

«Practising hygiene and fighting the natives' diseases». Public and child health in German East Africa and Tanganyika territory, 1900-1960 (*)

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ABSTRACT

For reasons of population policy and missionary strategies, childcare was a relatively early issue of colonial medical policy and services in East Africa. The main challenge for the adaptation of biomedicine to the local situation proved to be not so much schemes for treatment or prevention, but rather the question of staffing. Education and employment of females, as well as social acceptance and keeping up professional standards of biomedically trained personnel, posed major obstacles to the implementation of governmental health policies. In addition to these obstacles, European prejudices about African disinterest in child health contributed to the feeling that limited progress had been made after 50 years of biomedical efforts to improve African child health.

Palabras clave: Mortalidad infantil, salud infantil, Tanzania, Tanganika, África oriental alemana

Keywords: Infant mortality, child health, Tanzania, Tanganyika, German East Africa

Children's health is something many people in industrialised countries associate with development cooperation and emergency aid. Photographs of malnourished, feverish kids belong to the most efficient (though also much criticised) means to gain private donations for Africa. This popular emphasis on children's welfare, which indeed corresponds to a certain preference for infant and maternal health care projects, was certainly not characteristic of European medicine in Africa in its beginnings. However, preventive health services for small children did belong to the first and major specialised social services for native populations in many colonial territories. Apart from their quantitative importance, mother and child health services are also characteristic of colonial medicine from a qualitative point of view (1).

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- (1) I have discussed colonial and academic discourses on the relationship between culture and health in East Africa for a German-reading audience in my review: *Gesundheit durch oder trotz Kultur? Die sozio-kulturelle Dimension als Argument in Erforschung und Geschichte der Medizin in Ostafrika. Geschichte und Kulturen. Zeitschrift zur Geschichte und Entwicklung der Dritten Welt*, 2000, 9, 145–175. Relevant reviews of studies on colonial medicine in English referred to therein include ANDERSON, Warwick. Where is the postcolonial history of medicine? *Bulletin of the History of Medicine*, 1998, 72, 522–530; MARKS, Shula, What is colonial about Colonial Medicine? And what has happened to Imperialism and health? *Social*

As will be seen in the varying strategies for their implementation discussed in this paper, these campaigns play a crucial role in the clash of European and African ideas of the «right» way of living.

To discuss the economic and political motivations for the development of child welfare activities does not mean to accuse all colonial healthcare providers of lacking a genuine sympathy for the sick and a wish to relieve their suffering. Some providers expressed their moral sentiments and intentions in written and spoken words, and the dedication and affection of their care were proof of this attitude. Nevertheless, the reasons for the development of healthcare institutions and policies must be sought in more than just personal, moral feelings.

The main tasks of early colonial medicine were the conservation and restoration of the health of Europeans residing in tropical areas. The health of the natives was usually only considered when their diseases also threatened the Europeans, as in the case of malaria or plague. However, other motives must have played a role as well. For example, smallpox did not threaten the already-immunised European troops and immigrants, but nevertheless major vaccination campaigns were started soon after the beginning of colonial rule in East Africa at the end of the 19th century. Similarly, campaigns were initiated against parasitic diseases (first of all sleeping sickness), intestinal worms (especially hookworm) and bacterial infections (e.g. yaws and venereal diseases). Here the decisive argument for improving the natives' health was not self-protection of colonial agents, but the economic and political interests of the colonial powers (2). Within these developments of colonial administration and healthcare, the attention to children's welfare and health played an important, sometimes even pioneering role in East Africa.

History of Medicine, 1997, 10, 205-219; VAUGHAN, Megan. Healing and curing: Issues in the social history and anthropology of medicine in Africa. *Social History of Medicine*, 1994, 7, 283-295.

(2) For native «workforce» as argument for colonial health care in a West African region see LASKER, J. N. The role of health services in colonial rule: the case of the Ivory Coast. *Culture, Medicine & Psychiatry*, 1977, 1, 277-297 (p. 287).

The example chosen to demonstrate these developments is the area that is today mainland Tanzania. This area was part of the protectorate «German East Africa» from 1891 until World War I, and became «Tanganyika Territory» as British mandate of the League of Nations (and later the United Nations) until independence in 1961 (3). Thus three periods of European efforts in healthcare for East-African children will be distinguished and presented: the second half of German colonial rule, showing signs of an emerging social policy for the African population; the first half of the British administration until World War II, in the end heavily impaired by economic problems; and the last 15 years of British responsibility, with increasing preparations for independence (4). In an initial short section, general motives, reasoning and strategies for improving children's health will be outlined, followed by the main section on the implementation of the policy in relevant services, especially with regard to African staff. A concluding section deals with European opinions on African childcare, with regard to the success and failure of child health programmes.

During the colonial period and the following decades, historiography of medicine wrote the expansion of European medicine in colonial territories as a story of heroes and, despite serious set-backs, successes (which were considered a blessing for the native population). Later historians, influenced by the critique of colonialism and post-colonial anthropology, also focused on the «experience of the coloni-

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- (3) For the political history of the area see ILIFFE, John. *Tanganyika under German rule 1905-1912*, Cambridge, Cambridge University Press, 1969; ILIFFE, John. *A modern history of Tanganyika*, Cambridge, Cambridge University Press, 1979; OLIVER, Roland; MATHEW, Gervaise. *History of East Africa*, Oxford, Clarendon Press, 1963.
- (4) For the medical history of these periods see CLYDE, David Francis. *A history of the British medical services in Tanganyika*, Dar es Salaam, Government Printer, 1962; BECK, Ann. *A history of the British medical administration in East Africa*, Cambridge/Mass, Crossroads Press, 1970; BECK, Ann. The role of medicine in German East Africa. *Bulletin of the History of Medicine*, 1971, 45, 170-178; BECK, Ann. *Medicine and society in Tanganyika 1890-1930. A historical inquiry*, Philadelphia, The American Philosophical Society [Transactions 67/3], 1977; BECK, Ann. *Medicine, tradition and development in Kenya and Tanzania 1920-1970*, Waltham/Mass., Crossroad Press, 1981.

zed» and the «several competing systems of health and healing» (5). But with the anthropological move away from «systems» to «agency», recent historiography on colonial Africa strives to give equal attention to the Africans' actions in order to overcome the depiction of the autochthonous population as mere recipient or passive victim of European activities, as in the two earlier types of studies (6). However, this effort is confounded by the relative scarcity of written sources and the problems of oral history in matters of daily life. Thus the following article is mainly an analysis of European discourse and action. Nevertheless, there can be no doubt that the «success» or «failure» of certain health policies was not so much a matter of German or British cleverness or skilfulness. Rather, it was the result of the African population selecting and integrating elements of European healthcare into their health-related concepts and behaviours.

1. *THE INFANT AS EMERGING MEDICAL ISSUE: POPULATION POLICY AND PUBLIC HEALTH*

1.1. *Population growth or decline?*

«Not the products of fauna and flora, nor the minerals in the earth are the most precious that East Africa contains, but the black man himself» (7). This almost lyrical statement was written in 1900 by one of the most prolific writers on German East Africa, Hans Meyer, geographer, traveller and publisher of the leading German encyclopaedia named after his family. As a justification for a native social policy, this preference for the productive factor «man» became expert

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- (5) ARNOLD, David. Medicine and colonialism. In: William F. Bynum; Roy Porter (eds.), *Companion encyclopedia of the history of medicine*, London-New York, Routledge, 1993, Vol. 2, pp. 1393-1416 (pp. 1393-1394).
- (6) See KLEINMAN, Arthur. *Writing at the margin: Discourse between Anthropology and Medicine*, Berkeley, Los Angeles, London, University of California Press, 1995, p. 8 and ILIFFE, John. *East African doctors. A history of the modern profession*, Cambridge, Cambridge University Press, 1998.
- (7) MEYER, Hans. Zur Bevölkerungspolitik in Deutsch-Ostafrika. *Koloniale Zeitschrift*, 1900, 1, 102-103 (p. 102) [all translations by the author].

opinion (8). The welfare of the native population was even proclaimed an official end of the German administration when the Colonial Office re-orientated German policies in East Africa after the Maji Maji war of 1905-1906. As such, this reasoning was taken up by members of the medical profession in East Africa. Staff surgeon Otto Peiper expressed it in terms similar to Meyer's in 1912: «The most valuable good in our colonies, more valuable than all precious metals, is the indigenous human being» (9). The view of human beings as goods reflected the main aim of the colonial enterprise: economic development of the metropolis by means of natural resources.

This reasoning corresponds with the resolution of the «labour question» of 19th century Western Europe. Here, too, the improvement of living conditions for the urban working class was undertaken for economic and political reasons rather than for humanitarian motives of charity or social justice. The idea that the natives would become future customers of European industrial products had also already been taken into consideration (10). The resulting policy of improving some aspects of the natives' situation, however, had to be defended against the strong settlers' interests who rather favoured white immigration.

(8) See the *Denkschrift*/Memorandum by Dr. SCHILLING from 1908, Geheimes Staatsarchiv Preußischer Kulturbesitz [Secret Central Archives; W.B.] Berlin (GStA) I. HA Rep. 76 VIII B 4458 Sanitäts- und Medizinalwesen in den deutschen Schutzgebieten 3/1906-2/1911, pp. 203-253 (p. 204). After World War II, the author, Prof. (since 1919) Dr. Claus Schilling (1871-1946), a former colonial doctor in Africa and later member of the League of Nations' Commission on Malaria, was executed for his malaria trials on inmates of the concentration camp in Dachau.

(9) PEIPER, Otto. Sozial-medizinische Bilder aus Deutsch-Ostafrika. *Zeitschrift für Säuglingsschutz*, 1912, 244-259 (p. 244); see similar quotations in KOPONEN, Juhani. *Development for exploitation: German colonial policies in mainland Tanzania, 1884-1914*, Helsinki, Hamburg, Lit 1995, p. 461.

(10) See MEYER, note 7, p. 102. For a short description and exemplary literature of such explanations for colonial child care see BEINART, Jennifer. Darkly through a lens: Changing perceptions of the African child in sickness and health, 1900-1945. In: Roger Cooter (ed.), *In the name of the child: Health and welfare, 1880-1940*, London, New York, Routledge, 1992, pp. 220-243 (p. 220).

Whereas in 1900 the traveller Meyer noticed a fast population growth of natives in German East Africa, which he attributed to colonial peace and safety, the view completely changed ten years later. Then reports from most German overseas territories claimed a severe decrease of the native population. The actual existence of a decline and its extent, along with main causes for and possible measures against this tendency, were much contested issues that will be analysed in more detail for the East African protectorate (11).

After World War I, the fear of a population decline remained widespread within the British administration of Tanganyika Territory. Research done in Kahama District in the North East concluded that the Ubena area, named after the district's major ethnic group, was not depopulated by the Maji Maji war, but by a low birth rate (12). Malthusian speculation on possible population growth through improved hygiene, as common in the debate of neighbouring Kenya in the 1920s, is not found in Tanganyika (13). In 1930 the problem was discussed for the British Empire when the Secretary of State for the Colonies wrote to the Governors of African Territories: «It has recently been represented to me that the numbers of the native population in many parts of the Empire is [sic] stationary, if not actually on the decrease» (14). Even in 1941 the Tanganyikan population's future growth remained dubious, as is attested by the prediction of the locally-experienced sociologist A. T. Culwick. Culwick predicted that, contrary to the official reports,

(11) See ECKART, Wolfgang U. *Medizin und Kolonialimperialismus: Deutschland 1884-1945*, Paderborn, Schöningh, 1997 (Index «Bevölkerungsrückgang» p. 613); ITTAMEIER, Carl. *Die Erhaltung und Vermehrung der Eingeborenen-Bevölkerung*, Hamburg, Friedrichsen [Abhandlungen aus dem Gebiet der Auslandskunde Reihe B 13], 1923.

(12) See the copy for the Director of Medical and Sanitary Services by Governor Donald CAMERON, 31/8/28, National Archives of Tanzania (TNA) in Dar es Salaam 11568, Investigations and treatment of worm infections (ankylostomiasis), 1927-1936, pp. 41-42; see CLYDE, note 4, pp.127-128.

(13) BECK, note 4, pp. 146-148.

(14) Quoted after VAUGHAN, Megan. Measuring crisis in maternal and child health: An historical perspective. In: Marcia Wright; Zena Stein; Jean Scandlyn (eds.), *Women's health and Apartheid: The health of women and children and the future of progressive primary health care in Southern Africa*, Frankfurt, Medico International 1989, pp. 130-142 (p. 130).

the territory's population would fall to merely three million by the year 2000. In fact, it grew to 30 million (15).

1.2. *Infant mortality by harmful baby feeding?*

In the German investigation of the alleged population decline taken up after 1906, medical personnel were the experts most often consulted. Favouring medical doctors for giving explanations was not contested, although other experts might have given relevant causes for a decrease of the population, too. For example, scarcity of food or deliberate renunciation of children by desperate parents could also have been important points. What's more, the causes for the depopulation of some districts were clearly seen in economic and security problems, especially with the matrilineal people in the South after the deliberate destruction of crops by German troops in the Maji Maji war. The most important answer to the overall problem, however, was expected to be a medical one.

In 1914 a report by the Medical Director of German East Africa summarised the findings by investigators on the alarming development of the African population (16). Low fertility was one of the main causes, but again, due to several different factors. Part of it was ascribed to spontaneous abortions induced by the spread of venereal diseases, especially in Bukoba District at Lake Victoria and in Ujijidji (Ujiji) at Lake Tanganyika, where the medical officer stated that polygamy lead to prostitution. *Swahili* women in the urbanised centres of the coast were

(15) CULWICK, A. T. The population trend. *Tanganyika Notes & Records*, 1941, 11, 11-17. The figure of 29 727 thousand inhabitants was given in the 1994 census after which further censuses have been cancelled due to lack of financing and urgent expenses for elections. The figure includes Zanzibar, since 1964 united with Tanganyika to form the United Republic of Tanzania. However, Zanzibar's less than one million inhabitants do not change the population figure significantly. See STATISTISCHES BUNDESAMT, *Länderbericht Tansania 1994*, Stuttgart, Metzler-Poeschel, 1994, pp. 17-32.

(16) For the following see Familien-Nachwuchsstatistik über die Eingeborenen von Deutsch-Ostafrika. *Deutsches Kolonialblatt*, 1914, 25, 440-457.

accused of practising artificial abortion in order to avoid the high cost of additional food for the child and to evade the molestation of late pregnancy. *Wagogo* women were said to be denied sexual intercourse for the whole period of breast-feeding up to five years (17).

The other main cause for the low increase or even decline of the population was seen in the high infant mortality. As in the discussion of possible causes for population decline, various causes of children's deaths were discussed for their impacts on the rate. Thus, it was acknowledged that the African population's semi-immunity to tropical diseases like malaria was paid for by many deaths during infancy (18). However, faults in infant feeding were regarded as the most important (or at least best preventable) causes of infant mortality (19). Occasionally, a great diversity of causes was acknowledged. For example, after World War I Peiper stated with acuity: «Never is it one cause only (...) that produces a decrease of a population and destroys a people, but always several causes act in combination, one or more of which, nevertheless, might be more prominent» (20).

Among the first to address the topic of infant nutrition were members of the Christian mission societies in East Africa —some of which had been in the country long before the German conquest took place (21).

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- (17) Natural spacing of birth by prolonged breast-feeding as propagated later in developing countries was not accepted biomedical knowledge at that time.
- (18) See STEUBER, Werner. Malariaimmunität und Kindersterblichkeit bei den Eingeborenen in Deutsch-Ostafrika. *Deutsche Medizinische Wochenschrift*, 1903, 29, 72-73.
- (19) A recent study in Ghana suggests that weaning practices do not have a significant influence on neonate mortality. See BINKA, F. N. *et al.* Risk factors for child mortality in northern Ghana: a case-control study. *International Journal of Epidemiology*, 1995, 24, 127-135.
- (20) PEIPER, Otto. *Der Bevölkerungsrückgang in den tropischen Kolonien Afrikas und der Südsee, seine Ursachen und seine Bekämpfung*, Berlin, Schoetz [Veröffentlichungen aus dem Gebiete der Medizinalverwaltung 11, 7], 1920, p. 27.
- (21) For the general history of Christian missions in the country see OLIVER, Roland. *The missionary factor in East Africa*, London, Longman, 1965. There is no comprehensive monograph on mission medicine in East Africa. Some literature for the medical activities of the several mission societies is given in the relevant footnotes. For a general introduction into development, motives and strategies

In his influential book on the experiences of a medical missionary, Dr. Septimus Tristram Pruen of the British Church Missionary Society (CMS) wrote in 1891:

«It is always a surprise to me how babies in Africa could stand the treatment to which they were subjected. They are fed from birth upwards upon gruel in addition to their natural food. On theoretical grounds the majority of them should die from gastric irritation; but such does not appear to be the case, and most survive this utter neglect of the rules of physiology and dietetics» (22).

A later commentary with greater administrative influence was that offered in 1908 by the Catholic Bishop for the South of German East Africa, the Benedictine Father Thomas Spreiter. Often referring to infant mortality and the possible saving of souls, he urged the priors and prioresses of his diocese to inform the people of the «ignorance» of their traditional birth attendants and the damage done by various practices. One of the points was the allegedly harmful feeding of Uji, the local millet porridge, to newborn babies (23). A Protestant Mission Society in the Northeastern area of the *Shambala*, then called Wilhelmsthal, today Lushoto, wrote: «Our dislike of ‘papa’ (porridge) is so well known here already that women bringing babies for treatment of intestinal disturbances spontaneously emphasise that no ‘papa’ had been given, which, however, does not concord to the facts most of the time» (24).

of the medical mission movement see GRUNDMANN, Christoffer H. *Gesandt zu heilen! Aufkommen und Entwicklung der ärztlichen Mission im neunzehnten Jahrhundert*, Gütersloh, Gütersloher Verlags-Haus Mohn, 1992.

- (22) PRUEN, Septimus Tristram. *The Arab and the African. Experiences in Eastern Equatorial Africa during a residence of three years*, London, Darf, 1986 [First edition 1891] p. 156.
- (23) SPREITER, Circular letter, On the Indian Ocean, 2.11.1908, Kongregationsarchiv der Missionsbenediktiner [Missionary Benedictine Fathers’ Congregational Archive; WB] St. Ottilien (KAMBSStO), Folder Daressalam [sic!] 1, Bishop, Circular Letters, p. 6.
- (24) Quoted in MEIXNER, Hugo. Säuglings- und Kinderernährung in Deutsch-Ostafrika. *Deutsches Kolonialblatt*, 1914, 25, 354-65 (p. 355).

In the same district in 1911, the Lutheran mission society of Leipzig claimed that because of providing simple information on child-care and nutrition, none of the 13 Christian babies born that year had died despite the fact that the common infant mortality rate was 75 percent (25). In the neighbouring area of South Pare, missionary Dannholz of the same society counted, by what would be called «verbal autopsies» today, a mortality rate for children below 18 months of 70 to 75 percent before 1909 and of 13 percent after 1909 (26). Due to statistical uncertainties he cautiously concluded that the infant mortality rate after the start of missionary engagement in child health did not exceed 25 percent. Such survival rates were not altogether improbable at that time. A recent study of parish registers at the slopes of the Kilimanjaro, like the near Lushoto and Pare then an exceptionally healthy, fertile and secure area, revealed that infant mortality under German rule was probably not higher than in contemporary England, Germany or Italy (27). Yet it might be doubted that this was the result of health education by the missions. During the more than 40 years of missionary, medical and preventive activities, the mentioned parish registers do not demonstrate any significant improvement in survival rates. In fact, what they evidence is perhaps even a deterioration in the levels of infant and child survival. For South Pare, however, recent research in missionary records maintains a «real reduction in mortality levels» during the time of missionary activities on child health before World War I (28).

For reasons somewhat different from those of the missions, in 1908 the colonial administration's medical experts came to a similar conclusion about the «irrational, even brutal way» of substituting milk with «vegetable matters» (29). Six years later (and more than twenty

(25) See MEIXNER, note 24, p. 354.

(26) See HÅKANSSON, N. Thomas. Pagan practices and the death of children: German colonial missionaries and child health care in South Pare, Tanzania. *World Development*, 1998, 26, 1763-1772 (pp. 1768-1769).

(27) COLWELL, Stacie. Infant and child mortality on Kilimanjaro, 1894-1935, Research Paper, Harvard School of Public Health, Boston, n. d.

(28) HÅKANSSON, note 26, pp. 1769-1770.

(29) SCHILLING, note 8, p. 205.

years after the attempts of missionary Dr. Pruen), the Medical Director of German East Africa also tried to explain the problem of infant feeding in a scientific way, this time with the now-leading discipline, bacteriology: «In earliest age the baby is given with the nutrition truly pure cultures of micro-organisms among which many will be certainly pathogenic. Thus it has to be nearly regarded as a wonder that the tender, young organism is able to resist at all» (30).

As it has been argued for contemporary England, relating infant mortality to bacteriology was an implication that mothers were responsible —as they could have fought the bacteria and prevented the death by hygiene (31). In the colonial context this argument implied blaming traditional customs, and it justified European civilisation as a necessary remedy. It also means that the effect of native feeding practices had already been a topic of discussion long before the extensive debate on colonial malnutrition and infant mortality that began in the mid-1920s (32). Typically, the social reasons for this feeding practice were not discussed at the time. Although it was reported that «grandmothers had to give something to eat to the child when mothers are at work on the fields» (33), the previous introduction of the hut tax that forced women to grow additional cash crops was not related to malnutrition. Admitting or even regretting that colonialism often deteriorated the health of the African population was rarely done before the following inter-war period. After the «loss» (then often called «robbery») of German colonies, German authors criticized the colonial activities of other European powers and their negative influence on the health of the indigenous population. Still, a relationship between colonial econo-

(30) Familien-Nachwuchsstatistik, note 16, p. 441.

(31) See WRIGHT, P. W. G. Babyhood: The social construction of infant care as a medical problem in England in the years around 1900. In: Margret Lock; D. Gordon (eds.), *Biomedicine examined*, Dordrecht, Kluwer, 1988, pp. 299-329 (p. 303) with reference to LEWIS, J. *The politics of motherhood: Child and maternal welfare in England, 1900-1930*, London, Croom Helm, p. 13.

(32) WORBOYS, Michael. The discovery of colonial malnutrition between the wars. In: ARNOLD, David (ed.), *Imperial medicine and indigenous societies*, Manchester, New York, Manchester University Press, 1988, pp. 208-225. VAUGHAN, note 14, pp. 131-138.

(33) Quoted in MEIXNER, note 24, p. 355.

mic practices and infant feeding was not recognized when discussing the effect of allegedly traditional female labour on mortality (34). Accusations of colonial effects on health remained rather vague. The famous missionary doctor in West Africa, Albert Schweitzer, lamented in his widely read book of 1926 the deterioration of native health by colonialism (35). Similarly, Bruno Gutmann, Lutheran missionary among the *Chagga* at Mount Kilimanjaro, wrote in 1925 that the high infant mortality rates in German East Africa before the war «bear for the most part witness only to disasters of the new times» (36).

In fighting the native practice of feeding infants with porridge, the administration chose a less individual approach than the missions. Information about «proper» feeding practices was distributed by leaflet in the lingua franca Swahili —a means of propaganda repeated later by the British medical administration in the 1920s (37). In 1914, the Chief Medical Officer, Hugo Meixner, concluded from the complete survey of the protectorate that as far as measures specifically directed against infant mortality were concerned, informing the mothers was sufficient for the time being. He argued that the situation was not so urgent and that more could be done to preserve the native populations by activities indiscriminate of the age group, such as fighting hookworm (38).

1.3. «Practising hygiene and fighting the natives' diseases»

Thus differing from the missions' individualist and more curative approaches, the medical administrations supplemented education on

(34) See PEIPER, note 20, pp. 5, 9-10 and 20-21.

(35) SCHWEITZER, Albert. *Zwischen Wasser und Urwald*, München, Biederstein [First ed. Bern, Haupt, 1926], 1949, p. 145.

(36) GUTMANN, Bruno. *Das Recht der Dschagga*, München, Beck, 1925, p. 144.

(37) Shauri njema. Habari ya kutunza watoto [Good advice. News on child care], reprinted in PEIPER, note 9, p. 258. TANGANYIKA TERRITORY, *Mafundisho kwa watu wazima wa Afrika* [Lessons for adults in Africa], G[overnment]. P[rinter]. - D[ar es]S[alaa]M 12383 and 12893, n. d.

(38) MEIXNER, note 24, p. 365.

infant feeding with campaigns against smallpox and parasites. More generally, information on prevention as well as large-scale measures against single diseases, or, as Peiper named it, «Practising hygiene and fighting the natives' diseases» (39), were regarded as the only weapons against infant mortality during a period when individual biomedical care for all Africans was still out of question.

Such accounts of colonial preoccupation with infant nutrition cast doubt on the often expressed view that considerations of mother and child health came only after the major diseases had been already controlled (40). Apart from smallpox and plague, the incidence of most infectious diseases was still increasing when the first efforts to improve child health were started. The relationship between attempts to improve hygienic and overall living conditions on the one side, and to control single diseases by campaigns on the other, remains strained up to now. This can be observed for the African population, as well as for international policy makers. Thus the World Health Organisation favours a whole comprehensive community based approach, while UNICEF launches programs on individual health problems (41).

Because of European efforts during colonial times, many East Africans got the impression that hygiene was a prominent aspect of European education and culture. Petro Mutambo, one of the first Tanganyikans

(39) PEIPER, Otto. Über Säuglingssterblichkeit und Säuglingsernährung im Bezirke Kilwa (Deutsch-Ostafrika). *Archiv für Schiffs- und Tropenhygiene*, 1910, 14, 233-259 (p. 254).

(40) See e.g. EBRAHIM, G. J. Development of Medical Services in Dar es Salaam. *Tanzania Notes & Records*, 1970, 71, 173-174 (p. 174).

(41) On the international level in the 1970s, the controversy shifted slightly from a simple opposition of prevention by hygiene vs. by immunisation. The WHO with its «horizontal» strategy of comprehensive primary health care adopted in Alma Ata in 1978 advocated an approach integrating health education, nutrition, water supply and sanitation, control of diseases and basic treatment. UNICEF favoured selective «vertical» programs with measurable effects like vaccination, oral rehydration, child monitoring and breastfeeding. See WALSH, Julia; WARREN, Kenneth. Selective primary health care: An interim strategy for disease control in developing countries. *New England Journal of Medicine*, 1979, 301, 967-974; Antwerpen Resolution 1985. *Soc. Sci. & Med.*, 1988, 26, 880; TAYLOR, C.; JOLLY, R. The straw men of PHC. *Social Science & Medicine*, 1988, 26, 971-977.

with higher European education, wrote in 1944: «mostly the education taught to Africans was cleanliness for good health» (42). However, East Africans generally preferred to incorporate more concrete, material means of European origin into their conceptual repertory of means for prevention and cure. Thus, in East Africa where variolation as a type of immunisation against smallpox and scarification had been widespread before colonial rule people seem to have readily accepted the obviously less dangerous vaccinations (43). Just before the beginning of colonial administration, Dr. Pruen found in Mpwapwa, in the hinterland of the central Swahili coast: «Some of the tribes practise inoculation amongst themselves, and are eager to be vaccinated when they have the opportunity, frequently coming long distances to a mission station for that purpose» (44).

(42) MUTAMBO, Petro Ch. The African and how to promote his welfare. *Tanganyika Notes & Records*, 1944, 18, pp. 1-10 (p. 2).

(43) E.g. REICHS-KOLONIALAMT (Hg.), *Medizinal-Berichte über die Deutschen Schutzgebiete Deutsch-Ostafrika, Kamerun, Togo, Deutsch-Südwestafrika, Neu-Guinea, Karolinen, Marshall-Inseln und Samoa für das Jahr 1906/07*, Berlin, Mittler, 1908 [in the following quoted as *Medizinal-Berichte* and year reported on] p. 20 mentions «mostly great readiness for vaccination». The last medical report on the German colonial territories, STEUDEL, Emil. *Aus den Jahres-Medizinalberichten 1912/13 der tropischen deutschen Schutzgebiete*, Leipzig, Barth [*Beihefte zum Archiv für Schiffs- und Tropenhygiene, Pathologie und Therapie exotischer Krankheiten* 1924, 28, *Beiheft 1*] p. 7 states for German East Africa: «Nearly everywhere the natives had gained trust into the vaccinations, therefore in the reported year 747 000 natives, i.e. ca. 10 % of the whole population of the protectorate, could be vaccinated». Several millions of vaccinations as reported by the German medical administration over the years and never doubted by the later British medical department so critical of German healthcare in East Africa could not have been enforced by the small number of colonial agents. As resistance against European medical measures for other diseases, e.g. sleeping sickness, leprosy or hookworm, is often noted in medical reports, a certain plausibility for the reported acceptance of vaccinations could be assumed *ex silentio*. For the 25 years of German rule I found in my sources just two incidences of resistance to vaccinations, both related to other events. Thus the common resistance to vaccinations found in contemporary health reports from other parts of the world seems not to have played a major role in East Africa.

(44) PRUEN, note 22, p. 151.

The use of foreign materia medica was also a common feature in pre-colonial East Africa (45). It should come as no surprise then, that the enthusiastic acceptance of certain therapies resulted in some cases in unopposed mass treatment campaigns (46). Contrary to this traditional interest into foreign means for disease prevention and healing, people often resented the propagated changes in their way of living or found them impossible to follow. Latrines were «built for fear of punishment, but not used» (47). Drinking water was not boiled, as fuel was scarce. Children were not bathed and fed as recommended —often due to lack of water, soap and food.

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- (45) REYNOLDS WHYTE, Susan. The power of medicines in East Africa. In: Sjaak van der Geest; Susan Reynolds Whyte (eds.), *The context of medicines in developing countries: Studies in pharmaceutical anthropology*, Dordrecht, Kluwer, 1988, pp. 217-233.
- (46) Especially the mass treatment by injection for yaws and syphilis in the 1920es and 1930es was deliberately sought by ten thousands of patients, see e.g. RANGER, Terence O. Godly medicine: The ambiguities of medical mission in Southeastern Tanzania, 1900-1945. In: Steven Feierman; John M. Janzen (eds.), *The social basis of health & healing in Africa*, Berkeley, University of California Press, 1992, pp. 256-82 (pp. 263-269). These observations do not exclude, that mass treatment for yaws was enforced at times, too. However, VAUGHAN, Megan. *Curing their ills. Colonial power and African illness*, Cambridge, Polity Press, 1991, pp. 49-52, in a book dealing mainly with British Central and East Africa, had to use as an example that the injections for yaws, given in a truly dehumanising mass administration, were enforced through «indigenous representatives of the colonial state» a report from Nigeria, West Africa, in the 1950s —decades after and thousands of miles away from the events where *sindano* (Swahili for «needle», i.e. injection) gained its above mentioned popularity.
- (47) PEIPER, note 20, p. 13; see KOPONEN, note 5, p. 491. Despite strong emphasis on using latrines in health education for decades not using them was seen as a main cause for spreading hookworm even after Independence; see MEIENBERG, Hildebrand. *Tanzanian citizen. A civics textbook*, Nairobi, Oxford University Press, 1966 (pp. 67-68). The sudden, dramatic and locally focussed drop in hookworm cases after introducing safe water supply in the Ndanda area (where I did my field research) in the late 1990es seems to indicate that piped water might be more important than the use of toilets and shoes.

2. THE DEVELOPMENT OF CHILD HEALTH SERVICES

2.1. Early child health care under German rule: Government and Missions

Initially intended for Europeans and for African (i.e. Sudanese and *Zulu*) troops only, the German military health facilities were soon opened to the native population (48). This was regarded by the government as a means to enhance native acceptance of German rule, and at the same time demonstrate European good-will and superiority. The governor ordered in 1911:

«The public outpatient clinics which have to exist in all military medical institutions (*Sanitätsdienststellen*) of the protectorate will serve the medical care of the coloured population. Through a sensitive approach to the population's character, through calm and kind treatment of the patients that I explicitly oblige all the staff to, they [the clinics] are extraordinarily well suited to strengthen confidence towards the European administration. As they serve the country's interest, according to § 3 of the order 80 of 30 September 1904, in these clinics everybody must be medically advised and treated free of charge» (49).

This was part of «Medical civilisation» («*Ärztliche Kulturarbeit*»), as the doctors liked to call it (50). In the statistics of the governmental clinics for Africans there is a marked preponderance of male adult

(48) See Correspondence Dr. Emil STEUDEL to Chief Medical Officer Dr. Alexander BECKER, 1891, in: T[anzanian] N[ational] A[rchives] G[erman Records] 5/5 *Behandlung erkrankter (und verunglückter) Eingeborener* [Treatment of sick (and injured) natives], 1891-1906.

(49) See the Runderlaß 303a v. 24.08.1911, betreffend die poliklinische Behandlung [Governor's Circular concerning out-patient clinics]. KAISERLICHES GOVERNEMENT VON DEUTSCH-OSTAFRIKA (HG.), *Die Landes-Gesetzgebung des deutsch-ostafrikanischen Schutzgebietes. Teil II: Systematische Zusammenstellung der den Behörden zugegangenen Dienstanweisungen, Runderlasse etc. Nur zum dienstlichen Gebrauch*, Tanga, Dar es Salaam, 1911, pp. 489-490.

(50) E.g. STEUBER, Werner. *Arzt und Soldat in drei Erdteilen*, Berlin, Vorhut-Verlag Otto Schlegel, 1940, pp. 58, 74. Steuber had been Chief Medical Officer of German East Africa 1900-1903.

patients (51). Sick children rarely found their way to the German medical staff. Whereas the German medical officers and sergeants were principally accessible to all patients, German non-religious nurses generally worked in those wards where only Europeans were admitted. The major exception was the midwifery service in Dar es Salaam which was available to Africans, too (52). Thus mothers, new born babies and small children were the only African patients of German secular nurses.

The health of school children was certainly not the main target of governmental research in parasitic diseases. Yet besides the soldiers and the workers of the plantations, pupils constituted the group most easily accessible for medical investigation. As such, they are also the group on which most health statistics exist. In addition, they were probably the group that was most heavily affected by parasitic diseases. In the mission school at Masasi, nearly half of the examined children had Bilharzia, whereas less than 3 percent of the adults were infested (53). At the government school in Lindi, 75 percent of the pupils had hookworm and 35 percent Bilharzia (54). On neighbouring plantations only between 10 and 20 percent of the adult workers were infested (55). Thus schooling —because of the conditions of overcrowded boarding schools— and adolescence seem to have been major risk factors for contracting worms.

In contrast to early Government health care services, the Christian missions always tried to address the adolescent patient. Yet even in the Catholic missions where the religious sisters visited the sick at their homes, nurses were seldom called to see children —though they eagerly looked for them in order to save their souls by emergency baptism (56). Missionaries of all denominations attempted to fight

(51) General statistics start with the first «Nachweisung über die kranken Farbigen des Schutzgebietes 1/02-03/03», Bundesarchiv [Federal Archives; WB] Lichtenfelde (BA) R 1001/5745 Gesundheitsverhältnisse in Deutsch-Ostafrika vol. 1 December 1892 - December 1904 [contains in fact August 1892 - June 1904] p. 77.

(52) *Medizinal-Berichte 1908/09*, p. 169.

(53) *Medizinal-Berichte 1910/11*, p. 173.

(54) *Medizinal-Berichte 1911/12*, pp. 118-119.

(55) *Medizinal-Berichte 1911/12*, p. 318.

(56) See the many entries in the *Chronik der Schwestern von* [Chronicle of the Sisters from] (*Lukuledi, Nyangao und*) *Ndanda, 1895-1917*, KAMBSStO, note 23, Z.1.2.34.

«pagan» and «unhealthy» customs by replacing them with Christian rites and scientific medical practices (57). Risks for child health that were repeatedly mentioned in missionary reports included common colds by lack of clothing and maternal sweat when being carried on the back, the traditional way of male circumcision, and certain conditions of pregnancy, such as the young age of the mother and the occurrence of previous artificial abortions (58). Mission superiors called for female missionaries trained as doctors or at least as midwives, and it was recommended that when African girls were to be educated by the mission, their possible future role as «black midwives and nurses» should be considered (59). However, the services offered by the first German female missionaries in midwifery were hardly accepted by rural African women (60). And it took twenty years before the visions of female European doctors and the training of African women became reality in the remote missions.

2.2. *The training of Africans in child care under British rule*

2.2.1. *The first attempt after World War I*

The idea of training African women was also taken up by British first Director of Medical and Sanitary Services, Dr. John Owen Shircore. In the mid-1920s, he tried to get the support of the so called Native Authorities for the training of Africans in health care. He saw the greatest possible benefit for the native population in «trained native midwives who could conduct a confinement and instruct the mothers in infant feeding. It is perhaps not realised that amongst many tribes

(57) See WALTER, Bernita. *Proclaiming God's faithfulness: preparing the way for the Church in East Africa, Sustained by God's faithfulness: the missionary benedictine sisters of Tutzing*, St. Ottilien, EOS, 1992, vol. 2, pp. 279-280; see VAUGHAN, note 46, p. 66.

(58) See WALTER, note 57, p. 278; Spreiter, St. Ottilien, 5.02.1909, quoted in: KAMBSTO, note 23, Folder Dar es Salaam 1, Bischof [Bishop], Rundschreiben [Circular Letters].

(59) SPREITER, note 58.

(60) See WALTER, note 57, pp. 284-285.

a new born baby is fed entirely on gruel for the first week or so, a diet which must be responsible for a very large infantile mortality» (61). Thus the questions of training female natives and of newborn feeding practices were still pertinent twenty years after they were first raised.

Yet who should be trained? And how should it be determined who is likely to complete training successfully and deliver a useful service later on? Three groups of female natives were the main candidates:

1. Elderly women, preferably widows, who had born children themselves, were respected and already serving the community as birth attendants.
2. Younger girls who had completed some schooling and were thus able to read, to write and to follow formal instruction.
3. Hospital attendants and orderlies who had gathered some practical knowledge of basic rules on hygiene and medical treatment.

The discussion of these questions as expressed in memoranda, minutes and correspondences revealed enormous differences in opinions and influences. Respondents came from different religious backgrounds and political ideologies, worked in different ethnic groups and had different previous experiences. Those who had amassed some experiences in training African women typically worked with Christian missions and were marked by the characteristic missionary fear of paganism. Working in the country around Shinyanga among the territory's largest and «traditionally» minded ethnic group, the *Sukuma*, the Protestant missionary Mrs. Maynard had no doubts about her preferences: «any venturing along this line should be through girls who are not yet deeply contaminated by native customs, as are all the mature women. These girls will soon be women and in the meantime can have inculcated

(61) Extract of Letter 108/9/14 from 20.04.1927 by the Director of Medical and Sanitary Services, Tanganyika territory, TNA 10409, Training of native midwives, village and welfare workers, 1927, vol. 1, p. 1.

in them a measure of proper care of mothers, as well as infants and young children» (62). The precondition of social standing usually attributed to older women, which would enable the midwives' and their messages' acceptance, was no worry to Mrs. Maynard, as she wrote: «Girls trained in Hospital are given social standing by their training and I believe it is this standing rather, than age, that would give their word authority. (...) There is too much to train out of older women». Blaming the grandmothers, who were referred to as «The Last Fortresses of Satan», for keeping up detrimental customs was a common topic in missionary literature (63).

Chances for an extension of maternal and child health services run by such native staff did not seem too bad at the end of the 1920s. The future candidates from the schools could be expected to be well prepared. At the primary level, the Kiswahili booklet *Afya* (Health) written in 1923 by the Director of Education, S. Rivers-Smith, had to be studied (64). The syllabus for girls' schools of 1927 prescribed lessons on hygiene in each class, including «mothercraft» for the two highest classes (65). Ideological support from Europe was extensive. First intended to cover all the colonies but finally devoted mainly to Africa, the «Save the Children Fund» organized an «International Conference on the African Child» in Geneva in 1931 (66). Mary Blacklock, a medical expert on children's health in the British colonies, repeatedly stressed the importance of child welfare and health education (67). However,

(62) N. H. MAYNARD to District Officer McMahon, 27.06.1927, TNA, note 61, p. 11.

(63) Quoted after VAUGHAN, note 46, p. 67.

(64) RIVERS-SMITH, S. *Afya: Kitabu kwa school za Africa ya mashariki*, Calcutta, London, Macmillan, 1923. CLYDE, note 4, p. 119.

(65) *Tanganyika Gazette* 15.02.1927; for general thoughts on health education in schools see BLACKLOCK, Mary, Co-operation in Health Education. *Africa*, 1931, 4, 202-208.

(66) See the correspondence in Public Record Office in Kew/London (PRO) Colonial Office (CO) 323/1066/2, International congress on Children of non-European Origin, Geneva 1931.

(67) BLACKLOCK, Mary G. Certain Aspects of the welfare of women and children in the colonies. *Annals of Tropical Medicine and Parasitology*, 1936, 30, 221-264; BLACKLOCK, note 65.

the economic depression of the 1930s and the lack of suitable literate candidates prevented large-scale government programs (68). The missions continued to pioneer in this area, producing text books on midwifery and child welfare in Swahili and training dozens of African midwives (69). At that time, the activities of mother and child care, publishing and training were the only areas where mission health services received financial support from the government (apart from participation in campaigns such as those against hookworm) (70).

2.2.2. *The second attempt after World War I*

Infant feeding and child health had always been a concern of midwives, too. Nevertheless, the story told here might be suspected to slide too much into the professional history of midwifery instead of that of child health. Yet the later development of training schemes for African women preparing for work in healthcare outside health facilities broadened considerably the initially narrow focus on obstetrics.

In the influential report of the London-based Chief Medical Officer Pridie, delivered in 1949 after his visit to Tanganyika Territory, the idea of formal training for African women in midwifery was taken up

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- (68) See TANGANYIKA TERRITORY. *Annual Medical and Sanitary Report for [...] 1935*, Dar es Salaam, Government Printer, 1937, p. 20. For the general problem of female education and training in health professions in British African territories see NDEGE, George Oduor. *Health, state, and society in Kenya*, Rochester/New York, University of Rochester Press, 2001, pp. 85-89.
- (69) E. g. STINNESBECK, Sister Dr. Thecla. *Utunzaji wa Watoto Wachanga (Child Welfare and Mothercraft—Swahili)*, London, Sheldon Press, 1932; WALLINGTON, Dr. St. C. Archer. *Maarifa Yawapasayo Mama Katika Kutunza Watoto Wao (Swahili: A Series of Lessons in Mothercraft)*, London, Sheldon Press, 1943.
- (70) CLYDE, note 4, p. 129. TANGANYIKA TERRITORY. *Annual Medical and Sanitary Report for [...] 1931*, Dar es Salaam, Government Printer, 1933, p. 4; see the agreement with the missions TNA 11568, Investigations and treatment of worm infections (ankylostomiasis), 1927-1936, p. 103.
- (71) Published as LEGISLATIVE COUNCIL OF TANGANYIKA, *Sessional Paper No 2 1949. A review of the Medical Policy of Tanganyika*, Dar es Salaam, Government Printer, 1949.

again (71). Pridie suggested a central school for the whole territory. This proposal, characteristic of the centralist attitudes of the National Health Service's pioneering in the U.K., failed to consider the years of experience in local training by the missions, as well as the objections of Native Authorities and District and Provincial Officials to training far from home. Thus the actual plan drafted in the territory in 1951, based on the previous considerations and trials, dismissed the idea of a single central school and voted for the inclusion of the mission facilities (72).

These new governmental plans were more successful than the previous ones, perhaps because this time the demand was more often expressed by African representatives, too (73), and the scheme had special support from the Governor's wife, Lady Twining, who wrote teaching materials for the training course herself. The plan of 1951 was dedicated to «Rural Midwifery, Health and Child Welfare Service» and contained in the proposed syllabus, under the heading «Homecraft and village hygiene», a «Child welfare Course». The course covered the development and care of a healthy baby and the basic treatment of a sick child. The manual required instructors to give «simple demonstrations on child care at clinics and in houses» (74).

It was believed that the task of successfully training rural women as midwives would become easier as time under colonial rule increased and «illiteracy and taboos» diminished. Mary B. Craig, the Health Visitor who since 1928 had lived in the Territory and trained midwives for 16 years, stated «that the handicap of taboos has largely disappeared in the course of the last 23 years» (75). On the question of selecting

(72) Memorandum «Rural Midwifery, Health and Child Welfare Service. Notes and suggestions», p. 1, TNA 10409, Training of Native of midwives, village and welfare workers (*sic!*), 1951, vol. 2, p. 22.

(73) See the request of Chief Kidaha Makwaia for training facilities for African women in nursing and midwifery or the speech by Bihamarulo of the Africans' Association asking for maternity hospitals with qualified midwives, TNA 10409, note 722, pp. 7 and 19 resp.

(74) Memorandum «Rural Midwifery...», p. 4, TNA, note 722, p. 22.

(75) Notes of a staff meeting held at the Medical Headquarters 15.2.1950, TNA, note 722, 27a.

candidates for training, the 1951 plan on «Rural midwifery» favoured different individuals than those the missionaries preferred:

«For many reasons young girls are unsuitable for village midwifery and health work, one reason being that they seldom if ever inspire the confidence of the conservative African shamba [Swahili for «farm»; W.B.] dweller, many of whom have obstetric tribal customs which must be respected until they can be gradually overcome. The women of a mature age group —widows or childless or with grown families— provided they are literate (...) would appear to be the most suitable candidates for this service» (76).

Obviously, female education and the employment of married women with children was a hot issue in a social situation still heavily influenced by British Victorian and traditional African gender roles (77).

Ten years later, the annual medical report of the territory for 1960 still complained about the «difficulty in recruiting suitable persons for this training» (78). What is attested by the writings of the District Commissioner for Kilwa on the Southern coast, seemed to have been a widespread obstacle. In 1952 he wrote that the native Council «is quite convinced that it will be many years before any parent in this District has other ideas for his daughter than to marry her off at the earliest date —for this reason I foresee no candidates of “mature years”, “teachable and literate in Swahili” coming forward for some time» (79).

(76) Memorandum «Rural Midwifery...», p. 2, TNA, note 722, p. 22.

(77) See minutes meeting of the Committee on training of African Nurses and Midwives, 4.1.51, § 30., TNA, note 722, 56A; for the «tension between the ideology of women as mothers and the pragmatic demands of social policy» in British colonies see MANDERSON, Lenore. Women and the state: maternal and child welfare in colonial Malaya, 1900-1940. In: Valerie Fildes; Lara Marks; Hilary Marland (eds.), *Women and children first*, London, New York, Routledge, 1992, pp. 154-177.

(78) MINISTRY OF HEALTH AND LABOUR. *Annual Report of the Health Division for 1960*, vol. 1.

(79) Letter District Commissioner Kilwa to Provincial Commissioner 4.4.52, TNA 16/19/92, Training of African Village Midwives and Nurses, Station: Lindi, 1950-1952, p. 46.

The gap in qualified personnel for child care had to be filled by staff from Europe. These nurses and health visitors, of course, had several and serious disadvantages caused by their insufficient knowledge and acceptance of the local culture —and of curative medicine. They did not learn the language sufficiently, and were «given little or no opportunity to study what are the prevalent diseases of children, which they are supposed to prevent, or the local foods and customs which they are supposed to improve» (80). Almost scandalous was their disinterest in sick children, a result of the U.K. division of duties between the health professions. This often led to the referral of severely ill babies to far less qualified African auxiliaries, some of them with only three months of training: «It is absurd to see a health visitor and 3 or 4 students meticulously examine, weigh and comment, then write detailed notes on 6 healthy babies, while next door the R.M.A. [Rural Medical Aide; W.B.] struggles with a mob of 100 sick people, nearly half of which may be children in urgent need of care and dietetic advice» (81).

2.3. *Child care, local people and European judgements*

Gaining access to the population seems to have been the central aim of strategies for improving child health —even more important than medical quality. It was quite obvious from the very beginning that maternal and child health care were different from both ordinary curative medicine and disease control campaigns. The former —medical treatment for individual diseases— was sought by the suffering patients themselves; the latter —vaccinations, sanitation and mass treatment— could be enforced to a certain degree. Yet preventing obstetric complications or severe malnutrition demanded an amount of trust and co-operation that had to be built up slowly. Actions taken towards this goal were not confined to the selection of personnel. «Baby

(80) WILLIAMS, Cicily D. Report of the facilities for the treatment of children in hospitals, dispensaries and clinics, and the training of staff in child care in Tanganyika Territory, TNA 3/46/03 Part A, Treatment of Children, 1956, p. 37.

(81) WILLIAMS, note 80, p. 32.

shows» with prizes for the healthiest children, well known in English-speaking countries of that time, attracted thousands of mothers and infants in Africa, too (82).

Other attempts to gain the trust of the natives included building clinics in ways that were aesthetically similar to native-style structures. Chief Medical Officer Shircore explained this architectural approach at the opening of the first maternity clinic in Dar es Salaam in 1925:

«The buildings, although of better structure, are not unlike large native houses; their appearance is calculated to disarm apprehensions, and their situation in familiar surroundings that permit the approach, without undue misgivings, by women who might otherwise avoid the publicity of a general hospital» (83).

The belief that African mothers were growing to accept maternal and child health services was not unfounded. Statistics from 1929 to 1932 show a steady increase in patient attendance to healthcare facilities, though the number of deliveries in these facilities remained low (84). A possible reason for this discrepancy was already supposed by Shircore in his retrospective on the first clinic: «It was never very popular for lying-in because the ladies were not allowed to have all their female friends and relatives to assist, but was immensely popular as a welfare clinic» (85).

(82) E.g. the one in Mikindani in November 1926, see Annual Report Lindi Province 1926, p. 36, TNA 55.AB54, 1927, p. 40; for an attendance of «3500 infants and toddlers» near Lake Victoria, CLYDE, David Francis. Tanzania. In: E. E. Sabben-Clare; D. J. Bradley; K. Kirkwood (eds.), *Health in tropical Africa during the colonial period*, Oxford, Clarendon, 1980, pp. 98-115 (p. 100).

(83) Quoted by CLYDE, note 4, p. 127.

(84) See TANGANYIKA TERRITORY. *Annual Medical and Sanitary Report for [...] 1929*, London, The Crown Agents for the Colonies, 1930 (p. 107); *1930, 1931, 1932*, Dar es Salaam, Government Printer, 1932 (p. 4), 1933 (p. 5), 1934 (p. 9). In other areas of Africa, e.g. the much longer colonised Johannesburg, high attendances at the clinics in the early 1930s were claimed to be a «spin-off» of increasing numbers of hospital deliveries, see GAITSKELL, Debby. «Getting close to the hearts of the mothers»: Medical missionaries among African women and children in Johannesburg between the wars. In: V. Fildes, L. Marks, H. Marland (eds.), note 77, p. 194.

(85) Quoted by CLYDE, note 4, p. 127.

This is just one example that illustrates the incompatibility of colonial mother and child health services and traditional attitudes. Many reports from this period show even more distinct differences between local customs and modern childcare. The past practices of non-Christian Africans are mostly known from European accounts that are highly biased and sketch a gloomy picture of native care for the sick and the infant (86). The continuity of this picture over decades also reveals the European idea of Africa as a continent without «development», a prejudice found even today (87). Essential parts of this picture include direct harm to unwanted children and general indifference to children's fate. During German colonial rule, colonial officers and missionaries wrote about widespread infanticide, which is also mentioned by later Tanzanian authors (88). The case of an ethnic group rearing weak or disabled children was regarded as so exceptional that it was mentioned explicitly, as with the *Wakiturika* (89).

In 1933, a former German mission doctor in South West Tanganyika, Otto Fischer, wrote in a generalising statement: «Formerly, the fate of twins was the same in all regions of the colony. They were seen as a great misfortune, as a sign of the gods' wrath, and thus killed as soon as possible, either both or at least one of them, namely the latter born» (90). The truth of this proposition seems to be highly

(86) For early German views of East African medicine see BRUCHHAUSEN, Walter; ROELCKE, Volker, *Categorising «African medicine»*. The German discourse on East African healing practices, 1885–1918. In: Ernst Waltraud (ed.), *Plural Medicine*, London, Routledge, 2002, pp. 76-94.

(87) See ERIKSSON BAAZ, Maria. *The white Wo/Man's burden in the age of partnership. A postcolonial reading of identity in development aid*, Göteborg, Department of Peace and Development Research, 2002, pp. 133-135.

(88) KOPONEN, note 9, p. 497. OMARI, C. K.; KITILIA, L. Traditional childcare practices: The Wanyaturu. *Tanzania Notes & Records*, 1976, 77&78, 65-72 (p. 70).

(89) ANKERMANN, Bernhard. *Ostafrika*. In: Erich Schultz-Ewerth; Leonhard Adam (eds.), *Das Eingeborenenrecht. Sitten und Gewohnheitsrechte der Eingeborenen der ehemaligen deutschen Kolonien in Afrika und in der Südsee*, Stuttgart, Strecker & Schröder, 1929, Vol. 1, p. 166.

(90) FISCHER, Otto. Über die Sitten ostafrikanischer Stämme in ihrer medizinischen Bedeutung. *Münchener Medizinische Wochenschrift*, Jubiläumsgabe [jubilee gift], 1933, 44-48 (p. 45).

doubtful in light of a recent review about attitudes towards twins in the anthropological literature of sub-Saharan Africa. In this review, the South West of Tanzania is depicted as having favourable or at least indifferent reception of twins (91).

A similar misjudgement can be attributed to the District Officer for Kilwa who wrote in 1926: «The natives are most ignorant in their treatment of diseases. People are allowed to die without any effort being made to cure them, nor do they seek medical aid. (...) The native doctor seems to be non-existent» (92). Such common reports on widespread customs of infanticide, a lack of public funerals or mourning for deceased small children, and the alleged lack of medical care, seemed to indicate that the survival of every individual, especially in the case of a child, was not of much concern to the traditional society as a whole. This alleged fatalism can be found in writings of the early missionaries before colonial rule. Medical missionary Pruen wrote about «very young children» in the time before 1891: «their deaths being a matter of such complete unimportance, that the European would never hear of it, even if half their number were swept off by an epidemic» (93). However, the extensive application of protective amulets and special healing methods for children, provided mainly by female healers (94) and also for disabilities such as muteness (95), should be sufficient proof that children's survival did matter. And the readiness of mothers to overcome cultural, geographical and financial barriers in order to seek the best for their children's sake in a very foreign type of medicine is a powerful demonstration of concern for child health.

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- (91) PISON, Gilles. Twins in Sub-Saharan Africa: Frequency, Social Status, and Mortality. In: Étienne Van de Walle; Gilles Pison; Mpembele Sala-Diakanda (eds.), *Mortality and society in Sub-Saharan Africa*, New York, Oxford University Press, 1992, pp. 253-278 (p. 264).
- (92) District officer BELL. Annual Report Kilwa District 1925, TNA AB 60 (1926).
- (93) PRUEN, note 22, pp. 156-157.
- (94) KAYAMBA, H. M. T. [Assistant Secretary Native Affairs] African Medicines connected with religion (typescript), p. 6, TNA 21845 vol. I, 1933, Native Medicine, pp. 10-17 (p. 15).

Disappointment about the results of this first semi-century of colonial childcare in East Africa can be found in most sources. Some remarks on child health in reports from the end of this period could have been written 50 years earlier. The District Commissioner of Tunduru in the South wrote in 1951:

«I have heard from various sources in the short time I have been here that the people of this District are becoming very concerned at the falling birth rate and high infant mortality, and put down this as the main reason for the general exodus out of the District. This falling birth rate and mortality is stated to be due to a great degree, to Hookworm. Should this be true, purely from an administrative point of view an all out effort should be made to instil hygiene into the people, and probably the best approach is through their women folk. On this account midwives would be invaluable» (96).

Even expert opinion was not very enthusiastic. After a tour through many health facilities in Tanganyika Territory in 1956, the British paediatrician Dr. Cicily D. Williams came to the conclusion: «The African in Tanganyika as a rule take it for granted that a very large proportion of their children, probably 50% will die before maturity. They are so accustomed to this that they do not realise what can be done by an improved standard of child care» (97). Accusation of native indolence and lack of facilities were features that accompanied the development of child healthcare into the period of independence —and even up to date.

(95) See OMARI; KITILIA, note 88, p. 69.

(96) Letter to Provincial Commissioner, Southern Province, 14.1.1951, TNA 16/19/92, 1950-52, Training of African Village Midwives and Nurses, Station: Lindi, p. 7.

(97) WILLIAMS, note 80, p. 47.