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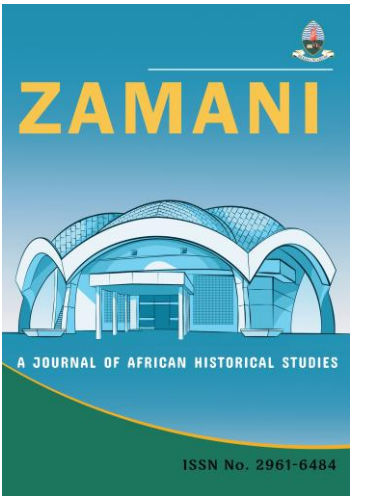

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Health Infrastructure Planning in Tanzania, 1961–1980s: The Problems of Future-making

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Abstract

Between 1961 and 1978, Tanzania invested significantly in the health service provision – from training requisite manpower, provision of health education to building the necessary infrastructure in order to improve health conditions of the population. As existing research indicates, the investment paid off considerably in qualitative terms, for instance, with a gradual increase in life expectancy and a decline in infant mortality. This paper examines the vision of the state of health in Tanzania by using the prism of infrastructure. Its focus is on direct and indirect physical infrastructures, particularly medical buildings and facilities. Through the analysis of archival and documentary sources, the paper contends that the vision of the state on health centred on provision of primary healthcare in the rural areas without paying enough attention to the broader population dynamics and critical health challenges. This set the antecedents for crisis in the health sector that unfolded in the neoliberal era, particularly in the 1980s. The latter position challenges the long-established narrative in neoliberal and health policies' literature that infers that health conditions started deteriorating in the postcolonial era due to neoliberal policies. As such, the paper presents a comparative juxtaposition of socialist and early neoliberal health infrastructures in Tanzania, and contributes to knowledge on the futures of public health in the Global South. It concludes by arguing that although the policy of rural health improvement was translated through construction of primary health infrastructure, the latter acted as a denial tool for the best healthcare infrastructure to rural populations.

Keywords: Health planning, health infrastructure, health education, postcolonial, SAPs, Tanzania

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Introduction

Attainment of independence in African countries brought high hopes on improvement in social policy and started a planning euphoria. In Tanzania, among other social issues, it guided the outlook on health services' development. The initial stance of the government was to make health accessible to all with the state posing as the sole provider of health services. The promise of the Tanganyika African National Union (TANU)-government and the expectation of the masses was that healthcare should be freely provided. Between 1961 and 1978, Tanzania invested significantly in health services provision and health infrastructure. One could observe a gradual increase in life expectancy and a decline in infant mortality with an ensuing population growth that caused itself significant problems. The consecutive development of health plans mostly failed and would not deliver the hoped outcome. In particular, staffing and an insufficient direct and indirect infrastructure remained a huge problem besides the economic problems and the inadequate financial investments. The goal of a completely free health services also remained unrivalled. In the following paper we will show that the developments in the 1960s and 1970s set the antecedents for crisis in the health sector that unfolded in the neoliberal era. The latter position challenges the long-established narrative in the literature of neoliberal and health policies which infers that health conditions started deteriorating in the postcolonial era due to neoliberal policies per se.

We will first analyse the developments in independent Tanzania until 1978 and show how failed plans, problematic infrastructure, and an ambivalent rural-urban divide shaped the health system even in times of relative economic success and during a gradual expansion of services in the 1960s and early 1970s. We will shortly discuss the changes after the Arusha declaration before analysing the post-Ujamaa era, particularly the decade of the 1980s. The argument we make in this paper is that there was a direct relationship between health infrastructure development and an improvement of the health conditions in Tanzania, especially between 1967 and 1978. Nonetheless, we seek to highlight that such infrastructure development was partial and contradictory, and therefore, it created the antecedents of the health crisis in the neoliberal era. In other words, this work builds on the gradualist thesis, explaining health crises as results of

broader socio-economic crises.[1] We posit that the health crisis did not commence but was exacerbated in the neoliberal age. This position is in line with what was dubbed as the "rhetoric-implementation gap" in Kenyan health future-making by FM Mburu.[2] Thus, the paper contributes to the understanding of health future-making through the rarely discussed issue of health infrastructure. To achieve this, we present a select statistical situation of health infrastructure against the population and qualitative changes in health services. Finally, we make a research intervention by invoking infrastructure as a key agenda hitherto downplayed in healthcare research of Tanzania in particular, and Africa at large. With this infrastructure turn in healthcare, we seek to show how infrastructure can also be a window of understanding health policies and practices in African history. We problematize healthcare infrastructure to complement infrastructure studies that have been conducted in other fields especially transport, sanitation, drainage, water, power, telecommunication, and recently, religion.[3]

Health and Health Infrastructure Planning until 1979

High Hopes, Failed Plans and (Post)Colonial Continuities after Independence until 1971

Intense planning for the future started in Tanganyika after independence in 1961. With Julius Nyerere as the new president, who had campaigned and fought for independence over years, the government of Tanzania saw itself at the beginning of a hopeful and prosperous development as can be observed in the many detailed plans that were issued during and after independence. Among the many issues that had to be dealt with, Nyerere highlighted poverty, ignorance, and disease in his speeches as important

[1] Jannik Boesen, Kiell J Hevnevik, Juhani Koponen, and Rie Odgaard, eds., *Tanzania: Crisis and Struggle for Survival* (Uppsala: Scandinavian Institute of African Studies, 1986).

[2] FM Mburu, "Rhetoric-Implementation Gap in Health Policy and Health Services Delivery for Rural Populations in a Developing Country," *Social Science and Medicine* 13 (1979): 577–583.

[3] On religious infrastructure see Yanti Hoelzchen and Benjamin Kirby, "Religious Infrastructure: Establishing a Research Agenda," *Religion, State & Society* 52, no. 2–3 (2024): 88–95. On other technical infrastructures see Frank Edward, *Circulation and Appropriation of Urban Technologies: Drainage and Traffic Infrastructures in Dar es Salaam, 1913-1999* (Darmstadt: TUprints, 2023).

challenges that should be addressed first.[4] This was also in line with the World Health Organisation (WHO) principles that were set out in its new constitution of 1946 and which stated amongst other issues:

> The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States.[5]

Newly independent states of the 1950s and 1960s were keen to adhere to the new principles of the WHO. Health planning after independence was strongly shaped by high expectations of a brighter future. Self-determination was seen as the most important aspect of freedom, and, according to Nyerere, being disease-free should also be part of this new freedom.[6] Therefore, health policy planning was a vital part of the larger developmental goals of the new nation.

However, the concrete planning of health facilities and health infrastructure in the early years of independence was not as optimistic as the first ground-breaking speeches would one let assume. The development plan for the first years 1961-1963 did not pay much attention to health issues. Generally, in the field of social policy, the new government had a strong focus on education. Nyerere himself, as a former teacher, was the founder of the *Tanganyika Education Trust Fund* in the late 1950s, still under colonial rule, and had long campaigned for better primary and secondary education for all Africans in Tanganyika.[7] Health issues were not his core concern. The plan for the period 1961-1963 was prepared before independence and officially adopted in December 1961. It was based on the information received through the surveys by the World Bank. As in other

[4] Julius Nyerere, *Freedom and Development: A Selection of Writings and Speeches*, *1963–1973* (Dar es Salaam: Oxford University Press, 1973), 15.

[5] Constitution of the World Health Organization. The Constitution was adopted by the International Health Conference held in New York from June 19 to July 22, 1946, signed on July 22, 1946, by the representatives of 61 States (Off. Rec. Wld Hlth Org., 2, 100), and entered into force on April 7, 1948, see https://www.who.int/about/governance/constitution, accessed March 1, 2024.

[6] Nyerere, *Freedom and Development*, 58; Wizara ya Afya, *Maelezo ya Mpango wa Pili wa Maendeleo ya Wizara ya Afya na Ustawi wa Jamii* (Dar es Salaam: Wizara ya Afya, 1969), 2.

[7] Andreas Eckert, *Herrschen und Verwalten: Afrikanische Bürokraten, staatliche Ordnung und Politik in Tanzania 1920–1970* (München: Oldenbourg 2007), 196–197.

newly independent countries, Tanganyika had to start its operations based on the arrangements of the former colonial system and on the forecasting of international organizations.[8] About twenty-four million sterling pounds were allocated to the development of the period between 1961-1963. Of this amount, only four percent were allocated to the whole budget of the health and labour sector. Choices had to be made between numerous needs. The Ministry of Health and Labour received the smallest share, compared to 24 and 13.7 percent allocated to the agriculture and education ministries respectively.[9] The main theme of the plan was "laying the foundation for future growth" which was largely based on developing agriculture, education and infrastructure. The general emphasis was placed on economic development. It is also worth bearing in mind that a substantial amount of the twenty-four million pounds of the 1961-1963 plan was to be funded through loans and grants.[10] This became a trend in the subsequent years as the government was not able to self-sustain its expenditure despite the principle of self-reliance that was embraced by the government and the leading party since independence.

The majority of local people had a rather positive attitude towards Western biomedicine during independence. An increase in patients had been observed in medical facilities managed by both the British colonial government and voluntary agencies, the latter mostly being mission health facilities. The number of in-patients at government hospitals and dispensaries had risen from 81,000 in 1950 to 149,000 in 1960. The demand for voluntary agency services, mostly missions, had also developed rapidly in this period; the figures showed an increase from 69,000 inpatients in 1950 to 143,000 in 1960. The number of out-patient first attendances at government hospitals and dispensaries rose from 12 million to 17 million.[11]

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[8] John Lance Geoghegan, "The Movement for Independence in Tanganyika" (Master's thesis, University of Pennsylvania, 1965), 12.

[9] Tanganyika, *Development Plan for Tanganyika 1961/62-1963/64* (Dar es Salaam: Government Printer, 1961), 13.

[10] Tanganyika, *Development Plan for Tanganyika 1961/62-1963/64,*10.

[11] Richard M Titmuss et al., *The Health Services of Tanganyika: A Report to the Government* (London: Pitman Medical Publishing, 1964), 27. See for the combination of government and mission services in the late colonial period also Michael Jennings, "Cooperation and Competition: Missions, the Colonial State and Constructing a Health System in Colonial

However, the health sector was still largely underdeveloped. The rural regions of Tanzania hardly had access to co-ordinated health services, even if the majority of the population lived there.[12] Most of the available medical services and infrastructures such as hospitals, out-patient clinics and doctors' practices were located in the urban areas. Even there, the services were seen as "scattered, partial, and uncoordinated."[13] In 1961, there were only around 7000 beds in hospitals run by the central government, around 8000 beds in hospitals run by local agencies and 1800 in Rural Health Centres (RHCs) and Dispensaries in the whole of Tanganyika. The rural areas continued to rely on understaffed RHCs run by local government: One would find only 22 RHCs and around 700 rural dispensaries in the countryside of Tanganyika.[14] Compared to a population of around 10.3 million people, this has to be judged as a very poor medical supply situation. By 1964, the infrastructure situation had hardly changed.[15] As statistical accounts between 1964 and 1993 reveal, it became a characteristic tendency of government to use the number of beds as a critical factor in determining the type, quality, and quantity of health services infrastructure since then. An official report evaluating the situation in 1961 laid the blame on the lack of financial investment during colonial times.[16]

During the first two years after independence, the situation hardly changed; the priorities of the Ministry of Health lay in maintaining the basic

Tanganyika," in *Beyond the State: The Colonial Medical Service in British Africa*, ed. Anna Greenwood (Manchester: Manchester University Press, 2016), 169.

[12] President's Office, *Regional Administration and Local Government: Rural Development Policy* (Dar es Salaam, Government Printer, 2003), 19; Meredeth Turshen, "The Impact of Colonialism on Health and Health Services in Tanzania," *International Journal of Health Services* 7, no. 1 (1977): 24.

[13] Oscar Gish, "The Way Forward: World Health Organisation," *Journal of World Health* 6 (1975): 8.

[14] Titmuss et al., *Health Services*, 34, 52, see also Oscar Gish, *Planning the Health Sector: The Tanzanian Experience* (London: Croom Helm, 1975).

[15] Tanganyika, *Annual Report of the Health Division 1964.* Vol. II (Dar es Salaam: The Government Printer, 1965).

[16] Titmuss et al., *Health Services*, 31.

services that existed.[17] In the new policy plan that was issued in 1964, the health situation in Tanganyika was described as follows:

> At the present time the people of Tanganyika remain subject to the risks of epidemic disease, although these risks are substantially less than they were a few decades ago. There is good reason to believe that between a quarter and a half of children born fail to reach adult life. (….) Finally, medical aid of reasonable standard is as yet generally within reach only of urban dwellers and of those living near large population centres.[18]

In 1964, considerable changes occurred. An important step was the publication of the Titmuss report in the same year. Richard Titmuss was a prominent social researcher and the first professor of Social Administration (later Social Work) at the London School of Economics. He had shaped post-WW2 social policy in the United Kingdom, particularly with publications such as *Problems of Social Policy* from 1950 and *Essays on the Welfare State* from 1958.[19] The first Minister of Health of Tanganyika, Derek Bryceson, asked him to chair a commission on the health services in Tanganyika in July 1961, to examine the present state of the medical services, to make recommendations how to extend the services in curative and preventive medicine, and to make predictions on the necessary finances and infrastructures.[20] Titmuss emphasised the importance of rural health centres and favoured preventive medicine. He advocated the training of rural medical aids in order to have a quicker staffing of health centres. He judged the long training of doctors as a major obstacle to a quick improvement of the situation.

In the same year, the first development plan of the new independent state Tanzania – after unification with Zanzibar– covering the years 1964-1969 was launched, taking up some of the recommendation of the Titmuss

[17] John Iliffe, *East African Doctors: A History of the Modern Profession* (Cambridge: Cambridge University Press, 1998), 201.

[18] Tanganyika, *Five Year Plan for Economic and Social Development 1st July, 1964-30th June, 1969, Vol. 1 General Analysis* (Dar-es-Salaam: Government Printer, 1964).

[19] Richard M. Titmuss, *Problems of Social Policy* (London: His Majesty's Stationery Office, 1950); Richard M. Titmuss, *Essays on the Welfare State* (London: Allen & Unwin, 1958).

[20] Titmuss et al., *Health Services*, IX.

report.[21] One can see a stronger optimism than in the earlier document of the 1961-1963 period. The government aimed to have a hospital of not less than 200 beds capacity per district by 1969. However, it was noted that building hospitals would not cater for the needs of the majority of the population and hence, the expansion of dispensaries and RHC services were seen as a better solution. The five-year plan of 1964 stated:

> It is considered that the early establishment of these health centres is the most important single factor in the improvement of the health services in this country and is vital if any progress is to be made in extending the service to provide for the rural population.[22]

83 additional RHCs should have been built by 1969 to add to the around 20 that were in existence in 1964.[23] However, by 1969, only 50 RHCs were to be found in Tanzania, and only one rural medical aid training centre existed in Kibaha.[24] As in colonial times, economic and financial difficulties prevented rapid expansion.

Even if the tendency to focus on rural health was in line with the new policy of the TANU-government, it had partly colonial roots. Already in the 1920s, Dr. Shircore, the first Chief Medical Officer of Health under British colonial rule, had identified the rural dispensary system as the solution of many health problems.[25] Also, the first five-year-plan of the Republic of Tanganyika strongly resembled social policy planning under British colonial rule.[26] From 1946 onwards, promising plans had been sketched out by the colonial government with goals to reach at the end of a defined period.[27] However, the colonial government hardly had the financial means to invest in social services, therefore, the goals were never reached. Titmuss

[21] Tanganyika, *Annual Report of the Health Division 1961 Vol 1. Prepared by the Chief Medical Officer, Annual Report* (Dar es Salaam, Government Printer, 1963), 1.

[22] Tanganyika, *Five Year Plan,* 69.

[23] Gerardus Maria van Etten, *Rural Health Development in Tanzania* (Assen: Van Gorcum & Comp. B.V, 1976), 41.

[24] van Etten, *Rural Health Development*, 42.

[25] Ann Beck, *A History of the British Medical Administration of East Africa, 1900-1950* (Cambridge, MA: Harvard University Press, 1970), 148.

[26] See for the similarities of postcolonial planning to forms of indirect rule under the British, Eckert, *Herrschen und Verwalten,* 259.

[27] See e.g. Tanganyika, *A Ten-Year Development and Welfare Plan for Tanganyika Territory* (Dar-es-Salaam: Government Printer, 1946).

wrote in his 1964 health report on the endeavours of the British colonial government concerning the health services:

> yet there has been no lack of careful thought about the present and the future; no shortage of plans (…) but none of these programmes has proved to be within the economic capacity of the country.[28]

After independence, the problem of a non-sufficient national tax-income prevailed and a gap between planning and execution remained. Titmuss himself came from the UK, having successfully implemented the National Health Services in 1948, financed by tax money of an industrialised nation. A similar state income could not be expected in Tanganyika in the following decades.

A grave further obstacle for developing a comprehensive health service was the population growth that needed constantly growing social services. The extension of services often only meant maintaining a basic standard for a rising population.

Year	1961	1970	1980	1990	2000
Population	10,3 Mil	13,6 Mil	19,2 Mil	26,2 Mil	33,4 Mil

Figure 1: Tanzania Population Growth
Source: World Bank

The development plans hardly priced in the significant population growth.[29] They argued from a general situation at the time the plan was written. Although an expansion was presented as a step forward, it was often rather an adjustment to the growing population than a progress in quality or quantity of services.

In July 1969, the second development plan was adopted for the five years to 1974. One of the goals of the plan was to increase life expectancy from 35 to 50 by 1980, emphasizing the crucial role of good health from

[28] Titmuss et al., *Health Services*, 31.
[29] See for this argument also Albert F. Henn, *Tanzania: Health Sector Strategy* (Dar-es-Salaam: USAID/Tanzania, 1980),10.

birth onwards.[30] However, just like in the previous plan, health was given a rather small share of attention in a plan that dealt mainly with the development of agriculture and economy. In the field of social services, education was still seen as the key element. As opposed to the insistence of rural health on paper, the main share of funds focused still on the training of doctors and high cadre medical staff, as the country was in dire need of new experts. Concerning the urban-rural divide, until 1971 the urban hospitals and facilities took up most of the financial investment in the field of health. The hospitals received double the amount of the RHCs. Again, it was planned to add 80 new centres to the now existing 50 RHCs.[31]

Medical Staffing and Training Infrastructure

As many African countries, Tanganyika had a blatant lack of qualified African doctors and medical personnel during independence. For a population of slightly above ten million, there were 400 doctors, the majority of whom were expatriates, and only 178 were working for the government in 1961.[32] Only 12 of them came originally from Tanganyika.[33] During the first decade after independence, the number of Tanzanian doctors rose only to 123.[34] The main reason for the shortage was the educational system under colonial rule, which had completely neglected university education. Doctors could only reach a degree-level education at Makerere College in Uganda. Therefore, even if new health centres and dispensaries were built under the new government or by self-help groups in the rural areas, the number of trained doctors remained low.[35] The available dispensaries were "ill-equipped and manned by staff who were only capable of dispensing pharmaceutical palliatives when these were available", as Oscar Gish, a medical expert and planner, described the

[30] The United Republic of Tanzania: *First Year Progress Report on the Implementation of the Five-Year Development Plan (Public Sector): 1st July 1964 to 30th June 1965* (Dar-es-Salaam: The Ministry of Economic Affairs and Development Planning, 1964), 13

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

[32] Titmuss et al., *Health Services*, 39.

[33] Aloysius M. Nhonoli and Aimon J. Nsekela, *The Development of Health Services and Society in Mainland Tanzania: A Historical Overview – 'Tumetoka Mbali' (*Kampala: EALB, 1976), 1; Gish, *Planning*, 1.

[34] Iliffe, *East African Doctors*, 202.

[35] Titmuss et al., *Health Services*, 60.

situation at the end of the 1960s.[36] This implies that infrastructure development for health services provision needed to go in parallel with infrastructure building for medical training. The two were critical for making a solid future of the health services in Tanzania had they been planned and developed by the then health sector decision makers.

Nonetheless, there was thin line in thinking in the government towards such a parallel infrastructure development out of necessity. In 1963, Tanzania began training its medical staff in the country to ease the overreliance on training in Makerere University in Uganda and other overseas countries. The government established a Medical School at Dar es Salaam.[37] The School was established in the area of Muhimbili Hospital, a national referral hospital. Attaching the School to the hospital was in part a realisation of the unfulfilled colonial vision. When funds were applied in 1951 for the group hospital that later came to be known as Muhimbili hospital, it was envisaged that the hospital "will serve as a training centre for the whole territory and will contain a medical school with laboratories, lecture rooms etc."[38] In 1968, the Medical School was incorporated into a University of Dar es Salaam and it was made a Faculty of Medicine. Three decades later, the Faculty of Medicine was upgraded to a college becoming the Muhimbili University College of Health Sciences (MUCHS). And since 2007, it is a full-fledged university, the Muhimbili University of Health and Allied Sciences.[39]

[36] Gish, "The Way Forward," 8.

[37] Ministry of Health and Labour, *Annual Report of the Health Division 1961 Vol. II (Statistics)* (Dar-es-Salaam: Government Printer, 1963), 2

[38] The National Archives of United Kingdom, hereafter UKNA, File no. CO822/557: Tanganyika: Colonial Development and Welfare Scheme for the Construction of a Group Hospital in Dar es Salaam.

[39] See 'Background History' in https://muhas.ac.tz/background-history/, accessed June 3, 2024.

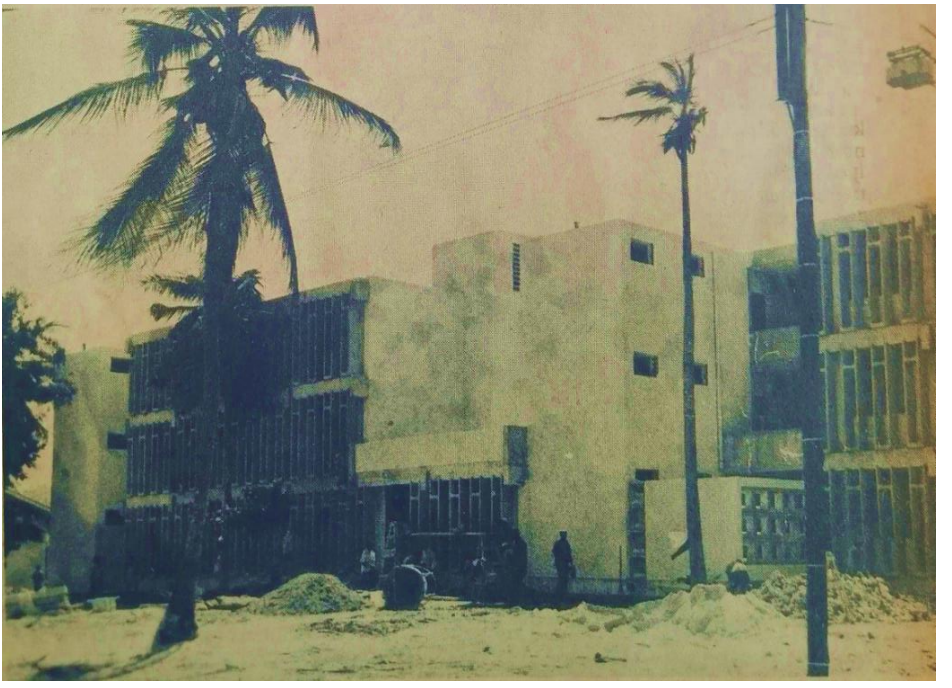

Figure 2: Dar es Salaam Medical School under Construction, 1970.
Source: JM Mwakisyala, "Muhimbili", Nchi Yetu, no. 78 (1970)

A number of challenges remained, showing a colonial-postcolonial continuity. First, there were only few people qualified to take up medical training. The education system under colonial rule had relegated Africans to a low level of education, ostensibly to help them acquire "practical" skills. Only an extremely small part of the population had reached university entrance level in school education. During the colonial period, Europeans and Asians had much better access to further education while Africans were denied this chance.[40] Secondly, the Medical School at Dar es Salaam took only 50 undergraduates per year during the first years after its foundation, mostly due to economic constraints. In 1968, 1969, and 1970, medical degree graduates from the Faculty of Medicine were 6, 9, and 9 respectively.[41] As John Iliffe writes, the faculty of medicine produced only

[40] George Kahama, TL Maliyamkono, and Stuart Wells, *The Challenge for Tanzania's Economy* (London: James Currey Ltd., 1986), 22.
[41] JM Mwakisyala, "Muhimbili", *Nchi Yetu*, no. 78 (1970), 7.

around 700 trained doctors until 1991 – far too few for the provision of comprehensive health services in Tanzania.[42] The situation was complicated by the fact that up to that year, Muhimbili was the only degree level higher learning institution in Tanzania. Other medical training institutions offered certificate and diploma level education with a huge emphasis on producing nurses and other health workers at the expense of medical assistants. These other institutions were, like Muhimbili, attached to hospitals, which were few, located in urban centres and run by the state.

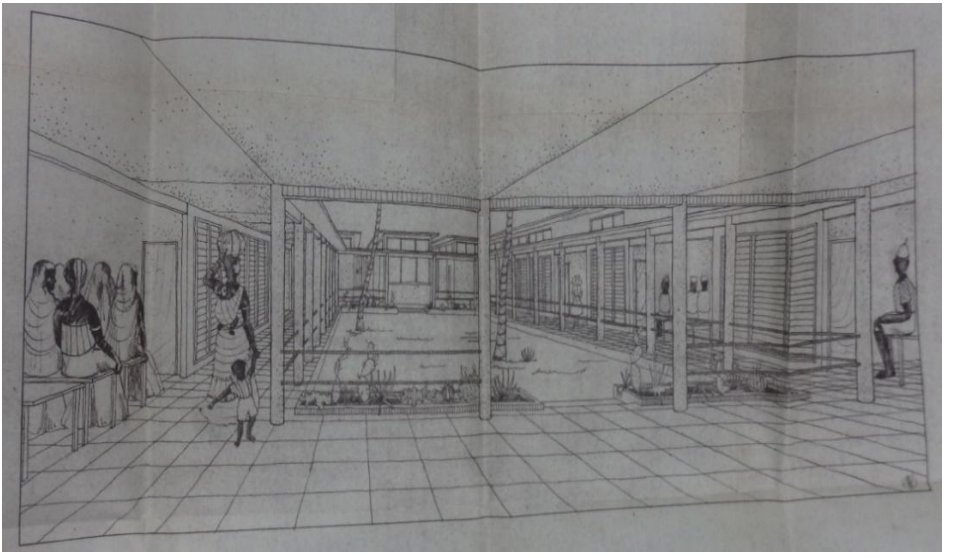

Figure 3: A Hospital-cum-Training School: The Architectural Design of a Group Hospital in 1951. *Source: UKNA, File No. CO822/557*

Other thresholds for entering medical education were high. For a university graduate, the entry requirement was a complete secondary school level into the university 5-year course followed by one year of pre-registration medical employment. Furthermore, the cost of training for a medical doctor was high – reaching $4000 per annum. Training of medical assistants and auxiliaries was far cheaper for the state with $2500 and $2000 for the medical assistant and the rural medical aide respectively. For the medical assistant, the entry requirement was eleven years of schooling plus 3 years of medical training, while the Assistant Medical Officers (AMO)

[42] Iliffe, *East African Doctors*, 215.

were trained as medical assistants and had 4 years of work experience and 18 months of upgrading courses.[43] With these conditions, it is clear that the Tanzanian health system had to strongly rely strongly on auxiliary staff.

The use of medical auxiliaries in health centres and dispensaries was criticized by the new independent government. It was seen as too intensely connected with the colonial health system and seemed to resemble the second-class treatment of African people by tribal dressers in rural dispensaries under British colonialism.[44] However, the lack of trained doctors made it necessary to use auxiliary personnel – it became more or less the norm in the rural areas.[45] In most of the rural centres, the AMOs de-facto did the work of trained doctors and were the only known 'doctors' to the local people.[46] Another reason for the staffing with medical auxiliaries was the unwillingness of the few trained doctors and nurses to live in the very rural areas themselves,[47]

Generally, the problem of staffing and adequate personnel remained one of the limitations of the health services even after the change towards a socialist health system in 1971/72. As Iliffe points out, the postcolonial social policies in the whole of Africa often failed to address development challenges that had begun in the colonial period due to their contradictions in theory and practice.[48] In Tanzania, the first Five-Year Development plan projected improving educational investment in order to end acute shortage of skilled manpower in economic, governance, health, and other sectors by 1980.[49] Independent Tanzania was very successful regarding primary education – 75 percent of potential primary school starters were being enrolled in 1980 –, however, only few students reached the university entrance level that was necessary for higher medical training, hence the

[43] Gish, "The Way Forward," 12–13.

[44] See for the role of the tribal dresser, Nhonoli and Nsekala, *Development of Health Services*, 29.

[45] Kue T Young, "Socialist Development and Primary Health Care: The Case of Tanzania," *Human Organization* 45, no. 2 (1986): 130.

[46] Gish, "The Way Forward," 13.

[47] Iliffe, East African Doctors, 210.

[48] John Iliffe, *The African Poor: A History* (Cambridge: Cambridge University Press, 1987), 231-233.

[49] This was envisioned in the first of the three five-year plans. See United Republic of Tanzania, *Five-Year Development Plan*, 70.

shortage of doctors and highly qualified nurses persisted through the 1980s.[50] This general inadequacy shows how personnel development was inextricably intertwined with infrastructure in medical sector development and explains why the problem lingered longer affecting the health future making. Seen from this perspective, Tanzania's problems are easier to understand: Compared to e.g. neighbouring Uganda which had one of the best health systems in Africa before Idi Amin reached power, one has to admit that independent Tanzania was in a very difficult starting position. With the strong tradition of prestigious medical training at Makerere College, Uganda constantly had access to enough well-trained medical personnel, the state had significantly higher resources than Tanzania thanks to a faster growing economy, and the state could hire enough personnel for its medical services.[51]

Changes after the Arusha Declaration

The general social policy of Tanzania had been considerably transformed following the Arusha Declaration of February 1967 that introduced a new form of African socialism – *Ujamaa*.[52] Whereas Tanganyika had followed a rather pro-Western course directly after independence, this changed after the revolution in Zanzibar and Zanzibar's unification with Tanganyika into Tanzania. The United States and also West Germany reduced cooperation and financial help significantly and Tanzania had to re-orient itself. When the British Prime Minister Wilson tolerated the independence of Southern Rhodesia under a white settler government, Tanzania broke off relations with Great Britain, until then its largest donor, in 1965.[53] The new policy is also seen by historians as a reaction to these international changes.[54] Generally, the Arusha Declaration emphasized the establishment of a socialist state in Tanzania, highlighted self-reliance, less dependency on

[50] Henn, *Health Sector Strategy*, 2.

[51] Matian van Soest, *The Political Ecology of Malaria: Emerging Dynamics of Wetland Agriculture at the Urban Fringe in Central Uganda* (Bielefeld: transcript, 2020), 141.

[52] The Arusha Declaration is reprinted in Julius Nyerere, *Freedom and Socialism* (Dar es Salaam: Oxford University Press, 1968), 230–250.

[53] Cranford Pratt, *The Critical Phase in Tanzania 1945–1968: Nyerere and the Emergence of a Socialist Ideology* (Cambridge: Cambridge University Press, 1976), 148–149.

[54] Eckert, *Herrschen und Verwalten*, 220–222.

international donors, and stressed the particular importance of rural development and agriculture.[55]

In the area of healthcare, there were a number of subsequent measures that were adopted by the state. Firstly, the government of Tanzania started translating the Arusha Declaration in the Second Five-Year Development Plan of 1969-1974. The government believed that to build a future equal and prosperous nation, it had to unroll free health services to all people. To achieve this futuristic vision of the Arusha Declaration, the Five-Year plan deliberated that the government should oversee and manage all health facilities. Partly, this meant the nationalisation of private health facilities, although in practice very few facilities were nationalised. Where private facilities could not be nationalised, the government entered into co-provision and management of health services with the private owners – most of whom were voluntary religious societies and missions.[56] However, it could quickly be noted that such vision faced two main challenges that would take longer to address: shortage of health manpower and infrastructure.[57] As a result, a decision was taken to adopt a gradualist approach in addressing the two challenges. It also implied emphasizing preventive health services, particularly proper nutrition, improving sanitation, increasing provision of health education, controlling communicable diseases, and improving maternity and child health.[58] The *Mtu ni Afya* programme that started from 1970 was part of this pragmatic detour.[59]

Secondly, it took until the TANU party conference in 1971 before major changes towards a rural socialist healthcare system could be implemented. From 1972 onwards, financial investments were shifted to the RHCs, rural dispensaries, and medical auxiliaries, away from the

[55] Tanganyika African National Union, *The Arusha Declaration and TANU's Policy on Socialism and Self-Reliance* (Dodoma: TANU, 1967), 7–9.

[56] Wizara ya Afya, *Mpango wa Pili wa Maendeleo ya Wizara ya Afya*, 11; *The Standard*, June 24, 1965, indicated that this co-provision had started before the Arusha Declaration.

[57] Wizara ya Afya, *Mpango wa Pili wa Maendeleo ya Wizara ya Afya*, 2.

[58] Ibid., 4, 9.

[59] The *Mtu ni Afya* (which literally translates to "man is health") programme was adopted by Tanzania as a mass health communication and education campaign after successful programmes in India, China, Ghana, and Cuba. For further details on the programme see Budd Hall, *Mtu ni Afya ("Man Is Health"): Tanzania's Health Campaign* (Ontario: SIDA, 1978).

hospitals and doctors' development. The new policy after the Arusha declaration favoured rural medical services and preventive medicine. It emphasized the role of auxiliary workers in the field of medical care and gave them more political weight. Rural Medical Aids and Medical Assistants were now the most important actors in the new strategy of the Tanzanian government.[60] Accordingly, their numbers had increased four and a half times by 1980 (from 813 in 1972 to 3,710 in 1980) while the number of doctors rose much more slowly and only doubled (from 634 to 1,145).[61] Furthermore, the government opened up the path for auxiliary medical workers to qualify over several steps for enrolling at university in order to obtain a M.D. degree and made the career paths for medical personnel more flexible.[62] A lot of effort went into the training of new medical auxiliaries. Even the WHO was engaged in the instruction of Medical Assistants in Tanzania. Seminars in Tanga and Iringa were held with active participation of WHO staff from1972 onwards. In his report to Geneva, WHO officer Dr. McMahon, judged the seminars as successful.[63] In a further memorandum, Tanzania was portrayed as "one of the countries of the African Region where the training of allied medical personnel is developing rapidly," that might be used as a possible blueprint for other regions.[64]

The third development plan of Tanzania, issued in 1976 with 103 pages, clearly reflects the political changes in the health sector. The new direction in health provision was introduced by stressing the usefulness of preventive medicine. It is interesting to note that it was also connected with the argument of lower costs in contrast to curative medicine:

> The Party politics is to encourage expansion of health services so that they can cover villages where more than 90 percent of Tanzanians live. This aim is also geared to restructuring the present situation by expanding and strengthening rural health centres in order to emphasize more on

[60] Henn, *Health Sector Strategy*, iii.

[61] Kristian H Heggenhougen, "Health Services: Official and Unofficial," in *Tanzania: Crisis and Struggle for Survival*, eds. Jannik Boesen, Kjell J Hevnevik, Juhani Koponen, and Rie Odgaard (Uppsala: Scandinavian Institute of African Studies, 1986), 310.

[62] Young, "Socialist Development," 130.

[63] WHO Records and Archives, Geneva, WHO022_AFRO_TAN_009, Dr RJ Mc Mahon, WHO Officer, Report on Medical Auxiliary Teaching Training Centre, Tanga, 5.6.1974.

[64] WHO Records and Archives, Geneva, WHO022_AFRO_TAN_009, Dr JP Menu, HMP for the Regional Director, Afro_memorandum, May 24, 1974, Subject: Seminar at Iringa, Tanzania.

> preventive services. Programmes for preventive services can bring quicker health results and are also relatively cheaper in implementing than the cost of implementing curative services. Given the situation that more people have already settled in villages, expansion of health services for the benefit of the villagers has to be implemented at a faster pace. This will enable participation by villagers in combating disease by emphasizing different preventive techniques.[65]

The initial stance of the government after independence in 1961 had been to make health accessible to all. In the rural health centres and dispensaries, treatment was and remained free of charge until the 1990s. It was clear that the rural health centres should concentrate on preventive medicine, community diagnosis of prevalent diseases, health education, and immunisation programmes. These elements, together with vaccination against polio, measles, smallpox, and other childhood diseases became the key elements of the rural health service.[66]

Now, at the end of the 1970s, with a focus on medical auxiliaries and an increase of rural health units one would find health centres or dispensaries in one third of all villages of Tanzania.[67] This meant a considerable improvement compared to the situation at the beginning of the 1960s. Furthermore, to emphasize the new strategy in health policy, non-salaried community health workers were being selected in many villages and trained shortly for three months in a hospital since the late 1960s. They then returned to their village with a first-aid box. The system of community health workers had many problems and grave shortcomings but contributed likewise to a wide-reaching yet rudimentary health provision in rural Tanzania.[68]

[65] The United Republic of Tanzania, *Third Five Year Plan for Economic and Social Development, 1st July 1976- 30th June 1981. General Perspectives (Part One)* (Dar-es-Salaam: Government Printer, 1976), 89.

[66] WHO Records and Archives, Geneva, WHO022_AFRO_TAN_009, Dr JP Menu, HMP for the Regional Director, Afro memorandum, May 24, 1974, Subject: Examples of Group Work, Aims and Objectives of Health Centres.

[67] Heggenhougen, "Health Services," 311.

[68] Kristian H Heggenhougen, Patrick Vaughan, Eustace PY Muhondwa, and Jean Rutabanzibwa-Ngaiza, *Community Health Workers: The Tanzanian Experience* (Oxford: Oxford University Press, 1987), 38–39.

In his analysis of the Tanzanian Health Sector for USAID in 1980, Albert Henn judged Tanzania as having "made remarkable progress in using paramedical personnel to extend its health services system throughout the country."[69] More recent research by Heggenhougen or Iliffe also considered the Tanzanian health service of the 1970s as having a rather successful strategy. Infant mortality decreased from 160 per thousand births in 1967 to 135 per thousand in 1978.[70] Less deaths during childhood also meant a rise of life expectancy.

On the contrary, in hospitals, the post-independent services were not free, and the Tanzanian government continued with the stratification of patients. Such a practice had existed during the colonial period. In the post-colonial period, the patients in hospital were still divided into four grades, dependent on what they were able to pay.[71] Grades 1, 2, and 3 were charged before receiving treatment while grade 4 patients received free services. At the Muhimbili Hospital for example, grade 1 in-patients were attended to by a medical officer and paid fifty shillings per day, while children under the age of 14 in the same grade paid ten shillings. Grade 2 paid thirty-five, while grade 3 was charged six shillings every three days. Grade 3 patients were attended by a medical assistant. The system was met with strong criticism, even within the Tanzanian parliament. However, the minister of health saw it as a necessity and as a way of getting those with better salaries to help meet the high expense of offering medical care.[72] In reality, class differentiation was very notable in this graded delivery of services.

Many other issues remained problematic. The rural health centres and dispensaries were only able to offer rudimentary curative treatment and referred patients to hospitals or other centres in the urban areas if necessary. This was largely demonstrating the colonial-postcolony continuity in health system structure. For instance, when the colonial government planned the construction of group hospital in Dar es Salaam, they also planned five dispensaries that would operate as 'Health Centres'

[69] Henn, *Health Sector Strategy*, 6.

[70] Heggenhougen, "Health Services," 316; Iliffe, *East African Doctors*, 205–-206; Kristian H. Heggenhougen and Jo LP Lugalla, "Introduction," in *Social Change and Health in Tanzania,* eds. Kristian H. Heggenhougen and Jo LP Lugalla (Dar-es-Salaam: Dar-es-Salaam University Press, 2005), XVIII.

[71] Mwakisyala, "Muhimbili," 26.

[72] Ibid.

in the United Kingdom. The main objective of these dispensaries was to act as outpatient satellites of the main hospital.[73] However, as Frank Edward has shown in his research, most of these colonial dispensaries were hardly equipped with reliable health facilities like medicine and curative equipment. This became a major factor for the continued reliance on traditional healthcare in most rural areas of Tanzania because that was what was readily available.[74] The situation of under-equipping rural dispensaries continued to be a problem. This was articulated through the persistence of the narrative that certain diseases could not be treated by the modern medical system. This narrative was probably a scapegoat for veiling the realities of underfunded rural dispensaries in the postcolonial socialist state for it would have been unpatriotic and scandalous. The ruling party and state newspapers had numerous accounts of heavy reliance on traditional medicine in rural areas. For instance, in January 1985, *Mzalendo* paper reported that one elder in Kibaya cured smallpox and other diseases that were uncurable in the biomedical health system.[75]

As a matter of fact, the colonial-postcolonial continuity was partly connected to the general bad state of infrastructure which oftentimes made healthcare access impossible (e.g. roads transport etc). The railway network was small and largely focused on facilitating the extraction of natural resources in few areas of north and central-west Tanzania. The road network was largely operational during the dry seasons with very few buses occasionally linking the rural populations.[76] As Edward revealed, most roads in both urban and rural Tanzania were in poor condition between the 1960s and 1990s.[77] The transport infrastructure problems were probably a factor as to why the best health services were not installed everywhere. Consequently, people had to walk longer distances in search of not only health services but also education and water services. Anthropologist Ralph

[73] UKNA, File no. CO822/557: Tanganyika: Colonial Development and Welfare Scheme for the Construction of a Group Hospital in Dar es Salaam.

[74] Frank Edward, "Health Implications of Witchcraft Beliefs and Practices in Uhehe: A Historical Perspective" (master's thesis, University of Dar es Salaam, 2013).

[75] *Mzalendo*, January 20, 1985.

[76] Frank M Chiteji, *The Development and Socio-Economic Impact of Transportation in Tanzania, 1884 – Present* (Washington, D.C.: University of America Press, 1980).

[77] Edward, *Circulation and Appropriation*, 165.

Ibbott states that most of the Ujamaa villages in the Ruvuma region were 8 to 20 miles away from the health facilities. In 1962, Ibbott encountered a situation in which the members of Litowa village attended a critical health case but "the only transport available was the Litowa tractor and trailer which pumped its way with him over the twelve miles to Peramiho."[78] This means, had there been better paved roads and abundant mobility facilities, accessing biomedical healthcare facilities would have been a less exacting experience. As such, healthcare and transport infrastructure are intertwined infrastructures.

Health Infrastructure and The Health Crisis in the Post-Socialist Period

Since the late colonial period, the infrastructure of the healthcare system was envisioned to cater for at least two of the three purposes: curative medicine, training, and administration. Hence, the buildings were supposed to reflect permanency, for instance by being reinforced with concrete or concrete blocks. Secondly, the buildings were supposed to reflect adaptation to the tropical weather conditions, for instance by being equipped with wide windows for maximum ventilation. Thirdly, they were planned to be "sufficiently flexible to permit several separate clinics being run at the same time."[79] This infrastructure design persisted in the postcolony and it brought uniformity across the country. However, for the curative medicine, the diagnosis and treatment infrastructure were lacking in most rural hospitals in both colonial and postcolonial periods. With this critical part of healthcare lacking, most dispensaries remained sites of primary healthcare and consultations.

The curative infrastructure was classified hierarchically into dispensaries that served rural areas and urban streets to health centres and hospitals that served administrative divisions, districts and regions. A striking feature for the curative infrastructure was the use of bed counts as a measure of how big and important a health facility was.[80] No counts were made for other critical equipment like X-ray machines, for instance. This has

[78] Ralph Ibbott, *Ujamaa: The Hidden Story of Tanzania's Socialists Villages* (London: Crossroads, 2014), 179.

[79] Ibbott, *Ujamaa*, 179.

[80] Wizara ya Afya, *Mpango wa Pili wa Maendeleo ya Wizara ya Afya*, 10.

been the case up to the 1990s. Below is the infrastructure statistics by government of Tanzania between 1973 and 1993:

Year	Hospitals	Beds	Health Centres	Beds	Dispensaries	Beds
1973	147	18104	108	2858	1560	8300
1974	147	18330	130	3260	1620	8420
1975	147	19400	138	3386	1786	8485
1976	147	19680	161	3788	1847	8546
1977	148	19823	181	3988	1997	8646
1978	148	20847	202	4230	2205	8900
1979	149	21291	235	4620	2568	9065
1980	149	21291	239	4676	2600	9329
1981	149	21352	239	4676	2644	9386
1982	149	22350	239	4689	2644	9395
1983	149	22350	239	4689	2644	9395
1984	152	22800	239	4689	2644	9395
1985	152	22800	260	5122	2831	11320
1986	152	22800	260	5122	2831	11320
1987	152	22800	260	6122	2831	11320
1988	152	22800	278	6168	2831	10000
1989	155	23400	279	6168	2831	11940
1990	173	23400	276	5992	2840	11940
1991	174	24130	276	5992	2851	--
1992	174	24130	276	5292	2852	--
1993	175	24330	276	5292	3014	--

Figure 4: Healthcare Infrastructure Counts in Tanzania
Source: United Republic of Tanzania, Statistical Abstracts, 1973-1993

The figures above represent both the state and voluntary agencies' healthcare facilities that existed in Tanzania. The facilities' statistics above indicate that the lower-level facilities were incrementally increasing. Their increase, however, did not match the increased number of beds – the then important element in the healthcare infrastructure. This implies that the dispensaries and health centres were meant to deal mainly with primary healthcare and for outpatients. Equally important, the number of hospitals was increasing very slowly despite the fact that the population was growing

fast. Most of these hospitals were initially dispensaries and health centres. There was a superimposition in health infrastructure development with the old infrastructure being expanded or being demolished to create space for new and bigger health infrastructure to meet the growing demand. One notable example is the Amana Hospital which was established as a dispensary in 1954 and was elevated into a health centre and a hospital in Dar es Salaam in 1982 and 1990 respectively.[81] This status change was accompanied by the construction of more buildings alongside older premises.

It was the state that influenced the pattern of healthcare infrastructure development between 1967 and the early 1990s because the country was largely a single party state with voters lacking voices in determining social policy agenda. The state was heavily influenced by Nyerere's governance approach that practically turned the public into children who needed guidance from parents all the time. People were invariably not consulted on what kind of health infrastructure they wanted and which areas should be given the priority. The leaders took monopoly of decision-making under the assumption that "always, the leader knew best," contrary to the official policy of bottom-up decision-making that was touted in the decentralisation.[82] This also explains why many hospitals and the best health centres were located in urban areas, where, for a long time, the population was smaller compared to the rural areas. Only recently, for example, did the urban-rural population ratio begin to narrow. In the 2012 National Population And Housing Census, out of the 45 million people, 29.6 percent lived in urban areas, while 70.4 percent resided in rural areas.[83] In the 1960s and 1970s, the urban-rural population ratio was 10 to 90 percent.[84] Thus, even if the state had a strong pro-rural social policy since 1972 with regards to health, the state was practically investing less in primary healthcare in rural areas and more in health centres and hospitals

[81] "Amana Hospital," in https://tanzmed.co.tz/hospitali-orodha/ad/amana-hospital,9.html, accessed July 30, 2024.

[82] Leander Schneider, *Government of Development: Peasants and Politicians in Postcolonial Tanzania* (Bloomington: Indiana University Press, 2014), 74.

[83] United Republic of Tanzania, *2012 Population and Housing Census: Basic Demographic and Socio-economic Profile* (Dar es Salaam: The National Bureau of Statistics, 2014).

[84] United Republic of Tanzania, *1988 Population and Housing Census: Preliminary Report* (Dar es Salaam: Bureau of Statistics, 1991).

in urban areas.[85] It was probably an unintentional future-making contradiction that explains the modern healthcare infrastructure asymmetry and the existence of incomplete infrastructure in the sense that there were abundance of buildings but with great shortage of internal curative infrastructure. Furthermore, looking at the population composition, the urban centres had larger numbers of elites than rural areas. The elites became a critical factor in diverting more health resources to the urban centres at the expense of rural areas, complicating the realisation of the rural-centred development policy. This also explains why many hospitals could rather be found in urban centres than in rural areas.

When looking at the developments of the health sector in Tanzania until 1978, one can observe many structural problems that shaped the health services for the following decade and made the impact of the financial crisis of the 1980s even worse. The problematic rural-urban divide favoured hospitals and urban centres, neglecting the rural areas. The change in 1971/72 led to a health policy that focused on the rural countryside, particularly in building new dispensaries. While in theory this would imply a shifting of funds that would eventually make the urban areas the victim, in practice this was not the case. The urban sector was affected only in general infrastructure stasis.[86] The urbanisation rate in Tanzania was high despite the Ujamaa ideology. Between 1960 and 1970 the urban population grew only from five to seven percent of the total population, however, between 1970 and 1980 the growth accelerated to 14 percent.[87] The growing population in the cities overwhelmed the local health services. In Dar es Salaam, for instance, the urban population rose fast from 356,286 people in 1967 to 1,360,850 people in 1988. In the government's assessment that was a "a very rapid growth" with an "an annual average of annual growth rate of 8.87 percent."[88] As a consequence, immunisation

[85] Julius Nyerere, *Decentralisation* (Dar es Salaam: The Government Printer, 1972).

[86] For the general infrastructure impact of rural development policy in 1970s see for instance Edward, *Circulation and Appropriation*, 179–182.

[87] Urban population (% of total population) – Tanzania. United Nations Population Division. World Urbanization Prospects: 2018 Revision. https://data.worldbank.org/indicator/SP.URB.TOTL.IN.ZS?locations=TZ, accessed October 25, 2024.

[88] The United Republic of Tanzania, *1988 Population Census: Preliminary Report* (Dar es Salaam: Bureau of Statistics, 1991), 5, 21.

rates in the cities went down, while malaria resurfaced, and cholera epidemics emerged for the first time in this period as well.[89]

Furthermore, lacking financial power, Tanzania adopted a pragmatic approach in developing the health infrastructure. Population became a main criterion in determining what type of health facility should be constructed in different geographical locations. In particular, it resorted to developing PHC in least populated areas with the hospitals being established in centres that had a population above 50,000 people.[90] It also influenced the design of the infrastructure: the bigger the population the bigger the structure and higher concentration of health facilities. This pragmatic and rational approach had unintended consequences: it was an execution of a policy of favouring best health facilities and services in the urban centres at the expense of the rural areas, a policy that had been in place since the colonial days. This was the continuity of deferral of health infrastructure development.

The above pattern of infrastructure development in health was slowly creating a crisis in the service provision. This gradualist narrative contradicts the position by some scholars that the crisis was essentially created with the adoption of neoliberal policies from the 1980s onwards.[91] We argue that the health system was already in crisis due the poor implementation of rural development policy and that the neoliberal policies only served to worsen the crisis. Neoliberal policies forced the state to reduce funding for the health infrastructure. The existing infrastructure was not only neglected and poorly maintained but also understaffed and lacking in critical facilities and medicines, especially in rural areas. This disparity contributed significantly in the rural-urban migration since the situation was somehow better in urban areas.

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[89] See "Cholera kills 160 in three months" in *Daily News*, January 4, 1979; "Cholera claims more lives" in *Daily News*, January 25, 1978; "Cholera quarantines paralyse Kamata" in *Daily News*, March 7, 1978; "Cholera kills 65 in Kigoma Region" in *Daily News*, April 2, 1988.

[90] Ministry of Health, *National Health Policy* (Dar es Salaam: Ministry of Health, 1990), 21–30.

[91] Rene Loewenson, "Structural Adjustment and Health Policy in Africa," *International Journal of Health Services* 23, no. 4 (1993): 717–730; Bianca Brunelli, "Structural Adjustment Programs and the Delivery of Health Care in the Third World" (PhD diss., Salve Regina University, 2007).

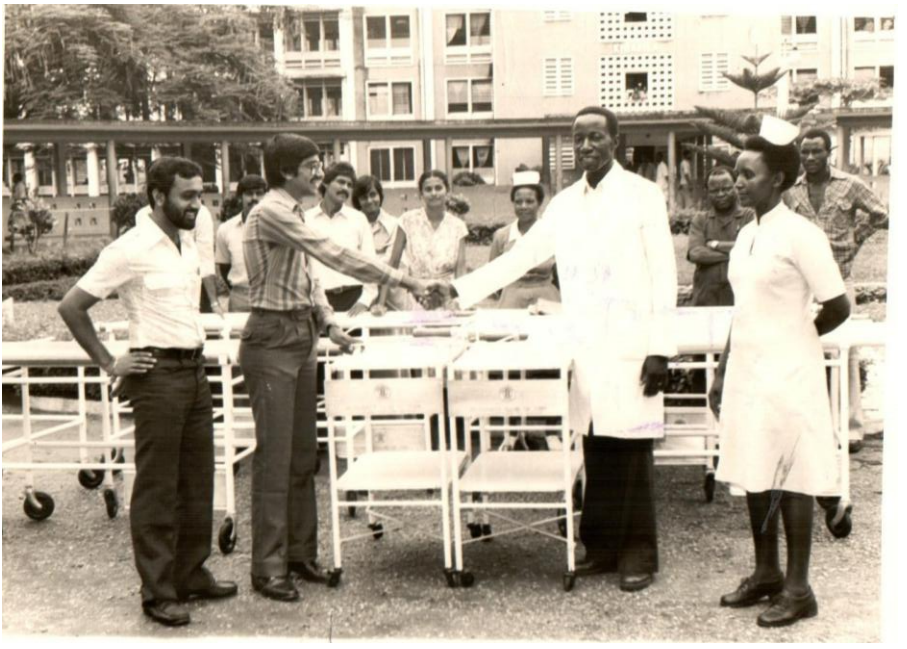

Figure 5: Rotary Club Donation of Internal Infrastructure Facilities to Muhimbili Hospital amid the Healthcare Crisis. *Source: Daily News, 14.06.1983*

Conclusion

Tanzania governments used development plans as a critical tool of modernisation in both economic and social policies. Most of what was laid down in the first two development plans was a continuation of what had been started and propagated by the colonial government. Such a colonial legacy was evident in health policies until at least 1971. Afterwards, the change to a more socialist health system became evident with the state offering free health services. The drive may have been intended for the good of the larger public, but its implementation was contradictory. Concerning infrastructure, for instance, it mostly favoured infrastructures in urban areas at the expense of rural areas – against the position laid out in decentralisation. It was this contradiction that ushered the country into a deep health crisis in the early 1980s, as well as in the post socialist period when neoliberal policies were implemented.

The development of plans in a series of five years were problematic in themselves. These plans were produced as blueprints; however, in most

cases, they were either partly or not followed up at all.[92] This made planning a one-moment affair, yet it should have been a process which frequent adjustments and monitoring. These plans ought to have been "regarded as a tool for implementers rather than an end product of the work of the planners"[93]. In a way, one can observe an enthusiastic future-making which was then affected by the budgetary underfunding of the social state. As a consequence, the future making of health infrastructure assumed a "rhetoric-implementation gap" situation: there was more substance in deliberations and plans that lacked equal and reciprocal actions in the real world.

This work has not only set out healthcare infrastructure as a research agenda in understanding Tanzania's public health history but also on understanding health infrastructure trends historically. On the latter, we have highlighted in this article that future-making in the health sector was gradualist in approach as it focused on gradual development of the curative and learning infrastructure. There was no outright policy in building learning infrastructure. On the curative infrastructure, the policy was clear at least in the 1970s: it aimed at building more dispensaries in the rural areas. This has been demonstrated in the healthcare infrastructure counts shown above. Finally, the rural areas were denied the right of having large scale and state-of-the-art health infrastructures. As another facet of the rhetoric-implementation gap the state built almost all big and better equipped hospitals and health centres in urban areas against its own health policy emphasis on rural healthcare development. This aspect also relegated rural healthcare infrastructure to providing only primary care, with critical health issues being referred to the few, often distant hospitals located in urban centres—despite inadequate and poorly maintained transport systems. It was this contradiction between policy and practice which created the foundation of the healthcare crisis that became evident in the neoliberal age.

[92] Diana Conyers, *An Introduction to Social Planning in the Third World: Social Development in the Third World* (Chichester: Wiley, 1982), 44.
[93] Conyers, *Introduction to Social Planning*, 4.

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