

# From the Old Dispensary to the new Aga Khan Health Centre

Healthcare in transition in Zanzibar





# Introduction

The opening of the Aga Khan Health Centre on the waterfront in Zanzibar Stone Town marks the most recent phase in the use and evolution of the grand and ornate building that was built in the 19<sup>th</sup> century both as a tribute to a British monarch and as a philanthropic act of providing healthcare to the residents of the island. Since July 1887, when its foundation stone was laid, the building has undergone successive phases of usage, restoration and modernisation which, in part, also symbolically reflect the history of healthcare in Zanzibar.

This booklet describes in broad terms the health conditions and the state of healthcare in Zanzibar at the end of the 19<sup>th</sup> century when trade and philanthropy went hand in hand. It traces as well several health-related conceptualisations underlying healthcare practices into the 20<sup>th</sup> and 21<sup>st</sup> centuries. The paper closes with a brief discussion of the current structure of the health system in Zanzibar, the health challenges to be addressed and the role of the Aga Khan Health Centre within the overall health system of Zanzibar and on the Tanzania mainland in providing promotive, preventive, curative and rehabilitative health services.

# Trade, Disease and Healthcare in Zanzibar, 1890 – 1964

In the last quarter of the 19<sup>th</sup> century, the island of Zanzibar, lying just twenty-two miles off the coast of the East African mainland, was at the height of its economic importance. Situated on the Western rim of the Indian Ocean, Zanzibar was a significant node in the trading system that included the Arabian Peninsula, the Indian sub-continent, the German Empire, the British Empire and the United States. In about 1820 Zanzibar annually accommodated large and increasing numbers of sailing ships that arrived with textiles, beads and sundries for the local market and to be transported by caravans to the mainland; the vessels left the island carrying slaves, ivory, gum copal (used as a varnish and waterproofing material), cowrie shells and orchilla weeds that produced a purple-blue dye.<sup>1</sup>

Zanzibar was incorporated in the Sultanate of Oman in 1698<sup>2</sup> and was ruled directly by a Sultan of the Busaidi dynasty from 1832 when Sayyid Said bin Sultan decided to reside in Zanzibar.<sup>3</sup> Zanzibar town by then housed a cosmopolitan society comprising the Swahili, Africans from the mainland, Arabs, Indians and other ethnic communities. Arabs and Indians participated actively in the economy: Arabs developed and managed the clove plantations; Indians financed the local and long-distance sea-borne trade and the caravans that travelled to the mainland as well as ports in the Indian Ocean. In addition, a small but not unimportant and increasing number of Europeans (British and Germans) and Americans served in their countries' consulates, represented trading houses on the island and ultimately occupied the upper strata of society.

At the end of the 19<sup>th</sup> century, the British Protectorate in Zanzibar, established in 1890 by the Heligoland-Zanzibar Treaty between the British and the German Empires, was working to update the administrative system, abolish slavery, which it did in 1897, and maintain the very profitable trading economy of the island.<sup>4</sup>



Acknowledging that the supply of labour, critical to maintaining the profitable economy, diminished after the abolition of slavery for many of the reasons outlined in the studies by Depelchin and others, Amina Ameir Issa examines the effects of the many diseases and the poor environmental conditions on the health and wellbeing of the community, especially its poorest and least resourced members.<sup>5</sup> The measures introduced to reduce disease and death, accepting that the wealthy and powerful were initially most favoured, were taken by the Protectorate and wealthy philanthropists to protect the labour supply. With no extant sources that provide data on mortality across the communities, this position is difficult to prove, although many visitors and residents testify to the devastating effects of the range of diseases that regularly visited Zanzibar. The fact that the Protectorate established departments in the 1890s to address health conditions give some credence to this position. Maintaining manpower sufficient to stabilize and increase the levels of clove production and a favourable balance in import/export operations became a critically important economic objective; it was also the rationale behind the British administration's actions to establish departments responsible for cleaning the urban environment and providing Western medicine.<sup>6</sup> As remarked by the Director of Public Health in 1913, "whatever happens to this country, its economic future does depend on the maintenance of its indigenous labour supply."<sup>7</sup>

The newly structured government departments established by the Protectorate were developed to provide a range of services. The Department of Sanitation, launched in 1894, was responsible for sweeping the streets and clearing away the garbage, while the Department of Hospitals and Medicine, formed in 1898, was charged with establishing and extending hospital facilities. The establishment of these Departments underscores the attention given by the British administration to addressing illness and improving health care. Both departments operated to improve the insalubrious environment and to address the high rates of illness and death that were jeopardizing the supply of labour vital to maintaining the economy.<sup>8</sup> The responsibilities of the first departments created were not clearly defined, and the work carried out by each department often overlapped with the activities of the other.<sup>9</sup>



OPERATION  
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ON PLACEMENT  
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HEALTH CARE

# The introduction of Western medicine in Zanzibar





In addition to establishing the departments, the government opened a public hospital in 1896 that introduced Western medicine and its approach to diagnosis and cure, i.e., the developing biomedical model that relies on empirical evidence as opposed to traditional texts and practices to assess and treat symptoms and conditions. The activities of the departments and the services of the hospital were financed with funds generated in Zanzibar, e.g., customs duties, other fees and payments for services. To complement the public measures introduced by the Protectorate, wealthy Indian traders and Omani Arab plantation owners financed private health services that adopted and operated according to Western medicine theories and practices.<sup>10</sup> In most cases, these private services were introduced to address the health needs of the donors' local communities.

Introducing Western medical practices in the newly constructed public and private facilities in Zanzibar confirmed the conviction of the British administration and medical staff that infection and illness were not the result of 'miasmas' containing 'bad air' and poisonous vapours but caused by the molecules (*germs*) carried by the air, water, insects, infected persons, etc., a proposition ultimately confirmed by the work of Robert Koch and Louis Pasteur at the end of the 19<sup>th</sup> century.<sup>11</sup> Still, those promoting the benefits of Western medicine recognized that environmental factors such as unsafe water, inadequate sanitation and poor hygiene contributed to ill health and sickness, and contributed to the introduction and expansion over time of public health measures.<sup>12</sup>

Despite the efforts of the government to encourage the community to attend facilities offering Western medicine, the miasma theory remained the most common explanation for the onset of illnesses like malaria until the middle of the 20<sup>th</sup> century. Those embracing traditional theories and remedies linked the higher prevalence of diseases and epidemics among the indigenous population and especially the poorest residents in Zanzibar with residing in filthy and foul-smelling environments. Throughout the century, numerous observers documented the presence and devastating effects of plague, leprosy, yaws, smallpox, venereal diseases, elephantiasis, cholera and especially malaria on the communities residing on the island.<sup>13</sup> While few commentators related the diseases, especially those that afflicted the poor, with poverty, many commented on the connection between the prevalence of diseases and environmental factors,<sup>14</sup> i.e., polluted water, unclean habits and clothing, poor diet, sexual behaviour and insufficient and crowded shelter.<sup>15</sup>

Despite efforts to promote the use of facilities offering Western medicine services, most were avoided by many of the workers on the clove plantations and by most women refused to be attended by men, who were mostly trained in the new schools of medicine in England and India.<sup>16</sup> Unlike most of the elite in Zanzibar society who adopted the new therapies, many of the poorest often continued to employ traditional practices that included a blend of Islamic, Hindu-Ayurvedic and African therapies, techniques and potions.<sup>17</sup>

The failure of the larger community to adopt Western medicine and to adopt public health measures and, in many cases, the community's resistance to the new practices allowed many diseases like malaria, cholera and smallpox to continue to spread throughout Zanzibar, along the trade routes on the mainland and at sea. It was not until the 1930s that leading members of the community and political leaders, merchants and educated elites successfully popularized Western medicine and promoted public health messages in Zanzibar.

While several infectious illnesses and other maladies routinely occurred in Zanzibar throughout the century, significant advances in Western medicine that controlled and/or prevented disease outbreaks were taking place in Western Europe and elsewhere. In Vienna, Semmelweis found that scrubbing hands before examining women about to deliver prevented the transmission of puerperal fever. In France, Louis Pasteur discovered that food spoiled because of contamination by invisible bacteria (germs) and not from spontaneous generation, [the hypothetical process by which living organisms develop from non-living matter, e.g., maggots arise from rotting meat]; and in Germany, Robert Koch found that a particular germ could cause a specific disease. These discoveries formed the basis of the germ theory of disease and were the result of applying the 'scientific method' calling for formulating hypotheses, conducting rigorous repeatable experiments, and making informed conclusions based on the results of the experiments. Along with Jenner's development of the vaccination process to prevent smallpox at the end of the 18<sup>th</sup> century, these discoveries were important advances in Western medicine.

Still, the discoveries and the connection between bacteria, viruses, parasites, and disease causation were only slowly

understood and applied in Zanzibar and elsewhere.<sup>18</sup> Moreover, effective treatments to remedy illness were slow to develop. Until well into the 20<sup>th</sup> century, the importance of the discoveries of Western medicine and the benefits of public health interventions were minimized and in competition with traditional therapies.

In some cases, medical practitioners, even those trained in Western medicine, were reluctant to introduce treatments to a resistant local population for fear of losing patients; in other cases, the local population refused to attend the newly founded health facilities.<sup>19</sup> As a result, Western medicine served only a small percentage of the community in Zanzibar, primarily Europeans and the Arab and Indian elite. Most of the Swahili community continued to follow traditional practices. Jagdish S. Gundara reports on traditional obstetrical care accepted by most of the Swahili/African community in Zanzibar.

*When the time comes for the delivery of the child, the father fetches the midwife who enters the house to attend the expectant mother. The woman is seated on a low stool, and the midwife sits in front of her and receives the child. When the child is born, the midwife ligatures the umbilical cord and cuts it. She then takes the child, washes it in cold water and lays it on a cloth in a flour sieve while she attends to the mother. ... At the head of the child in the flour sieve are laid a lemon, a razor, a silver chain and its mother's waist beads. This is to keep the devils off...<sup>20</sup>*

In the mid-1880s and throughout the 20<sup>th</sup> century, the writings of Christian missionaries recount stories about the 'darkness of the souls,' especially the souls of members of the Muslim community. Missionaries found it appropriate to educate potential converts to European ways, e.g., acceptance of Western medicine, to prepare them to accept Christianity. Throughout the period, providing modern 'medical work was viewed as important to advance evangelization.' For example, 'French missionaries were increasingly employing health education as a means of gaining access to the residents of urban Zanzibar for the purpose of evangelization.'<sup>21</sup> The text box (overleaf) records the efforts of the Seventh Day Adventist Church to offer Western medicine to promote its teachings and to establish itself in Zanzibar.

## A Short History of The Zanzibar Seventh Day Adventist (SDA) Dispensary

SDA evangelists started visiting Zanzibar Island in the late 1930s and several times tried to sell Adventist books to government officers. It was not easy to sell Christian books to Muslims. After 1956, SDA sent medical doctors to Zanzibar several times to conduct 'How to Stop Smoking' programmes and to present lectures on the hazards of using alcohol. These topics were compatible with Muslim beliefs and received a good response. Given a level of acceptance of these messages, the SDA leadership saw the possibility of establishing a health facility in Zanzibar that could be an opening for potential evangelism.

The SDA leadership received permission from the Chief Minister of the Zanzibar Revolutionary Government in 1987 to open a health facility, on the condition that health services be offered free. On January 31, 1988, the Ministry of Health officially registered the dispensary. After operating for almost 25 years, the dispensary was renovated in 2013 and reopened on August 4, 2014. The dispensary 'is ranked second in providing free maternal and child health services on Zanzibar, and its laboratory is one of the centres for malarial control on the island.'

'After decades of unsuccessful struggles to introduce itself, the SDA Church used its health ministry department to acquaint the communities of Zanzibar with Adventism. The dispensary that started in 1987 has acted as a *wedge* to allow the Adventists presence and message to reach the island.'



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However, since many of the Christian missions secured few converts in Zanzibar in the early years of the 20<sup>th</sup> century, many denominations left the island for the mainland.<sup>22</sup>

Many health facilities operated by Christian missionaries present in Zanzibar and on the mainland viewed 'modern' medical practice as a useful strategy to secure converts. Followers of many religions, especially among Muslims, rejected Christian medical services because their offer of assistance was seen by the person treated or introduced to public health practices as an inducement to convert. In addition, communities' resistance to Western medicine was associated with defending the privacy of their female members.

*As most doctors practicing Western medicine were male and white, their touch was considered polluted or worse, i.e., tantamount to sexual molestation. This was especially so when a physician searching for the bodily signs of plague tried to examine a woman's neck, thighs, or armpits.<sup>23</sup>*

It was not until the 1930s that Zanzibari women from the different communities began to be trained in Western medicine at medical, nursing, midwifery and public health schools in Egypt, India, Britain, and Uganda. Yet, despite increases in the number of public and private facilities practicing Western medicine and in the number of female health providers skilled in offering (biomedical) curative services, many women, especially in the Muslim and Swahili communities, remained reluctant to attend the health services even after fees were eliminated for the poorest.<sup>24</sup>

Home deliveries were common throughout the 19<sup>th</sup> and 20<sup>th</sup> centuries in Zanzibar, even though the colonial government established a maternity hospital in 1940, and several private maternity homes were operating before that date.

Well before midwives were formally trained in Western medicine and able to work as midwives in Zanzibar, Princess Salme bint Said, sister of Sultan Barghash, wrote in her memoirs, published in Berlin in 1886, that [western-trained] female physicians were needed in Zanzibar.

*People grow up in Eastern lands without particular attention to any rules or care of health. ... The Arab [in Zanzibar] has no idea of classifying diseases. He knows but two kinds, "pains in the body" and "pains in the head." To the first category belong any complaints affecting stomach, liver, or kidneys, while under the second he lists all manifestations of distress assailing the head, whether sunstroke or softening of the brain. No one ever discovers the fundamental cause of an illness, ...It seems to me that it were better to send female physicians to Zanzibar ... For my own part, I would willingly, if some association decided upon a suitable emissary, help her learn Arabic and Suahili - the least I could do for my beloved country. And the venture ought to be successful from a pecuniary point of view. But the doctor must be a woman. She could do more in the East than a dozen men.<sup>25</sup>*

*Princess Salme  
circa 1867; courtesy  
of Princess Salme  
Museum, Zanzibar*



## The Jessa Bhaloo Maternity Home, Zanzibar

In the early 1920s, Mr Jessa Bhaloo Walji built a large building in Zanzibar Stone Town at 1818 Mkunazini Street, opposite the Anglican Church of the Universities' Mission to Central Africa. One side of the building was established as the Jessa Bhaloo Maternity Home, while the Bhaloo family occupied the other side of the building. The facility was open to all members of the public; it was run on a philanthropic basis that enabled poor clients to pay lower or no fees. Mrs Kulsum Bhaloo, the eldest female member of the Bhaloo family, would often herself attend to the women coming for delivery, pending the arrival of the midwife. The building had a connecting door from the Bhaloo family side to enable Ma Kulsum, as she was affectionately known, to access the Maternity Home directly late at night. Ma Kulsum also had expertise in preparing homeopathic medicines and treating young children who had convulsions and other ailments.

During the Golden Jubilee of His Highness Aga Khan III in 1936, the maternity facility was donated to His Highness and renamed the Aga Khan Maternity Home.





By mid-century, the government Hospital for Natives and Subordinates (GHNS), now the Mnazi Mmoja Hospital, had a maternity room, four 'First Class' rooms and provided training for six to eight midwives at a time. The expansion of women's medical services was praised by members of the Arab Association and others because the presence of women health professionals and the removal of fees were likely to 'dispel the belief in witchcraft and other local pedantries that are rooted in the mind of women folk who spend hundreds of rupees in devil dance.'<sup>26</sup>

Still, before 1930, biomedical services were perceived to be 'alien' by most communities in Zanzibar. By and large only soldiers, a few government employees in the colonial administration, the Indian, Arab, and the tiny African elite and school children accessed the services.<sup>27</sup> According to the Medical and Sanitary report,

*It is impossible to give any statistics as the majority of the natives prefer to employ their own medicine men... practically only those in the employment of Europeans seek the advice of qualified men [biomedical practitioners] as they are compelled to do so.*<sup>28</sup>

Issa notes that 'the 1930s mark an important turning point in the provision of Western medicine services as more Indian and Oman Arab elites played an increasingly active role in the extension of medical services.'<sup>29</sup>

The activities of the Department of Medicine and Sanitation (DHSS) expanded slowly throughout the 20<sup>th</sup> century. The public health clean-up campaigns, which drained and cleaned swampy mosquito-infested locations in and around Stone Town, proceeded steadily but were viewed by the authorities as measures to segregate the native communities from European communities.

Since poor and indigenous communities continued to be considered the main cause behind the spread of disease, the government officials responsible for promoting public health measures and introducing Western medicine concentrated on protecting and maintaining the health of the wealthy and powerful. Over time, representatives of these communities served in the British administration.<sup>30</sup> In 1927, representatives from Arab and Indian communities - but no others - were allowed to join the Europeans on the newly established Legislative Council.<sup>31</sup> In the years following, with Arab and Indian representatives present, sessions became a 'platform for airing demands for the extension of medical services.'<sup>32</sup>



The work of the DHSS advanced steadily, benefitted all communities, albeit unequally,<sup>33</sup> and was complemented by the efforts of wealthy, primarily Indian merchants and philanthropists, who financed the establishment and operation of new hospitals and dispensaries that offered care to members of their communities. The hospitals, like the Hassanali Karimjee Jivanjee (HKJ) Hospital, which was opened on July 28, 1955, to replace the General Hospital and later operated as the Mnazi Mmoja Hospital (1964), offered medical diagnostic and treatment services and participated in the public health campaigns championing improved sanitation, health education, vaccination coverage and anti-malarial interventions sponsored by the government.

Western medical services were increasingly accepted over the course of the 20<sup>th</sup> century. Females from all communities who wanted to become health professionals were trained in the biomedical model and took positions in both government and private health facilities. More health facilities were established and, beginning in 1937, several clinics were treating 'women's diseases' and offering reproductive health services.<sup>34</sup>



### **Mrs Hemlata Kanji, midwife**

Mrs Hemlata Kanji, was trained as a nurse in Jamnagar, India; her physician husband mentored her to become a midwife. After his death, she travelled to Zanzibar and served as a private midwife who delivered women in their homes.

She also responded to calls for delivery assistance that she received from two private maternity homes, the Mwembeladu Maternity Home and the Jessa Bhaloo Maternity Home. A highly respected midwife, Mrs Kanji served in Zanzibar from about 1930 until after the revolution in 1964.

By the end of the British colonial period in 1963, health facilities offering Western medical services included the General Hospital<sup>35</sup> that was linked with thirteen clinics: the Tuberculosis Clinic, the Venereal Disease Clinic, the Schistosomiasis Clinic, the Antenatal Clinic, the Genito-Urinary Clinic, the Woman and Child Welfare Clinic, the School Clinic, and the Rahaleo Clinic. A Dental Clinic, an Eye Clinic, a Surgical Clinic, and an Orthopaedic Clinic were also operating. In addition, approximately ten government and private dispensaries and several health posts were also providing health services.<sup>36</sup>

Over time and specially in the decades immediately prior to the revolution, significant resistance coalesced among those militating against British presence and control, the continuation of fee-based public and private health services, and the limited attention given to the influence on people's health of social, environmental and cultural factors. Moreover, those championing change found the biomedical model, as implemented and assessed over time, to be very expensive and contributing to unjust and avoidable differences in health status across Zanzibar society.

Following the establishment of the Revolutionary Government in 1964, when private health services were prohibited and the government took over the healthcare system, the authorities observed that Western medicine offered an effective evidence-based approach to diagnose and treat illness. At the same time, it was noted that Western medicine viewed health as the absence of a definable disease and gave only limited attention to health promotion and prevention and, considering the fee-based system, was unaffordable to a significant percentage of Zanzibar's population.<sup>37</sup>

The new Ministry of Health and Social Welfare,<sup>38</sup> installed by the Revolutionary Government when joining the Union with Tanganyika on April 26, 1964, introduced a three-tiered public health system, based on the biomedical model, that offered health services to all Zanzibaris but abolished private health care provision and eliminated user fees. Along with many newly independent nations that severed their colonial connections in the last half of the 20<sup>th</sup> century, Zanzibar's new health system was promoted as an important component of the modern state.

After reviewing the important lessons learned in the years following its establishment, the Ministry restored private provision of healthcare and reintroduced fees for service in the 1990s.<sup>39</sup> It also charged first tier primary health care units with administering preventive and promotive services as well as basic curative care. All services are now delivered through a hierarchical health structure from the community to the national level.

The table below presents the facilities of the public health system, their number, and a brief statement on the responsibilities of each.

**Ministry of Health<sup>40</sup>**  
**Health Facilities, Number and Responsibilities**

| <b>Facility</b>               | <b>No.</b> | <b>Responsibilities</b>   |
|-------------------------------|------------|---|
| Primary Health Care Unit PHCU | 128        | First point of patient contact; provides basic primary health care service to populations of 3,000 to 20,000  |
| Primary Health Care Unit +    | 32         | Provides curative and preventive services for a defined locality  |
| Primary Health Care Center    | 1          | Provides all services offered by PHCUs but at a larger scale. Serves as first line of referral  |
| District Hospital             | 4          | Provides second-line referral and specialized services  |
| Regional Hospital             | 1          | Provides referral services to a larger population, 150,000+   |
| Specialized Hospital          | 2          | Provides specialized services to referred patients from throughout Zanzibar   |
| National Referral Hospital    | 1          | Mnazi Mmoja Hospital is a recognized 'referral hospital' as defined in the Mnazi Mmoja Act of 2016. It offers specialized services, graduate and postgraduate training and laboratory tests. The national referral hospital is dedicated to being a 'Centre of Excellence for Offering Comprehensive and Affordable Health Care in East Africa' |

According to the 2021 data presented in the Zanzibar Statistical Abstract, there are three thousand, six hundred and ninety (3,690) Tanzanians, mostly originating from Zanzibar, and 66 foreign nationals working in the 14 departments of the Ministry of Health. In addition to the government units, there are four private hospitals and 125 dispensaries in Zanzibar; the number of health personnel in the private sector is not recorded in the Abstract. Three private facilities, located near Stone Town, provide complementary diagnostic and curative services to a relatively smaller segment of the population.<sup>41</sup>

With an estimated population of 1.7 million people (2022 Census) and 48% of the population under 18 years old,<sup>42</sup> the health ministry is challenged to address HIV/AIDS, Tuberculosis, Malaria, Diarrheal Diseases, Reproductive Health conditions, Heart Disease, Diabetes and Cancers, and to reduce unacceptable rates of maternal, neonatal and child mortality. The Ministry and partners are also confronting conditions associated with mental stress, lifestyle choices, e.g., smoking and drug use and abuse, and toxins in the environment. While health indicators, e.g., infant mortality, under five mortality, etc., and the programme to reduce malaria, document significant achievements over the last 25 years, perhaps related to implementing activities linked with achieving the Millennium Development Goals (2000-2015) and the Sustainable Development Goals (2015-2030), many of the indicators documented in other countries in the East Africa region are better.<sup>43</sup>

Government ministries and institutes and the private sector currently face the challenge of responding to rapid and significant demographic growth. All parties in Zanzibar are outlining strategies and programmes to increase employment, provide adequate housing, and introduce more schools and enhance the quality of education. Those working in the health sector are committed to strengthening and expanding the partnerships in place, including the existing partnership between the Aga Khan Health Service, Tanzania and the Mnazi Mmoja Referral Hospital in Zanzibar.



## **Moving towards Zero Malaria<sup>44</sup> in Zanzibar: A Success Story**

Globally, malaria directly causes about 619,000 deaths annually; most of these occur among African children. It is likely that the true number of deaths is substantially higher because the disease undermines nutrition and exacerbates other infections. In endemic areas, malaria during pregnancy is believed to account for up to a quarter of all cases of severe anaemia in mothers and to contribute to a substantial number of maternal deaths, as well as neonatal and infant deaths among low birthweight infants.

The effects of malaria extend far beyond the direct measures of mortality and disease. Malaria can reduce attendance at school and productivity at work, and there is evidence that the disease can impair intellectual development. The failure of children to fulfil their educational potential and to achieve satisfactory educational levels play important roles in the intergenerational transmission of poverty. Until one decade ago, malaria was a leading health problem in Zanzibar.

To respond to the disease burden of malaria in Zanzibar, the Ministry of Health, with assistance from agencies providing technical support, training, financing and material, developed and inaugurated the five-year 'Zanzibar Malaria Elimination Programme (ZAMEP)' in 2017. The programme had five main objectives: (a) provide quality assured diagnosis and case management; (b) increase appropriate vector control measures requiring mass distribution of bednets and spraying of houses with insecticide; (c) reinforce malaria surveillance to investigate and classify all confirmed cases; (d) initiate vector surveillance in malaria prone areas; and (e) improve advocacy, behaviours, social communication and mobilization of the general population.

The review of ZAMEP, which took place in 2022, found that the programme objectives were reached, 'taking Zanzibar very close to elimination of malaria.' According to the review, the programme managed to ensure quality diagnosis and appropriate case management in all health facilities and at the community level.' There were no stock outs of test kits and a strong system for malaria reporting was implemented through the national health information system.

While successful, the programme identified a few new and emerging challenges that require vigilance. First, mosquitoes in Zanzibar appear to have increasing resistance to available insecticides. Second, people are being bitten more often outdoors than indoors, and third, some mosquitoes are adapting and escaping available control measures.

# From the 'Old Dispensary' to the new Aga Khan Health Centre, Zanzibar

Born in Kutch (British India) in 1823, Tharia Topan moved to Zanzibar in mid-1830s and, over time, became one of the most successful Indian merchants on the island. An advisor to Sultan Barghash, who ruled from 1870-1888, he also had close ties to British officials.<sup>45</sup> To celebrate the fiftieth year of Queen Victoria's reign, Topan decided to build a hospital both as a tribute to the British monarch and as a philanthropic act for the benefit of the people of Zanzibar.



*Tharia Topan  
advisor to Sultan  
Sayyid Barghash,  
circa 1880*



Topan, who returned to India in 1885, engaged the architectural firm of Gosling and Morris of Bombay to design the hospital.<sup>46</sup> The foundation stone was laid on July 8, 1887 and for two years following the ceremony, the Tharia Topan Jubilee Dispensary was left to 'weather and consolidate,' as was the customary building practice at the time.<sup>47</sup> With Topan's death in 1891, Lady Janbai, Topan's third wife, oversaw the management of the project. After exhausting the resources that she had reserved for the project, Lady Janbai found herself unable to provide the financing needed to equip the facility and hire the staff, and she decided to sell the facility when it was completed in 1894. It was purchased by the estate of another wealthy Zanzibari merchant, and it started operating from 1900, carrying the name 'The Khoja Haji Nasser Nurmohamed Charitable Dispensary.'

Between its opening at the beginning of the 20<sup>th</sup> century and the takeover of the building by the Government of Zanzibar during the revolution in 1964, the 'Old Dispensary' provided health services according to the Western (biomedical) model out of three ground floor rooms that provided consultations, treatments and pharmacy services. The remaining space, consisting of rooms on the upper two floors, served as apartments. The facility had a small staff – a doctor and several assistants – and responded to the modest demand for Western medical services until the Revolution in 1964.

Residents and visitors to Zanzibar routinely commented on the opulence of the dispensary's multi-cultural architectural style that incorporated African, Arabic, Indian and European features. The Old Dispensary was also noted for its prominent position on the waterfront, its significant contribution to urban architecture, along with the Sultan's House of Wonders (Beit al-Ajaib), and its reflection of the wealth of Zanzibar.<sup>48</sup>

# The new Aga Khan Health Centre, Zanzibar

On October 16, 1990, after standing vacant for more than a quarter century, the Revolutionary Government of Zanzibar agreed to lease the facility to the Aga Khan Cultural Services, Zanzibar, i.e., 'the Company.' The government charged 'the Company' with conserving, restoring, renovating and redeveloping 'all the buildings known as the 'Old Dispensary Building' and to 'hold the premises for a term of sixty-six (66) years in return for paying one thousand (T.Shs 1000.00) payable yearly on or before the first day of January in every year.' In return for permission to lease and restore the premises and comply with other conditions, the Company agreed not to 'assign or sub-let the premises without the prior written consent of the Government.'<sup>49</sup>

With the approval of the Government of Zanzibar and the endorsement of the Aga Khan Cultural Services, Zanzibar, the beautifully restored dispensary has now been transferred to the Aga Khan Health Services (AKHS). After renovating and adapting the building to respect fully the Zanzibar Stone Town conservation and design guidelines,<sup>50</sup> and with new equipment and staff in place, the building originally designed and built with the wealth of Tharia Topan is again a health facility, offering health care that meets the needs of the people of Zanzibar today.

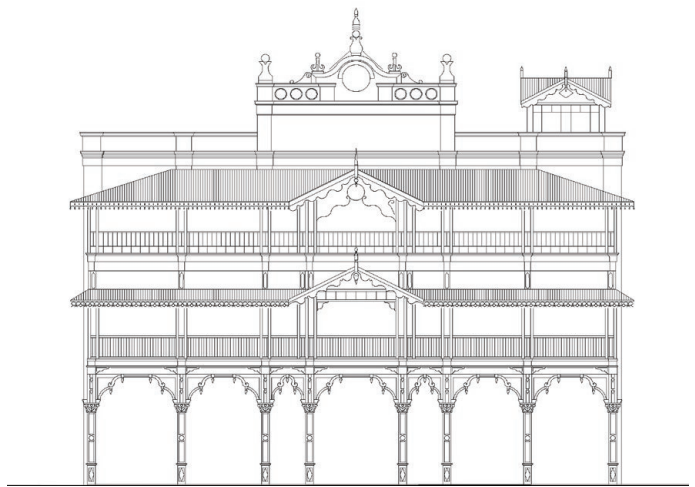
As structured, the new Aga Khan Health Centre, Zanzibar is designed to provide a continuum of care ranging from health promotion and disease prevention to treatment, rehabilitation, and palliative services.





By establishing operations in the Old Dispensary, the new Aga Khan Health Centre, Zanzibar can extend existing relationships and partnerships with government and private health facilities, specialized programmes and specialists in Zanzibar and on the mainland. The new Aga Khan Health Centre, Zanzibar, which is a family medicine doctor-led facility providing urgent care and regular specialist clinics offered by visiting consultants from Aga Khan Hospital in Dar es Salaam, is also eager to partner with government specialists and the community to address new threats to health and nutritional status.

The partnership is also looking to develop and propagate culturally appropriate health information campaigns, by using cost-effective digital health connectivity, to inform communities and change and sustain health-promoting behaviours, and to bring care closer to those in need.<sup>51</sup> In time, the new Aga Khan Health Centre plans to become a 'green' fit-for-purpose facility operating in a 'carbon neutral' environment with state-of-the-art equipment capable of diagnosing and treating infectious diseases, accidents and injuries and non-communicable diseases. By fostering partnerships with public and private sector providers and government policymakers, the new private-not-for-profit Aga Khan Health Centre, Zanzibar can contribute to assessing the options for reducing the overall cost of health care, achieving Universal Healthcare Coverage (UHC), and facilitating patient referrals to specialized facilities in Zanzibar, the Aga Khan Hospital in Dar and the 24 Outreach Health Centres operated by the Aga Khan Health Service, Tanzania.



## Concluding remarks

During its long and storied history, Zanzibar has experienced dramatic events and passed through important transitions. An economy once based on trade that enriched the island, Zanzibar's currently vibrant service sector now welcomes tourists from across the world who visit to sample Swahili culture and to be refreshed by the breezes that once propelled dhows to distant ports. A society where colonialism once stratified people into different social categories is now transitioning back into a cosmopolitan, multicultural community. And a health system in which facilities served different communities according to their wealth and faith and often left indigenous communities largely unserved has become a uniform platform of public and private health facilities serving all seeking and needing care.

The Old Dispensary witnessed each transition. Financed and built in the era when trade generated the wealth of the island, the dispensary played a modest role in providing biomedical health services to all communities it was mandated to serve. It operated throughout the 20<sup>th</sup> century until nationalized by the Revolutionary Government in 1964. Rehabilitated and restored to its multicultural radiance by the Aga Khan Cultural Service at the end of the 20<sup>th</sup> century, the Old Dispensary has transitioned to being the Aga Khan Health Centre, Zanzibar. The newly refurbished facility is committed to making important contributions, expressed as delivering a high quality of patient care and as working collaboratively with health professionals and facilities on the island and on the mainland, to enhance and maintain the health of all Zanzibaris.

<sup>1</sup> Abdul Sheriff, *Slaves, Spices and Ivory in Zanzibar*, Oxford: James Currey, 2002, pp. 87-109. Hereafter cited as Sheriff, *Slaves*.

<sup>2</sup> Zanzibar came under Omani control following the capture of Mombasa in 1798. See Abdul Sheriff, *Slaves*, p. 26.

<sup>3</sup> Some sources report that the Sultan moved to Zanzibar in 1832; others state that the move took place in 1840. See William H. Ingrams, *Zanzibar: Its History and Its People*, Abingdon: Routledge, 1967, and 'Said ibn Sultan,' Gilbert Stewart and Parker Freeman-Grenville, in *Encyclopedia Britannica*, 2023. See also *Zanzibar: A Plan for the Historic Stone Town*, Geneva: The Aga Khan Trust for Culture, 1996, p. 15. According to Stewart and Freeman-Grenville, the Omani administration in Zanzibar during Sa'id's reign 'had no developed system of administration. His government was essentially personal and patriarchal, and he sat daily in public to settle cases and complaints. He depended heavily in his commercial ventures on Indian merchants, whose immigration he encouraged.'

<sup>4</sup> Several studies document the effects of abolishing slavery in Zanzibar (1897) on the supply of labour, especially the number available to work on the clove plantations. (See Jacques Depelchin, 'The Transition from Slavery, 1873-1914,' in *Zanzibar under Colonial Rule*, edited by Abdul Sheriff and Ed Ferguson, London: James Currey, 1991, pp. 11-35.) These studies conclude that the abolition of slavery reordered the relationship between those who were once the masters, largely Arab plantation owners, and former slaves. Once slavery was abolished, the labour available to tend the clove trees and pick and clean the cloves at harvest time was substantially reduced.

<sup>5</sup> Amina Ameer Issa, 'From Stinkibar to Zanzibar': Disease, Medicine and Public Health in Colonial Urban Zanzibar', 1870-1963, PhD dissertation, University of KwaZulu-Natal, 2009, pp. 6-13. Hereafter cited as Issa, 'Stinkibar.'

<sup>6</sup> 'With the abolition of the slave trade in 1873 and slavery itself in 1897, labour shortages in Zanzibar became a serious problem. The Zanzibar economy changed from a dependence on slavery before 1897 to a colonial economy dependent on free labour after 1897. Labourers were needed to work in commercial sectors in the Town. Casual labourers and dock workers were needed to pack and transport goods to and from the docks. Labourers were also needed to pick cloves, the mainstay of the economy. The provision of health facilities was important to ensure the survival of the commercial sector.' Issa, 'Stinkibar' p. 20. In addition, the operations of King Leopold's Congo Free State (1885-1908) were a significant economic threat to the profitability of caravans organized in Zanzibar and led by Arab and Swahili traders like Tippu Tip bin Muhammad (1832-1905) and others based in the island. See Robert Harms, *Land of Tears*, New York, Basic Books, 2019, pp. 19-20. See also, Ann Beck, *Medicine and Society in Tanganyika, 1890-1930, A Historical Survey*, *Transactions of the American Philosophical Society*, Vol. 67, No. 3 (1977), p. 6. 'In their dealings with Zanzibar, the British were primarily motivated by two objectives. One was the restriction and eventual abolition of the slave trade and the second was the expansion of imports from India and England to East Africa as well as the export of tropical goods from East Africa to Europe.'

<sup>7</sup> Issa, 'Stinkibar,' p. 171. See also, Walter Bruchhausen, 'Practising hygiene and fighting the natives' diseases: Public and child health in German East Africa and Tanganyika territory, 1900-1960'. *DYNAMIS. Acta Hisp. Med. Sci. Hist. Illus.* 2003, p. 90. 'The most valuable good in our colonies, more valuable than all precious metals, is the indigenous human being.'

<sup>8</sup> Amina A. Issa, 'On Politics, Philanthropy and the Provision of Medical Services: Government Hospitals and the Expansion of Colonial Medicine in Zanzibar Town, 1896-1963' draft chapter, 1. Hereafter cited as Issa, 'On Politics.'

<sup>9</sup> Between 1894 and 1945, all government departments were managed by the colonial state and financed by locally generated funds. By 1900, the Department of Hospitals and Medicine and the Department of Sanitation were combined to form the Department of Medicine and Sanitation (DMSS). In 1955, the Health Department was formed to take responsibility for all work related to health facilities, disease, and health matters. See Issa, 'On Politics,' pp. 3, 5.

<sup>10</sup> Western medicine, the current model of care, promotes a system in which doctors and other trained

healthcare professionals, e.g., nurses, treat symptoms and diseases with pharmaceuticals, radiation, surgery, etc. Western medicine, also called allopathic medicine, holds that illness and disease is attributable to a specific, physiological dysfunction.

<sup>11</sup> During his experiments in the 1860s, French chemist Louis Pasteur developed modern germ theory. He proved that food spoiled because of contamination by invisible bacteria, and he proposed that bacterium caused infection and disease. In 1890 Robert Koch formulated 'postulates,' the guidelines for determining those specific microbes caused specific diseases.

<sup>12</sup> John Snow was an early proponent of germ theory. He noted that cholera could not be spread by poisons in the ambient air because the disease infected the intestines, not the lungs.

<sup>13</sup> Dr. David Livingstone (1813-1873), who began and ended his travels in Zanzibar, referred to urban Zanzibar as 'stinkibar.' According to Issa, Livingstone insisted that 'Africa was sick and suffering from the evils of the slave trade, paganism and the creeping forces of Islam.' Issa, 'Stinkibar,' p. 35. See Mary Dobson, *Disease: The Extraordinary Stories behind History's Deadliest Killers*, New York: Metro, 2007.

<sup>14</sup> *Ibid.* pp. 41-42. James Christie, who graduated in medicine at Glasgow University in 1863 and investigated cholera outbreaks in Zanzibar commented on the environmental conditions in Zanzibar. 'There are large numbers of cattle, and beasts of burden, horses, donkeys, and camels. The cows are driven out of their pasturage in the morning and in the evening, they are penned in the courtyard of the houses or in neighboring enclosures. In a very few cases, the cattle-pens are kept tolerably clean, but in general the droppings are allowed to accumulate till the cattle are standing knee-deep [in manure].'

<sup>15</sup> Issa, 'Stinkibar,' pp. 43-53.

<sup>16</sup> Issa, 'On Politics,' p. 5 and Issa, 'Stinkibar,' p. 14. 'Throughout the colonial period, Western medicine or biomedicine ... competed with indigenous medical treatment in Zanzibar. For almost sixty years, colonial administrators and medical doctors emphasized the use of biomedicine and tried to displace the use of indigenous medicines. The urban population, however, continued to seek advice from local healers. They consulted therapeutic experts who could identify a troublesome spirit or they bought local medicines. For Muslims in urban Zanzibar, Islamic healing methods were (and still are) popular. ... So while people adopted Western medicine during the colonial period, they also used African, Hindu and Islamic medicine.'

<sup>17</sup> Very few Zanzibari women were admitted to medical, nursing, midwifery or public health schools in the UK or India before 1940. 'Many Arab girls associated the work of nursing with slave work, ... between 1927 and 1945 the nursing services in Zanzibar were dominated by Zanzibaris born of slave descents. ... Also, from the early 1950s, more female nurses were trained in Zanzibar. ... Several Indian female physicians, trained at Bombay University, were working in Zanzibar in the late 1940s.' See Issa, 'On Politics,' p. 29.

<sup>18</sup> In some places in Europe and North America the germ theory was not popularized until 1920. See [curiosity.lib.harvard.edu/contagion/feature/germ-theory](https://curiosity.lib.harvard.edu/contagion/feature/germ-theory).

<sup>19</sup> *Ibid.*, pp. 70-71. 'Smallpox vaccination was attempted in Zanzibar Town by the British-Indian officials during the 1858 smallpox epidemic but was avoided by many people.' It was also the case that very few patients attended facilities promoting Western medicine and that until the 'late 1880s, Western medicine was not [judged] superior to indigenous medicine.' *Ibid.*, p. 112.

<sup>20</sup> Jagdish S. Gundara, 'Aspects of Indian Culture in nineteenth century Zanzibar, South Asia: Journal of South Asia Studies, Vol. 3, 1980, 247.

<sup>21</sup> Issa, 'Stinkibar,' pp. 97-98. See Josiah Tayati, Zanzibar SDA Dispensary, first published on April 12, 2021. <https://encyclopedia.adventist.org/article?id=2FLF>. See also Adu-Gyamfi S, Kuusaana MM, Darkwa BD, Tomdi L. 'The changing landscape of mission medicine and hospitals in Africa.' *Christian Journal for Global Health*. December 2020; 7(5): <https://doi.org/10.15566/cjgh.v7i5.417>. 'Missionary groups employed numerous mechanisms to make disciples. They constructed schools and hospitals, engaged in public health campaigns, provided charity for the poor, and contributed cheaper social welfare

programmes as their most effective tools. The establishment of hospitals and dispensaries stood as the most effective soul-winning mechanism for many Christian missions. Their public health role has been crucial in incorporating the principles of biomedicine as a viable option in African pluralistic medical tradition. Since the colonial era, medical missions have been active in most former colonies. Among the motivations for engaging in the act of healing are spreading the gospel, making healthcare more accessible, and providing holistic care. Aside from healing, missions have used various strategies to accomplish their goal of introducing Christ to Africa.' See also, Michael Jennings, 'Cooperation and competition: missions, the colonial state and constructing a health system in colonial Tanganyika', Chapter 8, in Manchesterhive.com, 157. 'Missions operated as the largely individual, atomized units they were, competing rather than cooperating with their fellow faith adherents.'

<sup>22</sup> Ibid., p. 113.

<sup>23</sup> Ibid., p. 152.

<sup>24</sup> Ibid., p. 32.

<sup>25</sup> Princess Salme bint Said, a sister of Sultan Barghash, took the name Emily when she married a German merchant. She left Zanzibar and settled in Germany where she recorded her memoirs 'for her children.' After being encouraged to publish her writings, she agreed to allow the book to 'go out into the work [where it might meet] with as many friends as was [her] happy lot to find. In the fifteenth of the twenty-one chapters she described medical practices in Zanzibar and emphasized the importance of engaging female doctors. *Memoirs of an Arabian Princess. Emily Ruete (Salme Saïd; Sayyida Salme, Princess of Zanzibar and Oman) 1844-1924.* Translated by Lionel Strachey, 1864-1927. New York: Doubleday, Page and Co., 1907, p. 98. (This edition was published in 2016.)

<sup>26</sup> Ibid., p. 27.

<sup>27</sup> Ibid., p. 24. Care was provided to children because they were viewed as future laborers in Zanzibar's economy.

<sup>28</sup> Issa, 'On Politics,' p. 22.

<sup>29</sup> Ibid., p. 322.

<sup>30</sup> Ibid., p. 21. Given contemporary beliefs about race and illness, it was common to separate communities according to race and to attribute illness to racial difference rather than poverty, poor nutrition, or unhealthy living conditions. Until antibiotics were available in the middle of the 20th century, the poorest communities benefited most from improved sanitation and hygiene, and better nutrition.

<sup>31</sup> African representatives joined the Legislative Council after World War II. 'The British administrators allocated biomedical facilities according to the social and economic positions of the communities. Europeans were given extensive medical services followed by the rich Arabs and Indians and lastly the poor Indians, Arabs and Africans. Issa, 'On Politics,' p. 14.

<sup>32</sup> Issa, 'Stinkibar,' p. 322.

<sup>33</sup> Most environmental improvements took place after 1900. See Amina Issa, 'Malaria and Public Health Measures in Colonial Urban Zanzibar, 1900-1956.'

<sup>34</sup> Issa, Op. Cit., p. 28.

<sup>35</sup> Established by the British during the early years of the Protectorate, the General Hospital and its satellite clinics became the Hassanali Karimjee Jivanjee (HKJ) hospital in 1955. With new financing and expanded facilities, the HKJ Hospital became the Mnazi Mmoja Hospital shortly after independence. Renamed the V.I. Lenin Hospital after the 1964 Revolution, the hospital was later renamed and still carries the name - Mnazi Mmoja Referral Hospital.

<sup>36</sup> Issa, Ibid., p. 2.



<sup>37</sup> Representatives from Zanzibar attended the Alma Ata Conference in 1978 and endorsed the Declaration that justified these positions.

<sup>38</sup> Established at Independence as the Ministry of Health and Social Welfare, the ministry became the Ministry of Health, Social Welfare, the Elderly and Gender until President Dr. Hussein Mwinyi split the ministry into a health division and a welfare division on March 8, 2022. Tanzania Daily News, 'President Mwinyi Splits Health Ministry.'

<sup>39</sup> After receiving no more than 10% of the cost of programmes and operations from the government, the Ministry of Health became dependent on contributions – finance, trained personnel and equipment/ supplies, and especially pharmaceuticals – from external donors, initially the Soviet Union, the German Democratic Republic, and the People's Republic of China. More recently, the American and Danish Government aid agencies, other governments and multilateral donors and organizations, e.g., the World Health Organization, UNICEF, etc., have been major contributors to selected programmes of the ministry, e.g., The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and The U.S. President's Malaria Initiative.

<sup>40</sup> 2021 Zanzibar Statistical Abstract, Office of the Chief Government Statistician, August 2022, p. 37. Revolutionary Government of Zanzibar, News and Events, 'Mnazi Mmoja Referral Hospital,' March 11, 2022.

<sup>41</sup> The three private facilities are Tasakhtaa Hospital (130 beds), Tawakal Hospital (60 beds) and Al Rahma Hospital (60 beds)

<sup>42</sup> UNICEF, Zanzibar, 2021.

<sup>43</sup> For details on the successful Malaria programme in Zanzibar see <https://www.afro.who.int/countries/ united-republic-of-tanzania/news/moving-towards-zero-malaria-zanzibar#:~:text=Zanzibar%20%2D%20The%20prevalence%20rate%20of,the%20Eastern%20and%20Central%20Africa>

<sup>44</sup> Sources: WHO Africa, 'Moving towards zero Malaria in Zanzibar, October 19, 2022; Kizito Makoy, Zanzibar close to zero malaria cases, April 4, 2022; and Bjorkman et al., 'From high to low malaria transmission in Zanzibar – challenges and opportunities to achieve elimination, BMC Medicine, 17:14, 2019. <https://doi.org/10.1186/s12916-018-1243-z>.

<sup>45</sup> Zanzibar Stone Town Projects, Historic Cities Support Programme, Aga Khan Trust for Culture, 1997, p. 9.

<sup>46</sup> Gosling and Morris, a highly regarded architectural firm, also designed and supervised the construction of the Blue Synagogue of David Sassoon, a very wealthy Baghdadi Jew who prospered by trading opium in China. See Joseph Sassoon, *The Sassoons*, New York, Pantheon Books, 2022.

<sup>47</sup> Topan himself never saw the building as he died in 1891; he was knighted by Queen Victoria in 1890 for his political and philanthropic achievements, including his role in the abolition of slavery. These events are recorded in the Historic Cities Support Programme, *The History and Conservation of Zanzibar Stone Town*. (London: James Currey, 1995) pp. 9-10. See also *Zanzibar under Colonial Rule*, edited by Abdul Sheriff and Ed Ferguson, London: James Currey, 1991, p. 170.

<sup>48</sup> Information on the type of services offered, the number of patients served and the facility's links with other health programmes and facilities in Stone Town throughout the 20th century is not readily available.

<sup>49</sup> The terms of the lease are set forth in the document dated October 16, 1990, between the Zanzibar Revolutionary Government (Chief Minister's House) and the Aga Khan Cultural Services Zanzibar, registered at Extelcom House, Stone Town, P.O. Box 3716, Zanzibar.

<sup>50</sup> <https://www.archnet.org/publications/4786>

<sup>51</sup> The Zanzibar Digital Health Strategy, released on September 25, 2020, promotes the transformation of the entire health system to increase the use of client level systems that facilitate the delivery of safe, quality health care.

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This richly illustrated booklet by Farouk Topan and John B. Tomaro describes the health conditions and the state of health care in Zanzibar at the end of the 19<sup>th</sup> century, when the Zanzibar Stone Town Old Dispensary was commissioned by Tharia Topan and constructed. It traces several health-related concepts as well as underlying healthcare practices into the 20<sup>th</sup> and 21<sup>st</sup> centuries and describes changes in the burden of disease, the determinants of health and the development of modern medicine, public health and health care. The paper closes with a brief discussion of the current structure of the health care system in Zanzibar, which is the context within which the new Aga Khan Health Centre is operating.

With this compelling narrative, the authors link the evolution of health and health care in Zanzibar with that of its iconic Old Dispensary building. The wealth of information here will enlighten anyone who is interested in Zanzibar, history and global health.

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