percent) period.

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[229] 23.GHMD.30072, Mbulu District, 16 April 2007.

[230] Sullivan, "Negotiating Abundance and Scarcity," 281–84.

[231] Maia Green, "Globalizing Development in Tanzania: Policy Franchising Through Participatory Project Management," *Critique of Anthropology* 23, 2 (2003), 133–34.

[232] 4.GHN.30145, Dar es Salaam, 24 October 2008.

[233] Stefan Hanson, "Control of HIV and Other Sexually Transmitted Infections: Studies in Tanzania and Zambia" (Doctoral thesis, Karolinska Institutet, 2007), 49–50, Karolinska Institutet web page, http://hdl.handle.net/10616/39342.

[234] Sullivan, "Negotiating Abundance and Scarcity," 283–97, 421. Also Songstad et al. found that the allocation of seminars, and the extra income generated, created great dissatisfaction among staff and influenced working motivation. See Songstad et al., "Perceived Unfairness in Working Conditions," 7–8.

[235] Eirik G. Jansen, "Does Aid Work? Reflections on a Natural Resources Program in Tanzania," *U4Issue* 2 (2009), 15–19, available at Chr. Michelsen Institute website, www.cmi.no.

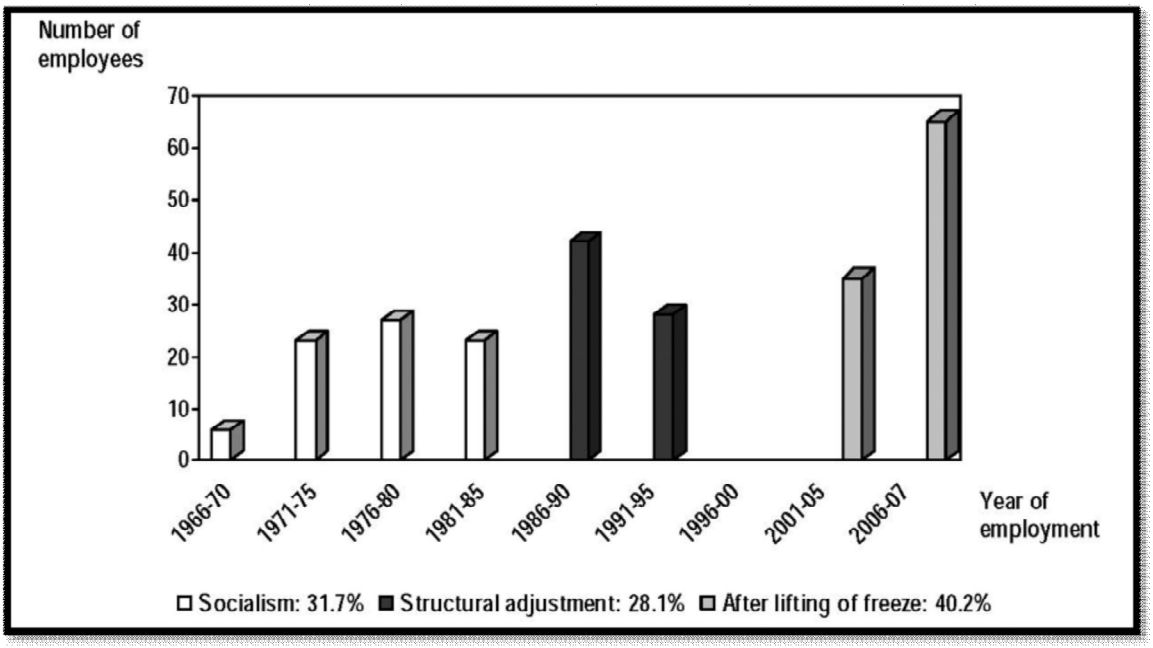


Figure 1. Mbulu District government health work force in 2007; 249 staff members arranged by year of employment based on Tanzania, "Orodha ya Ukubwa Kazini (Seniority List) Julai 2007 Idara ya Afya" (Mbulu, Mbulu District Council, Department of Health, 2008). The list of the health work force was confidential, but made available for statistical use. The total number on the list was 252. Three staff members with missing dates of employment could not be included in the figure. The columns include five years except the last column representing two years only. Fifty-two new employments were made in 2007.

Figure 1 shows the years of hiring freeze in Mbulu District (1995–2001) and how employment increased after lifting of the freeze. However, rural Tanzania, where the majority of the population lives, still lacks qualified personnel.[236] A retired male health worker in a former senior position in Mbulu District questioned the latest decentralization reform: "I am not sure whether it will work.... they say they are decentralising, but they keep all the [qualified] able people in the central level, while in the periphery where the services are needed we don't have the people who can do it; in the way of planning, in the way of implementing."[237] The challenge of recruiting skilled health workers in Tanzania has been discussed in several studies.[238] The epidemiologist and public health specialist

[236] In 2002, 76.9 percent of the population lived in rural areas. See Tanzania, "Tanzania Census ... 2002," 10: 9.

[237] 3.GHMD.30035, Mbulu District, 29 March 2007. For an overview of decentralization attempts in Tanzania and the health sector, see Nsekela and Nhonoli, *The Development of Health Services*, 107–109; Gilson et al., "Local Government Decentralization," 455–59; Semali, "Understanding Stakeholders' Roles," 33–62; Munga et al., "The Decentralisation-Centralisation Dilemma," 6–9.

[238] McKinsey & Company, "Acting Now to Overcome Tanzania's Greatest Health Challenge: Addressing the Gap in Human Resources for Health" (Report from Field Visit Tanzania 2004, McKinsey & Company, 2005), available at HRH Global Resource Center website, www.hrhresourcecenter.org; WHO, *The World Health Report 2006: Working Together for Health* (Geneva: WHO, 2006), 9–39; Christoph Kurowski, Kasper Wyss, Salim Abdulla, and Anne Mills, "Scaling Up Priority Health Interventions in Tanzania: The Human Resources Challenge," *Health Policy and Planning* 22, 3 (2007), 113–27; Munga et al., "The Decentralisation-Centralisation Dilemma"; Julie R. Kolstad, "How to Make Rural Jobs More Attractive to

Don de Savigny have pointed out that "[t]he era of structural adjustment may be over, but the effects of earlier damage continue to cast a long shadow."[239]

A major challenge relates to the need to sustain motivation among government health workers. Interviewees in Mbulu District complained about a shortage of qualified personnel, lack of medication and transport in remote dispensaries; and many were still requesting a living wage.[240] In a study by Songstad et al., government health workers in Mbulu District emphasized dissatisfaction of salary level, low rewards and recognition, and lack of upgrading and promotions as de-motivating factors.[241] In studies from other parts of Tanzania health workers gave much of the same reasons for de-motivation.[242]

Violation of work ethics remains a concern. Several interviewees in Mbulu District confirmed the existing use of insulting language, as acknowledged by a male health worker in a senior position: "Not only hearing it from the community. I have heard it with my own ears. Just sometimes walking slowly, and then you hear the abusive language. Especially in ... maternity wards."[243] Incidences of negligent government health personnel in maternity health have continuously been reported in the press[244]; also after 2005 when the Parliament passed an amendment, "A Code of Ethics." Under the new law medical and dental practitioners could face court actions.[245]

Health Workers. Findings from a Discrete Choice Experiment in Tanzania," *Health Economics* 20 (2011), 196–211.

[239] Don de Savigny, Harun Kasale, Conrad Mbuya, and Graham Reid, *Fixing Health Systems* (Ottawa: International Development Research Center, 2004), 8.

[240] All interviewees in Mbulu District engaged in formal or informal activities to supplement their salaries; as did government health workers in Sullivan's study. See Sullivan, "Negotiating Abundance and Scarcity," 294–95.

[241] During 2005–2008 the salaries were increased by 122–220 percent. The annual salary increases were much higher than the annual inflation rates. See Songstad et al., "Perceived Unfairness in Working Conditions," 3, 5–9.

[242] Rachel N. Manongi, Tanya C. Marchant, and Ib C. Bygbjerg, "Improving Motivation Among Primary Health Care Workers in Tanzania: A Health Worker Perspective," *Human Resources for Health* 4, 6 (2006), 3–6; Melkidezek T. Leshabari, Eustace P.Y. Muhondwa, M.A. Mwangu, and Naboth A.A. Mbembati, "Motivation of Health Care Workers in Tanzania: A Case Study of Muhimbili National Hospital," *East African Journal of Public Health* 5, 1 (2008), 34–36; Silvia Stringhini, Steve Thomas, Posy Bidwell, Tina Mtui, and Aziza Mwisongo, "Understanding Informal Payments in Health Care: Motivation of Health Workers in Tanzania," *Human Resources for Health* 7, 53 (2009), 4–7; Sullivan, "Negotiating Abundance and Scarcity," 260–78.

[243] 23.GHMD.30072, Mbulu District, 16 April 2007.

[244] *Guardian*, 19 August 2002, "Half Maternal Deaths Avoidable"; *The Citizen*, 11 June 2005, "Hell Hath No Fury: Like a Nurse Seeking a Bribe; Nurses Who Refuse to Hear the Screaming" (Dar es Salaam).

[245] *Daily News*, 13 June 2005, "Negligent Medics to be Prosecuted"; *Guardian*, 5 April 2006, "Six Mwanyamala Medics Suspended for Absconding from Duty."

Despite campaigns, petty corruption has persisted among government health workers.[246] Several interviewees in Mbulu District admitted that corruption existed in the health services; however, much more in other districts than their own.[247] They also talked about the grand corruption scandals among top officials and politicians in Tanzania during recent years[248]; and a male health worker in a senior position explained how those scandals influenced staff:

> [D]espite of improving the availability of drugs, supplies and materials, salaries; still the staff is de-motivated.... We are trying to keep them motivated by doing [on-the-] job training, continuing education, having meetings,... But people are dissatisfied ... about the system at the national level. When they [the health workers] hear that the system is that much corrupt, they are demoralised.[249]

The main justifications given by government health workers for taking bribes in other studies were poor incentives and salaries, greed, and pressure from patients.[250] However they also cited rampant corruption in the government, the public service, and the top management of the health sector.[251] Few of the national level leaders alleged to have been involved in corruption have been taken to court thus far. The ruling party CCM, led by President Kikwete (2005–2015), has been accused of trying to silence those who speak up against the grand corruption.[252]

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[246] Tanzania, "Mianya ya Rushwa katika Utoaji wa Huduma katika Hospitali ya Taifa ya Muhimbili" [The Loopholes for Corruption in Provision of Services at Muhimbili National Hospital] (Taasisi ya Kuzuia na Kupambana na Rushwa) [Prevention and Combating of Corruption Bureau], Dar es Salaam, 2009), 25, Tanzania Prevention and Combating of Corruption Bureau web page, http://www.pccb.go.tz/images/stories/download_center/publications/taarifa%20utafiti%20mhimbili.pdf; *Daily News*, 27 September 2009, "Government Lose 4.5bn/- to Ghost Workers, Most in the Health Sector," *Daily News* web page, http://www.dailynews.co.tz/home/?n=4057; Mæstad and Mwisongo, "Informal Payments and the Quality of Health Care," 109–12. The study included health workers in both government and non-government health facilities in Temeke District, Dar es Salaam Region, and Kisarawe District, Pwani Region, in 2006.

[247] The denial of corruption in own work place was also found in other studies. See Stringhini et al., "Understanding Informal Payments in Health Care," 5; Sullivan, "Negotiating Abundance and Scarcity," 123.

[248] *The Citizen*, 19 January 2008, "Kikwete Told to Sack More in BoT Scam," *The Citizen* web page, http://www.thecitizen.co.tz/newz.php?id=2707; 7 February 2008, "Step Down, Lowassa Told after Implication in Tender Scandal," web page: http://www.thecitizen.co.tz/newz.php?id=3222; 9 February 2008 "Former Premier Warioba: BoT Dirtier Than Richmond," web page, http://www.thecitizen.co.tz/newz.php?id=3267.

[249] 23.GHMD.30141, Mbulu District, 27 March 2008.

[250] Tanzania, "Ethics in the Public Health Service in Tanzania" (Dar es Salaam, Prevention of Corruption Bureau, 2004), 17; "Mianya ya Rushwa," 26.

[251] Stringhini et al., "Understanding Informal Payments in Health Care," 6.

[252] *The Citizen*, 17 September 2008, "PCCB in Blame Game as Corruption Cases Stall," web page, http://www.thecitizen.co.tz/newz.php?id=7792; 12 August 2009, "Why Unity within CCM is Facing its Biggest Test Yet. Scandals Rock CCM Ahead of 2010 Polls"; 24 August 2009, "Sitta: No Surrender in Anti-Corruption Battle"; Havnevik, "Postscript: Tanzania in Transition," 270–71.

Tanzania is a politically stable country with many natural resources such as agricultural land, gold, gemstones, gas, wildlife, and attractive tourist destinations. Yet, Tanzania was in 2009, after more than twenty years of "neoliberalist experiments," still one of the poorest countries in the world and heavily dependent on development aid.[253] A retired medical doctor in the Ministry of Health was critical to Tanzanian politicians who ruled according to donors' conditionalities: "The problem with external aid is first sustainability; it is not making countries learn how to be self sufficient. And secondly, you see these conditionalities of the donors; each one has got their own policies.... And because of the [Tanzanian] economy we tended to listen to their needs, to their demands. By doing so, we didn't have our own policy."[254]

Those who seem to be profiting most from the latest experiment are the ruling class in Tanzania, international companies (mining, gas, etc.), international financial institutions, and the development aid industry—not the majority of the Tanzanian people.[255] In the Human Development Index 2007 Tanzania ranked 151 of 182 countries, and in the medium human development group; while in the 2010 index Tanzania ranked 148 of 169 countries, and in the low human development group.[256]

Government health workers in Tanzania had divided views on the liberalization policies after 1986. The neoliberalist structural adjustment measures were not fully known but clearly felt in the work places in Mbulu District, and in all parts of Tanzania, as the government health sector was drained of financial and human resources; leading to inefficiency and corruption. However, in particular doctors were relieved when the ban on private-for-profit practice was officially lifted in 1991. It also became possible for doctors and other health workers in Muhimbili hospital in Dar es Salaam to protest and go on strike. Still, the "brain drain" continued. New health and public service reforms, improved working environment, and increased incomes sparked some optimism among interviewees in Mbulu District and other sources from around 2000. However, it appears the "neoliberalist experiment" in Tanzania, which still continues, has not managed to solve fundamental problems in the health system and in the country.

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[253] It was estimated that development partners contributed to more than 40 percent of the total funding to the Tanzanian health sector in 2007/2008. See Tanzania, "Health Sector Performance Profile Report: Mainland Tanzania July 2006–July 2007" (Dar es Salaam, Ministry of Health and Social Welfare, 2008), 13.

[254] 4.GHN.30145, Dar es Salaam, 24 October 2008.

[255] Havnevik, "Postscript: Tanzania in Transition," 269.

[256] The Human Development Index (HDI) measured average achievement in three basic dimensions of human development: a long and healthy life, access to knowledge, and a decent standard of living. See United Nations Development Program (UNDP), *Human Development Report 2009. Overcoming Barriers: Human Mobility and Development* (New York: Palgrave MacMillan, 2009), 171–75, 210; *Human Development Report 2010. 20th Anniversary Edition. The Real Wealth of Nations: Pathways to Human Development* (New York: Palgrave MacMillan, 2010), 143–47, 224. UNDP reports available at www.undp.org.

Conclusion

In this article we have explored the public health services in Tanzania mainland from 1967 to 2009 in a health worker perspective, using rural Mbulu District as a case. The foundation of Tanzanian government health workers' experiences was the endured consequences of political and administrative experiments. With support from international development experts and agencies, President Nyerere tried out "African Socialism" from 1967 to 1985. Following failures in realizing the articulated goals of *Ujamaa* and the subsequent pressure from the World Bank, IMF, and bilateral donors, the government of Tanzania has been experimenting with neoliberalist policies since 1986. The shifting policies clearly influenced the working abilities of government health workers and their services to the public, as articulated by the interviewees in Mbulu District, who had experienced profound changes during their working careers; and also by other sources.

The perceptions expressed in retrospect by government health workers in rural Mbulu District differed from those in two previous studies from Tanzania; a history of African medical doctors (John Iliffe) and a hospital ethnography (Noelle Sullivan). The interviewees in this study revealed that policies during both the socialist and the neoliberalist periods provided basic working conditions. During the 1970s medicines and equipment were available, and until 1978 it was possible to live on a government salary without supplementary income. These provisions, essential for a well-functioning and motivated health work force, were again maintained in the Tanzanian public health sector after 2000, sparking some optimism among the interviewed government health workers in Mbulu District. This optimism was also noted in the ethnography of a hospital near Arusha town. Yet, despite salary increases, in 2009 it was still not possible for health workers to live only on government wages.

The top-down policies pursued by development experts and politicians had some unintended and negative consequences. It is well documented how the socialist policies blurred responsibilities and opened up for indifference and corruption, and the expansion of the public health services was not financially sustainable. Less discussed by scholars are the implications of the subsequently adopted neoliberalist austerity measures, including cuts in public spending, that contributed to increased corruption, and the reduction of staff in the civil service led to staff shortage and lower efficiency in the Tanzanian public health sector. There was also an increasing "brain drain" of doctors and nurses. During two decades of ever-worsening working conditions from the late 1970s until the late 1990s Tanzanian government health workers in their local communities had to struggle and find creative measures to survive the hazards as results of political experiments based on national and global development models. It became almost impossible to provide essential medical and health services to the public, which was the role of Tanzanian government health workers as professionals and civil servants.

Our analysis of government health workers' experiences revealed some differences depending on the geographical location and size of their respective institutions. The full impact of the crisis in the economy seemed to have been felt earlier by urban than rural health workers, probably as a result of the rural focused health policies from 1971 as well as easier access to food in rural areas. Oral testimonies from Mbulu District abundantly showed that the worst impact was felt from the late 1980s. After liberalization policies,

doctors in Muhimbili in Dar es Salaam, the national consultant and referral hospital, were leading strikes from the early 1990s to show their dissatisfaction with appalling working conditions. We have not found evidence that government health workers in any other part of Tanzania initiated organized protests. That doctors—and other health workers—in Muhimbili increasingly have raised their voices to demand acceptable working conditions and living wages, and by going on strike to put pressure on politicians and administrators, can be seen as an important sign in the slow democratization process in Tanzania.

By taking a historical approach we have shown how some of the present challenges in the Tanzanian public health sector are rooted in past policies and structural reforms advocated by national and global actors. Perspectives from local government health workers in rural Mbulu District have shed new light on the postcolonial public health services in Tanzania mainland. More life stories and experiences from health practitioners—and health service users—are needed to complement and expand the history and the knowledge about the health services in Tanzania.

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