Healthcare, Missions, and the rise of the 'Voluntary Sector' in Colonial Tanganyika.'

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There has been a significant rise in the number of health facilities (hospitals, clinics, HIV and AIDS services, etc) run by missions and faith-based organisations over the past decade or so. We can see the rise of faith-based health services in this period reflected in three dominant narratives on the non-state sector and provision of welfare services in Tanzania (and sub-Saharan Africa more widely): First, the 'rise' of a publicly-faced religion, more muscular & assertive, newly encroaching on the secular project of development. Second, the 'NGO-isation' (privatisation through the voluntary sector) of the welfare sector, and the implications this has for state capacity, for power of liberal reforms, etc.. And third, an assumption that the privatisation of welfare (albeit largely through non-profit organisations) represents a qualitative shift in the 1980s from previously state dominated services.

However, all three arguments can be challenged through a better understanding of the history of voluntary sector engagement in service delivery (including health) over the course of the twentieth century. Firstly, the history of Tanganyika demonstrates the integral role played by religious organisations (in this case missions) in delivering welfare and in broader development interventions. In other words, they are not new actors, suggesting their increased profile over the past decade reflects more on the failure of observers to adequately understand the nature of religious engagement in this area.

Secondly, the notion of the 'NGO-isation' of welfare and development debate is similarly ahistorical in its understanding of the role of non-state, non-profit actors in service provision over the course of the twentieth century as a whole. It portrays the emergence of the formal voluntary sector in Tanzania as linked to rise of NGOs (indeed, NGOs are seen as synonymous with voluntary organisations by some), whereas the reality is that
NGOs entered a voluntary sector space already created in the colonial period by missions.

Thirdly, the story of the national provision of welfare services in Tanzania is a relatively short one – i.e. around 20 years from the mid-1960s. But for most of the twentieth century, and into the twenty-first, welfare has been a mix of public and private provision, with the state forced to rely on non-state actors to meet its welfare commitments.

This paper explores the establishment of the formal voluntary sector in Tanganyika, especially in relation to health service provision and the implications for debates about role of voluntary sector in Tanzania today.

**The voluntary sector in Tanzania:**
There has been a significant expansion of interest in the role of the voluntary sector in welfare provision, development and other social interventions, not least in the UK (albeit the big idea of the ‘big society’ seemingly having failed to capture the public imagination, or even explain itself in anything other than vague terms).

But when transplanted to sub-Saharan Africa, the analysis and depiction of the voluntary sector is still largely based on European and North American understandings of what it looks like, how it interacts with the state, who it comprises of, and its relationship with local communities. This presents a normative version of what the voluntary sector is, which may not be appropriate to the Tanzanian context, in which the evolution of the sector followed a different set of contours which shaped the particular model that emerged. In particular, we can see that the particular evolution of the sector in Tanzania shaped the type of organisations who made it up, its relationship with the state, and the reliance on funding from particular sources (notably the reliance on external funding sources).

For this reason, a history of the voluntary sector in Tanzania has relevance beyond the interesting historical narrative it creates, raising questions about current donor policy and academic analysis of Tanzania’s (and Africa’s) third sector.

**Emergence of the voluntary sector in Tanganyika**
Until the 1930s mission activity in provision of health care (as with education) was atomised. There was little coordination between missions; relationships with the state were largely personal and individual, especially with local authorities, and there was little attempt to create and push a ‘mission-wide’ vision on key issues (such as funding). Missions were mostly isolated, at some distance from each other. Where they were in
closer proximity, relationships generally perceived as competitive, not complementary, terms.

The result was that whilst missions were making a considerable contribution to health provision, they were not coordinating their activity, pursuing common goals and agendas, sharing information or presenting a unified front to the colonial state. The mission influence could not be ignored by state, but neither was the state compelled to listen to missions in designing medical policy that nevertheless impacted upon missions.

By 1930s the lack of a formal mechanism for coordinating mission and colonial government activity in health, and the reliance on personalised, informal, links was becoming more of an issue for both colonial and mission authorities. In 1932, the UMCA Bishop of Masasi wrote to all mission leaders in Tanganyika. He noted efforts by government to work with missions were being hampered by the lack of a clear ‘mission perspective’. Mission views were ‘so varied’, he wrote ‘as to appear bewildering, and the desire to give [missions] sympathetic support yields to disheartenment. The impression is given that we Missionaries do not know clearly what we do want’. He suggested the establishment of a single organisation to represent the entire mission sector, to enable ‘common counsel’, with the aim of ‘attaining a common policy’.  

In 1934, the Bishop’s plans led to the creation of Tanganyika Mission Council (TMC), bringing together the main Protestant missions in Tanganyika. The Roman Catholic missions did not join (fearing the modernising instincts they detected underpinning the organisation, but also already possessing a clear, centralised structure with which to represent Catholic interests to the colonial state), but agreed to meet with it on an ad hoc basis.

The establishment of the TMC signalled the beginnings of a more coordinated mission engagement with the colonial state, channelling a major section of the public Christian voice in Tanganyika into an umbrella organisation that could formulate ‘mission’ policy (rather than the policy of individual missions) to which all members would subscribe. It signalled, in short, the evolution of non-state, faith-based service providers from atomised, self-interested missions to a more formal voluntary mission sector.

**Health Policy in the TMC & MMC**

From the start, medical mission was a key priority for TMC business. In 1936, the Medical Missionary Committee (MMC) was created as a sub-committee of the TMC,
becoming the formal space for discussion of mission responses to govt policy. At its first meeting in July 1936, the MMC discussed how to build greater links with government services and ensure greater cooperation with medical department.\(^3\) There was a discussion on how the colonial government could make better use of mission expertise in the management of epidemics, maternal and child health services, and care for particular types of patients such as lepers or those with mental illnesses. In response, missions would place themselves under greater supervision of the state, submitting regular reports, cooperating in training, and committing to maintaining certain level of standards.\(^4\)

As with the TMC, the MMC was a clear assertion of mission identity in supporting and promoting a particular type of medical service. But it was a service that, from the perspective of medical missions, was an integral part of the Territory's health systems: complementary, not rival; filling in the gaps left by state services.

In the post-war period, the MMC sought to institutionalise itself as the sole representative organisation for all mission medical service providers in Tanganyika. It opened itself to all mission medical practitioners, regardless of denomination. The heads of any mission with a medical service was to be invited to meetings, and minutes of all meetings would be sent to all missions with at least one medical practitioner.

In 1952, the Director of Medical Services (DMS) agreed that the MMC should be recognised 'as representative of all Mission Medical opinion in Tanganyika, and should in that capacity be consulted and should advise on matters of Government policy affecting Mission Medical work'.\(^5\) It was subsequently re-named the Medical Mission Advisory Committee, and represented the culmination of a process that had seen fragmented, independent missions transformed into a formal voluntary sector with a place within the formal institutions setting medical policy in the Territory.

Two key themes dominated relations between the MMC and the colonial government – both of which would have implications for the voluntary sector (& NGOs) after independence: firstly the question of funding mission health care services; and secondly the level of engagement afforded to missions in the formulation of Tanganyika medical policy.

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\(^3\) Director of Medical Services, to the Chief Secretary, 25 February 1937. TNA 24848.

\(^4\) Secretary Berliner Mission to DMS, 6 July 1936. TNA 450 692 v.1.; Muller, ‘Medical Mission and its Relations to Government’. TNA 450 692 v.1. The document is undated and has no author mentioned, but it is the paper mentioned in the Agenda of the TMC meeting, 9-11 July 1936 (TNA 21247 v.1), where Dr Muller is named as the author.

\(^5\) Tanganyika Gazette, 19 December 1952. TNA 42300.
Funding
Perhaps the biggest constraint on mission medical work was financial. The colonial state did not provide regular Grants-in-Aid until after 1945. Missions relied on ad hoc funding from state, donations from faith communities back home and (very) limited fees charged in mission hospitals & clinics.

Inevitably, discussions within the MMC, and meetings between the MMC and medical department were dominated by calls for increased state funding of mission facilities, and for mission representation on bodies overseeing the grants-in-aid policy. Indeed, the colonial state regarded efforts by missions to enhance cooperation through the institutions of the TMC and MMC as driven by such concerns. In 1937, the DMS noted the push towards ‘closer cooperation between medical missionaries and the medical department’ was ‘largely a financial question’. The MMC was pushing not just for increased financial commitments from the state, but to able to ‘make recommendations as to grants’.

However, by the early 1940s, the colonial government had conceded the principal of state funding for mission medical services. In the 1943 post-war development plan for medical service, the need for the state to provide financial support for mission medical services was acknowledged:

... to the extent that medical missionary effort may comply with such standards as may be determined from the standards set for the Government and Native Authority medical services, as well as the training of medical and nursing auxiliaries and other trained subordinates; to that extent such effort should be state-aided.

The plan was to create what was in effect a hybrid health service: largely state-funded, but delivered through a mix of public and voluntary agencies. Mission services were to be incorporated as independent actors into a national health system: ‘to ensure the distribution of such [mission] institutions for the benefits of the community at large’. The government would in return have greater control and supervision over mission services,

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6 Secretariat Minutes, DMS, 25 August 1937. TNA 24848.
7 Secretariat Minutes, 27 February 1937. TNA 24848.
9 DMS (P A T Sneath), ‘Post-War Development – Medical Department’, September 1943, p.3. TNA AN 450 1179.
and missions would be expected to treat all Africans in their area. Constrained as the state was in human and financial capital, the plan was the only realistic model for expanding health care within the Territory.

One consequence of the settlement was that the model of the public-private voluntary partnership in health service delivery established created a voluntary sector that was almost totally reliant on external funding. Whilst the voluntary sector in Europe and North America emerged independently from the state (even if it would receive funding from that state), the sector in East Africa was a joint creation of voluntary actors and the state: it had no local constituency from which it could draw financial or moral support.

This would also affect NGOs as they began to emerge in Tanzania from the 1960s. Decisions on what services should be provided, where, etc, reflected external perceptions of necessity. They might be responsive to need, but they were not representative or accountable to their clients in a formal sense. It also contributed to the reliance upon the state that characterised the colonial voluntary sector, and can also be seen amongst NGOs in the 1960s and 1970s (before they shifted to increasing reliance on donors from the 1980s). The state relied on the voluntary sector, certainly. But the missions also relied on the state in order to maintain and expand their services. In other words a relationship based on mutual dependency was created.

**Influence on policy**

If by the 1940s the colonial government had conceded to the missions on the question of state funding for voluntary sector health care services, it was more reluctant to concede on the question of MMC influence over policy. It could accept the necessity of funding mission services, but was profoundly unwilling to give powers over policy formulation to those mission partners. This was to be the next main battleground for influence by the MMC.

The colonial administration saw the TMC & MMC as creating an opportunity to enhance the working relationship between state and missions, and was therefore broadly supportive. But whilst it accepted the need for greater coordination & utilisation of mission capacity, it regarded them as primarily existing to channel information to the government about what missions were doing.

In contrast, neither the TMC nor MMC shared such a limited view. In 1944, for example, the TMC outlined its future role in policy and planning processes, calling for formal and permanent inclusion in social welfare administration, including being invited to
participate in the post-war planning boards.\textsuperscript{10} In 1952 it again made a bold statement as to its right to participate in government decision-making, suggesting the role of the MMC was ‘to assist in administration of the Grant in Aid regulations, and to advise the Director of Medical Services on all matters related to or affecting the medical work of Missions in the Territory’.\textsuperscript{11}

In response the colonial state re-iterated its opposition. The Member for Social Services ruled out such a role emphatically, writing that the idea that ‘regulations, as approved by Executive Council, should be referred back to this Committee for \textit{their} further consideration … is out of the question’. He continued in a letter to DMS: ‘I think it most desirable to do nothing to suggest that there is an obligation upon you to seek advice or, most particularly, that it is necessary to act in accordance with that advice’.\textsuperscript{12}

But whilst government was determined to keep the MMC as a consultative organisation, it also recognised the need to work with missions. The DMS wrote in 1952:

\begin{quote}
I anticipate needless trouble if all reference is excluded [to such a mission role], and I would deprecate any step likely to affect adversely our relationships with the missions which I should say are probably better today than they have ever been.\textsuperscript{13}
\end{quote}

The creation of the MMAC was another site of victory for the voluntary sector in forcing its way into a formalised, structural relationship with the state. It was constituted as a body ‘advise the Director of Medical Services on all matters relating to or affecting the medical work of Missions in the Territory’. It was to be made up of four state representatives, including the Director of Medical Services, and four mission representatives, appointed by the MMC. The missions had won the second battle, the MMAC reflecting their demands, not those of the colonial state, in the debates over the place of mission medical services and representatives in the wider colonial state medical service.

The government had been unable to resist the logic of treating mission medical services as a ‘voluntary sector’, rather than disaggregated community of disparate, individualised services. If missions were of vital importance to the medical services offered within the

\textsuperscript{10} Secretary TMC to Chief Secretary, 14 August 1944. This was also reported in the Tanganyika Standard, 24 July 1944, following the TMC’s meeting on 20-22 July. TNA 21247, v.2.
\textsuperscript{11} Miss Phillips, MMC, to DMS, 13 August 1952. TNA 42300
\textsuperscript{12} B Leechman, Member for Social Services, to DMS, 26 September 1952. TNA 42300. Emphasis in the original.
\textsuperscript{13} DMS to Member for Social Services Leechman), 15 November 1952. TNA 42300.
Territory, if they were formal partners to the state in medical service delivery, they inevitably would seek to increase their say in the formulation of policy that impacted on them. In abrogating individual interests into the broader collective one, missions had gained a power that the colonial state was finding it increasingly difficult to resist.

As with questions of funding, the settlement had implications for the future place of the formal voluntary sector as regards its relationship with the state (a set of relationships that would be inherited by NGOs). The strength of missions in welfare service provision gave them a degree of power in their interactions with the state, as seen in the sector’s ability to wring concessions on funding and on its place within the policy process. But that proximity also served to reinforce the power of that state, not least because the sector was apparently willing to align its interests with those of the state rather than seek to challenge or offer alternatives.

Reliant as it was on funding from the government, unable to turn to local constituencies for alternative sources of material support, missions were beholden to the state. Public and voluntary sector were thus mutually dependent. The state had the upper hand, but because the sector was composed largely of non-Africans, not because it had the strength to do without the missions.

**Conclusions**

By the late 1940s, missionary medicine had transformed itself from the individualised, small-scale and isolated services that characterised its early decades, into a formal part of Tanganyika’s national health system. The state’s structural embrace of the mission sector (tentative & ambiguous as it was) was put in place in the 1940s, but built upon processes began in the 1930s by missions themselves.

The establishment of the TMC and MMC was not just about creating a new missionary umbrella institution. It also created a new identity for missions, a self-conscious acknowledgement of a shared identity. With formal structures in which missions could express their common concerns and hopes, the notion of a ‘mission sector’ emerged. And in doing so, it inevitably led to the creation of a formal voluntary sector, and the formal division of welfare services into Tanganyika into public and private (non-profit) sectors.

The history of colonial voluntary sector in Tanganyika challenges debates about the current voluntary sector, and its role in development and service provision in contemporary Tanzania. NGOs did not create for themselves the space they occupied and increasingly dominated. Neither did they forge anew the relationships between voluntary sector organisations and the state (even if they were to influence it). Nor were
they particularly unusual or unique in facing the challenge of reliance upon a particular set of funding agencies, questions over representativeness, or their ability to represent local demands and wants.

This was a terrain shaped primarily by missions (both in terms of their role, and their complicity in shutting-out local, indigenous forms of voluntary agency from formal partnerships with the state). To understand why NGOs have the role they do in local development and service provision; to understand what role private, voluntary organisations might have in meeting need; to understand the nature of voluntary sector in East Africa, we first need to understand its origins evolution into the modern forms we can see today.