

**Health and Healing in Contemporary Tanzania: Perspectives from The Legacies of
Colonialism and Neoliberalism**

**Sirey H. Zhang '20
Dartmouth College
Department of Anthropology**

**Elizabeth Carpenter-Song, Advisor
Lisa V. Adams, Advisor**

Abstract

This thesis examines the lived experiences of Tanzanian healthcare workers and patients in the context of colonialism and neoliberalism by analyzing their interactions in the clinic. By pulling from multiple streams of anthropological theory, this research aims to build conceptual bridges on how colonialism, neoliberalism, and their legacies reinforce broader forces of structural violence that add significant challenges to the healthcare system and construct subjectivities on individual health in Tanzania. Based on my fieldwork, I elaborate on four main ways in which colonialism, neoliberalism, and their legacies influence healthcare delivery and outcomes in Tanzania: (1) the initial implementation of western medicine and the construction of traditional medicine, (2) the substantial presence of foreign groups and individuals in contemporary healthcare development, (3) the contrast between western medicine and traditional/folk medicine in the context of post-independence politics in Tanzania, and (4) the search for dignity in care due to the manifestations from structural violence.

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Finally, I would like to thank my friends and, most importantly, my parents for supporting me on my personally motivated academic and professional endeavors. I am grateful that they support my desires to understand the social dynamics of the world and how they affect

the people who live within it, ultimately using this knowledge to work with and learn from others to combat health inequity in all of its forms. Writing this thesis is a small step in this journey, and I am so lucky to have all these people supporting me along the way.

Orienting Fieldwork

My inspiration for this work started early in my undergraduate career, during the summer after my freshman year. I worked for a Cameroonian doctor who runs a clinic in the rural western part of the country that offers free care to women and children in the area. Despite the fact that her clinic has better infrastructure to store and administer vaccines compared to the typical Cameroonian primary care clinic, vaccination rates in the area that her clinic serves had similar vaccination rates to the rest of the country; thus, she assigned me a research project to conduct interviews with pregnant women and nursing mothers about their views toward childhood vaccines. Initially, I believed that low health literacy played a crucial role—most of the women in the area do not complete primary school and have their first child at ages 16 or 17. While this was true for many cases, many other women that I spoke to cited a sense of mistrust based on the area's colonial history—many vaccines in Cameroon are provided by the aid branch of the French government.

Most narratives surrounding the alleviation of health inequities focus on tangible goals, such as better resource allocation and funding. This was the first time that I experienced a socio-cultural barrier to health equity. Fascinated by this, my academic interests pivoted to accommodate my newfound desire to understand socio-cultural and political factors that manifest into societal structural violence through the lens of medical anthropology. I engaged with faculty mentors and designed an ethnography to conduct in Tanzania, a country where Dartmouth already has had long-term academic connections through global health projects.¹

¹ In 2001, Geisel and Muhimbili University of Health and Allied Sciences in Tanzania began a research collaboration in the area of TB and HIV. This partnership, known as the DarDar Programs has expanded to include extensive programs in research, training/capacity building and healthcare delivery. Lisa V. Adams, MD is the director of the Center for Health Equity at the Geisel School of Medicine at Dartmouth.

I had trouble sleeping the night before my first official day of fieldwork. After waking up early from a restless evening, I spent the better part of the morning shaving and having a good breakfast to ensure that I would both look and feel my best. I spent time choosing the right shirt and tie that I would wear to my first meeting with my research advisor in Tanzania, Dr. Switbert Kamazima. I was not yet accustomed to the sultry Indian Ocean air and the smog-choked streets of Dar es Salaam, so I arrived at the hospital soaked with sweat. It seemed to cancel out any confidence that I gained from the process of putting myself together earlier that morning.

The Muhimbili National Hospital and the Muhimbili University that lies adjacent to it are the largest hospital and medical university in Tanzania, respectively. The entrance to the hospital and campus is a busy market with vendors selling cooked food, drinks, snacks, fruits, and pharmaceutical items. It is also a bustling transportation hub, a terminus for many local and intercity bus lines that funnel patients around the country to the highest level of referred care attainable in Tanzania. Navigating the hospital and university campus was not easy. Entering the gates, I was immediately taken aback by the sheer size of the hospital campus and the amount of people. After misinterpreting several maps and asking several people, I made my way to the building that I was looking for. I was caught by surprise from the air-conditioned blast of the lounge that contained the offices of all of the professors in the School of Public Health and Social Sciences (SPHSS). I stumbled in around faculty teatime, where the professors were sitting around and socializing. As I crept through the door, I felt the eyes of each professor fall onto me.

“Can we help you?” one woman asked me.

“I’m here to meet with Dr. Kamazima,” I replied. “We have a meeting scheduled for this morning.”

Another man chimed in. “Did you not hear? Dr. Kamazima announced his retirement yesterday. He is no longer here.”

I froze and panicked. My worst nightmare come true: a research project failed before it even began. How would I get any work done? What would I tell my funders, mentors, friends, and family? What would I do for the next several months until my return flight home?

Laughter from everyone else in the room was what eventually broke my spiraling thoughts.

“I am Dr. Kamazima,” the man who first chimed in said. “Welcome. Could we have the pleasure to have you as our guest for tea?”

And thus, my professional academic relationship with the social science professors at the Muhimbili University of Health and Allied Sciences in Dar es Salaam, Tanzania began. I spent the remainder of teatime sharing about myself and learning about the lives, work, and passions of the professors in the SPHSS. Dr. Kamazima, originally from the northwestern part of the country, received his doctorate in sociology in the United States before returning to Tanzania. He has spent the past twenty years conducting research on the impact of HIV/AIDS on sex workers and their livelihoods in urban parts of the country. The goal of his research, he told me, was to inform policymakers on how to improve health and dignity standards for female sex workers around urban Tanzania.

For the rest of the morning and afternoon, he took me around the department to introduce me to various students, administrators, and other professors. He gave me the paperwork necessary to submit to the IRB office at Muhimbili to ensure that my research followed the ethical standards of both Dartmouth and local research laws. Lastly, he gave me book after book

to read from his personal shelf, recommendations based on what he thought would be interesting after reading my research proposal.

“These books ought to keep you busy for the next week or two while we wait for your research proposal to be approved by our local IRB office,” he told me as he sent me off for the day.

I walked back home from the university and hospital with a smile on my face and a backpack filled with books, much heavier than the bag that I left home with that morning. I am eternally grateful for this morning. Dr. Kamazima and the rest of the people who I met that day became my support network as I went ahead with my fieldwork and daily life in Tanzania. They helped me through the challenges of moving to a new city and country and learning a new language. They were constantly on call for when I needed emergency help- from rounds of diarrhea to an express kidnapping/mugging (an unfortunate consequence of the structural violence that stems from poverty) to a still undetermined but thankfully short bout of either typhoid fever or malaria.

Two weeks after my arrival in Dar es Salaam, I received the green light from the Muhimbili IRB office. In a morning meeting with Dr. Kamazima, he told me that he wanted me to have independence in my work.

“I won’t inquire into your day to day work, Sirey,” he told me. “If you need any help or have any questions, feel free to reach out to me, but besides checking in with me occasionally, you have full control to make the necessary mistakes to learn. I learned the best as a doctoral student doing field research this way.”

The hands-off approach from my research advisor on the ground in Tanzania allowed me to have the valuable experience of doing bottom-up data collection. On my own, I reached out to and formed relationships with various medical departments and people in the hospital.

One of the less explicit goals of my 6-month stay in Tanzania was to grasp as much of Kiswahili as possible and become conversationally fluent with the Tanzanians around me. With a lot of help from the full language immersion on the streets and in the home and with a little help from Duolingo, I was able to become proficient within 2 months. My Kiswahili continued to improve with each passing day. My grasp of the local language allowed me to conduct many of my interviews and engage with patients and providers in the clinic with reduced amounts of interpretive assistance.

The formal ethnographic data collection was conducted at the Muhimbili National Hospital in Dar es Salaam, Tanzania. Specifically, I conducted recorded interviews with healthcare providers in the emergency, maternity, obstetrics/gynecology, neonatal, and pediatric oncology departments of the hospital. I also spent time in these respective departments doing observations on the experiences of patients and providers and their interactions. The providers who participated in the formal interview portion of the study all worked in the Muhimbili National Hospital and were over the age of 18. For the patients that I spoke with during my clinical observations, I omitted all identifying information about them. My interactions with patients, as opposed to my interactions with providers, were not recorded. Instead, I made notes reflecting upon the interactions that I had with them afterwards. In total, I recorded multiple interviews over time with six healthcare providers in each of the departments mentioned above and spent around 100 hours observing in the clinic at different times of the day.

The recruitment of participants for interviews was assisted by the School of Public Health and Social Sciences (SPHSS) at the Muhimbili University of Health and Allied Sciences (MUHAS). I was able to work with the faculty members in the department in connecting with healthcare workers throughout the hospital. I received additional assistance in reaching out to participants from the healthcare providers that I already connected with. They linked me with their colleagues and classmates. I initially approached the supervisors in each of the wards and asked for permission to conduct my research within their spaces. Once receiving approval, I spoke with the healthcare workers and patients individually to obtain consent for interviews and ethnographic observations.

Before conducting interviews and observations in the ward, study information was given verbally in both English and Kiswahili, with paper copies available on request. I notified each individual that information such as name and identifying physical features would not be collected, and that my work was continually monitored by an ethics board both at Dartmouth and at Muhimbili (Dartmouth CPHS# STUDY00031417, Muhimbili Ref# DA.282/298/01.C/). I gave an introduction of the background and nature of the study, as well as the end goal of understanding contemporary patient-provider interactions in Tanzania in the context of colonialism. I told participants that they were free and welcome to pose any questions to me and that if they were willing to speak with me, they would have the choice to select interview locations where they felt the most comfortable and at ease to speak. I made it explicit in Kiswahili to all of the patients and providers in the ward that participation was voluntary and that any of them could withdraw themselves from the ethnographic work upon request at any point.

The majority of data collected in the ethnographic interviews and informal conversations with patients were personal stories of individuals' experiences with healthcare in Tanzania.

Many of these interactions came from my regular visits to the clinic when I met someone who wanted to speak with me or when I stumbled upon interesting situations. During my clinical visits, many patients thought that I was a medical practitioner and asked for my advice. Even when I explained to them that I was a student, they were still willing to share their stories, expressing hoped interest to learn about healthcare and my life in the United States as well. Additionally, situations that required immediate attention from the healthcare providers that I was spending time with constantly popped up throughout the day, allowing me to give a first-hand view on the more pressing interactions between providers and patients in the clinic.

Formal interview data collection was done through voice recordings and observational data collection consisting of detailed written notes. My interviews followed a semi-structured style based on interview guides for the initial interviews. Subsequent interviews that I conducted were based off of notes from my first interviews. Although practitioners were given the option to choose the interview location that suited their comfort the most, they all were performed in the clinic or in their homes. In addition, with the help of a colleague who worked in the Tanzania Ministry of Health, I was able to gather some official publications on quantitative health metrics from throughout the country. I tried to find data relating to health access, maternal mortality, infant mortality, vaccinations, etc.

A large part of the data that I pulled for my thesis research also came from informal interactions that I had with people throughout my time in Tanzania. During my six months traveling around the country, I spent time with numerous bus and taxi drivers, vendors in the market, my housekeeper, and other friends that I made in the communities around me in each far corner of the country. My conversations with these people gave me just as much insight into the lived experiences surrounding healthcare and its relationship with contemporary Tanzania

politics as my ‘official’ data collection, and as such, I believe that my quotidian interactions also gave me invaluable data points to include in my analysis and writing.

The interpretation of my experiences, as written in the subsequent chapters, are tied to themes pulled from various streams of existing medical anthropological literature. Most broadly, I examine how patients and providers personally view the landscape of health and healing in the context of broad social forces around them. Kleinman, Biehl, and Good (2007) describe the formation of subjectivity of modern peoples, where people seek meaning in their personal circumstances within the broad forces such as neoliberal economics, colonial trauma, and post-colonial trauma.

Subjectivities are formed in complicated ways in Tanzania. Various forms of care exist, from western biomedicine that came with European colonialism to folk and traditional medicine that existed long before then. Anthropologists have long reflected upon medical pluralism, looking at the ways in which different realities exist in the same space based on different contexts. This thesis pulls from Kleinman (1978) to form its analytic backbone in understanding medical pluralism in Tanzania. These distinct therapeutic forms exist side by side, often bumping elbow rooms and competing, but sometimes mutually building upon each other as a patient seeks meaning in their illnesses. I argue that the divisions between coexisting systems of care in Tanzania are particularly reinforced by the political forces stemming from colonialism and neoliberalism and the biotechnical embrace of western biomedicine.

The hauntology of neoliberalism and colonialism impact the healthcare landscape of Tanzania. Hauntology, a term first coined by Jacques Derrida in 1993 by pulling from Marx, describes how political phenomena have the capability to persist as a specter in the present. The distinction between past and present are blurred. Walter Rodney, basing his writing off of Franz

Fanon, elaborates on how the memories of past societal and personal trauma by the colonial and capitalist state inform the worldview of the present; the linearity of time is disrupted (1981).

Mary-Jo DelVecchio Good, Sandra Hyde, and Sarah Pinto's ethnographic compilation examines this relationship between hauntology and healthcare subjectivity, a body of literature that I will extensively pull from (2008).

Furthermore, the biopolitical power of the state and the esoteric nature of the clinic described by Foucault (1963) also substantially impacts Tanzanian healthcare. I analyze in the following chapter how the British colonial regime's use of biomedical technology helped it achieve its goals of political control through healthcare. The biotechnical embrace that pervades among many aspects of western biomedicine forms a hauntology that harkens back to colonial-era violence that still forms uneasy feelings amongst many towards western medicine (Good 2001).



The bustling market and transportation hub at the entrance of Muhimbili following a rainstorm.



Fieldwork



My residential street in Dar es Salaam



My favorite shop near my house, especially in the context of neoliberalism.

Chapter One- An Experience of Seeking Healthcare in Urban Tanzania

During my second week in Tanzania, I received a desperate call from my roommate about a brief spasm of acute chest pain that temporarily knocked him out. Postponing all that I was doing in that moment, I frantically made my way home as quickly as possible. Entering through the front door, I saw him sitting at a table looking dazed but overall seeming alright. We made the decision to go to the hospital for a brief check-up. Little did we know, we would end up in a multi-week process throughout various departments of Muhimbili, a snapshot example of what it is like for Tanzanians to access primary and more specialized care.

I grabbed my Muhimbili-issued identification card that was given to me as a researcher affiliated with the institution before leaving the house to hail a taxi, thinking that the card might be helpful in getting expedited care for my friend. The roundabout outside the entrance of both the hospital and the university is both a marketplace and a city bus terminal that is constantly bustling with people. Our taxi driver elected to let us off before the roundabout to avoid the human and vehicle traffic, causing us to walk the remainder of the distance to the emergency ward. My friend and I weaved around vendors selling food, newspapers, and prescription medications. We dodged the *dala-dala* conductors on slow-moving busses yelling out their routes and final destinations. Muhimbili is a sensory overload for visitors unaccustomed to the area. The liveliness of the area reflects the importance of Muhimbili as a biomedical institution in Tanzania as it is both one of the only medical schools and largest hospital and biomedical research center the country.

Once passing through the gates and entering the hospital compound, we made it to the entrance of the emergency department, a *de-facto* triage center for all patients requiring medical care without an appointment already scheduled with one of the more specialized departments.

The reception area was filled with people, crowded and with no sense of order. In this moment, the restraints caused by lack of human resources were palpable. It was apparent by the luggage that some individuals sat upon that many families traveled a long way to access care. Wielding both my ID badge and elementary Kiswahili, I squeezed my way towards the front of the queue to the receptionist but found myself competing with several other families to get his attention.

Protocol in an emergency room in the United States seems pragmatic and straightforward: patients enter and check in with a receptionist. Individuals with the most serious cases skip this step and immediately undergo treatment. The rest of the patients are seen in the order of the severity of their cases. Upon arriving at the emergency department at Muhimbili, I expected the process to be the same. The only difference was an added effort to speak with the receptionist due to the increased amount of people in the ward, a common occurrence in urban healthcare centers of developing nations and under-resourced areas. When I finally received the attention of the receptionist, the expected protocol seemed to be the case. My friend was asked for his identification and some basic triage information was taken. After this was completed, I expected to be sent over to perhaps a nurse for a preliminary triage and evaluation, but instead I was asked to procure a payment.

Despite the myriad of qualms in the United States healthcare system, billing in an emergency room generally happens after the care is given. In many cases, care is given despite the ability of the patient or their family and friends to pay. In many private and public healthcare centers in Tanzania, a base payment for emergency department services is required before any care is given. A payment invoice was given to me by the receptionist. I ran it over to the payment office, in another part of the hospital campus, to make a cash payment and receive a receipt. I

then ran the receipt back to the emergency department reception area to compete with others for face time with the receptionist to submit the payment receipt and complete the check-in process.

The completion of the payment led us behind a set of doors behind the reception area, which was a preliminary triage room. This room had several chairs and computers against both walls with nurses at each computer station asking questions to patients in the chairs. The amount of people standing dwarfed the amount of people in the chairs. As soon as one chair opened up, I rushed over to reserve it for my friend. Thinking that a nurse would approach us to begin the process, we spent the next fifteen minutes waiting. Only after realizing that several of the patients that entered the room after us had already been seen, we decided that unless we specifically got the attention of a nurse, we would be spending the rest of the day waiting around.

In the process of waiting, I observed several patients and their families also undergoing the preliminary triage. Some groups of people carried various pieces of luggage with them, making me infer that they had traveled a substantial distance to seek care here at Muhimbili. I noticed while listening in on their conversations that a majority of the communication between the healthcare workers and the patients and their families was in Kiswahili, but English medical terminology was peppered throughout the questions that the nurses were asking. In many of the cases following a question containing a complex medical term, silence and confusion would fall on the side of the patients. In reality, these words would even be complicated for any person without formal medical training in an English-speaking part of the world.

In most instances when confusion followed a question, the nurses seemed adept in using Kiswahili to offer a simplified definition or give a roundabout way to ask the question. This clinical adaptation appears to come from the necessity to communicate with a population that predominantly speaks Kiswahili and knows very little English. I was told by some healthcare

workers later on in my time in Tanzania, however, that rare instances do come up where the provider finds it impossible to convey the meaning of a complex biomedical term on the spot for those who are under their immediate care. In these situations, the diagnosis or reason and protocol of a treatment aren't understood by the patients and their families. In urgent scenarios, treatments proceed due to necessity and the receivers of the care are completely clueless to what is happening.

After several attempts, we found a nurse who was not in the middle of completing another task to come to the triage station that we were waiting at. The computer screen was occupied with a window of a medical records software with innumerable blanks to fill and boxed options to drop down and select. After collecting my friend's medical history and asking questions about the reason for the emergency department visit, the nurse determined that both an electrocardiogram and echocardiogram would be in order. He printed out a sheet of paper, handed it to us, and ushered us through another set of doors that led into a hallway with a long bench that continued along the extent of the wall. He said that we should wait on the bench until my friend's name was called. Many people were already waiting at the bench, but we were able to find a spot to sit in the middle of the hallway.

A few hours into the wait, I glanced down to my watch and realized that it was well past midday. Seeing as we were both hungry, I offered to head over to the hospital canteen and grab some food to bring back for the both of us. Located on the other side of the hospital campus, the trek to the canteen through the crowded weekday foot traffic at the hospital took about fifteen minutes. The previous batch of food had already been sold when I arrived; I had to wait around after placing an order for the food to be finished cooking. With each passing minute waiting for the food to be prepared my anxiety rose a notch. Thoughts of bringing the food back only to find

the spot we sat on the long bench empty rung through my head. In the worst-case scenario, my friend would have been called up to have his ECG and Echo done. To me, he would be lost in the ocean of people that visit Muhimbili daily.

I bolted back to the emergency department after taking hand of the bag with two takeaway containers of food neatly stacked inside of them. In total, the time it took for me to find us some lunch took nearly an hour. Much to my surprise, I came back finding him still sitting at the exact same spot, talking away on the phone to explain his situation to various concerned relatives. As we ate the food, I couldn't tear my mind away from the realization on the sheer amount of self-advocacy needed to receive healthcare services in a public hospital in Tanzania. We both agreed that we should find the next step on our own to expedite the process. Thankfully, we knew the two cardiovascular examinations that my friend needed, so the only thing we had to do was to stroll along the busy hallways and find any people who would be able to point us towards the radiological portion of the emergency department. We made our way over relatively quickly with the collective directions gathered by flagging down various hospital employees who seemed to each be focused on their own tasks.

Arriving at radiology, it was very easy for my friend to get his name into the queue for an echocardiogram. When I mentioned the fact that the nurse told us to wait in the long hallway after the preliminary triage and history collection for my friend's name to be called by radiology, the receptionist had no idea about it. When it was time to pursue an electrocardiogram, my friend and I were already seasoned veterans. The persistent attitude that the former half of the day taught us to have expedited our process. Interestingly, it didn't seem like my Muhimbili badge did anything for us at all. The most it ever did was spark a few conversations throughout the day with a few physicians asking what I was researching. By the time we left the hospital to head

home, the sun had set. I was thankful that nothing seemed abnormal with my friend, it was still appalling to me how much time and effort it took for us to conduct two procedures that took a combined half an hour.

Throughout the day when things were going right and we weren't feeling lost and confused, sitting down and waiting for my friend's procedures to finish gave me a chance to take some notes and observe my surroundings. Looking back on my notebook many months later, it gave me a good laugh to see the bolded and capitalized words saying 'WALLE' heavily circled on the top left corner of the page. In the Pixar movie Wall-E, the remaining vestiges of humanity live on a large space station after having to leave an environmentally degraded earth. The station and the people on board are serviced by tens of thousands of robots who travel through the corridors of the spacecraft. At first glance the decks seem chaotic with the robots moving around with no apparent order, but in reality, each robot is focused on its own specific task. In many ways, I found the workers at Muhimbili to be doing the same thing. Each healthcare worker is focused on their specific assignment. The first nurse that gave his assessment was focused on getting patients through the first room after the emergency department reception; what patients need to do afterwards was outside of his focus.

Muhimbili seems to operate like this in both at an individual healthcare worker's level and at an institutional level. When we were wrapped up with our emergency department visit, the attending physician gave his final opinion. Although both tests seemed to indicate that my friend had a healthy heart and that the incident was most likely an anomaly, we should still go and visit the cardiac institute, a different department in the hospital, to have a cardiologist give the final say. The Jakaya Kikwete Cardiac Institute, named after the former Tanzanian president who spearheaded its creation, runs as its own disparate operation from the emergency department and

from any other department at Muhimbili, despite all being a part of the exact same hospital. Tanzania, being a low-income country, relies heavily on outside support to sustain its healthcare, where various form of capital comes from foreign governments and non-governmental organizations (NGOs). Surveys from the Tanzanian government have shown that development projects in the country rely on foreign funding for 58% of their expenses in 2015 (Ministry of Health, Community Development, Gender, Elderly and Children 2015).

For example, the pediatric oncology ward is funded by a Rotary Club in Ireland. The cardiac institute is funded by an organization in China. Being the recipient of funding from these organizations can be incredibly helpful to the development of both health infrastructure and delivery as the money often comes as a lump sum. The price of funding, however, is often the relegation of administrative directionality to the organization, instead of the hospital as a whole. This results in many of the hospital departments virtually running on their own, a salient aspect of healthcare structure in post-colonial Tanzania and something that will be explored in later chapters. Instead of working in a way where different departments can communicate with each other to streamline the patient experience as they jump from department to department, these departments are heavily influenced by the goals and vision of organizations overseas. The fragmentation does not form out of malice, but rather through ignorance from foreign aid groups. Their financial contribution and personal interests in a hospital department do not accommodate the cohesiveness that a hospital and healthcare system needs.

Bright and early on the very next day, we headed back to the hospital, this time to visit the cardiac institute for the specialist's point of view that the attending in the emergency department recommended the day before. We were given an official note from the emergency department doctor that we hoped would still hold value in the cardiac institute. All we really

needed was a few minutes with a cardiologist to look over the printouts of the electrocardiogram and the echocardiogram to reconfirm the optimistic reading that we were already told of. The differences in administration make it so that the entire process of taking patient information that my friend underwent the day before had to be repeated again. Much to our dismay, the day at the cardiac institute was a rude *déjà-vu* where the payment, medical history collection, and both scans were all re-done. The building was new and was filled to the brim with state-of-the-art cardiac equipment, but it felt as if it were the patients who paid for the cost of the charitable donation with their time and patience.

The attending cardiologist was not in during our second hospital day, so we made a final visit on the third day. This day was the least eventful and fortunately my friend finally got to know that nothing seemed out of line with his cardiovascular system. Having this experience near the start of my time in Tanzania was frustrating at the moment but serendipitous upon reflection. This reality, fueled by mixtures of human and physical resources constraints followed by strong foreign interests, forms the daily challenges at the largest academic hospital in Tanzania. Challenging as this was for me and my friend, this experience introduced me to the challenges facing patients and their families as they travel to the city to seek specialized care. The long distance and unreliable time expectations at the clinic make planning travel difficult. The need to constantly advocate for yourself to be seen by the right healthcare professionals is exhausting.

Healthcare workers are not to blame: they put in unwavering dedication despite the resource challenges of operating in a low-income country. They are incredibly overworked, yet they maintain a sense of duty and optimism, a theme that I will illuminate in the subsequent chapters. The environment where the healthcare workers and patients collide is a result of

cultural differences in care and colonial and post-colonial politics. This preliminary experience set the tone for my guiding questions over the six months that I spent in Tanzania. In the following chapters, I hope to do justice to all that I learned by my humbling experiences with the resilient patients and providers that I was privileged to interact with.

This experience, which unfolded into a multi-day ordeal, gave me valuable insight into the often complicated and intimidating process that many undergo to seek western medical care in Tanzania. Despite my visible Muhimbili identification badge that I brought along with me to expedite the process for my friend, we spent three separate days over the span of a week in various departments and clinics. In this time period I was able to observe the experiences of healthcare providers and patients in a medical system that is both under-resourced and heavily strained. The complicated nature of transferring from the emergency department to the cardiac department, despite being part of the same hospital, gave insight into how foreign influences on the healthcare system caused fragmentation.

The thesis will examine the lived experiences of Tanzanian healthcare workers and patients in the context of colonialism through clinical interactions. By first looking at the history of healthcare in Tanzania, from pre-colonial to colonial to present, followed by a pulling from multiple streams of anthropological theory, this writing aims to build conceptual bridges on how colonialism and its legacies reinforce broader forces of structural violence that add significant challenges to the healthcare system and individuals' health in Tanzania. Based on my research, I wish to elaborate on four main ways in which colonialism and its legacies influence healthcare delivery and outcomes in Tanzania: (1) the initial implementation of western medicine and the construction of traditional medicine, (2) the substantial presence of foreign groups and individuals in contemporary western medicine, (3) the contrast between western medicine and

post-independence politics in Tanzania, and (4) the lack of dignity in western care due to the manifestations of structural violence from colonialism. Tanzania's history of systematized violence conducted by the colonial state, as well as the coalescence of healing ideologies from native African, Arab, and European sources, have drastically impacted how Tanzanians today construct meaning in health and illness.

Chapter Two- Folk, Tradition, and Colonialism: The History of Tanzania's Healthcare System

Medical anthropologists put significant emphasis on understanding the diversity of medical systems and how they interact with each other (Gammel 2018). Mapping the lived experiences surrounding healthcare and healthcare delivery in Tanzania is remiss without acknowledging the diversity of medical systems within it. In a classic articulation of cross-cultural systems of healing, Arthur Kleinman, a psychiatrist and professor of medical anthropology at Harvard Medical School, describes a medical system as both socio-cultural and biomedical (1978). Shared beliefs based on group experience, customs, and history lay the foundation for how one may think about how illness appears and how to deal with it. This lays the foundation in the understanding and description of the experience of symptoms and the choices that people from different backgrounds make concerning biomedical treatment. In order to more deeply understand the contemporary diversity in the experiences of patients and providers in Tanzania's healthcare system, in this chapter I examine the history of healthcare in the modern geopolitical borders that make up the country.

The Eastern Bantu, a subdivision of people who originated in and migrated from West Africa, entered the area of what is modern Tanzania over 3,000 years ago, joining many non-Bantu indigenous groups that pre-existed in the area. The tremendous amount of linguistic and cultural variability between Bantu groups reflected the various medical beliefs and practices that they practiced. Gloria Waite describes how the influx of Bantu peoples brought with them their broad medical beliefs, which can be roughly traced and understood through the traditions passed down by the descendants of Eastern Bantus (1992). It is important to note, however, that their approach to disease and illness was not perceived in the same way that western biomedicine

systematizes it today. The Eastern Bantu constructed meaning in their illnesses and maladies with misfortune and malevolent activities. The activities of individuals with special abilities, such as sorcerers, were “of medical concern because they threaten an individual’s health and ultimately the health of the entire community” (Waite 1992, 12).

People and the actions between them, evidently, are the most important factors in the maintenance of the health of both individuals and communities. By tracing the lexicon of medical practices seen in contemporary Tanzanians, offending deities, disrupting spirits, conducting sorcery, and the breaking of taboos were major etiological explanations for disease (Waite 1992). In contrast to biomedical healthcare in a Western setting, delivering care is not monopolized by professionals characterized by certifications and training. While some specialists are important, most individuals are aware of the medicines that are available in the environment that can address some of ailments caused by social disruptions. Roots and leaves that were foraged, for example, could be ingested, rubbed onto areas of the body, inhaled, worn, or planted and cultivated (Waite 1992). These practices that originated in the past persist in the present, taking their own unique adaptations to modernity; this is an important point that will be examined in more detail in the following chapters.

For those who play a special role in care, they do not fill the same niche in their communities in the same way that we imagine healthcare providers to take in a western biomedical setting. The Bantu, Khoisan, and Nilotic, major groups that comprising much of the indigenous people in sub-Saharan Africa, all share common beliefs that the vast majority of spirits and deities were tied to their ancestors, who in turn are the instigators of illness and promoters of healing (Waite 1992). Spiritual elements rooted in Islamic tradition, especially in coastal areas of Tanzania, have also had a strong influence for at least a millennium. The

specialists who are present, therefore, have skills in acting as medium for spirits. The training that these specialists received, nor their practice, is organized in the same institutionalized ways that healthcare providers in western biomedicine are.

The arrival of Europeans into Africa and specifically in Tanzania, first as explorers and then as colonizers, ushered in novel ways of constructing meaning in healthcare in illness that competed with Bantu ideologies. Despite the diverse ways that Bantu ethnic groups understood illness and practiced medicine, Europeans placed them all in the same category termed as ‘traditional medicine’ to distinguish them from western biomedicine (Langwick 2010). Historically, German East Africa was politically organized in the latter end of the 19th century as the first European colonizer. It became the largest German plantation colony, facilitating economic exploitation through agricultural practices. Through, for example, the institution of tax policies, European powers facilitated the transition of people in their colonies to be producers for the colonial state. German colonial officials in Tanzania put forward self-interested public health interventions for Africans, focusing on population and reproductive health, reflecting the priority of the colonizers to keep their workforce alive and well (Bendix 2016).

When the British assumed control of German East Africa after Germany’s defeat in the First World War, they renamed the territory Tanganyika. Medical practices first instituted by the Germans continued under British rule, overseen by the Colonial Medical Service. Operated by medical officers, The Colonial Medical Service was a branch of the colonial governing body overseeing healthcare provision (Crozier 2007). For many prospective healthcare workers in Britain, Crozier writes that a career of practicing medicine in Africa was fueled by a “Victorian sense of adventure” and a formation of a cultural identity “based on race and Britishness” (2007, 1). Another alluring factor was the emerging field of tropical medicine, where European forays

into new parts of the world exposed novel kinds of illnesses to them. Healthcare providers saw a sense of novelty in practicing medicine in Africa and on native Africans.

In many ways, people in German East Africa and Tanganyika were not merely colonial subjects but were also research subjects for colonial healthcare providers. Having been long perceived as a source of medical knowledge for westerners, Melissa Graboyes describes how East Africans constituted a living laboratory, where they “were the human material necessary for research projects focused on malaria, trypanosomiasis (sleeping sickness), leprosy, onchocerciasis (river blindness), schistosomiasis (bilharzia), and lymphatic filariasis (elephantiasis)” (2014). For many native Africans in the colonial period, medical research was often their first exposure to western biomedicine. Historical records indicate an example in 1950 when biomedical researchers convinced the chief of a coastal community in Tanganyika to allow them to administer inoculations against elephantiasis and symptoms of lymphatic filariasis—no such vaccination existed. Instead, the research team wanted a large turn out to collect blood samples. Including this story, colonial records show that the number of native subjects in Tanganyika who gave blood, urine, or stool samples to the colonial medical service was over 43,000 in the 1950s alone (Graboyes 2014).

Running in parallel with the Colonial Medical Service, missionaries established clinics and health centers made up the majority of western biomedicine practiced in rural areas the colonial era. Since they were unregulated, medical missions could be more explicitly coercive in their actions compared with governmental service. At the end of the colonial period, nationalist Tanzanian writers were amongst the first to “criticize missionaries as at best connivers, if not active agents, in the imposition and maintenance of colonial rule” (Jennings 2008). It is interesting to note that missionary medicine struck a parallel with traditional Bantu forms of

care, attaching medical practices with spiritual elements. Past ethnographic research by Stacy Ann Langwick (2010) and others highlight how changing social conditions brought by missionaries allowed new linkages between spirits and disease to be linked. Christianity is not explicitly linked to health in the same way that traditional beliefs are, but many people in modern-day Tanzania seek explanations and meaning of illnesses through western religions, such as miracle healings in the Pentecostal tradition.

There is an evident juncture of colonial violence, medical research, and bodies in Africa. Missionary doctors often went to Africa to satisfy a personal desire to view ‘the other’ or to satisfy their fantasized ideas about black bodies. In the neighboring Belgian Congo, colonial medicine was obsessed with transferring all childbirths to a western biomedical clinical setting. By increasing the number of deliveries in a colonial hospitals, sanitation and hygiene measures could be taken into place that would decrease the infant mortality rate. As a biopolitical measure, this would increase population growth in the colony and also political control on an important part of biological life. This was not about public health; instead, it was based on a desire to increase childbirth and ‘biomedicalize’ motherhood in the growth of the colonial state (Hunt 1999). Histories such as this obstetric example demonstrate how colonial regimes pushed the development of governmental health programs and missionary medicine based on their desire to maximize economic production or increase biomedical knowledge in an easier fashion than could be achieved in Europe.

One salient example of the state-sponsored acts of structuralized violence against black bodies in Tanganyika is described in a paper written by Chau Johnsen Kelly, a professor of African history, highlighting a medical experiment gone awry conducted by the British Colonial Health Service in Tanganyika in 1936. In the colonial government-run Malangali School in the

region of Iringa, Tanganyika, a nutrition study with schoolchildren as subjects ultimately resulted in a poisoning that eventually took the lives of 37 children between the ages of 3 and 12 (Kelly 2016). The nutrition study, which was initially conducted to seek answers to malnutrition in the era, demonstrates a drastic consequence of the biomedical experiments that took place under colonial rule. European powers sought easy and haphazard remedies to issues such as human malnutrition or infectious disease through biomedical approaches, when in reality they were based off of more intricate environmental and social problems that arose out of colonial rule, such as a focus on a healthcare system that had a primary concern of keeping a healthy workforce and tough conditions on plantations (Hunt).

In the book *Black Skin, White Coats*, Matthew Heaton (2013) delineates how European colonial powers justified their intrusion into black bodies and Africans with humanitarian terms. In reality, however, these exploits were aimed towards gathering of medical knowledge and ensuring maximum economic gains from their colonies. By presenting Africa as a place ridden with novel diseases and African cultures responsible for the heavy disease burdens, colonial governments and their missionary surrogates were able to lure European healthcare workers to the continent by framing their work as both adventuresome and charitable. For example, published accounts by David Livingstone from the later 1800s, a prominent European who traveled through Africa and documented its landscape and people, constructed romanticized imaginings in European minds of a continent untamed. It's evident that for these communities, the scientific experimentations "did more harm than good in terms of understanding local conditions and providing for better health outcomes" (Heaton 2013, 7). These harms are expressed in the large-scale scientific exploitations that were conducted on black bodies, but also in the satisfaction of adventure amongst individual European doctors at the expense of Africans,

feelings that persisted into the European doctors who sought to work in the colonial health service past the 1950s.

The notion that Africans have primitive understandings of healthcare that result in the spread of epidemic diseases, such as HIV/AIDS, hold firm in the western imagination. Even today, when seeing how Africa is portrayed as a whole, “Africans get sick.... because their societies were fundamentally sick,” meaning that somehow being African is an inherent comorbidity (Vaughan 1991). The western gaze failed to examine the ways in which forced changes in lifestyle as a result of large-scale resource production that existed in European colonies or the weak public health systems put into place by colonial governments, as mentioned earlier (Foucault 2003). The ways that western biomedicine modeled health and disease in Africa focused on the shortcomings of the continent as a whole displaced attention from perhaps the larger environmental and economic causes of disease and towards the idea that Africans were differentially susceptible to certain diseases on account of their cultural practices. These ideas hold strong up until today, where ideas such as harnessing ‘white guilt’ and projecting ‘poverty pornography’ are effective means to fundraise development projects in the Global South (Willen 2011).

The narratives that characterized African patients transitioned into the modern day as Tanzania gained independence. Beginning in the 1960s, the new leaders of Tanzania shared a common socio-political and economic goal. They sought to transition its society from an under-developed to an industrialized one by improving the socio-economic conditions through socialist policies that would simultaneously serve as a symbol of African independence from the West. By seeking effective development while also distancing themselves from colonial-era policies, Tanzania could distance itself from its exploited state in its colonial past. The government

embraced a socio-political dogma of African socialism called ‘Ujamaa,’ a Kiswahili word that translates to ‘extended family’ (Mandalu et al. 2017). Through these political philosophies, many politicians believed that the inequities in society born during the colonial period could be shaken. Importantly, Ujamaa was an idealized, indigenous form of Tanzanian socialism, that sought to revive a strong sense of unity and strength from a precolonial era (Mandalu).

Tanzania’s collective political-economic management model failed to survive in an increasingly neo-liberal world. Capitalism outside of Tanzania’s socialist bubble eventually became an inevitability that was unavoidable. The country’s economy declined due to a laundry list of economic challenges that began in the 1970s into the 1980s. Oil crises, the collapse of coffee exports, a lack of foreign direct investment, natural disasters, and the onset of the war with Uganda in 1978 created conditions that the state was unable to address (Mandalu et al. 2017). By the mid 1980s, it was clear that Ujamaa had failed to address Tanzania’s postcolonial development ambitions; the nation required outside help that would require adoption of many market-based characteristics to Tanzania’s economy. Turning to multinational financial bodies such as the World Bank and the International Monetary Fund, Tanzania’s markets liberalized and opened, causing foreign entities to enter in exchange for much needed structural adjustment loans to address its development challenges.

NGOs and aid branches of foreign governments became heavily involved in development and poverty alleviation. In many ways, foreign NGOs became surrogates of the Tanzanian government: they were able to step in with the many ways that Ujamaa failed, and thus the state allowed them to operate in order to advance their development goals (Jennings 2007). Tanzania was unable to maintain state-run institutions because of the structural adjustment plans imposed onto the country as terms for the loans that it received. It’s important to note that postcolonial

theorists often had and continue to have negative views on foreign entities facilitating development, as healthcare workers to come into the development landscape with the arrival of foreign organizations were influenced by past narratives of Africans and illness.

Tracing the history of interactions between European medicine and African cultures in the colonial period unveils structural violence. The ways in which western biomedicine engaged in warfare against traditional forms of healing in pre-colonial Tanzania are important to understand in context of how medicine exists in postcolonial Tanzania. A complex combination of political agendas that interplay with traditional imaginings ultimately manifest in these forms of structural inequities. The historical era of direct biomedical violence created a legacy that carries into the present. This postcolonial hauntology manifests as “traumatic memory, inherited institutional structures, and often unexamined assumptions” that characterize health and illness (Good, Hyde, and Pinto 2008, 6). For example, Philip Setel’s work in northern Tanzania highlights how the presence of foreign healthcare workers and biomedical equipment in response to HIV/AIDS seems ubiquitous to importing the syndrome itself in the eyes of locals (2008). These historical legacies coupled with neoliberalism that ushered in structural adjustments created underlying political and economic foundations that shape the experiences that define what it means to be a medical subject in an anthropological context in Tanzania.

Many factors make up the understanding of healing in Tanzania today. Colonization, missionization, postcolonial state formation, capitalism and its proliferation, international development, and globalization make up just a fraction. In response, people embrace multiple systems of healing that will be elaborated in the following chapters. Sienna Craig’s book looks at the ways in which medical pluralism exists in Tibet, where care exists with a combination of Chinese, Tibetan, and western medicine (2012). Similarly, in Tanzania, the World Health

Organization (2002) estimates that 80 percent of people in Tanzania seek out both traditional medicine in conjunction with western biomedicine when they become ill. Many rely on both the institutionalized clinic and local healers and herbs to in their primary health care (WHO 2012).

For many, the use of traditional medicine is growing due to the inadequacy of western biomedical healthcare services, an ironic result often attributed to widespread poverty that comes from neoliberal economic reforms and colonialism, a notion that was confirmed in my informal interviews, where I learned that traditional healers are in many ways more trusted and more affordable than western biomedical practitioners.



British colonial-era buildings in downtown Dar es Salaam.



The Upanga commonwealth war cemetery, where soldiers who fought and perished for the British empire lay at rest.

Chapter Three- The Divergence of Western Biomedicine and Post-Colonial Tanzanian Politics

During rush hour in Dar es Salaam, vehicles form rows like ants carrying crumbs from picnic leftovers. Drivers inch forward ever so slowly, trying their luck at each intersection. Ali Hassan Mwinyi road, with only two lanes painted on each side, suddenly finds itself with eight cars abreast. Smaller vehicles finding rare, pedestrian-free areas on the pothole-filled sidewalk take their chances for a small lead over everyone else whilst the traffic police look away. The gap between cars, trucks, motorbikes, and busses is choked with smog, yet street vendors bravely venture into the toxic fumes, weaving between vehicles. They proclaim their product: plantains, groundnuts, cassava, and Coca-Cola, sacrificing their lungs for the few dollars they can scrape each day in their exchanges through car windows.

I was stuck in this city-planner's worst nightmare one afternoon during my second week in Dar es Salaam. Inside a *dala-dala*, a city bus which is really more of a glorified van, the sultry coastal air coupled with sardine-can proximity to other people in the packed vehicle formed beads of sweat on my forehead. Suddenly, the old man next to me asked me, "unakujua Kiswahili?"

A few seconds passed by as I attempted a translation in my head. *I think he's asking me if I speak Kiswahili*, I realized.

"Ndio, ninakujua kidogo. Ninajifunza pole pole," I explained, hoping that I told him what I meant to say: that I know only a little, and that I am still learning.

He smiled at me, and then replied in Oxbridge-style English, "very good, my boy. Kiswahili is what makes us proud to be Tanzanians."

Patriotism and national pride are strong sentiments amongst many people in Tanzania. After that conversation with the man that made being stuck in traffic more bearable, I found that I had similar conversations like that on a weekly basis with shop owners, taxi drivers, and any other person that I ever ran into. It is particularly interesting to note the political stability that exists in Tanzania. In comparison to bordering nations, political strife within the country has been a rare occurrence since independence. Since independence, The Democratic Republic of the Congo has been in a state of near-constant civil war, Burundi, Uganda, and Mozambique have faced coups and dictators, and Rwanda suffered from a genocide. In next-door Kenya, ethnic hostilities after every major election since 1992 has produced violence, resulting in thousands of deaths (Steeves 2006).

Like its neighbors, Tanzania also possesses many features that might have impeded social stability. Its borders contain a multitude of diverse ethnic, religious, and racial groups (Waite 1992). In addition, the poverty of its people and a history of indirect rule as a British protectorate easily sets the stage to initiate power struggles against status quos. Ethnicity uniquely makes divisive political mobilization; ethnic divisions offer surefire mechanisms to create political competition. By appealing to charged sentiments, political elites can easily convince the public, especially poor and illiterate people to support them through populist movements (Kim 2016). By using ethnic lines, political objectives can be made clear by political leaders.

The leader of Tanzania's independence movement and founder of the Tanzania African National Union (TANU) party, Julius Nyerere, sought to avoid any internal strife. TANU established goals to facilitate national integration and Tanzanian unity regardless of ethnic, religious, and regional backgrounds. The party consolidated its goals by banning the creation of social factions that could harm domestic security and by implementing universal suffrage. Local

leaders during colonial rule, who were generally leaders from the most powerful tribes in the area, were replaced by directly elected officials (Tripp, 1991, pp. 227-229). The result of these policies made it extremely difficult to reinstate traditional ruling systems that existed, in some cases, before colonialism began.

Another salient nationalist policy was through implementing Kiswahili as a national language (Kim 2018). This policy was not shared with Tanzania's neighboring countries, who instead opted to keep their colonial languages. A language with no ties to any ethnic group or colonial master, it is instead a mix of Bantu-languages and Arabic, a language formed through generations of trading done between the East African coast and the Arabian Peninsula. Schools taught only in Kiswahili and aimed to educate the people to understand the concept of Tanzanian citizenship with a single, unifying language. This paved the way for many of the socio-economic policies that TANU put forward.

Nyerere opted for African socialism, breaking ties with Britain economically. His thought was that Tanzania could only be truly independent if it stood on its own two feet. Ujamaa Vijijini (collective village) was a key policy of the socialist guidelines for development. The policy proposed the construction of cooperative village communities in rural areas all over the country, where peasant producers could cooperatively work and live. Between 1967 and 1976, "more than six million people were physically relocated in newly established villages as the map of rural Tanzania was transformed from scattered settlements to nuclear villages" as the government sought to remodel the country and implement a policy of rural socialism (Jennings 2007, 32).

Many citizens were randomly assigned to their villages; Kiswahili was therefore the only way that people could communicate, as other languages were specific to each tribe or ethnic group. Ujamaa failed in many ways economically, forcing the government to yield to the neo-

liberal West and allow structural adjustment. Ujamaa's political implications, however, are still alive and well, giving the pervasive nationalism that I observed. In the clinic where my work was conducted, I saw how these ideologies transcended onto the scientific stages as well. Heaton's (2013) writings on postcolonial psychiatry in Nigeria shows that anticolonial nationalisms and decolonization processes harbors the potential to influence scientific agendas. In the same way, as scientific agendas also have the capacity to reinforce nationalist political ideologies. However, my observations showed that there are major discontinuities between biomedicine and postcolonial politics.

Biomedicine had an intimate relationship with colonial expansions. The biomedical clinic held a marked role in shaping modern subjectivities for Tanzanian patients. Biomedical practices in both the colonial health service and missionary clinics interrupted the processes of traditional medicine (Langwick 2010). These interruptions made traditional medicine a part of anti-colonial practices. In the Ujamaa period, the national government attempted to instate effective healthcare policies in each constructed village, however, by 1980, only 37% of Tanzania's villages had a dispensary, or rudimentary clinic, and nutrition programs were widely thought of as ineffective (Iliffe 1998). At the end of the 1980s it was evident that "the socialist medical experiment was close to failure;" clinics were often found in dilapidated shape, struggling with money and lack of staff (Iliffe 1998, 211).

Many Tanzanians also feel that biomedicine's history in their country robbed their collective national intellectual property. Colonial historiographies shroud much of the world's knowledge on African plants that have healed for millennia, credited instead to European scientists who co-opted the chemicals of the plants into the biomedical lexicon (Osseo-Asare 2014). The results of colonial science obscured the role of African healers whose prior use with

plants was critical to the transformation of plants into a marketable drug. In response to this, many post-colonial politicians encouraged their constituents to seek traditional or folk medicines. The national government pushed initiatives to use biomedical science in making a 'National Traditional Medicine,' to constitute a body that is "compatible with both modern and traditional medicine and are intelligible to both modern and traditional healers" (Langwick 2010, 10). Dr. Baraka, an emergency physician in his last year of internships, told me of initiatives that Muhimbili University took to create some departments that have to do with traditional medicine. Biomedical researchers in Tanzania are realizing that it is often the case that the medicine that doctors have their origins from plants used in traditional healing.

A large barrier in fully implanting these ambitious goals lies in the nature of the medical field in modern Tanzania. While every single other major governmental and civil society organization uses Kiswahili, I gathered from my interviews that medicine in Tanzania is still taught and practiced in English, a colonial language. The language barrier to access biomedicine for the typical Tanzanian creates an association between western medicine and Tanzania's former colonial master. Many Tanzanians, I found, are hesitant to seek care with an institution where procedures seem complicated and where English is the primary language. In seeking a traditional healer or folk healer that is down the street from someone's home, patients are able to get treated by a community member in a more holistic, intimate, and caring atmosphere. Esther, a housecleaner that worked in my neighborhood, always chided at me whenever I went to the hospital for field work.

"Why would you go to the hospital, where people do things to you that you cannot understand behind masks, when you can go down the street and see a healer who has known three generations of your family?"

I noticed in many of my conversations that there are two types of illnesses that exist in the eyes of people who live in urban Tanzania: *homa za mungu*, illnesses of god, and *homa za bin-adamu*, illnesses of humans. The way that locals described it to me was that some illnesses could be cured at the hospital, while others could only be addressed with a traditional or folk healer. I believe that this is a remarkable way that demonstrates the ways in which Tanzania's colonial and neoliberal history have generated multiplicities in health epistemology. Stacey Langwick describes these multiplicities as a result of "disruption, (mis)translation, and interpolation" inherent in Tanzania's history (2010, 236). The emergence of biomedicine during colonialism in an area that already held diverse health beliefs was this disruption and mistranslation. These are continued in the relationship between the linkage between foreign aid and biomedicine with traditional healers and Tanzanian nationalism. In their book *Postcolonial Disorders*, Mary-Jo DelVecchio Good, Sandra Hyde, and Sarah Pinto write how "decolonization must therefore go well beyond the creation of new nation-states or even the reformation of neo-colonial economic structures. It must also involve the decolonization of our minds and bodies" (2008, 243). Many people preferred to initially seek local healers instead of going to the western clinic for help not only because of the proximity to their homes, but also because of a patriotic sentiment. I think of various taxi drivers in Dar es Salaam who touted their allegiance to Tanzanian medicine as a form of national pride.

With several disparate medical systems operating in the same system, it was important as a part of my work in examining the culture of Tanzanian healthcare delivery to understand how different parties cooperated and clashed based on each other's explanatory models in healing (Kleinman 1995). Jacobson-Widding's medical anthropology writing examines this phenomenon of medical pluralism, seeing if it is "possible to create cooperation based on equality between

medical practitioners who base their knowledge on two fundamentally different explanatory models” (1989, 272). Traditional healers will continue to operate regardless of the health policies that the government implements, and it will always remain a popular choice as a result of biomedicine’s reliance on English and link with Tanzania’s colonial past. Craig (2012) notes how in Tibet, traditional Tibetan and Chinese medicine build their legitimacy by having their medications be mass-produced in the same way that pharmaceuticals are, packaged in a clean, professional manner. On a similar note, I observed that many local healers are improving their services, forming professional organizations of traditional/folk healers, especially in urban areas, and setting agendas to increase their legitimacy with rubber gloves or having reception areas in their homes where they practice.

Dr. Baraka gave me his take on traditional medicine and western biomedicine’s interactions:

I think modern care is still new in our society in many ways and most of the people believe in traditional care. Most of the patients we see either one way or another sought traditional care. It doesn’t matter the education level of the patient. Often, if there is a non-communicable disease that are not curable, two things will run through a patient’s mind: either it’s a curse or there’s something else that will work. I know growing up that traditional medicine works in many ways, but it’s not quantifiable and verified. We can’t legally support a treatment like that unless it’s standardized. My grandparents in the village never went to the hospital. They would always just take some leaves and they get better. Most of the time the people who come into the emergency department are in critical condition or end stage. They come in because they have already tried traditional care and it didn’t work. Patients know of us as an option, but we are often not their first option. When I was in medical school, we had a patient in the ward who was receiving western medicine, but his relatives asked us to discharge him because they had a witch doctor lined up for him. This is something that is common: you see infants and old people who have all sought traditional medicine. When families visit and bring food to inpatients, they also bring some herbs or leaves. This is something that is integrated into our society. We have no legal right to refuse that if they want to try it.

Pluralism does not always imply that there is a mutualistic symbiotic relationship between disparate forms of care. I saw how the different forms of care vied for customers. With

biomedicine becoming an increasing presence in Tanzanian healthcare, traditional healers in the neighborhoods of Dar es Salaam step up their rapport through increased advertising along with the ‘professionalization’ of their work, such as creating waiting rooms in their home clinics and having more formal patient forms and records.

Arusha is a major town in the northern border region of Tanzania. Lying between the Serengeti, Ngorongoro, and Kilimanjaro national parks, the town is a part of the northern tourism circuit, a major destination for foreign visitors and a major source of revenue for the Tanzanian economy. With a climate similar to Britain, the region was popular for white settlers during the colonial period. The Masai people, nomadic herders indigenous to the area, have had long and continuous contact with the west. Tanzania’s transition to a market economy has had marked impacts on the livelihoods of the Masai; you can now find Masai in all parts of the country engaging in occupations that are distant from their predominantly nomadic ancestors. I engaged in a plethora of interactions with Masai people throughout Tanzania, especially during my time in the northern part of the country.

Samuel, a Masai who worked at a hostel that I stayed at in Arusha, told me about his upbringing. His family believed that a European education would help him stand out from his peers, so from a young age he began attending missionary schools. Samuel feels connections to both his family in his Masai village and his time at the missionary school; he described his social role often as a mediator between what is African and what is Western. For most health concerns, people from his village seek both western and traditional remedies. When it comes to reproductive health, however, the western clinic is hardly ever considered. He told me that there are plenty of rumors in the Masai community that western biomedical facilities and NGOs are taking initiatives to sterilize them. Nobody would go to a clinic to deliver anyways, he told me,

as rural health facilities were so poor and dilapidated that mothers had to bring everything, down to the blade used to cut the umbilical cord.

I engaged in this subject over dinner eating Mishikaki, or Swahili barbecue with my friend Dr. Zalika. A pediatrician by training and now working in the Tanzanian Ministry of Health overseeing vaccination programs, she had her own thoughts to supplement Samuel's story. Her current main project is a nationwide HPV vaccine campaign to target rates of cervical cancer amongst Tanzanian women. Each year, the ministry of health vaccinates 14-year-olds around the country thanks to a partnership with Merck. Women, especially in rural areas, have shown concerns with HPV vaccine as it relates to the cervix. Dr. Zalika linked this to broader concerns in general on things concerning with reproductive health. She linked past exploits by colonial governments to sterilize African women, which ties to the broader colonial obsession with obstetrics and gynecology and population health.

Dr. Nyah is an obstetrician and gynecologist that Dr. Zalika introduced me to. I was lucky enough to be able to spend many hours with her in the maternity unit of Muhimbili. Before coming to Dar es Salaam, she finished her residency and internships in Zanzibar, a predominantly Muslim island of Tanzania that is a 2-hour ferry ride from Dar es Salaam. A portion of work in reproductive health had to do with the cervix, so I asked about her views on the nationwide HPV vaccine program. She told me an anecdote about her friend's sister in law:

I have a friend whose sister in law who believed that if you are vaccinated for HPV, it will hamper with reproduction. She thinks that the people who make the vaccines do not want Tanzanians to reproduce or to conceive. There are plenty of routine vaccines that are given after delivery, and many women often think that these have to do with reproductive health. I have noticed that it is always the more religious people. In Zanzibar, for example, measles is still there because people don't vaccinate their kids after they are born.

I found it fascinating that she had similar observations with Dr. Zalika on how the vast majority of fear towards biomedicine relates to reproductive health. The crux of colonial medicine rested upon population health to sustain and uplift economic goals of production of the colonial state. Subjectivities fostered during that time period have endured until today.

Dr. Nyah mentioned to me how treatments that do not even deal directly with women's reproductive health trigger fears tied to it. In her time treating women with menstrual irregularities, she found that many of them refused treatment. Menstrual irregularities are often linked to hormonal imbalances that can be treated with combined contraceptive pills, but even the mere mention of contraception sparks fears in those receiving the treatment will not be able to conceive later on. Even with counseling in Kiswahili, where she tells them that the medications are meant to only change their hormonal profile, they will still think otherwise and refuse treatment. According to her, patient's minds are "always directed towards thinking about reproduction." The same feelings resided for women regarding clinics held for vaccinations that are routinely administered during pregnancy. Tetanus toxoid vaccines are given during pregnancy to ensure healthy in-vitro development of the baby. She told me that she knows many women who "refuse to come to the hospital for these clinics.... I don't know how many percent of women do not attend clinics, but I know that many of them choose not to come."

Seeking traditional medicine is prevalent anywhere in Tanzania, urban or rural. Dr. Zalika believes that it is more pronounced in rural areas, as biomedical healthcare workers aren't particularly close to the community, both in physical and social distance. She told me that chronically ill patients tend to seek traditional care more; it's easy to feel trapped with a non-communicable disease and more dignity is maintained by seeing a person you know well rather than constantly going to a dilapidated clinic. In their eyes, there's nothing to lose because what

they have is not curable according to biomedical science. In both urban and rural areas, patients don't feel a sense of respect. Not only is the medicine practiced in English, there is no time for healthcare providers to explain procedures and diagnoses thoroughly because they are too busy. This results in a power hierarchy between western healthcare providers and patients that reflects the hierarchy that existed during the colonial period. This is exacerbated with NGOs and foreign governments participating in healthcare development, something that will be discussed in the next chapter.

Chapter Four- A Charitable Impulse: Foreign Healthcare Workers in Dar es Salaam

It is nearly impossible to walk through the grounds of the Muhimbili National Hospital without noticing signs that point to the plethora of foreign involvement in the hospital's operations. Posters plastered on the walls of the emergency department advertise rotations that UK healthcare providers do in the department, while a plaque near the entrance of the cardiac institute gives thanks to the Chinese government who facilitated the construction. A flag of the European Union is painted onto the sign of the pediatric oncology ward, while a large billboard highlights new ultrasound equipment in the maternity ward that originated from South Korea.

Foreign involvement plays a salient role in Tanzania's healthcare system, whether through the supply of human, physical, or liquid capital. The palpable presence of both foreign governments and non-governmental organizations (NGOs) alike exert tremendous influences on the constructed experiences of care for many Tanzanians, as it is nearly impossible to seek western biomedical care within its borders without having their care influenced in one way or another by a foreign entity. Biomedicine's role in shaping subjectivity for modern Tanzanians in the clinic is a result of its intimate relation with both colonial expansion and postcolonial development, leading all the way into the present (Langwick 2010). It's difficult for Tanzanians not to be interpolated into some form of technoscience when they seek treatment for their maladies as a result of the historical processes that delineated development.

In the 1960s, the newly independent Tanzania had a vision of transforming its society from an under-developed to an industrialized one by improving the socio-economic conditions through socialist policies that attempted to guarantee social service delivery that would increase indices of human development. The nation's leaders, starting with the first president, Julius Nyerere, wanted to implement effective development while also distancing themselves from

colonial-era policies. It was quickly realized that continuing with the capitalist economic system governed by market economy that prevailed during colonial times would continue high levels of inequity; the government embraced a socio-political ideology of African socialism coined 'Ujamaa,' a Kiswahili word that translates to 'extended family' (Mandalu et al. 2017).

Tanzania's collective political-economic management model failed to survive in an increasingly neo-liberal world. A laundry list of economic challenges that began in the 1970s into the 1980s, such as oil crises, the collapse of exports in coffee, a lack of foreign direct investment, natural disasters, and the onset of the war with Uganda in 1978 created conditions that the state was unable to address (Mandalu et al. 2017). By the mid 1980s, it was clear that Ujamaa had failed to address Tanzania's postcolonial development ambitions. Turning to multinational financial bodies such as the World Bank and the International Monetary Fund, Tanzania transitioned to a market economy, causing foreign entities to rush in, in exchange for much needed structural adjustment loans to address its development challenges.

NGOs and aid branches of foreign governments became heavily involved in development and poverty alleviation. In many ways, foreign NGOs became surrogates of the Tanzanian government: they were able to step in with the many ways that Ujamaa failed, and thus the state allowed them to operate in order to advance their development goals (Jennings 2007). It's important to note that postcolonial theorists often had and continue to have negative views on foreign entities facilitating. They often quote Franz Fanon, believing that the presence of the white man in neo-liberal development has elements that are inseparable with colonial-era sentiments: that the "white man projects all that is bad on to the black person, according to Fanon, but his gaze annihilates that person, turning her or him into nothingness" (Vaughan 1991). In the ways in which missionary organizations were some of the first groups critiqued

post-independence, as they acted as NGOs during the colonial period, the rise of NGOs and foreign governments in Tanzania facilitating their development programs sparked similar sentiments of concern.

An important claim that is often made by foreign agencies is that their assistance is initiated by desires that are genuinely selfless. Such assistance in Tanzanian development may and often have underlying conditions attached (Jennings 2007). Groups enter with agendas that are based on their own objectives, agendas that are often misaligned with realities on the ground. This is especially true for academic partnerships from the global north with Tanzanian institutions. A partnership initiated by the UK Medical Research Council and the London School of Hygiene and Tropical Medicine helped construct a new laboratory at the National Institute of Medical Research site in Mwanza, which now handles HIV/AIDS clinical trials that the British institutions largely take credit for (Graboyes 2014). Research universities and medical schools worldwide interested in ‘global health’ establish partnerships that can give their students and faculty rotation experiences to work in ‘resource-poor’ settings, pointing to a juggernaut of global health programs engendering a twenty-first century “academic scramble for Africa” (Graboyes 2014).

These trends have tremendous impacts on the subjectivities of Tanzanian patients. The sentiments that foreign healthcare workers have when arriving in the country to work with a foreign-based health development organization strongly mirror the same sentiments that lured doctors to join the Colonial Medical Service. As the previous chapters have shown, the newly independent Tanzania viscerally rejected many notions of their colonial past, a reaction that shapes the robust sense of identity in the country today. These idealistic actions were to a large extent only discursive, as in practice many colonial institutions and norms carried over. These

notions are in direct opposition to the influx of foreign healthcare workers seeking to learn from a 'poor' setting and ameliorate what they view of as suffering. Didier Fassin (2011) writes on how this humanitarian reason arises: foreign healthcare workers see suffering in Tanzania as a political issue that they need engage with on a personal basis. Foreign NGOs and governments see Tanzanians as victims of structural violence with their efforts championing the cause to uplift them. Tanzanian patients therefore "also become political subjects" in a situation where foreign healthcare providers wish to bear witness to (Fassin 2011, 222).

In addition to the ideological clashes between the motivations of foreign healthcare workers and post-colonial Tanzanian politics, the presence of outside medical practitioners as a result of neo-liberal policies also brings in western biomedicine, another aspect of healing intimately linked with colonial rule. Foreign doctors are adamant in their own healing agendas. Mary-Jo Delvicio Good (1993) describes the difficulty in avoiding convictions that each individual's own system of knowledge reflects the natural order. In the eyes of foreign entities who engage in healthcare development, western biomedicine is a progressive system that has emerged through the "cumulative results of experimental efforts, and that our own biological categories are natural and 'descriptive' rather than essentially cultural and 'classificatory'" (Good 1993, 3). Therefore, when a collective trauma from Tanzania's colonial history drives many away from western biomedicine, outsiders frequently view this a cultural sickness, endemic to Tanzanians, blocking them from accepting biomedicine to increase the percentages that describe the nation's health outcomes.

Mary-Jo Good (2007) describes how in the western world, the continuous lauding of biomedicine and biotechnology in medical practice and education envelops the entire society in a 'biotechnical embrace.' The conceptualized dimensions in the imagination of a healthcare

worker trained in western biomedicine can foster convictions that a biomedical approach is the only means by which healing can occur. Thus, the cultural resistance that many Tanzanians have is seen as a pathological. As Sarah Willen and Ken Vickery write, culture is a “barrier to be overcome if optimal care is to be provided” (2011, 38). David Bendix’s ethnography following German healthcare providers in Tanzania indicated German doctors who “raised the point of possible incompatibilities of Western and Tanzanian medical paradigm” considering “giving up the transfer of health knowledge to Tanzanian hospitals but not considering alternative paradigms or ways of teaching health care” (2016). My experience interacting with foreign healthcare workers and understanding their motivations and thoughts illustrated a similar ‘us’ versus ‘them’ mentality.

The parallels that I drew between the colonial medical service and the influx of foreign bodies interested in healthcare in Tanzania as a result of neoliberal reforms sparked my interest. Factors from Tanzania’s history and present that contribute to the construction of subjectivities for Tanzanians need to be examined. Doctors and nurses from abroad who practice in Tanzania share similar sentiments that were common amongst western medical practitioners in the Colonial Medical Service. The modern-day medical environment in Tanzania clashes with post-colonial politics that revolve around the quotidian lives of Tanzanians. Medicine, as a result of its integral part of the colonial political agenda and the neoliberal development outcomes, serves as a case that provides a unique lens through which to explore whether colonial power is alive in contemporary development.

At the Muhimbili National Hospital, the pediatric oncology ward is a hallmark example of how NGOs take control of healthcare interventions in resource-poor areas. Funded by Rotary International and sponsored by a Rotary Club in Dublin, Ireland, the clinic began in 2007.

Founded by an Irish pediatric oncologist whose first foray into the Tanzanian healthcare system was through an academic visit as a part of their master's program, the clinic has since expanded to the largest and only center exclusively addressing childhood cancer in Tanzania. Located in the upper levels of the pediatric building, the ward now features 23 beds with functional CT/MRI facilities and a 24-hour laboratory. Furthermore, their work is sustained by teams of healthcare workers from Europe and the United States. Teaching hospitals in the West regularly send their students there on clinical rotations and professional staff on visiting clinical teams.

During my six months in Tanzania, I became good friends with two Irish doctors who were completing internships in pediatric oncology. Dar es Salaam's expats and short-stay foreigners often share similar social circles, and after several instances of crossing paths, they expressed interest in the fieldwork that I was conducting. Open to sharing their experiences, they invited me to observe their work in the pediatric oncology ward several times a week, where I learned more about them, their experiences, and the overall interaction between patients and providers in the ward.

Andrea, one of the physicians, has already been qualified as a physician for over 7 years in Ireland. After attending medical school in Dublin and completing her certification in adult medicine for three years, she decided to switch paths and give pediatrics a try. During the course of her pediatric training, she received an opportunity with her teaching hospital to come Tanzania and worked a month-long rotation at the pediatric oncology ward at Muhimbili. After working in pediatrics in Ireland for the past two years, Andrea decided to come back to Tanzania, feeling that, with her experience in oncological care in both places, she would be able to contribute to the furthering of childhood cancer care in Tanzania with her skillset.

There was a shared notion between Andrea and Lucy, her counterpart, that they both arrived in Tanzania with unique expertise to contribute to the pediatric oncology ward. David Bendix's time with German healthcare workers in Tanzania showed him that many of them believed that many Tanzanian healthcare workers "were unable to implement their acquired knowledge in practice and were merely capable of mechanically reproducing what they had learned by heart" (2016). In many ways, Bendix writes that "biomedically trained Tanzanian health personnel are depicted in a similar manner as were 'native midwives' during colonization: lacking skills and knowledge" (2016). Similarly, Andrea once told me that "Westerners are associated with the better care and the locals are associated with the lower quality care." Furthermore, when I asked about how she believed the patients in the ward perceived her, she said:

In our ward you can see that they recognize that we westerners are putting in an effort to make things better. It's clear that the type of work that they were doing before we got here is slow, definitely not something that we would deem as acceptable in a western context. The parents are always asking for translators to come up to us and say, 'thank you so much for helping our child,' or 'thanks for your work,' so I suppose to a large extent they associate us with positive outcomes.

I found parallels between in Andrea with the Germans that Bendix interacted with, where they believed that their presence in the clinic was invaluable compared to Tanzanians who worked there. Andrea thought that the Tanzanian providers were inherently unable in forming a human connection with their patients, adding that:

Very few of the Tanzanian doctors would actually be treated at Muhimbili since it's so poor. They don't meet their peers in the ward, instead they meet people who are poorer with lower education, so it's difficult for them to connect. It's hard enough back in Ireland where many of the parents only have a 3rd level education, but here the parents can't read or write; they come from abject poverty.

Andrea perceive that socio-economic divides and inefficiency resulted in a culture that branded Tanzanian healthcare providers as incapable of connecting with their patients. They weren't

effective in any of the work that they were doing; therefore, the clinic relied on foreign workers to ensure that any cancer care at all could be distributed throughout the country.

Lucy, who had a more restrained temperament compared to Andrea, still shared similar feelings when we talked about the subject in a separate instance:

It's very difficult because clearly no parents would ask to translate that they prefer to see us over local doctors in Swahili, but they make a particular effort to thank us through someone else, or they would ask specifically for us to go look at something, I think because they understand that we are here in some sort of knowledge capacity and they can see our active frustration at times with the pace and not being at the level that we expect to see at home, things not being done at the pace that they should be.

When I asked Lucy why the work in the ward was so slow-paced, she had a strikingly different opinion compared to me:

That's not resource led. That's a cultural issue. It's not something that they understand or incorporate... The Tanzanian doctors don't know how efficient things could be, so they don't know how to change that... the misuse of resources that drives us the most bananas. You know, if things were done in a timely fashion, lots of the things could be done so much better.

My experiences with the slow pace that often comes with care in Tanzania were correlated with resource-related issues. Shortages in crucial medical supplies or being understaffed led to many of the challenges that manifested with my time in both the emergency department and the maternity ward, as both a participant and an observer. The pace of a workplace setting is also a deeply cultural matter, where actions such as engaging in extensive greetings and sitting down for tea are deep parts of Tanzanian society. In many ways, this could be better than the fast pace of the western workplace, especially in the clinic.

For Andrea and Lucy, their adherence to biomedical technology and their western training within it superseded the medical knowledge that Tanzanians had. This wasn't a belief that they wore on a sleeve, but rather something that emerged after I had interacted with them over a period of several weeks. Andrea recounted the differences in the ward today compared to

four years ago when she first did a short rotation in Tanzania. Without an effective network of oncological care across the country, children with cancerous symptoms were presented to ‘witch doctors’ and received ‘potions,’ making the children more unwell:

Since I was here four years ago, the Rotary clinic has started this education program for doctors in other health centers around the country to start delivering rudimentary cancer care. Before, witch medicine was just as good as western medicine—they all die anyways—so might as well get treated by witch doctors. It was probably cheaper, maybe less invasive, and less painful. At least they could die at home instead of at an impoverished clinic.

She felt that all children with cancer could receive the care that they need at Muhimbili, but due to the distance that many people live from the hospital, she understands the need for these satellite clinics to exist to ensure that at least some level of care can be accessed everywhere.

Lucy and Andrea both agreed that one of the largest obstacles in maintain these satellite facilities were the cultural challenges that the healthcare providers at each local clinic posed.

Apart from their perceived incompetency embedded in the culture of Tanzanian healthcare providers, another source of constant frustration in their quotidian work was the high incidence of families who did not wish to adhere to the time-demanding nature of oncological care. Many families, after checking into the department, pull their children out in search of alternative healing methods when they realize just how invasive cancer care is. Laura told me of a case where a mother withdrew her son:

She was really questioning his treatment a lot for a day or two before they left... he was 12 years old and hadn’t been diagnosed yet but was showing signs that was indicative of leukemia. We administered IV fluids, which was something that she was clearly worried about. The protocol for when we think children have leukemia is to get them lots of IV fluids. She was really worried about this, thinking that it was getting to be too much. There was a moment when she wanted to take him out of the ward to go pray, but we were discouraging her to do that, but she eventually decided to self-discharge him and I think she is taking him to go and see a traditional healer.

Certain aspects of biomedicine form a collective hauntology in Tanzanian society. Even when care is administered by a black, Kiswahili-speaking doctor with the stethoscope and white coat, the fact that biomedicine is predominantly practiced in English puts many patients and their families in a state of unease.

Whenever the two Irish doctors told me each day's stories of self-discharged patients, I always asked them their views on the efficacy of traditional or folk medicine, forms of healing that have existed in Tanzanian communities for generations, long before any contact with white people. They didn't believe in any measurable efficacy; their methods of making sense of why people sought other forms of healing had to do with their belief that effective biomedical care only began to exist in Tanzania as foreign organizations began taking control of healthcare development. Andrea once explained this to me:

Only 12 years ago they all died with witch medicine or with western doctors, so from that recent history you can understand that there's a view in a culture like Tanzania that western medicine is ineffective. This hugely benefits the business witch doctors... we heard a really interesting story from a hematologist from the UK who worked here, where a woman with AML, which is really serious leukemia, survived for a year with some potion that some witch doctor gave her before being referred to Muhimbili. I think that's absolutely insane, and the hematologist is still trying to understand what exactly was given to her, whether it was something therapeutic. Clearly it was something because she was supposed to be dead in weeks but was still alive a year later with this potion.

In her eyes, this history made sense of her experience in the clinic where she noticed that patients preferred her services over her local peers. She believed that because of the poverty that existed in Tanzania before neoliberal policies were enacted, western biomedicine that was being practiced by local practitioners were perceived to be incapable of any real effect. Since she mostly saw patients specifically requesting her and the other Irish doctors, she believed that Tanzanians saw the effective care coming from those with white skin and foreign degrees.

Dr. Nyah, the Tanzanian OB/GYN, gave a slightly different observation based on her time with more conservative Muslim patients while practicing in Zanzibar.

Zanzibar has collaborations from many countries. We had consultants from China in my department, and we were collaborating with a hospital in the Netherlands, where both places sent specialists and students. Most people will trust these specialists, but I have also seen that some patients are hesitant to be taken care of by them. There are people who mistrust by people who come from the outside, thinking that they just want to do experiments on them. I think a lot of it comes from the miscommunication, as medicine is practiced in English. The patients and specialists won't understand each other. I will say that in our department, the care that we give to Tanzanians is different from the care that a foreigner might give. We will give comfort and most patients would prefer to see us, since we speak their language. Therefore, I think most of the time it is because of the communication.

Her experiences indicated that while the fear of biomedical experimentation was a factor, the communication barrier between English-speaking providers and Kiswahili-speaking patients was the dominant reason that she observed patients preferring Tanzanian healthcare providers. As she further elaborated, she told me that medicine practiced in English is disrespectful to locals, citing a decreasing number of Tanzanians donating blood due to their qualms with the healthcare environment of the country.

My observations and interactions indicated to me that present-day development interventions by foreign entities echo similar hierarchies that existed during the colonial period. Tanzania's relationship with foreign aid feels in many ways like a continuation of colonial-era relationship between a donor and recipient country (Biccum, 2005; Slater and Bell, 2002). The sheer size of the foreign government and NGO presence at the Muhimbili National Hospital and the attitudes shared among foreign healthcare workers support the assumption that colonialism and neoliberalism have placed the foundations that make up contemporary healthcare development in Tanzania.

Doctors and nurses who travel from the Global North to Tanzania are faced with resource-based challenges linked with poverty that are attributable, in many ways, to colonialism and neoliberalism. These clinicians arrive with a genuine desire to help in all the ways that their training allows, but the frustration of working in conditions that hardly exist in their home countries manifests in pointed ways. My time in other parts of Muhimbili with Tanzanian healthcare providers showed me that they realized the nuances in the care that they provided due to the challenges that manifest from poverty and colonial history. I found that local providers had adapted to these difficulties and yielded when they knew that there were factors beyond their control when it came to the decisions that their patients made in terms of what kind of care they wanted to get.

Foreign providers like Andrea and Laura step off the plane in Dar es Salaam hoping to apply their skills in a low-resource setting. In the stints that last between one and six months, these providers truly believe that their skillset and knowledge base from practicing in the global north will allow them to alleviate the inequities that exist in Tanzania as a result of colonialism and globalization. Frustrations that they meet in the clinic allow channels for their implicit biases that mirror the racist ideations that the colonial health service harbored, exacerbated through discourses of development and resource deficits. Colonial-era ideas seem to have come back into play as a result of structural adjustment, when Tanzania once again became tied to the west. Muhimbili National Hospital's phenotype of this phenomenon is a medical campus dotted with short-term foreign healthcare workers and continued foreign support that strengthens the dichotomy between western biomedicine and local forms of healing in Tanzania.

Chapter Five- Structural Violence and Low Resources: The Quest for Dignity in Care

The weather is unpredictable in Dar es Salaam. A sunny day can disappear quickly as strong winds from the Indian Ocean blow in a dauntingly gray storm front. Starting with only a few droplets, the clouds quickly transition to producing a torrential downpour that halts nearly all activity in the largest city in East Africa. Dar es Salaam's sewage and drainage infrastructure is ill-equipped for frequent storms such as these. Potholes and uneven portions in the road and sidewalk begin as puddles and flood over, immobilizing both pedestrians and vehicles.

One day a week consisted of my maternity ward shadowing. On this particular day, I was looking forward to going home as I was sleep deprived from unsuccessfully combatting a mosquito in my net the night before. As I was saying goodbye to the staff in the unit, a storm front blew in and the rain began to fall. With no option but to wait out the precipitation, I sat down in a corner of the ward in a chair and tried to doze off in my tiredness. A few minutes into my nap, I was awoken by shouting from one of the nurses calling for the attending. One of the expecting mothers began to have trouble breathing. She was struggling from pulmonary edema, a complication of her pregnancy. Fluid was quickly accumulating in her lung tissue; an immediate tracheal intubation, a process where a tube is inserted into the airway to allow for mechanical respiration, was needed to prevent airway compromise.

All of a sudden, I was pulled into the commotion. The attending physicians and nurses were all busy trying to keep the patient alert, leaving me as the only free person to grab the materials needed for them to perform the on-the-spot surgical procedure. In a well-supplied hospital in the Global North, the scalpel, sterile kit, and other tools needed to perform a cricothyrotomy are available at each bed station. At the maternity ward in Muhimbili, however, these tools are constantly in limited supply. In a frantic scavenge, I went around the ward,

through rooms and up and down stairs, asking around and shuffling through drawers for the needed supplies. I felt the pressure of the woman's life weighing on me. Every second mattered, but I felt as if I was taking forever. Nearly each station I stopped by was out of what was needed for the surgery.

Finally, with everything in hand, I sprinted back. As the attendings began the procedure, I stood in the background. I felt shell-shocked, in a daze as I stared blankly onwards. At this point, the rain was pounding on the corrugated-metal roof of the ward, creating a noise so loud that each of us had to scream over in order to be understood. Thunder cracked in the distance. The two other patients sharing the room stare at us. Inserting breathing tubes into the trachea is an incredibly challenging procedure, especially when urgency is factored in. My nerves manifested in beads of sweat on my forehead, attracting the flies that were buzzing around the room.

Just outside the room, the woman's family peered inside. They looked at us helplessly, wincing each time beds and equipment clanked into each other due to the crowdedness. The surreal experience ends when the procedure is declared successful. The woman's breathing stabilizes. A nurse made a sigh of relief and chuckled.

"If treatment fails, give the patient a hug," he said. "If the hug fails, then give them konyagi (a local hard alcohol)."

Still in shock from witnessing the ordeal, I don't think that I gave her the reaction that he was hoping for when she told that joke.

At Muhimbili, personnel and resource shortages place heavy stress on healthcare workers. The fact that medicine is practiced in English and that doctors and nurses don't have time to explain procedures and diagnoses removes patients and their families from the care that they receive. Every day is a battle for dignity in the care that healthcare providers give and

patients and their families seek. Kleinman (1978) writes that the social science researchers must relate political and economic oppression with the short cycle of illness. Struggling, coping, and resisting form the complex mix of deeply human practices that may present as a Marxist melodrama where characters exaggerate their reactions to economic and political pressures, but actually are rational choices. In order to understand the subjectivities of Tanzanian patients, health, illness, and healthcare need to be understood in relation to each other within the socio-cultural context that they live in.

Illness subjectivity for Tanzanians is constructed on how patients and their families experience healing processes. Siena Craig writes on how “the therapeutic process encompasses much more than a one-off interaction between doctor and patient; rather it is inclusive of micropolitics, affect, and the structures, at once the socioeconomic and political that define a therapeutic system” (2012, 4). The understanding of healing processes in Tanzania is a result of historical and ongoing factors that have socio-political and interpersonal ramifications. The structural violence that results from poverty, the presence of foreign players in the healthcare field, and a shared trauma of colonial violence are just some of the pieces that collectively build the therapeutic process. Tanzanians navigate these scenarios to find dignity and humanity in their care. As a whole, people’s choices and individual experiences with healthcare are shaped by the social forces around them.

The World Health Organization estimates that 80 percent of Africans south of the Sahara have sought out traditional medicine for their health needs (Mhame et al. 2010). Tanzanians often seek help from biomedicine and local medicine simultaneously and alternatively (Whyte 1991; Ngoma et al. 2003). Resource constraints makes it such that biomedicine constructs illness as the object of therapeutic work without legitimizing suffering; providers simply do not have the

time to connect with patients besides surface-level treatment (Kleinman 1995). On a more pragmatic note, Gammelín's ethnographic research in Tanzania notes that, while biomedical healthcare is accessible to most people in theory, it's not affordable to all (2018). The healthcare that people pay for in the biomedical clinic is care that is in many ways removed from the patient, due to the language barrier. From the perspective of people that I interacted with during my time in the country, many prefer to access someone who is in their neighborhood rather than a biomedical clinic if the cost is the same. The cost of health services has been on the rise since the introduction of structural adjustment policies as the state budget for public health care has shrunk. Structural adjustment policies made the majority turn to the informal sector for their survival as free healthcare ceased to exist (Jennings 2008). The replacement healthcare system followed a business model, engendering ideas in many African countries that

“Westerners are interested in money and are willing to get it at the expense of Africans. Many are convinced that a cure for AIDS has already been discovered in Europe or America but that the West has no interest in releasing it because there is too much money to be made in the sale of drugs and condoms and in international health programs” (Falen 2018, 71).

Upon first glance, traditional healers seem hidden in society, but walk enough times down the same street, advertisements for individuals practicing in their home become obvious. *Waganga* is the broad term that describes local, non-western healers. Including Muslim sheiks, Koran teachers, Pentecostal prophets, herbalists, itinerant witchcraft eradicators, shrine keepers, street sellers, traditional circumcisers and midwives, they sell their services in the style of a small business (Swantz 1990, 11). They are not cavalier practitioners: it is important to note that they all receive some sort of training, whether through lineage or mentorship or organized schools. In cities and villages, *waganga* put in efforts to product-differentiate from western clinics, relying mostly on a local and consistent clientele, offering personalized medicine for those who come in.

Some, however, are extremely well known and have patients who travel from all over the country to seek their services, in the same way that people travel long distances to seek care at Muhimbili.

There are unique elements in traditional and folk healing, such as more intimate exchanges, local relationships, and healing that aligns with local cosmologies. Patients easily feel immediately at home with the *mganga*. There are no invasive procedures such as injections or attempts to ask patients to remove articles of clothing for medical examinations. There is none of the strangeness that they encounter when going to the hospital or clinic. Some of these characteristics are inherently unique to the type of healing that *waganga* practice, such as the alignment with local cosmologies and lack of invasive procedures, but other characteristics such as more intimate exchanges and local relationships don't exist in many instances of western biomedicine as a result of language barriers and resource constraints. While traditional and folk systems are less technical, Kleinman (1995) describes them as more advanced in humanity. The efficacy of healing and therapeutic processes lies at the “intersection of ritual action and pharmacology,” and I would argue that a preference to seek traditional and folk care is an attempt for Tanzanians to seek dignity in their care (Craig 2012, 144).

It is interesting to note that those who are religious, regardless of Christianity or Islam, are more likely to exhibit the ‘health nomad’ behavior, going out of their way to seek the best traditional or folk healer possible. Although prevalent amongst all people, those who have stronger faith are more likely to travel around their communities and around the country to seek care with “traditional and neo-traditional healers, and a multitude of churches—in order to find healing and relief from their afflictions... after many had already tried biomedical health-care or traditional healers” (Gammel 2018). Literature written about African Christianity suggests that

Pentecostalism in particular may be a significant reason for the persistence and proliferation of witchcraft discourses (Newell 2007). Christianity is a western import that arrived in Tanzania as a result of colonialism, and postcolonial thinkers frequently critique the missions as institutions. Upon first glance, it seems counterintuitive that those who are more religious tend to avoid western medicine.

Christianity and Islam are practiced in ways that are Tanzanian. The process of syncretism between Christianity and traditional African religions were accepted by many missionaries because they saw it as a way to gain rapport with locals in order to convert more people. Colorful clothing, traditional performing arts, and traditional spirits have been co-opted into Tanzanian Christianity and Islam. Despite being foreign imports, the spirituality in organized religion is nearly ubiquitous with the spirituality that is expressed and valued in traditional and folk healing, pushing religious individuals to prefer care in a non-biomedical setting. Dr. Zalika told me her experience with patients who harbored especially conservative Islamic beliefs while practicing in Zanzibar:

“Zanzibar is a small place where the people are very religious. And they rely on God more than medicine. And even if you have death, they will say that everything is written. They wouldn’t say that the doctor did a bad job, they would just say that it was the plan of God. Sometimes very religious people don’t believe that their problem is a medical thing—you might see someone with an eclampsia that has convulsed, but they would not understand that this is from pregnancy and can be cured. They wouldn’t understand. Instead they would say that because it has something to do with evil.”

In rural northwestern Tanzania, between Arusha and Mwanza, my conversations frequently started with questions on my origins and reason for being in the country. Even in the most remote parts of the country, people know of Muhimbili. It stands large as the nation’s largest and only full-scale hospital and health sciences research institution, but its place in the imaginations of many Tanzanians is incredibly distant. Even though people were aware of my

status as only a student, even a mere mention of my ties with Muhimbili seemed to put a pedestal under me. Traveling the distance to Dar es Salaam to seek medical care seemed like an incredibly daunting task, reserved only for the worst care scenarios. “Even our local clinic is chaotic, hard to reach, full of bureaucracy, expensive, and low on supplies” one woman told me, “why would I want to go all the way to Dar es Salaam, where I have no family and friends?” She finished her thoughts with a brief apology to me for bashing western biomedicine, as she believed that it is something invented by westerners.

Poverty and resource and personnel constraints do manifest in modes of structural violence for Tanzanian patients, but doctors and nurses who work in biomedical settings are not complacent. Despite all of the challenges that are in place to allow effective and more humanistic delivery of biomedicine, local healthcare providers do the best with the constraints that they have. I was reminded of this every day in my time with Dr. Zuri, a neonatologist at Muhimbili who consistently went above and beyond. It was a typical day at the maternity block of the hospital as I entered. Women in colorful clothing wait at the door to enter the reception area; there are too many people for everyone to comfortably fit inside. Based on my emergency ward experience, it takes at least a whole day to just get your foot in the door, so families are camped out near the building, with luggage and food sprawled out on colorful *kitenge* blankets.

Walking up the three flights of stairs to the neonatal unit, I pass a mother and father heading down the stairs, smiling and carrying their newly discharged baby. In the unit, there are mostly mothers and very few fathers. The only men who are present seem to be healthcare workers. Despite the visible socioeconomic divide between the patients and providers, which I discern by looking at the types of cell phones each person is using, the healthcare workers do

their best to engage with the patients in humorous ways. Dr. Zuri spotted me from across the room and smiled, beckoning me over to observe the case that she was working on.

“The patients that we receive are mostly poor patients. Most of them have a very low education level. And only up to 15% have an education level where they actually know what kinds of questions to ask about their treatment. We try our hardest, and I think that most of them believe that doctors do the right thing regardless. And if they see someone die, they think that it is God’s wish and there is no blame on the doctor. Once we explain things to them in Kiswahili, they believe that doctors are doing their best. We are trying our hardest, but because we have so many patients, we can’t spend more than 10 minutes with each patient. We usually give the diagnosis and tell them which department to go to next. Despite these challenges, we get more praise than questions from the patients. The families will just come and thank you, but you feel bad because you know that you didn’t have enough time to truly explain things to them.”

Dr. Zuri understands the resource constraints that make it so that there are few instances of extensive patient involvement in their cases. She feels a sense of personal regret that most prognoses result in patients and their family members accepting what the healthcare workers tells them to do, even if they are hesitant or unsure, solely because it is an authority figure who relays the suggestion.

This indicated that healthcare workers in Tanzania are in no way apathetic or removed from their work. Armed with biomedical training and the best intentions, they boldly face the challenges in the healthcare environment that are shaped by colonialism, globalization, and neoliberalism. Doctors are often some of the first people who will offer personal financial support in dire situations. Dr. Zuri told me of several cases where patients were unable to pay from the few daily dollars that comprise their family income.

“As a national hospital, we are handing a lot of rural patients who are coming from far away and are staying a long time here. Most of them they don’t have money to pay... no insurance. And the hospital does the best that it can to not put any pressure on people. If the babies are born premature in a critical situation, they will be in the ward for a long time. Many months, maybe two, three, four, and they usually don’t have the money to pay, so usually the hospital tries to help them to pay the bills. On rare occasions, some of the doctors will step in, but we try not to do this too often as we know that this is an

unsustainable practice. I think that the hospital is trying to do a really good job, the doctors, nurses, attendants, everyone, all of them are putting their best foot forward.”

An interesting observation that struck me after several visits in various departments at Muhimbili is that there is not much of a visible hierarchy compared to a western clinic. From my experience in hospitals in the United States, there are surefire signs that distinguish attendings with residents, and nurses with advanced degrees from other nurses. I asked Dr. Zuri about this, and she described the phenomenon as a global effort by healthcare workers at Muhimbili to make patients more comfortable. If patients perceive equality and camaraderie among the providers, they are likely to seek equality and camaraderie amongst themselves.

“I receive mothers who have had babies born not in time as patients. It is challenging because many premature babies need to stay here for a long time in order to develop properly and, for example, breastfeed. It takes time to feel comfortable here. Most of the problems that we see are physical, such as financial and also family problems. We believe, however, that we can make an environment where some of the mothers’ emotional problems go away, such as fear and mistrust. If the mother gives birth to a baby with a congenital deformity, it is a hard reality to accept, so we need to counsel them and let them know that we can take care of that as a team. If they see that us doctors and nurses are working as a team and enjoy each other’s company, they will see other patients that are going through the same hardship as potential teammates. That gives them the motivation to let them know that they can, so then they are able to proceed. They give each other hope.”

Healthcare providers would universally agree that spending more time with the patient allows for deeper connections with them. The long-term interactions that I saw in neonatology shared characteristics with the long-term interactions that traditional and folk healers make with their patients in their communities. Sickness unveils vulnerabilities, and it’s ultimately trust that builds a meaningful connection with patients and providers.

Fostering trust in a Tanzanian biomedical clinic is met with its quotidian challenges. Dr. Zuri got emotional when she described these challenges to me.

I want to comment on our care here in this country. The doctor to patient ratio is not ok. American doctors would not accept the ratio that we have here. The quality of care that

we give depends on the number patients that we have and how busy we are. We are busy almost all the time, so often we don't expect the care to be good. The experience is so different between Muhimbili private clinics that cost a lot of money. Because of distance and because of poverty, often we have patients who are in the ward who have come from far places with no relatives. They have no family or friends here in Dar es Salaam to help out. Sometimes the patient has already been treated but cannot be discharged because she has to wait for money to come from her family from far away. These are just some of the challenges that we have here. I don't know how we will really solve them. I really don't know how things can change here. But we will always try our best. We will try our best to explain things to the parents. Before you do anything, you must first explain, and you ask permission before doing any kind of procedure. It is nice when you are seeing them for a long period of time because then can see that they are transforming under your care.

Seeing her visceral reaction to the reality around showed me that had immense empathy for the challenges that her patients face.

Patients and healthcare workers in Tanzania are both in a constant search for dignity in their receiving and providing of care. There is no ignorance or cognitive dissonance in either party regarding the structural challenges that form inequities in health delivery and health outcomes. Intentionality defined the actions of each person that I interacted with throughout the country that I interacted with, both in and out of the clinic, an intentionality that manifests from courage and hope in the face of daunting challenges.

Chapter Six- Soliwe's Story

The last chapter of this thesis deals with one incredibly strong woman's journey through a multiplicity of hardships. Soliwe's journey from the village to the city embodies the factors that build up subjectivities for Tanzanian patients. Her experience was built off of the country's colonial and post-colonial socio-political and cultural impacts and the medical pluralism that so clearly defines healthcare in contemporary Tanzania. Her story was a salient and hallowing example of the inequities that exist in healthcare and health outcomes all around the world, especially concerning the quality of life for women of color.

My path crossed with Soliwe after her fourth attempt at giving birth. She had already undergone one miscarriage and two life-saving abortions that arose from pregnancy complications. When I first met her, maternity ward nurses had just notified her of an unfortunate complication after she awoke from the anesthesia following an emergency caesarian. I was following Dr. Nyah on a routine weekly shadowing that I did with her through the maternity unit when we passed by her bed. Given the plethora of foreign healthcare workers in Muhimbili, she thought that I was a doctor from abroad with a knowledge capacity distinct from Tanzanian doctors. The nurse attending to Soliwe quickly called me and Dr. Nyah back, notifying me that she wanted to speak with me.

Soliwe didn't seem too disappointed when Dr. Nyah told her that I was still a student. That is to say, it didn't seem to impact her willingness to share her story with me. Listening to Soliwe's recount her journey to Muhimbili is an illness narrative that was a salient representation of all that I had learned in Tanzania, a sentiment that only grows stronger with each moment of reflection. Major details about Soliwe, such as but not limited to her geographical origins, are changed in my recounting of her life. I do believe, however, that the essence of her personal

strength and perseverance in the face of challenging social odds are still present in this recounting. Dr. Nyah and her colleagues see patients like Soliwe each and every day. As such, her reaction was much more tempered compared to mine when we sat down to learn of Soliwe's life. I hope that I can honor to her story in a way that also honors the myriad of Tanzanian patients who endure until hell freezes over.

Soliwe's mother was born in a village on the shores of Lake Victoria in Uganda, what was then a protectorate colony of Great Britain. Her grandparents were subsistence farmers and fishermen. Given their agricultural skills, they were offered to work on a large plantation in the Tanganyika Territory that was owned and managed by a large agricultural company based in London. This offer was quickly accepted by Soliwe's grandparents as they were eager to find ways to exit their subsistence-based lifestyle. Their departure was both physically and politically simple as they only had a small amount of possessions and both areas were under British control. With Soliwe's mother in hand, they joined hordes of other workers who migrated from subsistence lifestyles to contribute to the broader global market.

Recounting her mother's experience, Soliwe told me of a lifestyle that depended on company housing, food rations, and healthcare. In the day, while her mother's parents worked on the agricultural jobs that were assigned to them by the company, she attended a school that was run by a missionary group that the agricultural company virtually contracted educational operations to for the children of their workers. While all of the workers attended church as a way to network and interact with the community, it was in the missionary school where Soliwe's mother more seriously adopted Christianity in stronger ways than her parents had.

Tanzania became an independent state when Soliwe's mother was a teenager. Along with many industrial agricultural workers, her family was relocated to an Ujamaa village that focused

around agriculture. It was in this village where Soliwe's parents met, and where Soliwe was born. While her parents both spoke languages that originate from the Tanzania-Uganda border regions, Soliwe herself grew up speaking predominantly Kiswahili, as she was educated in a state-run village school and interacted with peers who had parents from different ethnic groups originating in other parts of Tanzania, all relocated to the same agricultural village. Soliwe's language experience is similar in many ways to first-generation children of immigrants, exposed to a different language at school and in the broader world around them compared to at home.

When Soliwe was old enough to leave home, the mandated socialist policies that defined post-independence Tanzania were long abandoned for structural adjustment policies. Armed with a primary school diploma and having partially finished secondary school, she moved to Mwanza, the second largest city in the country that lies on the Tanzanian shores of Lake Victoria. In Mwanza, Soliwe found work as a domestic cleaner. She met her husband, who worked as a mechanic for imported Toyotas and Land Rovers, and commenced a relationship that, for the past twenty years, has largely been defined by the challenge of starting a family.

Soliwe's first pregnancy ended with a septic infection that resulted in a miscarriage. Two months after the joyful realization between her and her husband that she was pregnant, she fell ill. Likely caused by an *E. Coli* or Cholera infection, the microbes made their way into Soliwe's cervix. What was initially a severe bout of diarrhea became severe abdominal pain and vaginal bleeding. Remembering stories from her childhood about her grandparent's experiences with medical care provided by the plantation company and, more importantly, unable to face the high costs that her local community clinic had, she resisted through the pain at home with herbal remedies until the tissue related to her pregnancy was eventually discharged.

Soliwe and her husband's second attempt at starting a family two years later was complicated by their first attempt. Soliwe attended maternal health classes that local NGOs offered to expecting mothers and sought pregnancy advice from a myriad of other traditional and folk sources. Keeping a healthy diet and avoiding sickness, none of her efforts were able to compensate for the fact that her uterine tissue was incredibly damaged from her septic infection. When her pregnancy came to term and labor began, the weakened tissue collapsed with the pressure of her membrane rupture, resulting in obstetric fistulas. The pain was unbearable to her, so her husband carried her for hours by foot, with the occasional help of a passing vehicle heading in a similar direction, to the nearest district hospital that had surgical facilities.

Since the procedure was urgent, Soliwe and her husband did not receive much information from the hospital staff, other than that surgery was necessary to save her life, before she was put under. Unfortunately, since her water had already broken, the procedure that would fix her fistula would also require an abortion. Soliwe said that she expected to wake up from the surgery with her new child in her arms. All she received from her surgery was a deep resentment for western medicine. She was not angry at the healthcare workers, she told me, as they were doing the best that they could with their training to save her life, but instead she was angry at biomedicine for having a medically-required abortion be the only way for her life to be saved.

For the next several years, Soliwe and her husband became 'healthcare-seeking nomads.' Amongst very traditional and conservative religious groups in Tanzania, a fistula is viewed as a divine punishment for disrespectful behavior or a curse from a jealous party that prevents a woman to have a child. Whenever her and her husband found time in their work schedules, they traveled around the region seeking various traditional and folk health practitioners. Leapfrogging from one healer to another through word-of-mouth recommendations from both friends, family,

neighbors, and other healers, Soliwe and her husband tried various ritual practices, jewelry worn on the body, and herbal remedies to get pregnant again. For some reason, however, Soliwe told me that the herbal remedies they tried worked “like a condom” and somehow prevented her to successfully become pregnant, the opposite of what they wanted. After successive failure, they gave up.

On her last attempt to have a child before I met her, Soliwe decided to give biomedicine another try after her nomadic health-seeking did not lead her to a baby for her and her husband. Knowing her past history with compromised cervical tissue, she believed that a caesarian section would be the safest way for her to have her child. Having saved money with her husband for an entire year to pay for hospital costs, she made the two-day long journey from Western Tanzania all the way to Dar es Salaam two weeks before her due date and checked herself in as an impatient in the maternity ward. She made the entire journey alone; her husband was unable to come as it would have cost too much money for them to find him accommodations.

The staff at Muhimbili, for the week or so before her procedure, ensured that Soliwe had adequate rest and nutritional intake so that she would be healthy and optimally fit for her surgery. This time, Soliwe’s fourth child was born alive. A consistent body of evidence indicates that infants delivered by elective cesarean experience higher rates of respiratory morbidity, from abnormally rapid breathing, than infants delivered vaginally, which was the unfortunate case for Soliwe’s newborn son (Hansen et al. 2010). The surgical team was unable to locate a breathing apparatus that would allow mechanical ventilation small enough for newborns in time, resulting in his death. I met Soliwe several hours after this incident, when she was laying on her bed in the ward, recovering from both the surgery and this news.

Soliwe was completely alone in Dar es Salaam—not a single friend, family member, or distant acquaintance lived in the eastern part of the country. Her support came from the friends that she made in the ward, women who had also traveled long distances to seek care. She already notified her husband of the bad news and he was already preparing for her return in several days. The last words that she spoke to me before slowly falling asleep were words of appreciation for all of the doctors and nurses who attended to her for the two weeks that she stayed at Muhimbili. She came to realize the dedication they put into their work, despite the long hours and overwhelming number of patients. Part of me left wondering if experiences like this for women could be mitigated by having long-term education and care in communities. What if Soliwe had access to both physical and caring human resources a short distance from her home, instead of having to travel for two days to Dar es Salaam?

Care is evolving in biomedical clinics. Tanzanian healthcare providers are putting in extensive effort to understand the concerns of their community and address the socio-political and cultural barriers that exacerbate them. All around the country, community-based health initiatives are taking root that address both primary care, reproductive health, children's health, and long-term disease care. Despite the progress, an important limitation is the fact that these grassroots health projects take place in urban and town centers, where technology is easiest to implement, leaving out those who are the most rural and remote. At the DarDar pediatric HIV clinic in Dar es Salaam, I was able to see amazing adaptations and responses by Tanzanian healthcare workers take place.

The clinic is located in the industrial port area of Dar es Salaam, a part of the city that is mostly full of storage yards and warehouses filled with shipping containers that are entering and leaving as maritime exports and imports. Hidden behind a car wash and pop-up mechanic's

garage, it is not some place that is easy to find—a purposeful act to protect the identity of those with HIV/AIDS from extensive stigma when they are seen entering or exiting the medical facilities. Even the *mandazi* vendor, who sold her fresh pastries a block down from the clinic, seemed puzzled when I told her that I was doing healthcare research, not knowing of any healthcare facilities that existed around her business.

The clinic² began full operations in 2007 as a result of a partnership between Dartmouth Medical School and the Muhimbili University of Health and Allied Sciences. With a goal to provide long-term care to HIV-infected children, the clinic has taken an approach that involves children and their parents for a community-based approach. The walls of the building interiors are filled with paintings of cartoon savannah animals and Disney characters that would definitely face a copyright infringement lawsuit if it were in the United States. While the care is given by healthcare providers who are affiliated with Muhimbili and who predominantly come on a weekly basis, the vast majority of the work that maintains the integrity of a community-based approach is conducted by a boisterous group of women with captivating personalities.

They called me *kaka mdogo*, or little brother, and expected me to address them each by sister. My conversations with them revolved around daily teatime, around 11 in the morning, where they would put down their work and engage in gossip over tea. As a demonstration of their encapsulating personalities, one teatime, my friend made banana muffins for them to try for the first time. They were taken aback in horror when they realized how sweet they were.

² In 2006, the DarDar Pediatric Program (DPP) was established with funding from the Foundation for the Treatment of Children with AIDS. Housed in a site adjacent to an adult HIV care program, DPP provides specialized pediatric care to over 700 HIV-infected children and their parents/caregivers. The care providers predominantly come from Muhimbili.

“Why would you add sugar when bananas are already sweet,” they said? “you Americans are foolish people.”

Over several cups of tea consumed over various days, I learned about their day-to-day work and broad-reaching goals. Knowing that HIV/AIDS requires attentive long-term treatment, the women create and oversee programs that encourage high levels of retention amongst patients and their families. On weekly and monthly bases, the clinic holds events where the children who receive care in the clinic come in and enjoy snacks and play games or make crafts. At the same time, this time slot is also given to parents or grandparents who bring their children to the clinic to meet as a support group. A few times a year, as a special occasion, these events will take place on the beach, where barbecue grills will be rented in advance and a large party is held.

In order to ensure retention in the daily clinical activities that ensure the children’s health, admittance into these weekly and monthly events is permitted only when the guardians arrive consistently with their children to the clinic to receive treatment. The sisters hope that the fun, communal aspects of each organized event encourages and motivates people to persist with their treatments. Besides the heavy-duty logistical work that the sisters do to build a supportive community in the Dar es Salaam area for pediatric HIV/AIDS patients, they also want to ensure a seamless transition into adulthood for these children. Antiretroviral treatment is free for all people who test HIV positive in Tanzania, and an individual can live a virtually normal life if they are on treatment. As children age and transition into adult care, the sisters ensure that they are connected with resources at Muhimbili and elsewhere to continue their treatment.

While I wasn’t able to speak with any of the mothers who came to the DarDar clinic, the sisters told me that retention rates and patient numbers were increasing each year. They have heard from many that weekly and monthly events are things that both the children and adults feel

support through and look forward to. As a result of their efforts to spread awareness around their work in the wider community, network new patients into the program, encourage current patients to continue care, and transition patients into adulthood, the sisters at the DarDar clinic have created a space where providers feel connected with their patients and patients feel their concerns heard and addressed by their providers.

Healthcare workers and patients in Tanzania face seemingly insurmountable challenges in giving and accessing care. The legacies of the country's colonial past and neoliberal present manifest in socio-political, economic, and cultural challenges that make it challenging to ensure equitable care for all people. Despite these large odds, the effort that is put into making spaces such as the DarDar pediatric HIV clinic is resulting in a reinvention of biomedicine in Tanzania. Personal efforts on behalf of both patients, their families, and health workers are put in to navigate around obstacles of resource scarcity and language barriers. My time learning from people both inside and outside of the clinical space has taught me that medicine and healing are fundamentally dependent on the actions of people, supplemented in important ways with technology and training. I saw how people were unwilling to seek biomedical care and stay home due to language barriers, crowdedness, and lack of resources. I saw how people forego biomedical care for the more personalized experience with traditional and folk healers. The best-trained physician in clinical technology and practices will be utterly ineffective if they are unable to connect and empathize with their patients, an insight that I will take with me into the future as I immerse myself more deeply in the deeply intimate world of medical care.



The tucked-away entrance of the DarDar pediatric HIV clinic.

Appendix**DARTMOUTH COLLEGE**

Patient-Provider Interactions at the Muhimbili National Hospital in Dar es Salaam, Tanzania, in the Context of Colonialism

RESEARCH PROJECT INFORMATION AND CONSENT SHEET

This research project is being conducted by Sirey Zhang from the Anthropology Department at Dartmouth College, Hanover, NH, USA. It is a study of stories about the lived experiences of healthcare providers at the Muhimbili National Hospital in Dar es Salaam, Tanzania. These stories are being understood through the lens of the insidious historical role that the British Colonial Health Service played in Tanganyika and the continuing influence of foreign entities on health development in the country.

Your participation is voluntary. Participation involves a 20-minute interview. You may choose to not answer any or all questions. With your permission, the interview will be audio recorded. You may request that the recording and interview be stopped at any time. The audiotapes will be transcribed and destroyed at the end of the project.

The information collected will be maintained confidentially. Names and other identifying information will not be used in any presentation or paper written about this project.

Questions about this project may be directed to:

Sirey Zhang, Student Investigator
sirey.h.zhang.20@dartmouth.edu

Lisa V. Adams, MD, Faculty Advisor
Lisa.V.Adams@dartmouth.edu

Dr. Switbert Kamazina, Muhimbili University of Health and Allied Sciences
skamazima@gmail.com

CONSENT

I have read the above information about this study and have been given time to ask questions. I agree to take part in this study and I will be given a copy of this form.

Participant's Signature and Date

PRINTED NAME

DARTMOUTH COLLEGE

Patient-Provider Interactions at the Muhimbili National Hospital in Dar es Salaam, Tanzania, in the Context of Colonialism

RESEARCH PROJECT INFORMATION AND CONSENT SHEET

Mradi huu wa utafiti unafanyika na Sirey Zhang kutoka Idara ya Anthropolojia katika Chuo cha Dartmouth, Hanover, NH, USA. Ni utafiti wa hadithi kuhusu uzoefu wa watu ulioishi kuhusu huduma za afya huko Iringa, Tanzania. Hadithi hizi zinaeleweka kwa njia ya lens ya jukumu la kihistoria ambalo Huduma ya Afya ya Kikoloni ya Uingereza ilicheza katika eneo hili na ushawishi unaoendelea wa mashirika ya kigeni juu ya maendeleo ya afya katika kanda.

Ushiriki wako ni wa hiari. Ushiriki unahusisha mahojiano ya dakika 20. Unaweza kuchagua kujibu maswali yoyote au yote. Kwa idhini yako, mahojiano yatakuwa redio iliyorekodi. Unaweza kuomba kwamba kurekodi na mahojiano kusimamishwe wakati wowote. Sauti za audiotap zitarekebisha na kuharibiwa mwishoni mwa mradi huo.

Taarifa zilizokusanywa zitahifadhiwa kwa siri. Majina na maelezo mengine ya kutambua hayatatumiwa katika mada yoyote au karatasi iliyoandikwa kuhusu mradi huu.

Maswali kuhusu mradi huu yanaweza kuelekezwa kwa:

Sirey Zhang, Student Investigator
sirey.h.zhang.20@dartmouth.edu

Lisa V. Adams, MD, Faculty Advisor
Lisa.V.Adams@dartmouth.edu

Dr. Switbert Kamazina, Muhimbili University of Health and Allied Sciences
skamazima@gmail.com

CONSENT

Nimeisoma habari hapo juu kuhusu utafiti huu na nimepewa muda wa kuuliza maswali. Nakubali kushiriki katika utafiti huu na nitapewa nakala ya fomu hii.

Participant's Signature and Date

PRINTED NAME

Interview Guide (English)

Hi, my name is Sirey. Thank you so much for finding the time to meet with me today. I'm working on a research project. I'd like to gather stories about healthcare providers' experiences with healthcare at the Muhimbili National Hospital. I value your experiences and I would like to hear about them if you would like to share them. I have a few questions and our conversation should take about twenty minutes. This project was reviewed and is continually monitored by an ethics board at Dartmouth College in the US and at the Muhimbili University of Health and Allied Sciences in Tanzania. Your participation is completely voluntary and if there's any question you'd rather not answer, you don't have to. Feel free to stop the conversation at any point if you don't want to continue. Does this make sense and sound ok with you, yes or no?

- 1) As a national referral hospital, I am interested about the patients and their families who travel from remote, rural areas far from Dar es Salaam. How often do you interact with these kinds of people?
- 2) If you are willing to share, can you tell me a little bit about yourself- tying into how you've arrived at this career as a healthcare provider?
- 3) What are some common concerns that patients and their families from rural areas share?
- 4) Can you tell me about times when rural patients and families showed a concern or mistrust towards western medicine? How did you handle these situations?
- 5) What are the largest difficulties when you interact with patients and their families from rural backgrounds?
- 6) What influences do colonial exploitation and heavy NGO presences have on healthcare delivery in Tanzania, in your opinion?
- 7) Is there anything else that you'd like to share? Is it ok if I contact you again for a follow-up interview if I have any more questions?

Interview Guide (Kiswahili)

Mambo, jina langu ni Sirey. Asante sana kwa kutafuta muda wa kukutana nami leo. Ninafanya kazi kwenye mradi wa utafiti. Ningependa kukusanya hadithi kuhusu uzoefu wa watoa huduma za afya na huduma za afya katika Hospitali ya Taifa ya Muhimbili. Ninathamini uzoefu wako na napenda kusikia juu yao ikiwa ungependa kuwashirikisha. Nina maswali machache na mazungumzo yetu yanapaswa kuchukua dakika ishirini. Mradi huu ulirekebishwa na unaendelea kufuatiliwa na bodi ya maadili katika Chuo cha Dartmouth huko Marekani na Chuo Kikuu cha Muhimbili cha Afya na Allied Sciences nchini Tanzania. Ushiriki wako ni kwa hiari na ikiwa kuna swali lolote ungependa kujibu, huhitaji. Jisikie huru kuacha mazungumzo wakati wowote ikiwa hutaki kuendelea. Je! Hii inakuwa ya akili na ya kweli na wewe, ndiyo au hapana?

- Kama hospitali ya rejea ya kitaifa, ninavutiwa na wagonjwa na familia zao ambao husafiri kutoka maeneo ya vijijini, mbali na Dar es Salaam. Ni mara ngapi unashirikiana na aina hizi za watu?
- Ikiwa una nia ya kugawana, unaweza kuniambia kidogo kuhusu wewe mwenyewe-kuunganisha jinsi umefikia kazi hii kama mtoa huduma ya afya?
- Je, ni mambo gani ya kawaida ya wagonjwa na familia zao kutoka maeneo ya vijijini?
- Unaweza kuniambia kuhusu nyakati ambapo wagonjwa na vijijini walionyesha wasiwasi au kutokuaminiana kwa dawa za magharibi? Ulifanyaje hali hizi?
- Ni shida kubwa zaidi wakati unavyowasiliana na wagonjwa na familia zao kutoka kwenye vijijini?
- Ni vikwazo gani hutumia unyonyaji wa ukoloni na vituo vya NGO vikali vinavyo na utoaji wa huduma za afya nchini Tanzania, kwa maoni yako?
- Je, kuna kitu kingine chochote ungependa kushiriki? Je, ni sawa ikiwa ninawasiliana nawe tena kwa mahojiano ya kufuatilia ikiwa nina maswali zaidi?

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