SOCIETY, STATE, AND INFANT WELFARE: NEGOTIATING MEDICAL INTERVENTIONS IN COLONIAL TANZANIA, 1920-1950

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Dedication

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Abstract

This dissertation is a historical analysis of colonial state infant welfare initiatives from preventive programs of the 1920s and early 1930s to policies that integrated preventive and curative medicine in the late 1930s and 1940s in colonial Tanzania. It argues that the development of these medical interventions was a negotiated process between colonial government officials, peasants, local chiefs, welfare workers, African dressers, and medical missions. In the 1920s the British colonial government initiated the welfare programs to reduce high infant mortality rates. Government officials explained poor infant survival in terms of maternal ignorance and focused on advising mothers on proper infant care, feeding, and hygiene. The government trained African welfare workers who performed the actual work of advising mothers in the communities. Peasants, however, challenged the early preventive programs as narrowly conceived both because they ignored local medical knowledge and indigenous practices and because they excluded western curative medicine that would help them tackle infant diseases such as malaria. Using their local chiefs, peasants demanded that the colonial government incorporate curative medicine in its welfare policies. Their bargaining strategies to achieve these demands included boycotting government-run welfare centers and refusing to pay taxes. The government eventually incorporated curative medicine in its welfare programs in the late 1930s, and it trained African dressers in preventive and curative medicine. The evidence for this dissertation comes from oral interviews, written archival documents, ethnographic accounts, and missionary and explorers’ writings. This evidence has
allowed me to explore the complex problem of infant welfare, a topic that has not received adequate attention from historians writing about Africa.
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Chapter One

Introduction: Bringing Infant Survival into the History of Colonial Medicine in Africa

1.0 Argument

This dissertation offers an historical construction of the interplay between colonial government political administrators, medical officials, peasant men and women, medical missions, welfare workers, and dressers\(^1\) in the development of infant survival interventions from 1920 to 1950 in colonial Tanzania. The British colonial government first initiated the interventions in the 1920s to deal with the perceived problem of high infant mortality. Colonial population surveys conducted in the early 1920s indicated that as many as half of infants in Tanzania died in their first two years of life.\(^2\) Colonial officials posited that high infant mortality was the reason behind low African population numbers in the territory, which they estimated to be 4,107,000 in 1921.\(^3\) The government officials, who claimed that maternal ignorance in infant care, feeding, and hygiene were the root causes of the problem, produced the Memorandum on Infant Welfare Policy of 1925 to guide future infant welfare policies. The Memorandum on Infant Welfare Policy emphasized that indigenous ideas and practices of infant nurturing were unfavorable for

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\(^1\) Dressers were Africans whom the British colonial government trained in preventive and curative medicine in order to provide medical services in rural areas in Tanzania. Thus, rural residents encountered colonial medicine in their communities through the work of these dressers.

\(^2\) These surveys reported in Tanganyika Territory, Annual Report of Medical and Sanitation Services, 1924, (Dar es Salaam, Government Printer, 1921); p. 83; Tanganyika Territory, Annual Report of Medical and Sanitation Services, 1922, p. 100

\(^3\) Tanganyika Territory, Report on the 1921 Census of the Native Population of the Tanganyika Territory (Dar Es Salaam, Government Printer, 1921).
infant survival and were the cause of preventable illnesses, ill-health, and premature deaths.\(^4\) It proposed preventive medical programs to alleviate maternal ignorance through mothercraft classes, advice on infant care, and practical demonstrations on infant management in rural African communities. Effective implementation of the programs, which essentially aimed to change African ideas and practices of infant care, began in 1928. As I show below and in chapter three, colonial officials conceived of the infant survival problem as a platform that would enable the government to reach African homes and communities directly. Infant welfare initiatives were thus necessary for enhancing the presence of the colonial government among Africans.

The implementation of infant welfare programs placed the government in conflict with the interests of medical missions that had pioneered rural medical services since the late nineteenth century. Until the 1920s, the colonial government supported and subsidized medical missions’ work and looked at missions as important partners in providing Africans with medical care in rural areas. Throughout this period, work on maternal and child welfare was an important preoccupation of medical missions.\(^5\) In the 1920s, however, the government wanted to reach African rural homes and communities directly. In 1928, the Director of Medical and Sanitation Department revealed the motive for this new interest when he wrote that “… [w]e must make the native see and feel our efforts to improve his welfare”\(^6\) so that Africans could appreciate the “good work” that the


\(^6\)“The Memorandum on Health Services in Rural Areas” enclosed in TNA 450/108/9 *Maternity and Child Welfare General*, referenced 28/10/8
government did to improve infant health. The government thought that tangible welfare work that Africans could “see and feel” was an important strategy for building its presence, acceptance, and legitimacy within African communities. Thus, in the 1920s the colonial government came to see the medical missions’ work as competing with its new agenda of directly reaching rural African homes and communities, and it attempted to undermine medical missions by cutting their financial subsidies. The government wanted to do the welfare work that the missions previously did on its behalf. This strategy was necessary as the government attempted to create direct connection with Africans and to change what it perceived to be dangerous African ideas and practices of infant care.

Despite the colonial government’s attempts at changing African ideas and practices of infant welfare, peasant men and women from southwest Tanzania frequently interpreted the interventions as lacking the viability to achieve the intended objectives because they did not incorporate curative medicine. This interpretation was a form of peasants’ acknowledgement that the problem of poor infant mortality that colonial officials grappled with in the 1920s indeed existed, and that curative medicine would cure some diseases such as malaria that caused premature infant deaths. Through their local chiefs, these peasants demanded that the colonial government incorporate treatment of infant diseases as an integral component of the welfare programs. In response to this demand, the colonial government integrated preventive and curative medicine in the late 1930s.

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7 Bomani Kibona, Interview at Kafule, July 4, 2006; Sindondile Swilla, Interview at Isoko, July 3, 2006; Jopho Kibona, Interview at Isoko, July 3, 2006; Filingisoni Kajange, Interview at Chija, June 4 and 9, 2007; Kujobenane Kamwela, Interview at Isegelo, September 8, 2007.
The government’s accommodation of peasants’ demands exemplified the social relationships and engagements between social actors that were integral components of the development of infant survival interventions.

This dissertation argues that the development of the colonial infant survival interventions from exclusive preventive educational programs in the 1920s and early 1930s to those that integrated preventive and curative medicines in the late 1930s was a negotiated process. The negotiations between peasant men and women, health officials, political administrators, medical missions, local chiefs, and dressers formed the integral components of the development of these welfare programs. By negotiation, I refer to the social engagements and relationships that these actors, as historical agents, entered into with each other as they grappled with the infant survival problem. As I will demonstrate below, participants in these negotiations produced competing visions of the problem of infant survival, evaluated and critiqued the perspectives of others, sought to have their own ideas incorporated into medical interventions, or simply facilitated the implementation of the welfare policies.

The negotiations between these social actors changed over time. Early negotiations, evident in the 1920s and early 1930s, centered on the viability of infant survival interventions. For example, government officials viewed preventive medical programs as a viable strategy for alleviating infant deaths. Peasant men and women engaged with the content of these interventions and acknowledged their relevance. Despite this
acknowledgement, they critiqued and challenged the credibility of the colonial government’s formulation for excluding curative medicine. Bomani Kibona’s oral recollections suggested that peasants’ critique reflected their cumulative understanding that “effective interventions to improve infant survival had to consciously integrate preventive and curative medicines.” In addition, Kujobenane Kamwella emphasized that “[such integration] gave people the confidence of alleviating the threats that diseases, spiritual forces, and environmental forces posed to the survival of infants.” These early forms of negotiations, therefore, took place over the meaning and viability of the colonial interventions, and they evolved as both the government officials and peasant men and women grappled with the infant survival problem in the 1920s and early 1930s.

Later forms of negotiations, which were evident from the mid 1930s, centered on peasant men and women demanding that the colonial government incorporate curative medicine within the infant welfare programs. Peasants presented their demands to the colonial administration through their local chiefs, who wrote letters articulating the demands. Peasants’ bargaining powers resided in withholding taxes to the government and in boycotting government welfare centers. Peasants’ demands provoked intense debates and conflicting ideas among the government officials over the appropriateness of accommodating them. Political administrators and some health officials supported the incorporation of curative medicine, arguing that implementing African demands would

8 Interview with Bomani Kibona, op.cit.
9 Interview with Kujobenane Kamwella, op.cit.
10 TNA 18/22/6 Musomba to Philip Huggins, DO Tukuyu, 2/10/1934; TNA 18/22/11 Chief Mwangamilo to Philip Huggins, DO Tukuyu, 2/3/1935; Kaswashi Pwele, Interview at Kapelekesi, September 11, 2007.
increase the popularity of the colonial government in rural communities. Other medical officials disagreed, arguing that the infrastructure that would enhance the provision of quality curative medical services in the remote rural areas were not available. Eventually, the supporters of incorporation emerged victorious when the colonial government, through the Legislative Council, produced *A Review of the Medical Policy of Tanganyika* that made the incorporation of curative medicine a formal policy in infant welfare provisions.\(^{11}\)

Taken together, the early and later sets of negotiations that I have analyzed above suggest that peasant men and women were not passive recipients of the government officials’ ideas and practices on infant welfare. Rather, peasants were important historical agents whose negotiations were integral to the development of the infant welfare programs. I use the term agency to refer to a process in which peasants drew on a repertoire of past ideas and experiences and then redefined them in ways that shaped their social engagements and relationships with government officials, medical missions, local chiefs, and other social actors. This understanding of agency draws from the work of Mustafa Emirbayer and Ann Mische who defined it as “a temporary embedded process of social engagement, informed by the past (in its iterational or habitual aspect) but also oriented toward the future (as a projective capacity to imagine alternative possibilities) and toward the present (as a practical-evaluative capacity to contextualize past habits and future projects within

the contingencies of the moment).”\textsuperscript{12} The implication of their definition is that agency must be “situated within the flow of time” since the actions that people pursue are located within particular temporal and relational contexts. This conceptualization allowed Emirbayer and Mische to argue that “[a]s actors respond to changing environment, they must continually reconstruct their view of the past in an attempt to understand the causal conditioning of the emergent present, while using this understanding to control and shape their responses in the arising future.”\textsuperscript{13} Susan Reynold Whyte reiterated some of the issues that Emirbayer and Mische raised. For her, agency is a transformative process that develops as people enter into interactions and relations that result in particular consequences.\textsuperscript{14} Her conceptualization of agency suggests that people enter into these interactions and relations with particular intentions that they use “to make claims that further their projects and agenda.”\textsuperscript{15} Building on this conception of agency, I posit that the repertoire of ideas and experiences that peasants drew from reflected their cumulative understanding of infants and infant survival that they learned from their parents and grandparents who lived in the late nineteenth and early twentieth centuries. Peasants understood that infant survival pertained to the interactive spheres and negotiations between the social, environmental, and spiritual worlds; and that conscious integration of preventive and curative medical interventions was a prerequisite for any serious efforts

\textsuperscript{13} \textit{Ibid.}, p.968-969
\textsuperscript{15} Whyte, “Health Identities and Subjectivities,” pp.6-9
designed to maximize infant survival potentials.\textsuperscript{16} The implication of this cumulative understanding is that the colonial government officials imposed the infant welfare programs on African men and women who already held these ideas and used them to deal with infants’ medical challenges before the 1920s. In the 1920s and 1930s, peasant men and women drew on this cumulative understanding to evaluate and critique the viability of the colonial preventive medical interventions and to engage with other social actors who had an interest in the welfare of infants.

Particular interests and agendas motivated the social actors to engage with the colonial infant survival interventions. For example, colonial government officials utilized the interventions to gain access and intervene directly in the intimate issues of African health, death, and reproduction. This access gave government officials an opportunity to spread their cultural ideas and practices pertaining to infant welfare and to legitimize colonial rule among rural Africans.\textsuperscript{17} Infant welfare was not the only strategy that the colonial government used to legitimate its rule. Another was the introduction of indirect rule whereby the government intended to administer Africans using African local chiefs, a phenomenon that has received adequate attention from scholars.\textsuperscript{18} Legitimating British control in the 1920s was critical because Tanganyika was in the process of transition from German colonialism. The British colonial government portrayed its new

\textsuperscript{16} I develop this point in chapter two in order to highlight how Africans in southwestern Tanzania understood and dealt with the challenges of infant survival before the colonial government initiated its welfare programs in the 1920s.

\textsuperscript{17} “The Memorandum on Health Services in Rural Areas” enclosed in TNA 450/108/9, \textit{Maternity and Child Welfare General}, referenced 28/10/8; Letter to the Chief Secretary dated 4\textsuperscript{th} March, 1928 and referenced 22/5/37 in TNA 450/108/9 \textit{Maternity and Child Welfare General}.

\textsuperscript{18} For an extended discussion of Indirect rule in colonial Tanzania during the 1920s, see John Iliffe, \textit{A Modern History of Tanganyika} (Cambridge, Cambridge University Press, 1979), pp.318-341
administration as more committed to the advancement of African welfare and to political democracy than the previous German administration. The Germans, I will show in chapter three, depended on military discipline and direct rule to administer the colony.

For the medical missions, the interventions presented an opportunity to win Christian converts and to portray Christianity as an important institution for promoting the welfare of Africans. Investment in the welfare of infants gave the missionaries an opportunity to be close to African homes and communities. In this sense, medicine and religion reinforced each other, and together, they promoted the religious agenda of missionary institutions.¹⁹

Peasant men and women, local chiefs, and dressers, too, had their own interests and agendas in the colonial interventions. Peasants used the welfare programs to expand medical resources for dealing with the health challenges of infants. They demanded the construction of ‘tribal’ dispensaries where they could access curative western medicines such as quinine and sulpha drugs. This access presented an important addition to the existing indigenous preventive and curative medical resources that they already practiced to deal with threats to infant survival. For the native dresser, the interventions offered a career opportunity with a reliable income to meet basic needs of their families.²⁰ For them, practicing medicine became a profession, and as John Iliffe has argued, dressers

were the foundation of the medical profession among Africans in the region.\textsuperscript{21} Finally, but no less importantly, local chiefs mediated between rural peasants and the colonial administration in order to consolidate their position as representatives of both peasants and colonial government. The letters they wrote to the colonial administration\textsuperscript{22} articulated the demands and pressures from the peasants and appealed to the colonial government to implement them in order to make their work of tax collection easier as well as to make their position relevant to the needs of both the rural peasants and the government officials.

The importance of this argument, and thus this dissertation, is that it brings infant survival into African history. The complex processes of how households and social communities understood the threats to infant survival and attempted to alleviate them have not received attention from social historians producing African histories. This neglect is surprising because the development of infants into adulthood ensured the continuity and renewal of generations, households, families, communities, states, and other cultural institutions that historians have been studying in the past five decades. Understanding how social communities understood and dealt with the threats to infant survival is thus an important field of inquiry in the history of Africa. This dissertation contributes to this inquiry by historicizing infant survival in colonial Tanzania. It probes different social actors that had interests in the survival of infants and uncovers the

\textsuperscript{21}Ibid.
\textsuperscript{22}I analyze these letters in chapter five.
negotiations, social engagements, and relationships that unfolded between them as they attempted to maximize the potential of infants to grow into adults.

Tanzania is an apt setting for this research because the British colonial government initiated and implemented ambitious infant survival interventions there from the 1920s. Moreover, African colonial subjects participated in the programs in multiple capacities. For example, they ran the infant survival programs as welfare attendants, they funded the programs as taxpayers, they critiqued the viability of the interventions, and they demanded the incorporation of curative medicine in the welfare programs. Other social actors, such as the medical missionaries, local chiefs, and dressers played a role in shaping the evolution of these negotiations. This setting, therefore, is suitable for studying the negotiations between these actors. This dissertation draws extensively on oral interviews I conducted with men and women in colonial Rungwe district in southwest Tanzania. The medium of communication was Chindali, for which I am a “native” speaker, making the region an apt setting for eliciting oral recollections that complemented written accounts to shed light onto processes of negotiations that characterized the dynamics of the interventions. I was able to study the recollections carefully and discover that negotiations over developing colonial infant survival interventions were a continuation of broader social negotiations between people, ancestors, environments, and communities that predated the 1920s but also continued after that.
Although the main period of my dissertation is from 1920 to 1950, the narrative begins in the 1870s/1880s in order to uncover how parents, households, and communities understood and dealt with the challenges of infant survival before the colonial government’s programs of the 1920s. The Africans had a long history of dealing with medical challenges confronting their infants. This temporal frame allows me first to delineate African conceptions of infant survival that predated the British colonial period and then show how these conceptions shaped peasants’ social engagements with colonial interventions from the 1920s to the 1940s. By moving the temporal frame back to the late nineteenth century, we are able to capture multiple levels of negotiations over time—such as those that evolved between pre-colonial people and their shifting communities, between people and their environments, between people and their ancestors, between people and slave raiders, between peasants and government officials, between medical missions and the government, between members of the colonial government itself, and between peasants and African chiefs.

1.2 Historiographical Context.

This dissertation builds on three strands of literature: medical histories produced in Africa, studies of infant welfare produced outside of Africa, and anthropological studies of infancy in Africa. I begin with the medical histories produced in Africa. In particular, this dissertation builds on institutional, political economy, discourse analysis, and social histories of health and healing in Africa produced in the past four decades. I will briefly
review the first three historiographies produced until the 1990s in order to set a background for recent social histories produced in the late 1990s and 2000s.

Institutional histories, produced mostly from the 1940s to the 1970s, focused on the evolution of western medicine, medical institutions, and health policies in the colonies. They conceptualized the construction of hospitals and dispensaries as an example of the positive contribution of colonialism in Africa. Scholars such as David Clyde and Michael Gelfand wrote positively about western medicine, arguing that it improved the health of Africans because of the campaigns against endemic diseases. In the 1970s, some scholars such as Ann Beck began to be critical of colonial medicine. She emphasized in her writings that until the 1920s, western medicine could not have led to the overall improvement in the wellbeing of the majority of Africans because it did not extend to rural areas where most of them lived. She pointed out that western medicine was spatially limited in urban and production centers where it protected European health, maintained African laborers in a good working condition, and prevented diseases from erupting into epidemic proportions.

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In the 1970s and 1980s, histories of the political economy of health moved from a focus on the development of medical institutions and policies to situating health, illness, and healing within broader political, economic, and social structures or material condition of communities.\(^25\) We can roughly distinguish three strands of these histories based on the units of analysis used. Meredeth Turshen’s study of health and disease in Tanzania used the nation as a unit of analysis. She argued that the integration of Tanzanian societies into colonialism undermined the health of Africans.\(^26\) According to her, political processes of conquest and dislocations increased sleeping sickness and smallpox epidemics; economic policies of labor migration created conveyor belts for transmitting infectious diseases; and production of cash crops for exports compromised food production and exacerbated malnutrition. In contrast, Steven Feierman and John Janzen advocated local units of analysis. They argued that “[t]he path of change in health and disease (like that of healing) cannot be understood apart from change in farming, household organization, politics, and migration, among many other elements.”\(^27\) The third strand utilized an imperial unit of analysis by conceptualizing colonial health and healing as extensions of

\(^{25}\)The political economy approach to health exerted enormous influence in the analysis of my own study on the relationship between colonial penetration and the spread of disease in southwest colonial Tanzania. See Oswald Masebo, “Colonialism and the Spread of Diseases; The Case of Ileje District, Tanzania 1890-1950s” (MA Dissertation, University of Dar es Salaam, 2002).


metropolitan imperial relations in the colonies. The work of David Arnold and that of Roy Maclead and Milton Lewis, which conceptualized medical interventions as technologies that facilitated expansion in the colonies, colonization, and control of the colonial subjects, illustrate these studies.²⁸

In the 1990s, historians transcended the materialism and structuralism inherent in political economy histories by paying attention to colonial medicine as cultural process with underlying assumptions, ideologies, and theories that colonial agents used to make claims about African health and illnesses. Megan Vaughan, in her book *Curing their Ills*, analyzed how colonial agents used western biomedicine as a cultural tool to construct African health and illness, and to intervene into African social life.²⁹ Vaughan examined texts that colonial officials and missionaries produced to uncover how they understood and constructed ideas about African health and healing. In this approach, she conceptualized colonial medicine as a form of representation.³⁰


Taken together, the institutional, political economy, and discourse analysis histories share two major limitations that recent social historians are addressing. First, they marginalized and rendered invisible the role of African colonial subjects in shaping the development of colonial medicine. Second, these studies framed colonial medicine in binary relations between Africans and colonizers. In so doing, they missed the complex colonial negotiations that unfolded between and within them. Recent social histories produced from the late 1990s and especially in the 2000s have addressed these limitations by conceptualizing colonial medicine as a terrain of complex medical encounters and negotiations between Africans, colonizers, missionaries, intermediaries, and other social actors. I now turn to these recent histories that have addressed four main areas of inquiry.

Some recent historians have explored the role of medical intermediaries in facilitating the development of western medical interventions in Africa. Nancy Rose Hunt, for instance, has demonstrated that the making of colonial public health interventions in the Congo basin involved negotiations and transactions between African social groups and colonial agents, especially missionaries.\(^{31}\) In her study of medicalization of childbirth in the Congo basin, Hunt demonstrated that the penetration and acceptance of western biomedical practices depended upon the translation of these practices in local terms by the “middle figures” (people such as midwives, nurses, teachers, and medical attendants) who mediated between the colonized populations and the colonizers. These medical

intermediaries made the western medical ideas and practices intelligible to fellow Africans. Another historian, Shula Marks, has argued that the Christian nurses in South Africa popularized European medical culture among Africans. Marks also highlighted the struggles over gender, race, and class that occurred as African male and female nurses sought recognition from their white counterparts during the development of the nursing profession. In so doing, Marks uncovered the negotiations (between doctors and nurses, blacks and whites, males and females, the poor and the rich) that shaped and structured the evolution of the nursing profession in South Africa. These works are important for highlighting that the introduction of western medicine resulted in complex negotiations between colonizers, colonial subjects, and African intermediaries. Particularly, they demonstrated that African intermediaries were central actors in mediating contacts between the colonizers and the colonized. They played a critical role in making Africans understand and comprehend western medicine. These works have informed my own thinking about the intermediary work that local chiefs did between peasants and colonial administrators as the former demanded that the government incorporate curative medicine in its welfare interventions.

Other recent social historians have focused on African responses to western medical interventions with an emphasis on the ways in which African men and women resisted and reconfigured these measures. African responses varied: they included resisting western medical interventions, appropriating them, or infusing them with new meanings.

and uses that addressed their own interests in the changing colonial medical landscape. The work of Richard Waller and Kathy Homewood, for instance, provides an example of studies that have highlighted African resistance to western medical practices.\(^{33}\) Their work uncovered the local contestations between the Maasai pastoral societies and colonial veterinary officers over western veterinary knowledge for dealing with cattle diseases. The Maasai contested the knowledge that colonial veterinary officers propagated in their communities because it did not fit within their own understandings of managing cattle diseases. While veterinary officers advocated the quality of cattle, destocking, and eliminating or quarantining cattle that contracted diseases, the Maasai valued large herds of cattle and believed in managing diseased cattle instead of eliminating them.\(^ {34}\) The varied interpretations of the value of cattle and handling of their diseases resulted in negotiations between pastoralists, veterinary officers, and colonial medical knowledge. Amy Kaler’s study of contraception in Zimbabwe settler farms is an example of a study that focuses both on resistance and on how Africans gave western medical interventions new meanings that addressed their own concerns.\(^ {35}\) Kaler uncovered the varied responses and meanings that women and men assigned to family planning methods. While men resisted the interventions because they undermined their power to control the reproductive processes of their wives, women appropriated these


\(^{34}\) Ibid., pp. 69-75.

interventions because they empowered them to exert more control over their sexual and reproductive potential than was previously possible.\textsuperscript{36} I look at the processes of resistances, appropriation, or infusing interventions with new meanings as components of negotiations that evolved between men, women, settler farmers, and colonial officials during the complex medical encounters. These sorts of social engagements are evident in my dissertation as well. Peasants’ criticisms of early colonial infant welfare programs for lacking curative medicine, including their boycott of attending government welfare centers, were some of the acts of negotiation that characterized the development of infant survival interventions in colonial southwest Tanzania.

Furthermore, scholars have underlined cultural exchanges and hybridism in the development of colonial medicine. According to Lynn Thomas, for instance, the evolving reproductive concerns in Kenya from the 1920s resulted from the mixing of local and imperial concerns over reproduction, health, and population as a way of demonstrating that such concerns were “never simply about colonial subjugation and anticolonial resistance.”\textsuperscript{37} Rather, they involved cultural entanglements of indigenous and colonial concerns that hybridized the evolving medical and social interventions. Thomas demonstrated that the developments of reproductive health reflected negotiations and collaborations that culminated in these cultural entanglements. Writing about South Africa, Karen Flint argued that the development of medicine in South Africa was a product of cultural exchange of ideas, technologies, and practices between Africans, 

\textsuperscript{36}Kaler, “The White Man in the Bedroom.”
Europeans, and Indians. In putting forward this argument, Flint destabilized the categories such as African medicine or indigenous perspectives that scholars have taken for granted to mean “authentic” African. She emphasized that what is usually considered African medicine or medical knowledge is nothing but an amalgamation of multiple cultures and influences that evolved as Africans continuously interacted with other social communities, such as the Europeans, Indians, Chinese, and Arabs. For Flint, therefore, medicine in South Africa was neither exclusively African nor western, but a cultural hybrid that embodied and integrated both elements. I interpret the processes of medical hybridism and cultural exchanges in Kenya and South Africa respectively as instances of negotiations that characterized the development of colonial medicine. This interpretation has informed my own analysis of the development of colonial infant survival interventions in this dissertation. The integration of preventive and curative medicines beginning in the late 1930s was a culmination of negotiations and hybridization of the ideas and agendas that peasants, local chiefs, dressers, health officials, and political administrators injected into the interventions.

Finally, recent social histories of colonial medicine have studied it as a terrain of knowledge production. Osaak Ollumwullah argued that the production of knowledge on viruses, bacteria, epidemics, diseases, health, and landscape was one of the central preoccupations of the colonial administrators, anthropologists, colonial health/medical experts, natural historians, nutritionists, missionaries, and other agents of colonialism.

According to him, “the importance of colonialism lay in its capacity to build an enormous battery of texts and discursive practices that concerned themselves with the construction of its own authority, legitimacy, and control…” and that “the accumulation of knowledge thus produced…contributed to the political evolution and ideological articulation of the colonial system.”

Furthermore, Helen Tilley’s research demonstrated that colonialism offered scientists an opportunity to study African environments, parasites, and humans that generated complex ecologies of epidemics such as sleeping sickness and that highlighted the difficulty of eradicating or even controlling the epidemic if interdisciplinary approaches that integrated ecology, human settlement, parasites, the natural environment, and political will were not taken into consideration. Tilley highlighted that colonial researchers pushed the epidemiological and epistemological boundaries of knowledge production of medicine in the colonies to new heights that elevated tropical medicine, particularly ecology, as an important area of scientific inquiry by the late 1930s. However, as several historians have commented, knowledge production was not a preserve of the colonial scientists alone. Africans too, continuously engaged in studying their environment and they accumulated knowledge that they used to deal with medical and environmental challenges. In fact, they used this knowledge to evaluate the ideas and practices that colonial officials imposed in their daily lives.

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communities. These insights have informed my own thinking of peasants’ social engagements with government officials, missionaries, and local chiefs. The cumulative knowledge of preventive and curative medicines that peasants continually recreated and deployed to deal with infant medical challenges shaped their demand for the incorporation of curative medicine in the colonial infant welfare programs.

My dissertation joins these recent medical histories to shed light into the negotiated character of colonial medical interventions. Its modest contribution lies in producing the historical understanding of infant survival as another site of negotiation. This understanding sheds light on the way in which rural peasants, local chiefs, colonial government officials, and dressers interacted to shape the evolution and dynamics of the infant survival interventions from exclusively preventive programs to those that integrated preventive and curative medicines. Looking at infant survival interventions as a site of negotiation reveals that colonial officials were not hegemonic in their dealing with Africans. Although the officials created and implemented the welfare interventions, it was the complex negotiation of ideas and practices with peasant men and women, medical missions, local chiefs, and dressers that shaped their evolution and dynamics.


Looking at infant survival as a site of negotiation also reveals the diverse and shifting agendas and interests that motivated all these social actors to engage in the infant survival interventions, as the previous section has highlighted.

This dissertation also contributes to the history of Tanzania in particular and to that of East Africa more generally. While historians have explored many themes, institutions, and social communities in the past four decades, the historical construction of infant survival has remained an important lacuna in the history of the region. In this period, history has moved from the earlier romantic nationalist and politically motivated histories and the Marxist economic histories to new social histories that have uncovered the lived experiences of ordinary Africans in their homes, communities, and workplaces. While nationalist and Marxist histories focused on African political initiatives and larger economic structures producing underdevelopment respectively, later social histories explored the lives of ordinary and marginal social groups such as the peasants, women, ex-slaves, and prostitutes. In addition, social historians have explored complex interactions between individuals, communities, and the environment to

uncover gender relations, struggles over natural resources, and household efforts to expand livelihood opportunities in the changing colonial and postcolonial developments. In an important way, historians are foregrounding the institution of family as an entry point for studying changes and continuities in Tanzanian history. James Giblin and Blandina Kaduma, for instance, have paid attention to the institution of the family and family networks on which individuals depended to meet the daily challenges of livelihood, subsistence, reproduction, social security, and identity. Another historian, Kathleen Smythe, has studied the family as a window through which to study the struggles between the Fipa and missionaries over social and biological reproduction as well as over the creation of the Catholic community in southwest Tanzania.

This dissertation joins Smythe, as well as Giblin and Kaduma, to underline that understanding the social processes that took place within families over time is an exciting area of historical inquiry. In particular, I am interested in the family as a site where infants were born and raised. I pay attention to how men and women in their own

households and communities, together with the colonial government, understood, intervened, and engaged each other to make households and communities better places for infant survival. Infant survival is an important site where the interests of peasants, colonial government officials, missionaries, and local chiefs intersected as they sought to prevent premature deaths. As a point of intersection and negotiation, the study of infant survival reveals that the dominant narrative of African resistance to colonialism, such as the African resistance to the imposition of colonialism, African resistance to colonial exploitation and oppression, or African resistance to end colonialism after the Second World War present one side of the story of complex colonial encounters. Left out of the story, are points of congruence and intersections that the historical understanding of infant survival exemplifies, points which this dissertation uncovers. Taken together, the two sides of these stories complement each other to enrich the social history of colonial Tanzania. Although this dissertation is about the historical understanding of infant survival in colonial Tanzania, the significance and necessity of carrying out similar studies in other parts of Africa cannot be gainsaid. Such studies would allow comparative analysis on infant survival initiatives across time and space.

This dissertation also builds on the histories of maternal and child health produced outside Africa. Measures taken in colonial Tanzania had precedence elsewhere. For instance, historians such as Deborah Dwork, Jane Lewis, and Richard Merkel have demonstrated that the efforts to improve the welfare of mothers and children in Britain, in the United States, and in Western Europe more generally began in the second half of the

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54 Typical example of this thinking is Kaniki, *Tanzania under Colonial Rule.*
nineteenth century, but gained momentum after the First World War. Over time, interest in the welfare of children acquired an imperial drive particularly among American and Western European nations as they consolidated their position in their Asian and African colonies or in their spheres of influence in the Pacific and the Atlantic Oceans. The global interest among imperial powers over the welfare of children culminated in the Geneva Declaration of 1924 that urged all nations to invest in the welfare of children at home and in the colonies. This declaration led to the International Conference on African Children held in 1931 in Geneva. This conference pushed all governments with possessions in Africa to investigate conditions that made child mortality a major health problem. The implementation of the infant survival interventions in colonial Tanzania coincided with the growing imperial concerns over infant health in the colonies.

While historians have credited the pioneering effects of the educated middle class men and women in the initiation and development of ideas and practices of maternal and child

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welfare in metropolitan countries and in the Asian colonies, my dissertation reveals that even the illiterate African peasants helped to shape medical programs in colonial Tanzania. Writing on the history of maternal and child health in Ceylon, Margaret Jones pointed out that concerns over the health of children and mothers in the colonies “followed the precedent set in Europe at the beginning of twentieth century, when concerns over infant and child health and the needs of empire were among the factors which prompted the British Government, for one, to initiate a range of social policy measures to improve the health chances of future generations.”58 The colonial Tanzanian experience with infant survival initiatives was not unique because the colonial discourse that linked poor infant survival to maternal ignorance was common in other colonies and in the metropolitan countries. Nevertheless, the implementation of infant survival interventions in colonial Tanzania had different characteristics to those in Europe, the United States, or in Asian colonies. Studies on the development of maternal and child welfare in the latter areas show that it was middle class educated women and men who spearheaded the demands for the reforms meant to expand welfare programs.59 By highlighting the role of the educated social groups in putting forward the reform agendas, these studies underscored the elitist nature of the evolution of welfare interventions in those areas. In contrast to these studies, my dissertation reveals that the development of

59 Ibid. See also footnotes 41 and 42 above.
the infant survival interventions in colonial Tanzania was not a creative product of the elites alone. Rather, the development resulted from the social engagements and negotiations between many social actors, including the mostly illiterate peasants.

Finally, this dissertation also builds on the works of anthropologists who, unlike Africanist historians, have produced a small but growing literature on infancy. Earlier anthropological works focused on the socialization processes of infants and other children. Such works, popular until the 1990s, looked at infants as passive recipients of the ideas and practices that adults imparted to them. Recent anthropologies of infancy have enriched socialization studies by constructing infants as important social actors who produce their own world and influence their relationship with adults. An example of this new trend in the study of infancy is the work of Alma Gotlieb who studied the daily lives and actions of babies among the Beng of West Africa. Although this dissertation is not about the socialization of infants or on infants as autonomous historical agents (even though these topics offer exciting questions for historical inquiry), I find an anthropological approach of studying issues related to infants from the perspective of Africans to be a productive strategy for producing socio-cultural histories because it allows the possibility of uncovering the interior views held by the societies that we study.

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In my dissertation, I employ this approach to probe the local ideologies and conceptions of the threats to infant survival.

1.3 Methodology

A combination of written archival documents, extant ethnographic accounts, and oral recollections forms the evidentiary basis for my effort to understand the negotiations that shaped the development of colonial infant survival interventions. Although different social actors produced these evidentiary materials, I read them as complementary because none of them can stand alone. Since all of this evidence reflects the subjectivities or perspectives of people who authored and produced them, interpreting them as complementary evidence allows the possibility to read and evaluate them against each other. Reading them as complementary evidence is also a way of acknowledging that the social actors who produced them, such as government officials who wrote archival documents or peasants whose reminiscences I have uncovered through their descendants, did not live in isolated worlds. Rather, they influenced, engaged, and shaped each other within the limits that colonialism imposed. These social engagements allow us to glean the negotiations and relationships between the different actors who produced these materials.

A variety of written documents has offered an important evidentiary basis for this dissertation, including archival records written by colonial government officials. I accessed these documents at the Tanzania National Archives in Dar es Salaam, the largest
depository of historical documents in Tanzania. A sample of documents I consulted includes files such as *Maternity and Child Welfare General* that contain important details on colonial child survival concerns and initiatives. I also read the *Annual Medical and Sanitation Reports* for districts, provinces, and the territory with detailed information on the development of medicine and medical interventions from the 1920s to the 1950s. In addition, I read memorandums such as the *Memorandum on Infant Welfare Policy* of 1925 and the *Memorandum on Health Services* of 1928 that specify government initiatives in addressing concerns over infant survival that reached rural communities. Files in Grants to the Missions and the letters on communications between missionaries and colonial officials provided detailed information on the changing relationships between the colonial government and the medical missions in the territory.

Through a critical reading of the documents authored by colonial government officials, I have generated data that sheds light on ideas about infant welfare that informed the government’s policy formulation, propositions, and implementation of the colonial initiatives. They also provide insights into the changing content of the interventions, particularly a change from the early exclusive preventive interventions of the 1920s and early 1930s to those that integrated preventive and curative medicine in the late 1930s. In addition, while economic reasons, such as expanding the population for a cheap labor force and expanding markets motivated the British colonial government to invest in infant welfare, a point that many historians have noted,\(^6\) the evidence I have collected

reveals another important motive: the government utilized the welfare programs to legitimize its presence in the rural communities. I develop this argument in chapter three.

The archives also contain letters between government officials at different administrative levels: district, province, and territorial headquarters. The content of these letters provides important insights into the negotiations among the colonial government officials over infant survival interventions. The letters reveal the agreements, disagreements, conflicting ideas, and debates between colonial officials holding different positions in the hierarchy of administration and power. The analysis of these letters, which has informed the content of chapter five, suggests that although colonial officials were part of the colonial administration, colonialism was not monolithic, and officials’ opinions were not always harmonious. I have drawn on these disagreements to point out that the evolution and dynamics of infant survival interventions in colonial Tanzania constituted a contested and negotiated terrain between officials in the colonial government.

and *Malafyale* Mwakiembe wrote to the colonial administration in the district. These letters, which are contemporaneous with the implementation of infant survival interventions, articulated rural peasants’ demands for the colonial government to provide curative medicine as part of its welfare interventions in their rural areas. The letters contain invaluable information on the strategies that rural peasants used to express their dissatisfaction with the early colonial infant survival interventions that excluded treatment of infantile diseases, such as withholding taxes, boycotting government-run welfare, and using their *Malafyale* to convey their demands to the colonial government.

The letters provide glances into the contribution of the *Malafyale* in effecting the negotiations between rural peasants and colonial government officials that shaped the dynamics of the infant survival interventions.

Written documents, particularly those that the colonial government officials and local chiefs wrote, provide important insights into the negotiated character of the development of the infant welfare policies. Both government officials and local chiefs made references to rural peasants. Local chiefs wrote letters to the government officials that voiced rural peasants’ demands for the incorporation of curative medicine in the welfare interventions. Colonial government letters and reports frequently emphasized the necessity of incorporating curative medicine because that is what peasants wanted. As Ralph Scott (the Director of Medical Services) acknowledged, it was important to provide treatment services as demanded by rural peasants because that is what peasants expected in return.
for the taxes they paid. Analyses of this documentation, therefore, provides important glimpses into the multiple actors—government officials, local chiefs, and peasants—whose social engagements helped to shape the dynamics of these interventions.

The written accounts of early European missionaries, explorers, and colonial officials in the late nineteenth and early twentieth centuries have also informed parts of this dissertation. Early European explorers and missionaries who visited late pre-colonial southwest Tanzania and left documentation of what they witnessed in the region include D. Kerr-Cross, Dr. Merensky, J. F. Elton, Joseph Thompson, and H. B. Cotterill. A reading of their reports indicates clearly that their intended audiences were Europeans in Europe who were grappling with the anxieties, expectations, and challenges of colonizing the region during the second half of the nineteenth century. However, their rich and sometimes detailed documents remain the only available written evidence that we can read to understand the historical contexts of the region as they witnessed and recorded them in their reports. For example, they help us to understand the ravages of slave raiding, colonial penetration, diseases and famines, and local responses to them. These accounts have helped me to understand the historical context of infant survival during the

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63 TNA 18/27/3 Ralph R Scott, the DMS to Huggins, Tukuyu DO, July 8, 1936.
transition from the late pre-colonial to early colonial periods, which I document in chapter two.

A set of ethnographic accounts also forms an evidentiary basis for this dissertation. Three ethnographic works stand out. The first is by Theodor Meyer, whose work, *Wa-Konde: Maisha, Mila na Desturi za Wanyakyusa* details the life of local communities in the region from the 1890s to the early 1910s. Meyer was a Moravian missionary who lived in the region for twenty four years, from 1890 to the outbreak of the First World War, when German missionaries were forced to leave the territory. D. R. Mackenzie, a British Livingstonia missionary who lived around the northern end of Lake Nyasa for over twenty years published an ethnographic work in 1925, titled *The Spirit-Ridden Konde*. His work, which I have also mined for this dissertation, sheds light into customs and ideas of the local residents as he observed them until the 1920s. Finally, I used the ethnographic works that Monica Wilson and Godfrey Wilson produced after their intensive ethnographic work from 1934 to 1938. Taken together, the work of Meyer, Mackenzie, and the Wilsons provides glimpses into local peoples’ moral systems,

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cosmologies, social structure, legal system, common diseases, witchcraft beliefs, as well as their experiences of labor migration, commodity production, and missionary influence. Reading these ethnographic works presents a challenge because the authors rarely addressed the internal dynamism of the social systems or communities they witnessed and wrote about. They recorded them in order to preserve in writing the lives and cultures of these “traditional” communities that they perceived to be under threat of extinction by colonial modernization.⁶⁸

Oral recollections constitute an important evidentiary basis for this dissertation. I conducted interviews with men and women, most of whom had witnessed the colonial infant survival interventions as young boys, girls, or youths; or they had heard about the interventions from their parents and grandparents. I conducted the interviews in what is today Ileje district in southwest Tanzania, but which was part of Rungwe district in the colonial period. A local language called Chindali, of which I am a “native” speaker, was the medium of communication during the interview sessions. I received cooperation from my interviewees partly because of my own social position in the region. Since I was born and raised in the district, some of my interviewees knew me, my parents and grandparents, or my clan. When I described my research project to them, they looked at me as their own grandson who wanted to learn issues related to the welfare of infants from them. Their recollections generated important material on how their parents and

⁶⁸ The exception is Monica Wilson’s publication titled *For Men and Elders*, published almost forty years after her research in which she approached her material historically by studying how the Nyakyusa society underwent changes in the course of a century of intersection with the outside world. See Wilson, *For Men and Elders*, Ibid.
grandparents had understood and dealt with threats to infant survival, their encounter with early colonial infant survival initiatives, their perception of these programs, and their demand on the government to incorporate curative medicine into the welfare interventions.

I interpret the oral recollections as cumulative knowledge that my interviewees learned from their parents and grandparents and which they recreated in their contemporary world to make sense of the past. Core ideas of how earlier generations dealt with the challenges of infant survival pass from one generation to another, and each subsequent generation infuses these ideas with contextual meanings to make them relevant in their time. Thus, oral recollections contain traces of the past, the contemporary experiences, and the dialectical interplay between them. This cumulative dimension has enabled me to interrogate contemporary oral recollections as a window into the world in which infants were born and raised in the past. It has also offered glimpses into negotiations and social engagements between peasants, local chiefs, and government officials during the implementation of the colonial infant survival interventions.

As a cumulative form of knowledge that defines individuals and social communities, each generation passes this knowledge to the next one. The process of passing memories from one generation to the next involves change and continuity in the nature and character of these memories. This change and continuity, Jan Shetler has noted, results from the fact that new generations tend to redefine and contextualize these memories in
their own times, social contexts, and historical experiences. As they redefine them, they no longer reinforce the received facts that no longer have relevance in the new contexts and such facts may disappear in the contemporary recollections of the past.\(^{69}\) Thus, new generations construct the memories of the past in ways that reflect the changing social and historical contexts of their time. In this way, oral interviewees are not passive recipients of the versions of the memories they learned from their predecessors. By redefining them, and making them relevant to their own times, they become actors who produce recollections that reflect continuity with the past and which they use innovatively when they adapt them to new circumstances.\(^{70}\)

I also look at oral recollections as mediated oral texts that demand careful reading and critical analysis. The interview I had with Mwatabhika Swilla illustrates this point. As he reflected in one of his recollections,

> What our parents forced the British colonial government to offer is exactly what [Julius Kambarage] Nyerere’s government did after independence: taking care of the health of its children for free. Even today, although the government has introduced cost sharing for adults, but the government provides free medical services to infants. This practice of providing free services to infants is good, and that is what our parents were fighting for when we were young [during the British rule].\(^{71}\)

Although Swilla witnessed colonial infant survival interventions as a boy, almost sixty years separated the interventions that the colonial government implemented and the time


\(^{70}\) Shetler, *Imagining Serengeti*, p.6

\(^{71}\) Mwatabhika Swilla, Interview at Kafule, May 25, 2007
I conducted interviews with him in 2007. The intervening developments such as the socialist politics of the 1960s and the 1970s and the liberalization drive associated with the implementation of Structural Adjustment Programs in the mid 1980s formed part of his recollections of earlier periods. Consequently, Swilla infused stories of his parents during the British colonial period with those of Nyerere’s socialist ideals as well as the cost-sharing schemes that came with the Structural Adjustment Programs. In so doing, his recollections reveal the ways in which the contemporary postcolonial developments that shaped his life left traces in the memories of what he witnessed as a boy in the 1930s and 1940s.

Finally, oral recollections embody the self-interests and personal agendas of the interviewees. Through recalling the past, narrating about it, and systematizing the role that their parents accomplished in reshaping the medical interventions, oral interviewees assumed the role of repositories of the memory of the social processes that have shaped the development of their communities from the past to the present. For instance, elders narrated the stories about infant survival in the past with confidence and authority, and they sometimes presented these stories as objective reality or truth. However, I interpret their oral recollections as subjective and interpretive constructions that they used to make sense of infant survival in the past. These recollections are as subjective as any other form of evidence that historians (both Africanists and non-Africanists) utilize to produce historical knowledge. To deal with the challenge of subjectivities, I conducted interviews with several men and women in order to corroborate their recollections.
Despite the potential limitations of oral recollections, they embody the perspectives of the descendants of the rural peasants who encountered the colonial infant welfare programs and socially engaged with the government officials and local chiefs to shape their dynamics. First, the recollections constitute the interior view of the peasants who witnessed the programs or those who heard about them from their elders. They shed light into the cosmological understanding of the threats to infant survival that I examine in chapter two, and how peasants built on this understanding to interpret and engage with the colonial infant welfare programs in the 1930s. I examine the latter in chapter four and five. Second, these oral recollections provide important insights into the practical actions that rural peasants utilized in their social engagements and negotiations with the colonial government as they attempted to inject their opinions into the colonial initiatives. They utilized actions such as withholding the taxes, boycotting attendance at the government-run welfare centers, and their local chiefs’ letters to increase the strength of their influence, as they demanded the incorporation of curative medicine in the interventions. Third, the oral recollections reveal that the rural peasants were not passive recipients of the colonial welfare policies. They received the government welfare interventions, interpreted their relevance, and made conscious efforts to engage colonial government officials in making sure that curative medicine became an integral component of the programs. Finally, these recollections have made our understanding of the threats to infant survival more complex than could be deciphered from colonial archival documents alone. Reading the visions of peasants and government officials expands our
understanding of the complexity of the threats to infant survival that ranged from maternal ignorance to the disruptions caused by the slave raiding and colonization.

I have interpreted the colonial officials’ documents, ethnographic writings, the letters by local chiefs, and the cumulative oral recollections as dialogical and complementary texts that different actors produced as they dynamically engaged with each other during the implementation of the infant survival interventions. I have taken all the evidence seriously, without privileging any of it, because each set of evidence represents the perspectives and actions of the social actors who produced them and who “were bound by their mutual engagement”72 with each other during the implementation of the interventions. The advantage of taking seriously different types of evidence without privileging any sub-set is that it allows me to corroborate them and to study negotiations between social actors. As Tamara Giles-Vernick has pointed out, interpreting documentary and oral evidence without privileging either of them, allows the materials to “flesh out” and “contextualize” each other.73 This interpretive strategy becomes a window not only into how government officials and rural peasants understood and dealt with threats to infant survival, but also into how they entered into social engagements and relationships that shaped the development of the infant survival interventions. In this way, we get a fuller picture of the socio-cultural history of infant survival than if we

relied on one single source or if we treated the different sources as competitive and oppositional absolutes.

1.4 Dissertation Architecture

The dissertation has five chapters. The current chapter introduces the dissertation’s argument, its historiographical context, and the methodology. In essence, the dissertation argues that the negotiations between multiple social actors, including the local chiefs, the colonial government officials, and the rural peasants, shaped the evolution and dynamics of the infant survival interventions that the government implemented from the 1920 to the 1950. The importance of this argument is that it brings the historical understanding of infant survival into the histories of colonial medicine in Africa. Finally, the chapter introduces the evidentiary basis of the dissertation, particularly the colonial officials’ authored documents, local chiefs’ letters, ethnographic accounts, and the oral recollections of the descendants of the rural peasants who engaged other actors in shaping the interventions in the 1930s and 1940s.

The second chapter examines how residents of southwest Tanzania understood and dealt with the threats to infant survival before the British colonial government implemented the infant survival programs of the 1920s. There were two types of threats that shaped the late nineteenth and early twentieth century understandings of infants and infant health, which I analyze in this chapter. First, there were socio-historical threats. By socio-historical threats, I refer to the disruptions that slave raiding and the imposition of
colonialism precipitated in the region. Second, there were ethno-geographic threats. By ethno-geographic threats, I refer to the disruptions that ancestral spirits and the surrounding social and physical environments precipitated in the households and communities. The central argument of chapter two is that the preventive and curative medical interventions were a crucial part of the efforts that households and communities deployed to deal with the challenges that socio-historical and ethno-geographical threats posed to infant survival in the late nineteenth and early twentieth century. Some of these interventions included practicing hygiene in the homes and communities, sacrificing to ancestors, performing rituals, coping with disruptions, and seeking individual medical treatment of infant illnesses and diseases. These practices reflected peoples’ understanding that infants and their survival were continuous with and connected to the spiritual life of ancestors, the environmental forces (such as landscape, water bodies, atmospheric entities, and diseases), and social relations that developed between individuals and communities. Ensuring the survival of infants, therefore, was a complex process of negotiations between parents, families, ancestors, environment, and other social disruptions. Chapter two is important for this dissertation in two ways. Local understandings and strategies of dealing with the threats to infant survival during this historical period shaped peasants’ interpretation and evaluation of the viability of the early colonial infant survival interventions in the 1920s and 1930s. In addition, their belief that infant survival depended on preventive and curative actions shaped their demand for making curative medicine an integral component of welfare interventions in the 1930s and 1940s.
Chapters three and four examine early forms of negotiations and social engagements. Chapter three examines how the British colonial government officials defined and proposed to solve the infant survival problem in the 1920s. Furthermore, it examines government officials’ interests in infant survival and introduces the negotiations between the colonial government and the medical missions. It argues that colonial officials linked the problem of infant survival to maternal ignorance of proper infant care, hygiene, and nutrition, and they proposed maternal education as a solution to the problem. In probing the colonial government’s interest in the welfare of infants, the chapter argues that the government utilized infant survival measures as a strategy for building its legitimacy and presence within African rural communities. This strategy led to the struggles with medical missions who had occupied and controlled medical interventions in the rural areas since the late nineteenth century. The British colonial government, as well as the previous German colonial government, had utilized the missions as agents of providing medical services in rural communities through subsidies. To achieve this new strategy, the government redefined its relationship with medical missions. It now perceived medical missions as competitors in reaching rural communities. Subsequently, the government limited subsidies to mission training of welfare workers only, cutting funding for the actual running of medical missions. The chapter uses two medical missions, the Moravian church and the Church Missionary Society to exemplify the negotiations that unfolded between the government and the missions as they debated over subsidizing mission welfare work.
Chapter four examines how peasants engaged with the content of early colonial interventions that were exclusively preventive in nature. While the colonial perspective narrowed down the infant survival problem to maternal ignorance, rural peasants linked it to the larger changes that colonialism produced. They thought that the consolidation of colonialism affected infant survival through increasing nursing mothers’ workloads, compromising infantile nutrition, and increasing disease incidences. For peasants, increased workloads due to the absence of migrant men meant that mothers spent more time in agricultural fields and little time nursing infants in the homes. Leaving infants home with grandmothers as mothers worked in the fields meant that they rarely breastfed infants during the day, forcing infants to rely on porridge. I argue that the visions of peasants and government officials complemented each other to reveal the multiple threats to infant survival that ranged from maternal ignorance to the effects of the consolidation of colonialism in the 1920s and 1930s. This chapter complements chapter three to highlight early negotiations that centered on colonial officials and peasants producing visions on the viability of the early infant survival interventions in the 1920s and 1930s.

Chapter five extends chapter three and four to examine later forms of negotiations and social engagements that centered on the incorporation of curative medicine in the infant welfare interventions from the mid 1930s. It argues that the social engagements between rural peasants, local chiefs, and government officials were integral components of this incorporation. The negotiations began when peasants took actions to improve on the
colonial formulations of early interventions. While the colonial government put emphasis on maternal ignorance, the peasants witnessed infants dying from diseases such as malaria, dysentery, and pneumonia, because there were no dispensaries to provide curative medicine for them in their rural areas. Peasants’ beliefs that the absence of curative medicine in the early policy undermined the viability of the welfare programs made them engage government officials to incorporate curative medicine. They withheld taxes, boycotted attending the government-run welfare centers, and expressed their demands through letters that their local chiefs wrote to the colonial administration. Local chiefs facilitated the social engagements between peasants and the colonial government officials. The chiefs wrote letters to the colonial administration that articulated rural peasants’ demands, concerns, and strategies. The chapter further highlights colonial officials’ response to rural peasants’ demands, and how they eventually implemented them. It notes the contestations among the colonial government officials. Some officials thought that accepting rural peasants’ demands could not improve the welfare of infants because there was insufficient manpower and infrastructure to offer quality curative services in the rural areas. This chapter is significant for highlighting the negotiations that shaped the development from exclusive preventive interventions to programs that integrated preventive and curative medicines. It treats peasants, local chiefs, government officials, and dressers as social actors who, although holding different positions in the colonial landscape, entered into social relationships and engagements that defined the development of the interventions. The chapter is also significant for revealing that the colonial government was not a homogeneous institution. Divergence of ideas, conflicting
opinions, and contestation of the proper direction of the interventions among colonial officials shed light into the heterogeneous nature of the government in the 1930s and 1940s.
Chapter Two

Social Change, Cosmology, and Infant Survival during the Late Pre-Colonial and Early Colonial Periods.

2.0 Introduction

This chapter examines how people in southwest Tanzania understood and dealt with the threats to infant survival before the British colonial government instituted the welfare interventions in the 1920s. There were two types of threats that shaped understandings of infants and infant health in the late nineteenth and early twentieth centuries that I analyze in this chapter. First, there were socio-historical threats, by which I mean the disruptions that the slave raiding and the imposition of colonialism precipitated in the region. Second, there were ethno-geographic threats, which were the disruptions to both relationships with ancestral spirits and to the surrounding social and physical environments that affected individuals, households, and communities. The central argument of this chapter is that the preventive and curative medical interventions were a crucial part of the efforts that households and communities deployed to deal with the challenges that socio-historical and ethno-geographical threats posed to infant survival in the late nineteenth and early twentieth century. Some of these interventions included practicing hygiene in homes and communities, sacrificing to ancestors, performing rituals, coping with disruptions, and seeking individual medical treatment of infantile illnesses and diseases. These practices reflected peoples’ understandings that infants and their survival were continuous with and connected to the spiritual life of ancestors,
environmental forces (such as landscape, water bodies, atmospheric entities, and diseases), and social relations that developed between individuals and communities.

I have included this chapter within the dissertation for three reasons. First, it introduces early forms of negotiations that were part of household and community efforts to deal with the medical challenges to infants before the imposition of colonial welfare programs in the 1920s. Ensuring infant survival during the transition from the pre-colonial to colonial period involved continuous negotiations between parents, households, ancestors, environments, and new outside forces including slave raiding and colonial penetration. Second, analyzing peasants’ preventive and curative medical practices and beliefs in the late nineteenth and early twentieth centuries sets the historical foundation for the subsequent chapters that examine their negotiations with medical missions, colonial health officials, government political administrators, and local chiefs from the 1920s to the 1940s. Peasants built on this knowledge to challenge the viability of the early colonial infant survival interventions that lacked curative medicine. In addition, this knowledge inspired peasants’ social actions to demand that the colonial government incorporate curative medicine in the infant welfare programs.

The third reason for this chapter is that the oral reminiscences of men and women I interviewed challenged my dissertation’s temporal frame and questions that aimed to generate data on infant welfare programs during the British colonial period, roughly from the 1920s to the 1950s. These men and women retrospectively grounded their
recollections and reflections within ideas and developments that frequently predated the onset of British colonialism. This longer historical framework challenged my temporal frame of the 1920s as the starting point and the defining moment for understanding infant survival in their homes and communities. Their memories were based upon cumulative knowledge that my interviewees learned from their parents and grandparents, and thus reflected longer term continuities in ideas about the threats to infant survival that endured over time.

This chapter has two sections. The first section presents the historical context of infant welfare before the colonial government imposed infant survival measures in the 1920s and reveals the changing ideas about socio-historical threats to infant survival as communities moved from the pre-colonial to the colonial periods. While slave raiding disruptions posed major threats to infant survival in the 1870s and 1880s, wars, famines, and diseases associated with colonial penetration brought new challenges to infant survival from the 1890s to early 1920s. Subsequent chapters will show that the consolidation of colonialism that increased women’s labor burden presented new challenges from the 1920s to the 1940s. Despite these changes, there were also conceptions and practices of infants and infant welfare that continued throughout this historical period. The second section examines these continuities. One of the beliefs was that infants and infant welfare were inseparable from ancestral spirits and the social and physical environment in which they lived. The other was that both curative and preventive medical interventions were central to promoting infant survival. The section
examines the measures that households and communities mobilized to deal with the social, spiritual, and environmental threats to infant survival.

2.1 A Brief Socio-Historical Context of Infant Survival in the Late Nineteenth and Early Twentieth Centuries

Evidence from oral recollections, accounts of early explorers and missionaries, and archival documents reveals that the local residents of southwest Tanzania linked infants and infant survival to the social disruptions of slave raiding and colonial penetration during the transition from the late pre-colonial to the colonial period. Periodic slave raiding in the 1870s and 1880s destroyed villages, compromised food production and nutrition, and relocated infants and adults from their natal homes to new residences in the mountains or in congregated stockades. Colonial penetration by German colonial forces provoked wars of resistance and coincided with rinderpest pandemics, locust plague, famine, wars, and epidemics such as influenza that affected the normal functioning of households and communities. This section briefly examines the extent to which these factors made it difficult for parents, households, and communities to ensure the welfare and survival of infants.

Map 1 below shows the socio-spatial context of people and geography that serves as a background for understanding people’s ideas on infant survival in the late pre-colonial period. I conducted fieldwork interviews among the Ndali and Lambya in southwest Tanzania whom the early European explorers, missionaries, and German colonial
officials perceived to be related to the Nyakyusa, Ngonde, Ukukwe, and Sukwa communities, and believed that all these social groups belonged to one “tribe” or “culture,” which they called “Wakonde.” These communities are geographically located to the north and northwest ends of Lake Nyasa and they extend north beyond the Songwe River, which became an official boundary separating the German and British colonies of German East Africa and Nyasaland. This name “Wakonde” stemmed from the fact that missionaries, explorers, and colonists who arrived in the region through Lake Nyasa found people north and south of the Songwe River who identified themselves as “Nkonde,” and Europeans generalized this concept to apply to all the African social groups they saw in the region. D. Kerr-Cross, for instance, argued that these groups of people were “one tribe” and that although they had different names, “their language, their physique, their dress and peculiar intonation of speech prove[d] them to be members of one great family.” Europeans divided Kondeland into three geographical environments: the plains around Lake Nyasa settled by Ngonde, the highlands and mountains of Bundali.

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75 The British renamed Germany East Africa as Tanganyika after taking over the administration of the colony from the Germans at the end of the First World War. Tanganyika got independence in 1961. In 1964, Tanganyika and Zanzibar united to form what is now known as the United Republic of Tanzania.

settled by the Ndali and Sukwa and those of Rungwe settled by the Nyakyusa and Kukwe, and finally, the western plateau settled by the Lambya and the Nyiha.  

Map 1: Southwestern Tanzania as Perceived in the Late 19th Century


In the late nineteenth century, this region lay at the intersection of slave routes that connected the Indian Ocean with the East-Central African interior and integrated it into global capitalism. The area was part of the hinterland of the Lake Nyasa region which

made up the Southern route of slave trade that the Yao dominated during the second half of the nineteenth century. In addition, the Central route that the Nyamwezi controlled branched southwards to join the Lake Nyasa region, and subsequently the Southern route. Southwest Tanzania, therefore, was centrally located within this commercial network of slave routes to “become part of a vast hinterland connected with Zanzibar through …coastal towns,” and the region’s role in this commercial network lay in supplying slaves and porters who were taken to the Indian ocean coast. The Sangu, Ngoni, Nyamwanga, and Arabs organized raiding expeditions in southwest Tanzania for slaves and porters to the Indian Ocean.

A number of early explorers and missionaries witnessed slave raiding expeditions in the local communities that resided in the plains and highlands settled by the Nyakyusa, Kukwe, and the Ndali. J. F. Elton, the British consul in Mozambique who explored southwest Tanzania in 1877 to determine the level of slaving operations, witnessed the disruptions and insecurities that these expeditions generated in the local communities. As he passed through the region, he found villages deserted, their inhabitants having fled.

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into the inaccessible mountain ranges. Another explorer, Joseph Thompson, narrated his encounter with local communities, who mistakenly thought his caravan was a slave raiding expedition,

Although we took every precaution to intimate our approach and our friendly mission, we found every village deserted on our route. Every here and there could be seen villagers flying for their lives in all directions, carrying what they could with them. Away on the high mountain peaks groups of the villagers could be faintly discerned, watching our movements, and doubtless expecting to see a grand conflagration of their villagers.

D. Kerr-Cross’s narrative further illustrates that running to the mountain tops was a defensive strategy to contain and fight the raiders. He recorded the following incident,

As late as September, 1892, 600 of Merere’s fighting men came down to the neighborhood of Rungwe. On their appearance the people fled to the hills, and with their cattle, took refuge in caves and inaccessible fastness. Merere’s men followed, when the fugitives hurled stones down the steep slopes, and killed many of the men. This so discouraged the invaders that they left the country. This is Africa.

Slave raiding expeditions among the Lambya and Nyiha came mostly from the Bemba, Nyamwanga, and the Sangu. Kerr-Cross described a particular experience of the Awawemba who were armed by slave-dealing Arabs and who destroyed villages, carried off people, and generated traumatic experiences in the villages in the Bulambya plateau. During his visit at the village of Chitete, he found out that

The Chief was suffering from a bullet wound in his right shoulder. In a fight a year ago with Chikanamalira, the chief of Inyamwanga, he was wounded and

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nearly lost his life. This Chikanamalira has lately had extensive dealings with Arabs, and has been supplied with guns and powder, and has lately begun to molest the weaker villages around him. He attacked this village a year ago, wounded the chief, killed several men, and carried off all the cattle.\textsuperscript{55}

The oral recollections reveal that the social responses to slave raiding, which involved moving to the mountain tops and caves as a defensive strategy against raiders such as the Nyamwanga, Ngoni, and Sangu, generated a social environment that undermined infant care. As Kwikoshi Masebo pointed out about this strategy, “the turmoil of slave raiding expeditions forced people to flee and relocate to Mughubhi caves [located in the Bundali Mountains].”\textsuperscript{86} He emphasized that using mountain caves served two roles. First, caves in the mountains, coupled with mountain landscapes, offered better defensive posts against enemy expeditions than facing enemies in the lowland plains. Second, caves hosted the vulnerable social groups (such as infants, children, and women) as men fought to protect their communities and belongings from the raiders. One interviewee, Sikanyagha Kibona, claimed that although climbing the mountains allowed local communities to defend themselves and strike back against the raiders, the inclusion of infants accompanying parents to these refuges presented parents with new challenges of ensuring healthy growth of infants. She reminisced,

Frequent raiding compromised food supply in the communities. People in the caves ran out of food supplies if raiders stayed longer. Nursing mothers and infants suffered when food supplies ended. It meant insufficient breast milk to meet the requirement of infants.\textsuperscript{87}

\textsuperscript{55} Kerr-Cross, “Geographical Notes,” p.288
\textsuperscript{86} Kwikoshi Masebo, Interview at Kafule, May 27, 2007.
Kibona emphasized that sustained raiding expeditions affected food supplies in the mountain refuges to the detriment of maternal and infant nutrition. Her recollections highlighted that mothers’ failure to get adequate nutrition compromised their ability to generate the breast milk necessary for healthy infant growth and development.

The effects of relocating to the mountain caves, however, transcended nutritional problems by exposing infants to unhealthy cave environments that were dirty and congested. As Steven Mogha recalled,

> Slave raiding expeditions produced family dislocations. Families left their homes and found refuge in the higher mountains of Bundali and Rungwe. Infants accompanied their parents and lived in few caves that were congested, dirty [bhunyali], and unhygienic [bwifyushi].

While Mogha stressed that living in dirty and unhygienic conditions was not a good environment for the healthy infant development, other interviewees highlighted that the infants living in unhygienic conditions became vulnerable to diseases. Fumbachisu Songa, citing Mughubhi caves more specifically, claimed that

> Congesting infants with adults of all sorts made them vulnerable to diseases. The Mughubhi caves accommodated children and adults alike and it was difficult to maintain cleanliness. Diseases such as diarrhea broke regularly and claimed the lives of people. It was not good for infants to live in those congested caves. It was improper for infants to be in contact with so many adults at the same time. If there was no raiding, these infants would only be in regular contact with adults in the households and rarely in large congestions.

Although Songa’s recollections may have embodied his contemporary knowledge and ideas of hygiene, they underscored that the conditions of dirt, poor hygiene, diseases, and

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89 Fumbachisu Songa, Interview at Isegelo, September 5, 2007
crowding in the caves threatened the welfare of infants in the time of slave raiding. Another interviewee, Jengapho Kamwella, emphasized, “children born during the era of Sangu or Nyamwanga disruptions in this society suffered from many problems such as poor nutrition, *indubhi* (smallpox), and the anxiety of their mothers. Diseases were rife then.”

We can amplify the reference to diseases in these recollections by complementing them with the accounts of the late nineteenth century missionaries and explorers who produced accounts of diseases such as diarrhea, dysentery, cholera, smallpox, and yaws. These diseases may have easily broken out or spread in the context of congestion and poor hygiene in the caves. Historians such as Juhan Koponen and Hedge Kjekshus have argued that most of these diseases became rampant during the late nineteenth century because of increasing mobility, social tensions, caravans of slaves and porters, and raiding expeditions that marked this historical period.

Like slave raiding, colonial penetration from the 1890s to the aftermath of the First World War presented new challenges to infant survival by provoking outright war and through its coincidence with epidemics and famines. Prophets and prophetesses, *abhasololi*, in several places in the region prophesied the coming of colonialism.

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Angolwisye Malambuhi’s study of the relation between Ndali and Christian beliefs identified five *abhasololi* who produced this prophecy as Mwatubi Tuja who lived at Ibungu, Mwalubungo Mulungu and Mwalusuto Mtawa at Mulenda, Nakapala (prophetess) at Lusalala, and Mashasha Mushani at Isoko. One of these prophecies went as follows,

*Kalikwo kamu akelu kalimukakumbe pamwanya pa sumbi. Kakuti nyikinyiki! Gwise kakachitoshe ichisu choshi. Gwise kakakomanie ingwegho shoshi pya! Po ubwomalafyale indibhukashilaghe* [A certain white thing is in a pot on Lake Nyasa. It glitters. It will defeat the whole country. It will destroy all the spears. It will mark the end of chieftainship].

Malambuhi further pointed out that *abhasololi* also prophesied that the glittering white things would bring *abhopalala* [locusts]; *indubhi/akhandu* [smallpox]; *isala* [famine]; and *ubhufwe* [deaths].

Successive crises and the social disasters of wars, famines, and locusts, as the *abhasololi* had prophesied, characterized the penetration of colonialism in the region. Formal German colonial penetration began in 1890 after the Germans and British agreed that the Songwe River would be an official boundary separating the two colonies. Because African communities were not willing to be under colonial rule, the penetration process triggered African military resistances. Territory wide, Hedge Kjekshus documented fifty-four wars of African resistance against German colonial imposition from 1889 to 1896.

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Germany’s colonial imposition entailed brutal and ruthless campaigns to suppress this resistance, a process that continued through the *majimaji* wars (1905-1907) in which approximately 250,000 to 300,000 Africans died.\(^{96}\) Seven years later, in 1914, southwest Tanzania became a battleground of the First World War between the German and British armies from 1914 to 1918. Britain emerged victorious and became the new colonial rulers of the territory. Scholars such as Kjekshus and James Ellison suggest that the colonial conquests, military expeditions, and the First World War created insecurities, resulted in famines, and elevated diseases such as smallpox to epidemic proportions in the region.\(^{97}\)

Early explorers and missionaries recorded some of the disasters that prophets and prophetesses had prophesied. For example, the explorer Alfred Sharp witnessed and recorded communities struggling with the rinderpest pandemic, a cattle plague that reached panzootic proportions in Sub-Saharan Africa in the 1890s, in the following account,

> Shortly before my arrival at the north end of Nyasa, that district had been visited by the cattle plague, which has been raging through East Central Africa during the past year. Practically all the cattle of the north Nyasa country are cleared out, the mortality being over 90 per cent. On my way across to Tanganyika … [d]ead and dying beasts were all around…[and] the whole country was scattered with dead bodies [of animals].\(^{98}\)

Kerr-Cross, too, witnessed the rinderpest pandemic in 1892 and 1893. He wrote,

\(^{96}\) Juhan Koponen, *Development for Exploitation: German Colonial Policies in Mainland Tanzania, 1884-1914* (Helsinki, Tiedekirja, 1995), p.597


Formerly cattle abounded, but eighteen months ago these were nearly swept away by the plague of anthrax, which devastated the African continent in its central portion. We passed through many villages where the long cattle kraal was falling to decay. Elephants, zebras, varieties of deer, are found in certain localities, and at one time enormous herds of buffalo were seen roaming over the plains; but these, like the cattle, have now almost disappeared.\(^99\)

While these Europeans recorded the effects of the rinderpest in destroying the cattle and other animals, men and women I interviewed in the region recalled and reflected on *ubhubhine bwa finyamana* and locusts in terms of their effects on infant nutrition, life, and health. According to Lyojyo Swilla, for instance,

> The Germans brought *ubhubhine bwa finyamana* [disease that exterminated cattle and goats, and most likely rinderpest that entered the north end of Lake Nyasa in May and June 1892\(^100\)] that killed livestock and created a shortage of meat and milk. They brought *abhopalala* [locusts] that destroyed crops. Households did not have meat or vegetables to eat. It was terrible. There was not enough breast milk to feed infants. There was no cattle milk to feed infants. They brought bad things.\(^101\)

For Swilla, therefore, *Ubhubhine bwa finyamana* depleted potential food resources, especially meat and milk, needed for the healthy growth and survival of infants. In addition, *Abhopalala* depleted crops and vegetables, a source of nutrition to mothers and thus to infants through breast milk. Another interviewee, Agnes Kashililika, shared this view when she recalled that the depletion of meat and vegetables affected maternal nutrition as well and undermined the ability of mothers to nurse their infants. She emphasized that “the shortage of milk and meat resulting from *ubhubhine bwa finyamana* and of crops and vegetables resulting from *abhopalala* generated food

\(^99\) Kerr-Cross, “Crater-Lakes of Lake Nyasa,” p. 119. Kerr-Cross noted that Bundali highlands were less affected with the anthrax and thus more cattle could still be seen in this part than others. He provided no reason for this varied experience of the pandemic, see page 120 in the same document.


\(^101\) Lyojyo Swilla, Interview at Ngumba, September 3, 2007. For similar reminiscences, see Elizabeth Mogha, Interview at Kafule, September 7 and 16, 2007.
scarcity that made feeding, breastfeeding, and raising infants difficult during these tumultuous years of colonial penetration.” Historians such as Helge Kjekshus have built on the accounts of early explorers and missionaries to underscore the economic and political dimensions of the rinderpest pandemic, arguing that it “broke the economic backbone of many of the most prosperous and advanced communities, undermined authority and status structures, and altered the political contacts between the peoples.”

In contrast, the oral reminiscences of Lyojo Swilla and Agness Kashililika articulated the disease as a template through which to reflect on the basics of human existence, particularly its potential to compromise infant survival through undercutting dairy food products. Their memories interpreted the pandemic (and locust plague) in terms of its threats to infant survival that was central to the reproduction and renewal prospects of families and communities in the region.

People recalled the First World War in terms of *ichigwajya cha mukinya* [influenza epidemic] that undermined health of the local population, including children. As Steven Mogha recalled,

> The armies looted cattle, goats, chicken, and food granaries to feed soldiers. They also came with a dangerous disease. Our parents said that the disease was *ichigwajya cha mukinya*. They said it was like common flu, *umukinya*. But it killed many people than *umukinya* that was a common infection in this country. *Ichigwajya* destroyed families. It did not spare children.

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104 Steven Mogha, Interview at Kafule, July 6 and 8, 2006. See also Kaswashi Pwele, Interview at Kapelekesi, September 5 and 11, 2007; Kwikoshi Masebo, Interview at Kafule, May 27, 2007; Lyoijyo Swilla, Interview at Kafule, September 3, 2007.
Chigwajya is a generalized term for epidemics while mukinya is ordinary flu. Thus, ichigwajya cha mukinya entailed flu in an extraordinary form, an epidemic with higher rates of infection and death. For Mogha, this ichigwajya caused deaths to both adults and children. Another interviewee, Filingison Kajange, remembered,

ichigwajya came with the war of the British and Germans. There was no peace during the war. There were fighting all over. People did not grow crops. For those with food, when the soldiers arrived they took everything. Everything! And then ichigwajya came. It affected all people. Many people died from it. Even children died. Some children did not die. But their parents died. They remained orphans. They were bad times.  

His recollections showed that ichigwajya and the war affected agricultural production, generated food scarcity as a result of looting, and affected nutrition. These memories make it clear that ichigwajya killed both adults and children. The available archival documents support the oral reminiscences that influenza affected infants and adults alike. According to John Wells, the District Officer for Rungwe, influenza was detected in October 1918, and by December 1918 it had killed a substantial population of Africans in the villages. An estimated 15,000 to 20,000 of Africans out of an estimated population of 180,000 died in the first three months of the pandemic. When an African clerk, Ben Msowoya, died from influenza and several European and African employees contracted the illness, Wells closed the Boma (offices of the district headquarters) at New Langenburg (Tukuyu) for six week in 1919. Wells thought that demobilized soldiers and members of the carrier corps who were returning home after the war and who dispersed from Tukuyu carried influenza to all villages in the district. His report on

105 Filingison Kajange, Interview at Chijya, June 9, 2007
106 TNA John Wells, New Langenburg District Annual Report, 1918/19.
107 TNA John Wells, New Langenburg District Annual Report, 1918/19.
influenza after touring some villages in the district offers hints of the gravity of influenza’s impact on both children and adults. He wrote, “I have found instances in which a man, his three wives and five children have all died, in many places the entire wiping of a family was not an uncommon occurrence.”

Wells’s report stated that the pandemic killed men, women, and children. His report and the oral recollections I have analyzed above suggest that the First World War military expeditions and *ichigwajya cha mukinya* made it difficult for parents to maintain the welfare of infants.

### 2.2 Mobilizing Preventive and Curative Medicines to Tackle Ethno-geographic Threats to Infant Survival in the Late Nineteenth and Early Twentieth Centuries

This section examines continuous negotiations between the social, spiritual, and physical worlds that ensured infant welfare during the transition from the late pre-colonial to the colonial period in southwest Tanzania. These negotiations stemmed from the central understanding of the residents of southwest Tanzania that infants and infant survival were continuous with and connected to the ancestral spirits, the social and natural environments in which infants lived (such as hygiene in the homes, atmosphere, water bodies, and landscapes), and illnesses or diseases that infants contracted as they interacted with these worlds. The responsibility of parents, families, and communities

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108 TNA John Wells, New Langenburg District Annual Report, 1918/19.
109 As David Petterson pointed out, “[n]othing else, not slaving, colonial conquest, smallpox, cerebral spinal meningitis, the rinderpest panzootics of the 1880s and 1890s, nor the great trypanosomiasis outbreaks in East and Equatorial Africa after 1900 killed so many Africans in so short a time.” Quoted by James Gordon Ellison, “Transforming Obligations, Performing Identity: Making the Nyakyusa in a Colonial Context” (PhD Dissertation, University of Florida, 1999), p. 91. D. Ann Herring has suggested that the effects of influenza in causing deaths were not age selective. See Herring, “There were Young People and Old People and Babies Dying Every week.” *Ethnohistory* (1994), 41 (1): 73-105.
was to ensure that this continuity and connection maximized the potential of infants to grow healthily into adulthood. This responsibility hinged on mobilizing preventive and curative programs that enhanced ancestral protection of infants, made the social and physical environment accommodating to infant health, and alleviated perceived illnesses and diseases.

Preventive medical interventions began after birth. The first measure involved excluding an infant from the general public. During this stage, unyagho, a woman specializing in the public health of infants, cut the umbilical cord of an infant. She also bathed infants using water that contained special medicine she had prepared. According to Theodor Meyer’s ethnographic accounts from the 1890s to the 1910s, bathing with this special medicine strengthened and protected infants from potential dangers such as witchcraft, sorcery, and illnesses.\(^\text{110}\) The other intervention involved naming infants. According to Numwenye Mwotela this process involved “giving an infant the name that identified him/her to the family and clan in which they were born.”\(^\text{111}\) An infant received a name of the parent, grandparent, or any older relative in the clan lineage, whether this relative was still living or dead. For instance, a baby boy received the name of his father, grandfather, or other male relative. Similarly, a baby girl could be named after her mother, aunt, grandmother, or any other older woman in the lineage. As Nakasebeta Kabage pointed out, “giving an infant a name of an elder or an ancestor was an important ritual process that officially registered an infant into a family lineage and mandated the ancestors and

\(^{110}\) Meyer, Wa-Konde, p. 143
living elders to protect an infant from potential dangers like misfortunes, curses, or witchcraft.”

Another interviewee, Sikanyagha Kibona, recalled that “naming an infant with names of elders in the lineage was a public statement of the elders’ commitment that they accepted the responsibility of supplying the basic needs that would ensure healthy growth of an infant.” This declaration reflected an understanding among residents of southwest Tanzania that infants and infant welfare were connected to the social and spiritual life of the members and relatives of the lineage.

Like the living relatives, ancestors were important actors in the life and welfare of infants. Their importance derived from an understanding that infant welfare was connected to the wishes of ancestral spirits because infants were the incarnation of ancestors, abhashuka. People believed that abhashuka held innate powers that they could deploy to cause infant illnesses or diseases. Mwatabhika Swilla pointed out that

Ancestors never targeted infants [and that] causing an illness to an infant was a way of punishing or reminding parents that they had done something wrong and that they needed to repent. When an infant contracted an illness that parents could not explain, they resorted to reconciling their relationship with their ancestors. It was an indication that ancestors were angry with something.

Jengapho Kamwella shared much of the views expressed by Swilla. He recalled,

... causing an illness to an infant was a strategy that ancestors used to punish parents or grandparents for failing to live righteous lives. Usually ancestors communicated with the elders through dreams and other means. If elders did not change the behaviors and practices that angered ancestors, that is when ancestors would punish them by inflicting illnesses and discomforts to their infants. Ancestors monitored the lives and conduct of the living descendants all the time and they acted to any one who acted contrary to the normal pattern that the

112 Nakasebeta Kabage, Interview at Isegelo, September 22, 2007
113 Sikanyagha Kibona, Interview at Kafule, May 5, 2007
114 Mwatabhika Swilla, Interview at Kafule, May 19, 2007
lineage sanctioned. Infants suffered because of the sins and the wrong doings of their parents and grandparents.\textsuperscript{115}

The recollections of Swilla and Kamwella support the proposition that ancestors exerted influence on the welfare of infants. \textit{Abhashuka} inflicted infants with these problems as a way of reminding parents that they had contravened customs and traditions that defined the family lineage.\textsuperscript{116} \textit{Abhashuka} punished fathers and mothers indirectly by withdrawing protective power over infants, or by causing illnesses to infants and thus rendering infants vulnerable to premature deaths. They brought misfortunes such as infant illnesses, premature deaths, disabilities, inability to suck, and poor body growth.\textsuperscript{117}

The accounts of the early missionaries and explorers in the late nineteenth and early twentieth century provide evidence that parents understood the intricate connection between the ancestral spirits and infant welfare. Theodor Meyer recorded a parent’s prayer following a child’s illness:

\begin{quote}
You, father, help me. The illness of this child should be mild. I made a mistake, I accept that. Is that the reason you are so angry with me? My fathers, leave alone my child to recover from this illness. The words I said that day were simply a joke (I had no ill conceived motives). Did those words anger you that much? You could have sent the illness to me who angered you! Please remove the illness from the child. Please allow the child to recover.\textsuperscript{118}
\end{quote}

In this prayer, the parent acknowledged the direct connection between ancestral spirits and the health of his child. It also illustrates the situation in which a father accepted responsibility for angering ancestors, and thus admitted his role in the illness of his child.

\begin{flushright}
\textsuperscript{115} Jengapho Kamwella, Interview at Ngumba, September 3, 2007 \\
\textsuperscript{116} Alinine Masebo and Sikanyagha Kibona, Group Interview at Kafule, May 29, 2007 \\
\textsuperscript{117} \textit{Ibid.} \\
\textsuperscript{118} Transcribed from Meyer, \textit{Wa-Konde}, p. 212
\end{flushright}
We note the effort of the parent to reconcile with ancestors as a way of asking ancestral spirits to withdraw an infant illness. Meyer also recorded a prayer in which a parent did not know whether he had committed wrongs that provoked ancestors to cause an illness to a child.

Father, help me. The illness should be mild and go away. What is the reason for this illness? I am very worried. If I had committed a mistake, I would repent. But because I am innocent, am very surprised. Help me in that illness, you my fathers. I am standing here. Look, you fathers; you know me. You left me here... Do you want to kill the child? Why have you given the child an illness? Help me, you fathers! Let the child survive from this illness. Let the child recover.119

Taken together, Meyer’s accounts illustrate a local belief that connected ancestral spirits, infants, and infant health: the notion that ancestors could either protect the welfare of infants or cause infantile illnesses and premature deaths. Alinine Masebo’s oral recollections illuminated how ancestors protected the infants when he pointed out that

*Abhashuka* protected infants by instilling in infants the innate powers that helped them to escape the attention of witches and the envious; by empowering infants to recover from infant related illnesses, especially those thought to be caused by witches; and by counteracting forces which potentially undermined infant survival.120

His reflections claimed that the health of infants depended on how *abhashuka* worked to protect them by instilling innate powers in infants that protected them against social, cultural, and natural perils which could cause premature deaths. The interviews I conducted with elders indicated that these ancestral protective responsibilities for infants continued in the spiritual world when infants died, borne out of the perceived continuities of life after death. They used the following farewell phrases to part with the dead infants to illustrate this continuity: *indiukhabhaghe* [you will find them], *bhamwitisha* [they have

called him/her], abhuka [he/she has gone], indibakhakhusunge [they will take care of you], ukhabalamuke [go and greet them], ukhatengane [go and live peacefully]. These phrases reflected this connection between the spiritual worlds of abhashuka and the social world of the living descendants, together with the protective roles of abhashuka both in social and spiritual worlds. In essence, therefore, abhashuka were responsible for protecting infants.

Individuals, households, and lineages sacrificed to abhashuka at special lineage shrines, known as masheto. Through these sacrifices, people built positive relations with ancestors and ensured a flow of blessings and protections from them. D. Kerr-Cross described these sacrifices as he observed them in the 1880 and early 1890s.

The superstitions and beliefs of the people are interesting subjects, but I will only mention two or three, which struck me as peculiar. In various parts of the country, and often on the crests of rounded mounds of considerable size, are to be seen clumps of thick forest. These are their “isyeta[isheto],” or sacred groves, or burial-places of their ancestors. The undergrowth is so thick than the sun’s rays seldom penetrate. In their days of troubles, the “waputi,” or priests, resort there to pray to the spirits of their fathers. In these the prophets, “awaraghushi,” deliver their messages. No other living creature is allowed to enter. Should war or disease visit the tribe, the “mputi” kills a bull, and offers the blood and the head of the animal….

Kerr-Cross recorded incidences of the Lambya who sacrificed to the spirit of their late chief:

My boys led me reverently to a small hut inside the village raised over the spot where the late Nyondo [the chief of the Lambya in the western part of the region]
sleeps, and where his nsyuka, or spirit, rests. The villagers constantly make offerings of food and beer to the spirit of the great departed.\textsuperscript{123}

These observations highlight the extent to which ancestor veneration was integral to the cosmological understanding of promoting welfare, fertility, and dealing with crises in the local communities, like those related to ensuring infant survival. D. R. Mackenzie, the missionary who had resided in the region for twenty-four years and recorded much of the customs and ideas of local populations, emphasized that whenever parents had a new baby, families prayed and conducted sacrifices that enhanced lineage ancestral protection of infants from illnesses and misfortunes. He witnessed a ritual in which a grandfather made the following remarks while praying,

\begin{quote}
May it be well with you, my child. Ye spirits, be not surprised at this child of yours whom I present to you. I am old: let him take my place. Care for him in this world of sickness. I was alone, and ye have multiplied me and made me a company. Be not angry, but bless the child….
\end{quote}

Mackenzie’s long years of experience living with the local communities convinced him that the importance of ancestors to the social reproduction and continuities of health and welfare were so critical that “[f]rom the day that the month-old infant is presented by the head of the family to the spirits of its ancestors… until the day of death, when the spirit is directed to go in peace and confidence to meet his forefathers, living and the dead are mingled in one stream of life, form one community, and are dependent upon each other for many of the best things “above” on the earth here, and “below’ where the spirits are.”\textsuperscript{125} Mackenzie’s observations and reflections while living with African communities in the region underline the intricate connection between the living population and their

\textsuperscript{123} Kerr-Cross, “Geographical Notes,” p. 288
\textsuperscript{124} Mackenzie, \textit{The Spirit-Ridden Konde}, p. 45
\textsuperscript{125} \textit{Ibid.}, p. 190
lineage ancestors that allowed ancestors to protect and ensure the welfare, survival, and development of infants into adults.

People clearly differentiated ancestral spirits from evil spirits. One of my interviewees, Mwatabhika Swilla, highlighted this distinction in his oral explanation as follows,

Evil spirits are natural forces. They are part of the wilderness of mountains, forests, and other landscapes where people do not live. They do not want to be disturbed by people. And they can cause lot of human suffering if people go to the wilderness and evil spirits are angered by their presence. But ancestors are human beings. They descended from human beings. They have only departed [died] to live in a new form of life. But this life is in our communities. We share life [social space] with them. They ensure the health of their descendants. They protect the delicate lives of infants. But descendants must sacrifice to ancestors to receive these protective powers.126

For Swilla, therefore, ancestral spirits protected the living descendents (including the infants) in their social communities, while the evil spirits, believed to live in the mountains and forests, were harmful to human lives.

Following Swilla’s claims about the connection between natal communities and ancestral spirits, the onset of raiding (analyzed in the previous section) brought about extensive and formidable challenges to infant survival by relocating people to the mountains. Kaswash Pwele pointed out that the act of people taking refuge in the mountains exposed infants to the dangers of evil spirits. He emphasized,

Moving to the mountains was dangerous because people could no longer have access to the protective powers of ancestors. Ancestors did not live in the mountain and forests as these wildernesses were home to the evil spirits. Ancestors could not protect living descendents in the wilderness. So, infants taken

to the mountains could not get ancestral protection. Wilderness was beyond the control of ancestors.127 Tumulikeghe Swilla offered similar insights when she produced the following recollections,

Mothers took lots of precaution against evil spirits. They would not take infants to the forests, bushes, mountains believed to harbor the evil spirits. Infants always remained in the homes where they had access to the protection of elders and ancestors. When the raiders invaded the villages, mothers sought refuge to the mountains or forests. They could no longer keep infants within the protective realm of ancestral spirits. It was difficult for them.128

These reminiscences suggest that ancestral spirits could protect the living descendants from evil spirits in their homes and communities, but they could do nothing when living descendants moved away from their natal social environments. Moving to the mountains in times of slave raiding, therefore, divorced infants from the ancestral protective powers in the homes and left them vulnerable to attacks from evil spirits.

People also understood infants and infant survival to be continuous with and connected to the physical environment, including water bodies, celestial bodies, and landscapes. For example, people located at the northern and northwestern end of Lake Nyasa perceived the lake both as potential provider of, and a threat to, the health of infants.129 According to Jengapho Kamwela, Lake Nyasa (together with rivers such Songwe, Kiwira, and Mughelela) was a source of fish which was integral to the diet of the local population, including children. In addition, many people believed that rainfall, which played an

128 Tumulikeghe Swilla, Interview at Isongolo, June 12, 2006
129 Lake Nyasa is locally known as Sumbi. The official name Lake Nyasa owes to the Nyasa people who live around the lake.
important role in watering food crops for people and grasses for livestock, originated from the lake. Furthermore, people in the highlands of Bundali and Bunyakyusa obtained *ichilambo*, a supplementary livestock food for cattle, goats, and sheep from Busale which is located in the lake plains. *Ichilambo* stimulated cattle to generate large quantities of milk, part of infant and child nutrition. As a source of fish, rainfall, and cattle supplement, Lake Nyasa constituted an important physical resource that offered the means for infant survival.

Some men and women in the region also understood the lake as being dangerous for infant survival. This perception revolved around three qualities people used to characterize Lake Nyasa. First, they looked at the lake as a breeding ground for *imbwele*, a fly that bit people at night. Second, they believed that the lake generated heat that made nights excessively hot and that brought fevers. Bundali and Bunyakyusa highland residents who visited the plains to buy *ichilambo*, fishes, pots (made by the Kisi), and to sell bark clothes which the Ndali were renowned for producing, took precautions against these potential dangers by returning to the highlands before nightfall.

Theodor Meyer observed that people were worried about the lake because it infected

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130 Jengapho Kamwela, Interview at Ngumba, September 3, 2007
132 Most possibly, imbwele referred to mosquitoes. Jamson Swilla, Interview at Isegelo, September, 8, 2007; Bomani Kibona, Interview at Kafule, July 3, 2006; Steven Mwogha, Interview at Kafule, July 6, 2007; and Lineli Masebo, Interview at Isongolo, June 25, 2007.
133 Ibid.
people with fever, emphasizing that newcomers to the plains were especially vulnerable
to these fevers and needed to take maximum precautions to avoid contracting them.\textsuperscript{135}

Residents of the region, too, perceived the lake to be dangerous because it strengthened
the malicious practices of witches, \textit{abhaloshi}, and sorcerers, \textit{abhateghi}, who harmed
infants and brought premature death. As Theodor Meyer heard from local residents in the
1890s and early 1900s, \textit{abhaloshi} were people believed to have ‘snakes’ in their bellies,
giving them power to harm other people by eating their flesh and blood at nights.\textsuperscript{136} The
interviewees for Monica Wilson’s ethnographic research in the 1930s believed that
witches preferred the meat and blood of infants because they considered them more
delicious and tender than those of adults.\textsuperscript{137} \textit{Ubhuteghe} was as dangerous as \textit{ubhuloshi},
although \textit{abhateghi} operated by using destructive medicines to harm other people,
including infants. The recollections of men and women I interviewed suggests that to
harm a person or an infant, sorcerers had to acquire objects used by or associated with the
potential victim, such as clothes, urine, feces, blood, saliva, hair, nails, foot prints, and
even shade.\textsuperscript{138} They mixed these objects with special medicines to harm targeted
individuals. To avoid the potential danger of sorcerers, people carefully disposed these
objects so that they (sorcerers) could not gain access to them.

\textsuperscript{135} Theodor Meyer, \textit{Wa-Konde}, p.36.
\textsuperscript{136} \textit{Ibid.}, pp.101-104
\textsuperscript{137} Wilson, \textit{Good Company}, pp.91-96
\textsuperscript{138} Mwatabhika Swilla, Interview at Kafule, May 19, 2007; Steven Mwogha, Interview at Kafule, July 6,
2007; Jengapho Kamwela, Interview at Ngumba, September 3, 2007; Lineli Masebo, Interview at Isongolo,
Although sorcery and witchcraft were powers that people could inherit at birth, some people learned to use these powers during their adulthood, and continuously strived to innovate and strengthen their abilities to perform them successfully. Oral reminiscences suggested that the favorite place to strengthen these powers was inside Lake Nyasa. People would use their innate powers to visit the lake during the night and undergo procedures that enhanced and increased their effectiveness in witchcraft or sorcery.\textsuperscript{139} The missionary Meyer noted in the 1890s and early 1900s that people were so much concerned with the role of witchcraft in endangering the lives of infants that it became one of the reasons why some Africans converted to Christianity. Moravian Christianity discredited these powers to the moral satisfaction of some Africans.\textsuperscript{140} Christian theologies taught people that if they had a total belief in Jesus, they would be free from the constraints of witchcraft. Wolfgang Gabbert has argued that many people in the region, especially women and young men, converted to Christianity because the new religion promised them freedom from spiritual powers of witches, ancestors, and elders.\textsuperscript{141} It is important to note, based on Meyer’s ethnographic accounts, that families and communities alleviated the impact of witches to harm the innocents through public accusations of the suspect. Local chiefs, \textit{malafyale}, deported the suspects from their areas of jurisdiction if they proved that they were witches. Proving involved the suspect drinking a special liquid, \textit{umwafu}, and when the suspect vomited, it meant he/she was

\textsuperscript{139} Ibid.
\textsuperscript{140} Meyer, \textit{Wa-Konde}, pp. 247-248
innocent. Failure to vomit after drinking umwafí was empirical evidence that the accused was indeed a witch. The role of trying and deporting those proved to be witches gave local chiefs credibility as guardians of the health of their subordinates, including infants.

Men and women in the region connected infant survival to the celestial bodies, especially the sun and the moon, in their cosmological understanding of life and welfare. Mwatabhika Swilla contended that the sun provided energy to individuals involved in important activities such as cultivation, milking, and hunting: activities that generated food needed for family nutrition, including that of infants. Particularly, he infused the sun with masculine embodiments: arguing that it generated masculine energy that men needed to handle masculine activities like hunting, milking, cultivation, and sex. Symbolizing masculine energy, the sun was always present, enhancing productive and reproductive powers in men. According to him, “that is why men possessed reproductive abilities to bring life everyday: the ability to procreate children everyday.” Communities expressed their moral imaginations of the energy and power derived from the sun in children’s popular songs of the time. Theodor Meyer, in the 1890s and early 1900s witnessed children’s excitement at seeing the sun after rainy and cloudy moments during which they sang “Balaga, balaga, gwe Kambalila, ngupifumbi, gwe Kambalila,

142 For empirical examples of trying and proving that the accused were indeed witches, see Meyer, Wa-Konde, Ibid., 217-218.
143 Mwatabhika Swilla, Interview at Kafule, May 19, 2007. See also similar cosmological perceptions in western Kenya, Osaak Ollumwullah, Dis-Ease in the Colonial State: Medicine, Society, and Social Change Among the AbaNyole of Western Kenya (Westport and London, Greenwood Press, 2002), pp. 74-75
144 Ibid. See also Kujobenane Kamwela, Interview at Isogelo, September 7, 2007.
145 Mwatabhika Swilla, Ibid.
ilya Ngwangu, gwe Kambalila [Shine, shine, You who provide light, I will give you an egg, You who provide light, of the last born, You who provide light].” Kambalila was a way of glorifying the sun as the provider not only of light, but also of the energy embodied in the productive and reproductive functions of men. Meyer emphasized that people equated the sun to God due to its perceived powers and energy that went into the constitution of infant survival. Like the sun which generated energy everyday, men were always potent. They possessed the energy to produce food that mothers ate, enabling them to breastfed their infants. Like the sun that shone and released energy everyday, men could release energy in the form of sperms on a daily basis to create new life.

These men and women infused the moon with feminine qualities that simultaneously mirrored the temporal nature of women’s menstrual periods and the variable nature of weather conditions: all of which had important implications for infant health and survival in local cosmologies. Theodor Meyer observed that when an infant was born, and during its first experience with the moon’s waxing, the mother took the child outside the house and told it, “unino jula [there stands your fellow infant],” referring to the moon. Then the mother turned to the sky, looked at the moon, and exclaimed “twatola akapya akanitu [we have got a new infant]. In this way, a mother was announcing the arrival of an infant to the moon. After these introductory remarks, a mother took the infant’s nasal fluid and threw it to the moon, saying ngupele akatyemule… manye ukaghalushange [I have given

146 Meyer, Wa-Konde, p. 32. My transcription in English.
147 Ibid.
you common flu, do not return it to my infant].

This ritual practice indicates that people in the region infused the moon with human characteristics as they did with the sun. But they also recognized that the moon generated a particular energy that was harmful to infants. This energy made infants susceptible to *akatyemula* [common flu], together with *ichifubha* [chest problems], *ichilita* [stuttering], and *imbombo* [hernia] during the moon’s waxing. As Numenye Mwotela emphasized, the ritual process was a culturally and cosmologically grounded preventive intervention that minimized the potential dangers of the physical environment to instigate infant illnesses such as flu, which escalated during the moon’s waxing.

There was another means through which people understood the moon: they likened it to the variable weather conditions associated with the wet season, and mothers avoided giving birth during this period. Strong winds, heavy rains, and cold weather characterized this season, especially from November/December through June/July. This understanding, Tufingene Swilla reflected, was rooted in local cosmologies that infused the moon with the feminine sphere of human life, and since the moon shines and is available in certain seasons of the year; people equated the moon’s seasonal appearance and disappearance to the temporal nature of menstrual periods in women. As opposed

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148 Meyer, *Wa-Konde*, pp.32- 33. *Akatyemula* is also known as *umukinya*.
149 *Ibid*. See also Mwatabbika Swilla, Interview at Kafule, May 25, 2007; Fumbachisu Songa, Interview at Isegelo, September 6, 2007. See also Olumwullah, *Dis-Ease in the Colonial State*, p.75
151 This was also an agricultural season. I suspect that mothers may have avoided giving birth during this period which demanded maximum labor from everybody in the households and communities. This would undermine care support that nursing mothers needed from husbands and relatives.
to men, women were reproductive only during certain moments in their menstrual cycle. Swilla stressed that “women studied the changes in the moon carefully in ways that allowed them to conceive early during the wet season so that they could give birth during the dry summer weather which presented few potential threats to the survival of infants.”153 For Swilla, therefore, women understood that the extreme weather conditions that coincided with the moon’s waxing had potentially negative impacts on infant health and thus avoided giving birth during this season. Her argument is important for showing that people, especially women, studied the internal working of their bodies in relation to space, seasons, and weather conditions in order to determine appropriate moments to conceive a pregnancy: moments that would allow them to give birth during the physical environments with fewer risks to infant health.

In addition, the residents of southwest Tanzania understood that a connection existed between infants, infant health, and the social environment of households during the transition from the late pre-colonial to the colonial period. Oral recollections indicate that family members practiced hygiene in order to make households a conducive social environment for the healthy growth of infants. As Mwamukono Kajange emphasized,

> Ensuring hygiene of the homes was an important duty that parents, households, and communities pursued to enhance the survival of infants even before the coming of Europeans. Maintaining clean homes, utensils, disposing of dirt products away from the household surroundings in which infants lived were the major responsibilities carried to ensure healthy surrounding for the healthy growth of young children.154

Another interviewee, Numenye Mwotela, recalled,

154 Mwamukono Kajange, Interview at Chija, June 2, 2007.
Before colonialism, our grandparents believed that a woman could not be a good mother if she did not practice the hygiene of her body, of her house, of her babies. She would be ridiculed by other people. The people and ancestors would not like a dirty home. And a mother who did not practice hygiene endangered the lives of babies with dirt and diseases. Our grandparents stressed hygiene as a precondition of healthy infant growth.\textsuperscript{155}

Although Kajange and Mwotela appeared to speak passionately and even romantically about the efforts of their forefathers and mothers to practice hygiene in the past, a corroboration of these reminiscences with the accounts of early explorers and missionaries seems to suggest that the oral recollections were not an exaggeration. For example, Thompson portrayed a sense of beauty, hygiene, and cleanliness of the homes and villages that he witnessed in the 1870s and 1880s when he pointed out that

The scene that opened up before me I believed with astonishment. It seemed a perfect arcadia, about which idyllic poets have sung, though few have seen it realized.\textsuperscript{156}

He continued,

The character of cleanliness which I first observed about the village, I found to be by no means outward show. All their domestic utensils, pots, and C., were kept scrupulously washed and free of dirt, and not an article was to be seen that any European might not have used without reluctance…. Cattle were not allowed to come into the village, but were housed in most commodious and cleanly-kept quadrangular huts which would have compared favourably with any similar building in Europe. Fowls were also kept outside.\textsuperscript{157}

D. Kerr-Cross left the same impression on the cleanliness of the houses and communities in the Bundali-Bunyakyusa highlands,

Over and over again have I been struck with the beauty of the villages occupied by the Awanyakyusa…. All weeds, grasses, garbage, and things unsightly are kept swept away by little boys who spend their morning sweeping, while, hidden

\textsuperscript{155}Numenye Mwotela, Interview at Isongolo, June 25, 2007
\textsuperscript{156}Thompson, \textit{To the Central African Lakes and Back}, p.271
\textsuperscript{157}Ibid.
away among the trees are the circular houses of the natives. Each house is built of bamboo, with clay worked by the women into little rounded bricks. The roof is of a thatch, which greatly overlaps in mushroom form, while the door is so large that a man can walk in upright.… Their cattle-houses are oblong, and equally prettily wrought.… Nor is this character of cleanliness visible in their villages confined to the outside. All their cooking-pots and drinking-cups are kept scrupulously clean and sweet, and the insides of their houses free from dirt— a rare quality in the native African.…The description I have just given holds good of the four sections at the north and west of Lake Nyassa, embracing the Awanyakyusa on the lake shore, the Awakukwe, the Awabundali, and the Awamesuko on the higher lands. These four names are but sections of what all who know them acknowledge to be one tribe.  

The cleanliness and hygiene that these early missionaries and explorers portrayed supports the claim embodied in the oral recollections that infants were born and raised in the clean, sanitary, and hygienic social environment of their natal homes. Taken together the recollections and explorers accounts indicate that the late nineteenth century residents of southwest Tanzania practiced hygiene as a prerequisite for ensuring healthy lives for both children and adults.

Although people recognized and practiced hygiene as a precondition for infant survival, both the oral recollections as well as early explorers’ accounts suggest that the beginning of slave raiding in the late nineteenth century made it difficult for parents to observe hygiene all the time. The social responses to slave raiding that involved relocating to the mountains or congregating in the stockades, as the previous section have demonstrated, divorced infants from the hygiene that natal homes offered. As Gideon Swilla pointed out,

   Ensuring peace and hygiene for healthy growth of infants was the prerequisite for all parents. They maintained clean homes, took care of infants, and ensured

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158 Kerr-Cross, “Geographical Notes,” pp. 283-284
warmth in the homes. Clean homes were the space for raising healthy infants. But raiding expeditions forced parents to flee their homes to the mountain caves. In so doing they removed infants from the hygiene and security that homes offered.  

Namwasa Kajuni echoed Swilla’s reflections when she claimed that

People maintained hygienic homes as a way of minimizing diseases of infants. When the Sangu invaded people ran away to the mountain caves. Infants could no longer enjoy the comfort and hygiene of the homes. Caves were congested and it was difficult to practice hygiene in them.

Swilla’s and Kajuni’s recollections highlight evolving challenges in the eastern sides of southwest Tanzania where relocations to the mountains were common. The building of stockades in the western side of the region presented new challenges to hygiene as well, as the following accounts of Kerr-Cross among the Lambya illustrates,

All the villages on the plateau, from here right on to Tanganyika, and north and south of the road thither, are stockaded. That is to say, all the houses in the neighbourhood are built in a cluster with a palisade of strong trees around, while outside is a ditch of 20 feet deep and 10 broad encircling the trees, and thorns are hung high up and around…. All the people in the country live inside such an erection with their cattle, sheep, goats, fowls, and every other belonging… [and] as a consequence the villages are simply abominable from filth of every kind. During the rainy season the smell of the village can be felt long before it is reached. The people do not take to such a life willingly, for they are naturally cleanly, but are driven to this unnatural existence by their enemies. On one occasion, when their enemies, the Awawemba (Bemba) were hovering about with guns on a raiding expedition, I knew of the people being cooped in such an enclosure – men, women, children and cattle for three days, during which no creature passed out, and so excited were the women that they were unable to cook food or eat. Villages such as these are not numerous in the country, but scattered, and on an average one will be found every two or three miles, while great tracts are found without an inhabitant.

Kerr-cross’s account is important for two reasons. First, it clearly shows that children and adults who lived in the stockades suffered from congestion and poor hygiene. Second, his

159 Gideon Swilla, Interview at Isegelo, September 4, 2007
160 Namwasa Kajuni, Interview at Kafule, May 28, 2007
account in this quotation that “the people do not take to such a life willing, for they are naturally cleanly, but are driven to this unnatural existence by the enemies” indicates that practicing hygiene had been part of the experiences of the residents of southwest Tanzania and that the beginning of slave raiding made continuous observation of this practice difficult. Joseph Thompson, who witnessed these stockades among the Nyiha, also noted that slave raiding raised new challenges that made practicing hygiene difficult:

Owing to the almost constant state of warfare in which they live, the Wanyika are compelled to live in stockaded villages. The huts are huddled as closely as possible, leaving barely room to creep about among them. The area to be defended is thus lessened. At night their cattle are brought within the stockades filling up all the odd spaces; and as the filthy is never removed, the frightful condition of the interior of a Wanyika village may be conceived. Personally they have no delicacy or cleanliness; hence the ground outside their gates is one great dunghill. This filthiness extends to everything else - the inside of their huts and their domestic utensils….

Both Thompson’s and Kerr-Cross’s descriptions of the conditions in these evolving late nineteenth century residential patterns were gloomy, and infants born and raised in those stockades may have faced insurmountable challenges to survival by virtue of the lack of hygiene and sanitation. The epidemic diseases such as cholera, dysentery, smallpox, and jiggers that early explorers witnessed from the mid nineteenth century could easily spread in these unhygienic environments, presenting further challenges for the health and welfare of infants.

A perception that evolves with regard to hygiene in the oral recollections and in the accounts of the early missionaries and explorers in the region is that people lived a

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163 See footnotes 91 and 92 above.
hygienic life. The accounts of the explorers described the unhygienic life they began observing in the stockades as a new development brought by peoples’ responses to the slave raiding. Taken together, this evidence suggests that unhygienic life was not a cultural attribute of the nineteenth century residents of southwest Tanzania, and as Kerr-Cross attested, people were “naturally clean.” Paying attention to the way early Europeans thought of and conceptualized hygiene as a cultural attribute of the pre-colonial African homes and communities is important because later European colonial officials in the 1920s produced an image that portrayed these African communities as “naturally” unhygienic. As I will show in the next chapter, this conception was necessary in order to justify and legitimize the infant survival programs they introduced in the 1920s.

An equally important understanding of the residents of southwest Tanzania was that the conscious integration of preventive and curative medical interventions was necessary for any efforts to promote infant survival. The oral recollections I have collected suggest that the weaving of preventive and curative medical interventions protected infants from the dangers that ancestors, environment, and diseases presented to the normal and healthy growth of infants. One of my interviewees, Bomani Kibona, recalled,

Each household held knowledge on preventive and curative practices that ensured the survival of infants. Conducting rituals, strengthening infants at birth and in various stages of growths, protecting infants from witchcraft and sorcery, and acquiring knowledge on medicinal components that treated varied afflictions of infants were some of the preventive and curative knowledge that each family struggled to learn, understand, and practice.”

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164 Bomani Kibona, Interview at Kafule, July 4, 2006.
When parents learned that an infant was sick, or if they suspected that the infant was potentially ill, they prepared medicines, *imikota*, that cured the suspected illness. As Lyojo Kamwela, pointed out, “parents knew most of medicine for common illnesses of infants such as diarrhea, fever, boils, constipation, and fever.”\(^{165}\) They extracted most of the medical cures from the surrounding environment, and as Gloria Waite has pointed out, most of the medical products used to cure illness in East-central Africa were prepared from plant barks, leaves, roots, saps and from body parts of animals, birds, and insects.\(^{166}\) Knowledge of these medical cures allowed families to alleviate the illnesses and diseases that potentially threatened the health and welfare of infants.

If treatment in the households failed to cure an illness afflicting an infant, parents or guardians consulted specialist healers, *abhaghanga*, who possessed specialized knowledge in curing ordinary and complex illnesses. On other occasions, especially when curing the affliction was proving difficult, parents consulted diviners, known as *abhalaghushi* who had the ability to divine and identify the causes, nature, and magnitude of the problem affecting infants. By revealing the concrete problem, *abhalaghushi* made it easier for *abhaghanga* and the parents to figure out the best solution that could eradicate the dangers threatening the survival of infants. Occasionally, in pursuing these interventions, parents consulted the advice of relatives, friends, and neighbors with whom they were on good terms, and these social networks were central in making decisions and

\(^{165}\) Lyojo Kamwela, Interview at Ngumba, September 3, 2007.

suggestions on healing, divination, and forms of treatments and their management. Families did not confine themselves to seeking the service of healers and diviners located in their immediate social environment. When locally available healers and diviners failed in handling the case, families traveled extensively in search of healers supposed to possess greater powers than were locally available. They traveled to Ufipa, Usafwa, Unyiha, Ungonde, and Ukinga in pursuit of such specialists. Household efforts in dealing with infant medical challenges took center stage.

In dealing with infants’ medical survival challenges, households mobilized local and regional resources in ways that culminated in social networks between people living in distant places. These networks were critical for knowing of potential healers in distant places and for exchanging advice on actions to alleviate the potential threats to infant survival. Steven Feierman’s study of the Shambaa in northeastern Tanzania has documented the extent to which healers were consistently engaged in journeys to practice their specialized training in medicine throughout the surrounding regions. Feierman argues that healers’ regional travels presented a rare opportunity for them to learn new medical practices as well as to demonstrate their capacities against practitioners from other regions. These travels opened up opportunities for healers to borrow healing

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168 See Map 1 above for the location of these places.
knowledge from other parts and thus to innovate their own practice.\textsuperscript{169} My analysis of households’ struggles to seek local and regional medical cures suggests that these extensive travels were not limited to healers alone, as Feierman’s study indicated. Like healers, ordinary people seeking their services and expertise traveled extensively in search of these practitioners and created regional social networks that made it possible for people to know of potential experts in distant places. This interconnection suggests that public health, medicine, and healing blended local and regional relations, and thus, they were not part of a closed system in the pre-colonial and early colonial periods as some scholars, such as Robin Horton,\textsuperscript{170} have theorized.\textsuperscript{171}

The efforts of residents in southwest Tanzania to mobilize local medical resources and to seek or appropriate foreign medical knowledge, practices, and expertise reveal their flexibility and openness to new ideas, practices, and culture. Understood in this context, and as the subsequent chapters will demonstrate, peasants’ demand for western curative medicine in the 1930s and 1940s was thus not surprising. Rather, it was integral to local adaptation and responsiveness to new technologies of preventing or curing the diseases and other medical challenges that they faced in their communities, just as their parents and grandparents had practiced in the late nineteenth and early twentieth centuries. As Susan Reynold Whyte has documented, the use and appropriation of foreign medical ideas and technologies was one of the most common practices for coping with medical

\textsuperscript{169} Steven Feierman, \textit{Peasant Intellectuals: History and Anthropology in Tanzania} (Madison, Wisconsin University Press, 1990), pp.102-103.


\textsuperscript{171} For a nuanced critique of Horton’s formulation, see Feierman, \textit{Peasant Intellectuals}, p.101.
challenges in East African pre-colonial communities. Thus the accommodation and appropriation of western medical interventions would later be integral to an effort to graft new European medical cures in order to expand the medical resources for infant health in their communities.

Although the oral recollections I have analyzed above suggest that individual households or clans forged preventive and curative medical interventions to ensure the survival of infants, people looked at the *malafyale* (local chiefs) as custodians of the health of infants at the larger community level. Namwasa Kajuni emphasized that “the health and survival of every member of the society was in the hand of the malafyale [and that he] had the responsibility for the welfare of everybody, whether an infant, a youth, or an adult.”

Kajuni’s recollections romantically attached societal health issues to the normal functioning of the chiefs, yet her description of what chiefs did in southwest Tanzania was not unique. As Steven Feierman has demonstrated in his study of the Shambaa in northeast Tanzania, people defined the role of chiefs in terms of healing or harming the land. It would appear from this example that all over, people expected local chiefs to assume the responsibility of ensuring the survival of infants into adulthood. As Anosisye Masebo recalled about health and power relations in the society, “the *malafyale* organized regular public rituals that minimized the misfortunes which potentially

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173 Namwasa Kajuni, Interview at Kafule, May 28, 2007
174 Feierman, *Peasant Intellectuals*, pp.69-93
undermined the survival of infants.” Nikubhuka Kashililia reiterated Masebo’s recollections when he pointed out that “the rituals that malafyale conducted aimed to make the physical, social, and atmospheric environments accommodating to infants, and to undermine the powers of the witchcraft and sorcery in the communities.” Apart from these rituals, the malafyale coordinated community efforts to deal with the outbreak of epidemics such as smallpox that threatened the survival of infants and the general population. The aim of coordination was to minimize the risks of infections and strategies included restricting house to house visits; burning the houses of people already infected; and seeking the help of specialist healers whose credibility in managing smallpox was highly regarded. By performing these duties, “people regarded their malafyale as playing an important duty in safeguarding the welfare of infants.” It seems from these recollections that the malafyales engaged actively in public health problems that affected large segments of the population and required a broad range of community efforts, such as those related to public rituals, witchcraft and sorcery eradication, and containing epidemics.

2.3 Conclusion

The oral recollections I have analyzed in this chapter, coupled with colonial records and the accounts of missionaries and explorers, provide glimpses into the proposition that

175 Anosisye Masebo, Interview at Isegelo, September 14, 2007
176 Nikubhuka Kashililia, Interview at Chija, June 8, 2007
178 Musomba, Interview at Malangali, December 20, 2007.
infant survival was embedded and inseparable from the historical, geographic, and cosmological contexts that shaped the transition between the late pre-colonial and early colonial periods. Infant survival was connected to historical processes such as slave raiding and disasters associated with colonial penetration, such as diseases, famines, and wars which generated a social environment that made it difficult to raise healthy infants who would survive into adulthood. In addition, it was connected to the ancestors and the social and physical environment in which infants were born and raised. The chapter emphasizes that households and communities were not passive observers to the threats that social disruptions, ancestral spirits, and environments presented to infants. Rather, they mobilized various preventive and curative medical interventions in order to enhance the healthy growth and development of infants in homes and communities. These measures helped people to deal with threats that would potentially undermine the survival of infants. Africans were practicing these interventions when the British colonial government introduced its infant survival interventions in the 1920s. However, when the colonial government officials initiated infant welfare work in the 1920s, they discredited these African ideas and practices and attempted to propagate their own notions of raising infants. In chapter three, I turn to the colonial officials’ ideas, propositions, and actions as they grappled with the infant survival problem, together with the reasons that motivated the colonial government to be so preoccupied with infant welfare starting in the 1920s. While chapter two has highlighted negotiations between households, ancestors, environments, slave raiders and others, chapter three introduces negotiations between the colonial government and medical missions over infant survival initiatives.
Chapter Three

State Ideologies and Colonial Infant Survival Interventions, 1920 – 1940

3.0 Introduction

In the early 1920s, the British colonial government in Tanganyika identified poor infant survival as the cause of low African population numbers. This conclusion emerged as the impetus behind the production of the *Memorandum on Infant Welfare Policy* to guide the colonial government’s interventions for improving infant survival in 1925. British colonial officials perceived maternal ignorance in infant care, feeding, and hygiene to be the major cause of this problem. Consequently, they proposed maternal education as a solution to the problem.

This chapter examines the colonial government’s motivation to produce infant welfare policy in 1925 in colonial Tanzania. Existing studies have emphasized that that the colonial governments utilized colonial medicine in Africa to increase indigenous populations that were necessary for cheap labor supply in economic investments and for expanding the number of consumers for the growing industrial commodities from Europe. These studies have privileged the economic basis of colonial medicine in

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Africa, and I do acknowledge the validity of this perspective. In this chapter, however, I argue that the colonial government’s justification of its own presence and legitimacy among Africans played a far more significant role in pushing policy makers in Tanzania to initiate infant welfare programs in the 1920s.

In order to build its own presence in rural areas, the British colonial government changed its relationship with medical missions from symbiotic collaboration in the early 1920s to competition in the late 1920s and 1930s. By symbiotic collaboration, I refer to the interactions between the colonial government and medical missions that benefited the contemporary strategic interests of both parties. These interactions developed before the mid 1920s when the medical missions were the sole providers of medical services in rural areas of colonial Tanzania. During this period, the government did not have its own rural medical programs and thus depended on the infrastructures of medical missions to deal with medical needs of Africans who lived there. The government provided missions with subsidies for running medical and welfare services, paying salaries, expanding mission work, and buying equipment and drugs. This symbiotic relationship had two consequences. First, the government used missions as its agents in meeting the medical needs of its colonial subjects. This strategy allowed the colonial government to interact with Africans through the medium of medical missions. Second, the medical missions got


financial resources from the government that they used to expand their medical and missionary work. This opportunity gave medical missions the strategic advantage of establishing direct contact with Africans in their homes and communities using the government’s financial resources.

When the colonial government wanted to consolidate its presence in rural areas in the mid 1920s, it made efforts to reduce the visibility and dominance of missions because it perceived them as obstacles to its new mission. The government redefined the criteria for subsidizing mission work by providing subsidies to mission activities that enhanced its new agenda. Mission activities that qualified for subsidies were those related to education and training, such as the training of African welfare workers, the production of instructional materials, and the education of children in schools. The government would potentially employ mission-trained welfare workers in its own work and it could utilize instructional materials that missionaries produced in its own training programs. Furthermore, children in mission schools were future parents who would be inculcated with the basics of infant care defined by colonial officials. The government now refused to fund mission activities that would not directly aid its new agenda, such as the actual running of medical missions, construction work, salaries, and building of new institutions.

This chapter serves two roles in this dissertation. First, it examines the evolution of infant welfare policy in the 1920s, uncovering colonial ideas, assumptions, and propositions that
went into the constitution of infant survival interventions. It is important to understand
the policy whose initiation and implementation turned out to be a significant terrain of
negotiations and competing interests/agendas between government officials, medical
missions, peasant men and women, local chiefs, and African dressers. Second, it
introduces the negotiations and social engagements between the colonial government and
medical missions over infant welfare programs which changed from symbiotic to
competitive relations in the 1920s and 1930s.

This chapter has three sections. The first section provides a brief background for the
British infant welfare policies in colonial Tanzania, demonstrating that the colonial
government’s initiations and implementation of the welfare programs were part of its
efforts to discredit the rule of the previous German colonial government while also
attempting to legitimate its own presence among Africans. The second section analyzes
colonial ideas about infant survival and proposed social interventions to alleviate the
problem. It argues that policy makers defined poor infant survival in terms of maternal
ignorance and proposed educational measures concerning infant care, feeding, and
hygiene to solve it. The third section examines the timing of the government’s interest in
infant welfare initiatives in the 1920s. It pays attention to the government’s effort to use
these measures to build its own presence and to secure African acceptance and
legitimacy. The section also examines changing negotiations between the colonial
government and medical missions.
3.1 Contextualizing the British Colonial Infant Welfare Interventions, Late 1910s and Early 1920s

The British took over the administration of colonial Tanzania from the Germans at the end of the First World War. The ratification of the Versailles Treaty gave Britain power to administer the Tanganyika Territory under the mandate of the newly formed League of Nations in 1920. Horace Byatt, who arrived in the territory in January 1919 as a military chief to oversee military activities there, became the first British Governor and commander in chief of Tanganyika after Versailles’s ratification. The League of Nations required Britain to submit annual reports of its administration. Its first report in 1920, titled *Report on Tanganyika Territory Covering the Period from the Conclusion of Armistice to the End of 1920*, spelled out three challenges that Britain intended to deal with in the territory: revitalizing the economic sector, improving the social welfare of the indigenous population, and increasing the African population.\(^\text{181}\)

Britain’s *Report on Tanganyika Territory* placed addressing low African population numbers as a clear priority in her administration of the territory. The report identified three factors explaining the low African population. The first was the historical experiences of the Arab-led slave trade, Portuguese militarism, piracy, looting, and burning of the villages and towns in the coast in the seventeenth and eighteenth centuries, and intertribal warfare among Africans themselves. The second was the effects of German colonialism, citing its violent and militaristic nature, the *Majimaji* War, and the

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\(^{181}\) Great Britain, *Report on Tanganyika Territory Covering the Period from the Conclusion of Armistice to the end of 1920* (London, His Majesty’s Stationary, 1921).
First World War that transformed Tanganyika into a battleground. The third was high infant mortality problem, which the report attributed to improper feeding practices, Africans’ lack of hygiene, and venereal disease.\footnote{182} The report also blamed the Germans for doing nothing to alleviate the problem of infant mortality. In particular, they accused German colonialism of failing to build medical services for Africans in the territory. Britain’s accusations against German colonialism were probably not an exaggeration. In 1910, two decades after the Germans began to exert control in the territory, the German Colonial Secretary, Benard Dernberg, acknowledge,

A system of medical care for the blacks, even in the government sector of the medical services does not yet exist. The introduction of such a system is our goal although the means to secure it will probably surpass the present capability of the protectorate.\footnote{183}

The British drew on these sorts of German colonial officials’ reports to emphasize that the Germans did not invest in the welfare of the colonial subjects.

The British portrayed themselves as having the objectives of building the foundation of progress and welfare of the African population that the Germans had failed to do during the three decades of their rule in the territory. The infant survival plans that the British colonial government initiated and implemented in the 1920s were one of the strategies they used to publicize those objectives. These welfare programs were part of Britain’s propaganda efforts to show Africans and the League of the Nations that she had a different mission, a more productive and beneficial mission to Africans than the

\footnote{182}{This point also emphasized in Tanganyika Territory, \textit{Report on the 1921 Census of the Native Population of Tanganyika Territory.} (Dar es Salaam, Government Printer, 1921)}

Germans. Subsequent sections will demonstrate that these welfare initiatives were key components of the colonial government’s efforts to build its legitimacy and presence among Africans.

The infant welfare programs also evolved in the context of the British colonial government’s institutionalization of indirect rule policy as the official political system for administering the territory. Indirect rule involved organizing Africans into “tribes” and administering them through African chiefs. Indirect rule was a form of local administration. It consisted of three institutions: native authority led by a chief who held legislative and executive powers; native courts that maintained order and laws in the area; and a native treasury that collected taxes and remitted some of them to the central government.184 African chiefs became representatives of the colonial government in the rural communities. As I show in chapter five, these chiefs would play an important role in mediating between peasants and colonial government officials over the incorporation of curative medicine in the infant welfare programs.

Indirect rule, however, was not simply a political system of administration: it was also a calculated strategy that the colonial government used to enhance its legitimacy. Through the implementation of indirect rule, the government claimed that it prepared and involved Africans in political administration of the territory. As Governor Sir Donald Cameron stated, the government “sought by means of indirect rule to create areas of limited African self-government… as training grounds and power bases for future African

This kind of claim appealed to the League of Nations which had mandated the British to improve the welfare of Africans and to prepare them for the administration of their own political affairs. Within the territory, the colonial government used indirect rule to portray itself among Africans as a more democratic government than the German, and in so doing used it to enhance its legitimacy and acceptance among Africans. Under these circumstances, infant welfare interventions were not an isolated government initiative. Rather, they were part of the 1920s’ government programs that included the creation of indirect rule administration, and together, they served the interest of the colonial government to establish its presence and legitimacy within African communities. The next section examines British colonial ideas and propositions that constituted the infant welfare programs in the 1920s and 1930s.

3.2 Colonial Ideologies and Policy Initiatives on Infant Survival, 1920-1930s

When the British colonial government took control of Tanganyika from Germany at the end of the First World War, it identified high infant mortality as a critical problem accounting for low African population numbers in the territory. The underlying colonial assumption was that maternal ignorance of infant care, hygiene, and feeding produced low infant survival. The Memorandum on Infant Welfare Policy, which was the culmination of almost four years of the colonial administration’s concerns and discussions about infant welfare, embodied the government’s propositions to solve the problem.

185 Ibid., p. 321
The British medical and political officials identified improper African cultural practices related to infant care, feeding, hygiene, and venereal disease as the causes of poor infant survival. D.S. S. Skelton, the Senior Sanitation Officer of Health in Tanganyika in 1920, asked district medical and political officers to investigate African infant deaths, which he claimed were as high as between 40 and 50 percent. Skelton challenged these officers to investigate whether there was validity in the popular claims that infant deaths were “chiefly due to improper feeding … (and) the widespread presence of venereal disease…” In their first census estimate of the African population in Tanganyika released in 1921, colonial officials confirmed Skelton’s claims about infant deaths. They argued that improper feeding practices, unhygienic lives, and venereal disease caused infantile illnesses and deaths. By linking infant deaths to these practices, colonial officials were in effect blaming African cultural practices for poor infant survival and demonizing African women’s roles in mothering and child rearing.

Surveys conducted in response to Skelton’s proposition in the early 1920s confirmed an infant survival problem in many parts of Tanganyika. The Annual Medical Reports for 1921 and 1922 presented the findings of three surveys. Philip E. Mitchell, the District Officer in Ufipa, conducted one of these surveys. He found that only 48.2 percent of

\[186\] It is not clear from the sources I have consulted who made the claims referred to by Skelton. TNA 2060, Colonial Secretariat Early Series: Native Population- Tanganyika Territory, 1920. See the letter from D.S.S. Skelton to district Medical Officers

\[187\] Ibid.

\[188\] Tanganyika Territory, Report on Native Census, 1921, p.3

\[189\] For broader discussion on blaming the victims, see Paul Farmer, AIDS and Accusations: Haiti and the Geography of Blame (Berkeley, University of California Press, 1992).
infants survived their childhood and that almost 40 percent among them died before their second birthday. Another survey from Charles Dundas, the District Officer in Moshi, who surveyed 34 chiefs with a total of 285 wives, reached a similar conclusion. These wives gave birth to 707 babies, but only 405 survived to weaning (approximated at two years). The government reported a third survey carried out in Tabora in its 1922 Annual Medical Report. This survey reported that 295 of 447 babies died in the South Uganda and Ngulu communities, equivalent to almost 66.2 percent of all births. The implication of these findings was that almost half of all infants died within their first two years of life. Taken together, these surveys’ findings confirmed colonial administrative concerns that poor infant survival was a problem in Tanganyika, and that a lack of maternal education on the part of African mothers was the root of the problem.

Colonial officials singled out maternal ignorance as an element in African cultural ideas and practices that was responsible for generating poor infant health, infantile illnesses, and premature deaths. For example, according to John Stuart Wells, the district

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190 Tanganyika Territory, Annual Medical Report, 1921, p. 83. Mitchell did not mention the number of infants born in the survey area and from which he calculated these percentages.
191 Ibid.
192 Tanganyika Territory, Annual Medical Report, 1922, p. 100.
194 Tanganyika Territory, Report on Native Census, 1921. The other factor which is identified in these sources but not as emphasized as maternal ignorance is disease, especially venereal diseases and malaria.
political officer of Rungwe district, the “knowledge on infant feeding and care that traditional midwives passed to nursing mothers was wrong …” because it encouraged mothers to feed infants with porridge in the early days after birth. E.B. Watt, who succeeded Wells as the Rungwe political officer pushed this argument further by claiming that faulty feeding and unhygienic conditions “… made infants susceptible to micro-organisms … (and thus) vulnerable to infections and ill health.” For Watt, therefore, maternal ignorance on proper infant diet and unsanitary lives made infants vulnerable to infections and susceptible to premature death. Watt underscored infants’ vulnerability in his communication with the Senior Sanitation Officer in Dar es Salaam when he wrote that

… the women are deplorably ignorant in the treatment of their babies, and it will only be by continually drumming at them that we will make them realize how delicate a small infant is. They little realize that in the majority of cases death is the result of mothers’ carelessness or ignorance.

In this quotation, Watt reinforced the evolving assumption among colonial officials which attributed poor infant survival in African communities to maternal ignorance. By highlighting that European colonial officials could help mothers to “realize how delicate a small infant is,” Watt was in essence projecting colonial interventions as a rescue mission in infant survival improvement. In addition, Watt’s claims were loaded with unprovable and culturally arrogant assumptions in which he saw African women as


195 TNA 18/7 John Stuart Wells, District officer of Rungwe District to DMSS, 23/5/1922 ref 18/3/2
196 TNA18/8/0 E.B. Watt, District Officer to DMSS, 24.03.1923.
197 TNA 450/108 E.B. Watt, Administrative Officer i/c Rungwe district to the Senior Sanitation Officer, Dar es Salaam, 4/2/1923
lacking the basic knowledge of infant care. Other colonial officials shared Watt’s assumptions, like those who prepared the 1925 *Annual Medical Report*. The report explained poor infant survival in the following way:

> Whereas the African mother breast-feeds her child, as a rule, for a full year and sometimes longer, the beneficial results which would otherwise accrue are destroyed in the belief that the colostrum bearing milk is harmful, and that the mothers milk of itself is insufficient nourishment. The result is that from birth extraneous matter in the form of course indigestible carbohydrates is forced upon the child which naturally proves disastrous.¹⁹⁸

The report, therefore, reinforced the underlying assumptions attributing poor infant survival to maternal ignorance of infant care and feeding. The language used to characterize infant feeding, such as “course indigestible carbohydrates is forced upon the child” picture African mothers as uncaring and unresponsive to their infants. This report reflected contemporary thinking among medical and political officials who situated infant survival in the context of maternal cultural practices: a thinking which informed officials’ explanation of poor infant survival in Tanganyika in the 1920s.

The perspective of privileging maternal ignorance in accounting for poor infant survival was not unique to Tanganyika. Mary Blacklock, who advocated for the improvement of the welfare of women and children in the colonies during the 1920s and 1930s commented that the “appalling high infant mortality rate and much of the ill-health of the people (was) due to … the ignorance of women in the care of the home and the health of their children.”¹⁹⁹ Embodied in these colonial claims is the notion that ignorant mothers

did not understand the basics of infant care, feeding, and hygiene which kept them from raising healthy infants. For some infant welfare commentators in the 1920s, therefore, a combination of maternal ignorance and faulty feeding increased the chances of infantile illnesses and premature deaths.

Colonial officials believed that solving the infant survival problem depended on educating mothers. The 1922 Annual Medical Report underscored this perception as follows:

A campaign against venereal diseases would probably result in a marked increase in the number of births, but the percentage of deaths could only be reduced by the spread of education, especially in the female population. Suitable diet … would have the greatest influence in reducing the present high infant mortality throughout the territory.200

H.C. Stiebel, the government official from Tabora, stressed the need for mothers to acquire the basics of infant care. He argued that such an education would help to solve the problem of “mother’s nonobservance of childrearing and feeding principles” such as the practice of “washing babies with cold water in a stiff breeze, pouring quantities of porridge down at a very tender age and poor hygiene in native huts,” condition he thought brought chest troubles, dysentery, and death.201 In addition, H.A. Owen, the Acting Director of Medical and Sanitation Services, articulated the significance of educating women on infant care and feeding when he pointed out that

… one of the greatest benefits which could be conferred on the female population of the territory would be the provision of trained natives who could … instruct the mothers in infant feeding. It is perhaps not realized that amongst many tribes a

200Tanganyika Territory, Annual Medical Report, 1922, p. 100
201Letter from Stiebel to Director of Medical and Sanitation Services, op.cit.
new baby is fed entirely on gruel for the first week or so, a diet which must be responsible for a very large infantile mortality.\textsuperscript{202}

The views held by Owen and Stiebel and those expressed in the 1922 \textit{Annual Medical Report} reflected the assumption that improving maternal education was essential to infant survival. They envisaged training African agents as cultural intermediaries who would eventually spread education to mothers, and women more generally, in homes and communities. Historians have documented the fact that in many parts of Africa, both colonial governments and medical missions relied extensively on the use of Africans who had received basic training in colonial medicine.\textsuperscript{203} In Tanganyika, too, colonial officials considered producing trained African agents who would then instruct mothers on infant care, feeding, and hygiene as a critical approach in reducing infant deaths, and ultimately, improving infant survival.

John Shircore, the Director of Medical and Sanitation Services (DMSS), formulated the \textit{Memorandum on Infant Welfare Policy} in 1925 to guide educational interventions for improving infant survival in Tanganyika. The memorandum was a “broad program to minimize child wastage of the native infants in Tanganyika.”\textsuperscript{204} The DMSS’s use of the phrase “child wastage” to describe the perceived problem of infant mortality reflects the crude language of the colonizer as he attempted to make sense of the problem. The

\begin{itemize}
\item \textsuperscript{202}TNA 450/108/10 Acting Director of Medical and Sanitation Services to Chief Secretary and Provincial Commissioners, May 4, 1927, p. 2
\item \textsuperscript{204} My emphasis. Tanganyika Territory, \textit{Memorandum on Infant Welfare Policy} (Dar es Salaam, Government Printer, 1925), p.1
\end{itemize}
language was industrial, and equated infant deaths with the waste products emitted from industrial production. The DMSS also presented the content of this document at the Conference on Education held in Dar es Salaam under a slightly modified title, *Hygiene, Maternity and Child Welfare*. The DMSS wrote:

> The problem that we have to deal with in Tanganyika is the practical application of accumulated experience (of the British infant welfare movement) to a community which might be considered to be still living in the Dark Ages…. The foundation that we lay down must be solid …. Whatever we do, we should leave no room for the uncertainty or doubt in the minds of the people we are dealing with.

The DMSS claimed that the British infant welfare movement provided a model for colonial infant welfare propositions in Tanganyika. His claim that they were embarking on the program to improve Africans “living in the Dark Ages” suggests an evolutionary understanding that colonial social efforts would push Tanganyikans from primitive to higher standards of infant care. According to the DMSS, these welfare programs would transform African cultural environments “where there are overcrowded filthy dwellings, in which man and beasts live together, where disease is uncontrolled and sanitation non-existent, where in place of medical supervision infant life contends with superstition and witchcraft….” The social interventions, they argued, would solve these problems and thus eradicate African cultural practices which, according to colonial officials’ views in the 1920s, produced the conditions that precipitated infantile deaths.

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205 I thank Julie Weiskopf for this linguistic interpretive insight in our informal discussions in Dar Es Salaam, Tanzania, August, 2009.
207 Tanganyika Territory, *Memorandum*, p. 1; Shircore, “Hygiene,” p. 44
208 Tanganyika Territory, *Memorandum*, p. 3; Shircore, “Hygiene,” p. 46.
The DMSS recognized that improving infant survival required collaboration between the administrative, educational, and medical and sanitation departments. The administrative branch would deal with poverty, the educational branch would deal with ignorance and provide instruction on the principles underlying hygiene, and finally, the medical and sanitation branch would apply hygiene and prevention in saving infants.

In addition, the DMSS proposed and charged infant welfare centers with the task of providing education that would ultimately improve motherhood and infant survival. The centers would be a “nucleus for imparting knowledge and advice to mothers on infant care through mothercraft classes, monitoring growth of infants, and keeping record on infant weight and progress.” This educational initiative assumed a particular mission of transforming “primitive” and “wicked” mothers whose maternal practices and ideas the colonial officials defined as the root cause of the infant survival problem into “new” and “modern” women capable of observing the basics of motherhood.

The collaboration between the medical and education departments was especially important in these medical measures. Infant welfare workers and hospital nurses would visit schools to teach pupils about hygiene, infant care, and mothercraft by theoretical instruction and practical demonstration. At the same time, women would visit infant welfare centers to gain first hand experience of activities related to infant care and feeding. The DMSS

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209 Shircore, “Hygiene,” p. 44
210 Ibid.
211 Tanganyika Territory, Memorandum, p. 5; Shircore, “Hygiene,” p. 48
212 For discussions of wicked mothers in colonial Africa, see Dorothy L. Hodgson and Sheryl A. McCurdy eds., “Wicked” Women and the Reconfiguration of Gender in Africa (Portsmouth, NH., Heinemann, 2001).
213 Tanganyika Territory, Memorandum, p. 2; Shircore, “Hygiene,” p. 45. By 1925, Native Authorities as a form of Indirect Rule Policy was being prepared, since it became official and operative in 1926.
envisioned that the combination of these administrative, educational, and medical measures would go a long way towards bringing the desired end of improving infant survival.

In his memorandum, the DMSS underscored that improving infant survival hinged upon the education of mothers in infant care, feeding, and hygiene, synthesizing popular opinions held by colonial officials in the early 1920s. He wrote: “The African mother must be educated gradually to realize that …her health and habits, her capacity on domesticity, her skilful care and management, are vital to the welfare of her child.”

This claim was in line with a vision that … the African woman … must be led to see the advantage of a clean home, a clean body, clean children and clean clothes. She must be taught how to care for the sick, and learn that the appalling waste of life as she sees it around her today, is not only unnecessary, but can be prevented by her, to a large extent, if she has a knowledge of the simple laws of health and mothercraft. At present the ideas of wifehood and motherhood are very low indeed and all education must aim at raising these ideals, so that the children of the future may be able to look up to their mother with respect.

These quotations reinforce the notion that colonial medical initiatives to improve infant survival revolved around transforming “primitive” mothers into “modern” or, at least,
partially civilized women. Indeed, they reveal colonial perceptions that African women were deplorably ignorant of infant care, hygiene, and feeding; and that only through educational programs addressing this ignorance would the government be able to alleviate the problem. In addition, these quotations suggest a particular notion held by colonial officials concerning the role and position of women in society. They limited the role of women to the domestic duties of giving birth, caring for children, and ensuring cleanliness and hygiene in the homes. Domesticity, in this sense, entailed confining mothers and women to the reproductive realm of the household in which their main responsibility concerned child birthing, raising, and nurturing.\textsuperscript{216}

Colonial officials’ desire to relegate mothers to the domestic sphere of child rearing in Tanganyika was concurrent with the nineteenth-century European middle class understanding of proper family life and motherhood, a subject that Mary Jo Maynes has carefully explored. For Maynes, this understanding demanded intense mothering that involved mothers working with domestic child rearing and not engaging themselves with wage employment outside the family.\textsuperscript{217} This concurrence further indicated the extent to which colonial officials in Tanganyika drew on the European experience and history to formulate infant welfare measures. In so doing, these colonial officials were imposing European notions and ideas in Tanganyika. They looked at their definitions, explanations,

\textsuperscript{216} For examples of literature on transforming the roles and social positions of women in colonial African, see Hodgson and McCurdy eds., “Wicked” Women; Jean Allman and Victorian Tashjian, “‘I will Not Eat Stone:’ A Women’s History of Colonial Asante” (Portsmouth, Heinmann, 2000), See especially chapter 5.

and propositions to solve infant survival problem as “scientific” knowledge which, as the language in the memorandum suggested, was held to be universally true.

The language used in the memorandum, together with the communications between colonial officials on infant survival examined above, was a manifestation of a colonial power willing not only to name and characterize African infant health and welfare needs, but also to transform African ideas and practices on infant care.218 This language manifested a colonial perception which looked at African ideas and practices of infant care as symbolic of African primitivity and their uncivilized mentality. Using phrases such as “living in the Dark Ages,” “teaching,” “drumming at them,” “child wastage,” or “deplorable,” to characterize African practices suggest the extent to which colonial officials positioned Africans at the lowest levels of development and culture relative to the level reached by Europe. The memorandum and other communications on infant welfare were thus infused with a colonial “superiority complex” in which colonial officials perceived African ways of life, ideas, and practices as backward. Officials’ propositions of social and educational interventions to transform Africans into higher levels of culture indicate the degree to which they looked at these welfare programs as

218 Studies on colonial power to define conditions of health, illness, and healing in African colonial context have been written and these works have not only paid a particular attention to discourse analysis of the language used by colonial officials in colonial medicine, they have also highlighted colonial medicine as a tool of colonialism which served to subject Africans under medical colonialism. Important works in this category, and which have inspired this proposition, include Megan Vaughan, “Healing and Curing: Issues in the Social History and Anthropology of Medicine in Africa,” Social History of Medicine, 7, no.2 (1994):283-95; Megan Vaughan, Curing Their Ills: Colonial Power and African Illness (Stanford, Stanford University Press, 1992); Diana Wylie, Starving on a Full Stomach: Hunger and the Triumph of Cultural Racism in Modern South Africa (Charlottesville, University of Virginia Press, 2001).
part and parcel of a civilizing mission which would uplift Africans (especially African mothers) from primitive to civilized ideas and practices of infant care.

However, as Chapter Two has made clear, African men and women were not ignorant of proper ideas and practices of infant care. They had both preventive measures and curative techniques that helped them to address infantile medical challenges. I look at these colonial claims as indicating the failure of colonial officials to recognize and accept African ideas and practices as culturally different ways of managing infant health. These colonial documents remind us that colonialism was not simply a relationship meant to exploit natural and human resources in Africa, it was also a cultural process meant to transform Africans in accordance with ideas and practices which colonial officials deemed acceptable.

Government officials’ views on infant survival provide glimpses into their understanding and perception of the condition in which infants were born and raised during the 1920s. They perceived infants as vulnerable to premature death because their social and cultural contexts inhibited healthy growth. The inhibiting influence derived from maternal ignorance in infant care, feeding, and hygiene. That is why colonial propositions to solve the infant survival problem revolved around educational interventions. By explaining the problem in terms of maternal ignorance, the government blamed African culture and

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219 I am building on the findings of Steven Feierman whose study among the Shambaa underscored that local systems of knowledge and practice, together with intellectuals who produce and make them intelligible to people in the communities, are socially recognized and sanctioned in the society. See Steven Feierman, *Peasant Intellectuals: Anthropology and History in Tanzania* (Madison, University of Wisconsin Press, 1990).
African women’s ideas and practices as unsuitable for infant survival. The government’s 
*Memo*randum on Infant Welfare in 1925 served as a guide for these interventions. 
Through these propositions, colonial officials assumed a modernizing and civilizing 
age*ncy* to impart to Africans ideas and practices considered conducive for healthy infant 
survival. In the next section, I examine the strategic agenda of the British colonial 
government for the welfare of infants, and how this agenda generated changing 
relationships between the medical missions and colonial government.

**3.3 Colonial Strategic Interests in Infant Survival**

British officials in Tanganyika thought that infant survival interventions, involving new 
ideas and practices about infant rearing, would help the colonial government to build its 
own presence and justify its activities among Africans. But the colonial government 
found that medical missions had dominated infant welfare activities from the late 
nineteenth century to the mid 1920s. Since the colonial government had not established a 
health service infrastructure for Africans during this period, it depended on the 
Christian medical missions to provide African welfare services. For the government to 
built its own popularity and influence through welfare investment, it had to reduce its 
total dependence on the medical missions. John Shircore, the Director of Medical and 
Sanitation Services summed up the government’s changing position in 1928 when he 
pointed out that “[w]e can no longer work behind the shadow of the medical missions as 
this will undermine our ability to … make the native see and feel our efforts to improve
In addition, the government attempted to reduce the visibility and dominance of medical missions by stopping financial subsidies for the running and expansion of medical missions. The government did, however, continue to provide grants-in-aid to mission activities which advanced the government’s efforts of staking its claim in infant health services. For example, it continued to support the training of midwives and welfare workers who could potentially work in government services, the production of Swahili booklets and instructional materials for training welfare workers, and the health education of children. This mission work had the potential of aiding the government’s own agenda of directly intervening in infant welfare.

Although the colonial government intended to use infant survival interventions to build its own presence and to justify its activities among Africans in Tanganyika, it did not have the necessary health services infrastructure to carry out these interventions. Colonial archival records testify to the absence of these services in the early 1920s. In 1923, four years after the beginning of British colonialism in Tanganyika, the Director of Medical and Sanitation Services circulated a letter to all District Medical and Administrative officers in which he made it clear that “the present (medical) provision is intended primarily to meet the emergencies and can not yet cope with the requirement of the whole native population throughout the territory.” And in 1924, the government again recognized this limitation when it declared that the public health enterprise for improving

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221 TNA 7488/1/A. Director of Medical and Sanitation Services (DMSS) to all District Medical and Political Officers, November, 23, 1923.
infant welfare was non-existent. These records show that the colonial health services inherited from the Germans in 1919, and which the British did little to improve in their first six years of administration, could not handle the government’s new desire to improve infant survival.

Historians of colonial medicine, including Ann Beck and Lesley Doyal, have suggested that colonial health services were limited in their potential to improve African welfare. First, they had an urban bias, serving the needs of Europeans as well as a few elite Africans (such as civil servants, policemen, soldiers, and prisoners) who worked in the colonial civil service and resided in the urban headquarters of district and provincial administrations. Second, they catered to the needs of African laborers working in the colonial economy – especially in the plantation, mining, and construction sectors. Third, they dealt with epidemic outbreaks such as sleeping sickness, plague, and cholera because the impact of these epidemics affected both Europeans and Africans alike. Fourth, there was a shortage of manpower needed for any form of organized efforts to improve the welfare of colonial subjects. In 1920, for instance, the Medical and Sanitation Services Department had only two permanent medical officers, Davey and Shircore. In 1921 the number of medical officers increased to 15 and the government

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224 Apart from epidemic diseases, colonial medicine also took a particular interest in endemic diseases that potentially affected the constant supply of laborers in the colonial mining and plantation investments, diseases such as leprosy and smallpox. See for instance, Eric Silla, *People Are Not the Same: Leprosy and Identity in Twentieth Century Mali* (Portsmouth, Heinemann, 1998); N.D. Balslev, *A History of Leprosy* (Nairobi, AMREF, 1978)
brought 19 sub-assistant surgeons from India. By 1924 the number had increased to 34 in
the government medical service. These characteristics suggest that the government’s
health services in the early 1920s catered to the needs of European communities in the
colony and to the few Africans working in colonial economic investments and in the civil
service in urban centers. Arguably, these meager services had little ability to support
infant welfare interventions, especially in rural African communities.

In the absence of government health services for the majority of Africans, the medical
missions continued to dominate the provision of these services to Africans up to the mid
1920s. According to T.W.J. Schulpden, the colonial government in Tanganyika
reinforced this dominance by giving medical missions the financial support for the actual
running and expansion of their medical and welfare work because the former perceived
and used the latter as agents for providing welfare services to Africans. Thus, until the
mid 1920s, the relationship and negotiations between the government and medical

225 Clyde, History of the Medical Service of Tanganyika, pp 104-105; 109.
226 A brief note on Christian missions sets the background for understanding missionary precedence in the
health and welfare of Africans in the rural areas, as opposed to the government whose orientation
privileged urban areas. For example, the Holy Ghost Fathers established a series of dispensaries around
Bagamoyo in Eastern Tanzania as part of their missionary work from 1868 (Zucchelli, 1963). The Church
Missionary Society (CMS) opened its first hospital to care for the missionaries and African converts in
1877, a mere three years after the group’s arrival. In addition, a missionary, Dr Adrien Atiman, started a
hospital at Kalema near Lake Tanganyika in 1886 to deal with health of his early Christian converts (Clyde,
1962). In southwest Tanzania, the Moravian Missionaries arrived in Rungwe in 1890 and started to
evangelize around Rungwe-Bundali highlands, Mbozi, and the Lake Nyasa plains. Medical-related work
took center stage among the Moravians, and of the first four missionaries who arrived in Rungwe, one,
Theodor Meyer, had studied and practiced medicine in Germany and South Africa (Meyer, 1994). As
Angetile Musomba has documented on the early part of the Moravian history in Rungwe, evangelization
went hand in hand with the care of leprosy patients, midwifery, child welfare, and illness treatment
(Musomba, 1990). Christian missions pioneered and dominated the provision of health services to Africans
long before the onset of government’s interventions in the 1920s.
227 T.W.J. Schulpden, Integration of Church and Government Services in Tanzania: Effects at District Level
(Nairobi, African Medical and Research Foundation, 1976), pp.42-43. See also Fr. Severino Zucchelli,
missions involved symbiotic collaboration. The government subsidized all mission medical and welfare work, expecting the missions to complement its efforts in the provision of medical services in rural areas where government health services were virtually nonexistent. For Schulpen, the government’s strategy to include the Christian missions in providing health services was crucial in improving African social conditions because mission societies understood African health problems better than the government did. Terence Ranger’s study in the southeastern parts of Tanganyika indicates that the absence of government organized health services in this region made the medical work of the University Mission to Central Africa (UMCA) very influential with Africans because it was the sole provider of health care and western medicine to Africans more generally. Ranger suggested that the Director of Medical and Sanitation Services utilized this medical mission in the daily oversight of endemic diseases, such as yaws. Thus, the colonial government’s engagement with African populations in matters of health and disease, especially in the rural areas, relied on the medium of medical missions. Doyal and Pennell have analyzed this government-mission relation in the 1920s in the following way,

In East Africa, as elsewhere, missions generally served rural areas remote from direct government control and, until the establishment of the native authority system in 1926, they were the sole purveyors of western medicine to the local population. Through the favourable contacts they developed with African communities their medical work was acknowledged to be most helpful to the government in their endeavour of opening up tropical Africa. Indeed, even after the new dispensaries began to appear, the continuing advantages offered by European medical missions gained recognition in the form of government

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subsidies. In return, the colonial authorities saw the limited scope of existing facilities somewhat expanded and far more cheaply than was possible by direct means.\footnote{Doyal and Pennell, \textit{The Political Economy of Health}, p. 251}

Central to Doyal and Pennell’s analysis is that by the mid 1920s, the colonial government found it cheaper to support and subsidize missions’ medical services rather than making direct investments on its own. Their analysis underscores the extent to which medical missions were important to the colonial government’s attempts to deliver health services to the colonial subjects living mostly in rural areas. As many other studies on colonial social and health interventions have underscored, the colonial government used medical missions services in dealing with epidemic diseases when they happened;\footnote{An example for this is the way in which the Germany government used the Lutheran Mission to deal with smallpox epidemic in Ubena in the late 1890s. See Wright, \textit{German Missions in Tanganyika}, p. 24.} in taking care of the health of government employees where government medical services had not yet developed;\footnote{See For instance, Ann Beck, “Medicine and Society in Tanganyika 1890 – 1930: A Historical Inquiry,” \textit{Transactions of the American Philosophical Society} Vol. 67 No. 3, 1977.} or in broader programs of vaccinations and preventive health as those against yaws, measles, and malaria.\footnote{Clyde, \textit{History of the Medical Services in Tanganyika}, pp. 33 – 40; See also Ranger, “Godly Medicine” pp.263-270.} On the cooperation between governments and the medical missions in the field of maternal and child health, Doyal and Pennell argued, Elementary medical training together with maternity and child health therefore became major concerns of the missions throughout the colonial period. Their increasing role in medical training reflect the government’s view that both the need for low-level African medical staff as well as the demands of Africans themselves for skilled employment could be met most economically by modest state support for existing work of the missions. With regard to maternal and child health the missions were especially zealous. Their hospitals tended to favour female patients, making ample provision for child birth so as to deliver as many new candidates as possible for baptism. Given the existing labor shortages, high infant mortality rates were of particular concerns and small grants-in-aid were therefore made to medical missions to encourage their work in this field.\footnote{Doyal and Pennell, \textit{The Political Economy of Health}, p. 252}
Doyal and Pennell’s argument underlines the point that both the medical missions and colonial government had a shared interest in addressing maternal and child health in which the government subsidized missions’ efforts instead of making its own direct investments. Thus, up to the 1920s, the colonial government utilized medical missions to deal with the health and welfare of the vast majority of Africans who lived in rural areas. The effect of this arrangement was that Africans encountered infant welfare services though medical mission provisions. These services helped the medical missions not only to build direct contact with Africans in their homes and communities but also to enjoy more popularity among Africans than the government in matters of welfare interventions.

The collaboration between government and medical missions favored the missionaries who perceived medical services, including maternal and child welfare work, as integral to evangelization, to social control, and to winning the hearts and minds of Africans. According to Roland Oliver,

As the churches grew, and as increasing numbers of baptized Christians had to be disciplined on charges of witchcraft and polygamy, it came to be realized that the medical mission was necessary as a social institution of Christian community. If the witch doctor was to be eliminated, with all that symbolized of sub-Christian fears and hatred, the missionary doctor must abandon his evangelistic itineration, stay in his hospital and train African nurses and medical assistants to replace the sorcerer in the village life. And equally, if the children of monogamous marriages were to survive in sufficient number to compensate for the renunciation of polygamy, then maternity work, child welfare and infant dietetics must all come within the missionary sphere.  

Oliver’s argument concerning medical missions in East Africa claims that maternal and child welfare projects, together with medical work more generally, were integral to missionary work. Missionary investment in infant survival was necessary for fighting African cultural practices, such as polygamy, and to facilitate African acceptance of Christianity. Missionaries’ utilization of medicine and welfare as tools was based on contemporary assumptions that

The usefulness of the medical arm of the missionary service is indisputable. It breaks down opposition, dissipates prejudice, and wins its way to the hearts and homes of the high and low, the rich and the poor. It receives the highest official recognition, and thus facilitates the employment of all other agencies.236

This assumption shows that missionaries perceived health services as tools for winning Africans in the process of evangelization. This perception was concurrent with how missionaries viewed western medical sciences more generally. As Debby Gaitskell has observed, “the mission church white medical personnel seem to have seen their task as both a scientific onslaught and a spiritual assault on ignorance, insanitary conditions, superstition and ill-health.”237 Thus, missionaries looked at medical and welfare services as important tools for converting Africans to Christianity.

The Colonial government’s and missions’ shared interest in infant welfare interventions was not unique to Tanganyika. Nancy Rose Hunt’s study on the Congo basin238 and that

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236 Quoted in Doyal and Pennell, The Political Economy of Health, p. 251
238 Hunt, “‘Le bebe en brousse,”
of Jean Allman and Victoria Tashjian on Asante women in Ghana, demonstrate that elsewhere, colonial governments and medical missions worked together in infant welfare interventions. Allman and Tashjian, for instance, have argued that in implementing maternal and child welfare work in Ghana, the colonial government in the 1920s-1930s depended on the medical missions, believing that the missionary practitioners could perform this work better than government medical officers. As a result of this perception, the government provided grants to the Methodist mission that was used in the construction of buildings, in maintaining medical and nursing staff and, partly, in maintaining the welfare centers. Because of these arrangements, Allman and Tashjian concluded that “… the mid-1920s witnessed the colonial government’s empowering of missionary societies as junior partners in maternal/child welfare work and girls’ education.” In this way, medical missions worked as agents of colonial governments in delivering health and welfare services to African colonial subjects. This interplay between the colonial governments and medical missions shows that the former depended on the latter in meeting the medical and welfare needs of African populations in the colonies, including infant welfare interventions. The government considered the role of mission medical services critical in alleviating health-related and welfare problems in the colony because of missions’ extensive medical services and experience in these areas. The colonial governments used subsidies and grants-in-aid to exploit the experience and network of medical missions in furthering the government’s medical and welfare agendas. The result of this partnership is that medical missions had an opportunity of

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239 Allman and Tashjian, I will Not Eat Stone. See especially chapter 5.
240 Ibid., p. 185.
241 Clyde, History of the Medical Services in Tanganyika, p. 38.
reaching African homes and communities directly at the expense of the governments. The government had to devise a strategy that would uproot the central role that missions played in welfare-related interventions.\(^{242}\)

For the colonial government to use infant survival services to build its own presence and to justify its activities among Africans, it needed to reduce the dominance that the medical missions had enjoyed up to the mid 1920s. The government’s effort began on January 4, 1928 when John Shircore, the Director of the Medical and Sanitation Services, wrote a memorandum and circulated it to Provincial Commissioners and Medical Officers in Tanganyika. He urged these colonial authorities to ensure that Africans recognized government efforts to improve their health. In a paragraph that outlined the relationship between the government and medical missions, Shircore wrote:

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\text{We must establish our physical presence in the rural areas. We can no longer work behind the shadow of the medical missions as this will undermine our ability to reach the natives, to improve native health and to set the native in the trend for upward population growth. We must make the native see and feel our efforts to improve his welfare. I believe that the best means to achieve this is through saving their children from premature deaths …}^{243}
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Shircore’s memorandum set in motion the new social engagement and negotiation between the government and medical missions as the former attempted to undercut the

\(^{242}\) Historians have interpreted the general relation between colonial governments and medical missions that I have briefly outlined above as suggesting mutual interdependence, arguing that not only did missionary medical missions further the government’s medical agendas in the colonial context; they also provided ideological justification that made Africans accept colonial relations as legitimate and potentially beneficial for them. Although these interpretations are generally valid, the fragmentary evidence I have collected suggests that the exclusive story of mutual co-existence between the state and missions disguises moments of tension like those which evolved in infant survival interventions from the mid 1920s in colonial Tanzania.

latter and reduce its dominance. The memorandum makes clear that from the late 1920s, the Medical and Sanitation Services Department wished to take on a greater role in managing African health and welfare rather than relying on medical missions. Recall that up to the mid-1920s, the department provided necessary financial support in the actual running of mission medical and welfare activities, including maintaining and expanding buildings, paying salaries for nurses and doctors, buying drugs, and education. Shircore’s claims that the department could “no longer work behind the shadow of the medical missions” signals a shift in the government’s position: the department intended to assume a direct responsibility of improving African welfare as a way of reaching African homes and communities. This direct investment attempted to enhance the department’s effort to build its acceptance among African colonial subjects. An equally important point in Shircore’s memorandum is the notion that the department was redefining its health activities in ways that would eventually make Africans, to use his own language, “see and feel” the department’s efforts to improve their welfare. The department’s strategic interest to build its own presence among African colonial subjects is also echoed in a letter that Shircore wrote to the Chief Secretary in Dar es Salaam on March 4, 1928. He wrote:

… we must be careful with our grants-in-aid provided to the work of the medical missions. We must make sure that these grants enhance our own interest of enabling the natives to recognize our efforts to improve their health and welfare.…

Shircore’s letter underscores the department’s interest to make sure that Africans recognized its efforts to improve their welfare. He understood that this awareness would ultimately enhance the government’s effort to build its own presence and to justify its activities among Africans. In the process, the government’s direct investment in activities related to African welfare would boost government legitimacy because Africans would see it as serving their own interests and concerns. Shircore’s position had a precedent in the neighboring colony of Kenya where Dr Gilks, the Medical Director of Kenya Colony, articulated similar views in 1921 when he argued that

A government hospital is a tangible sign of government activities which is understood by every native, but it is doubtful whether a subsidized mission hospital is in anyway connected in the minds of the majority of the patients as being anything more than a token of benevolence of the missionaries who therefore reap the credit and the resulting influence. It is a fact which can not be gainsaid, that the provision of medical attendance, even of the crudest and most primitive description, is the best form of advertisement for any form of activity among natives … and therefore every penny of government money which is available for medical work should be spent by government rather than by any independent body ….  

Gilks’s argument, like Shircore’s, revealed the government’s intentions to invest directly in the health and welfare of the African population rather than using the medium of other institutions (like the medical missions) as was the case before the mid 1920s. Gilks made it clear that direct investment in health and welfare was a form of advertisement demonstrating government’s efforts to improve African welfare. He assumed that Africans would easily recognize, understand, and appreciate this form of government investment. In addition, he challenged the government’s strategy of providing medical missions with subsidies and grants-in-aid. For Gilks, this was a wrong-headed strategy.

245Quoted in Beck, *A History of the Medical Administration of East Africa*. p. 82.
because it enabled medical missions to “reap the credits and resulting influence” at the expense of the colonial government.246 Government subsidies enhanced medical missions’ popularity among Africans because they enabled missions to reach African homes and communities directly. His proposition was for the government to make direct investments in the welfare of Africans which would enhance the government’s popularity, and thus build its own legitimacy. Views such as “government money… should be spent by government rather than any independent body…”247 provide important evidence that colonial officials in the medical department were looking at institutions like medical missions as obstacles to the colonial government’s goal to build its position, presence, and legitimacy among Africans.

The interest of the government’s Medical and Sanitation Department to build its presence among Africans by displacing medical missions was associated with defining the types of mission services that would qualify for government support. This interest is evident in the communication between the Medical and Sanitation Department and the Moravian Church. The Moravian church in Rungwe district requested a government grant–in–aid to extend its medical work at Isoko mission in 1928. The government created this grant in 1927 to assist missions in medical related works that would complement the efforts of the government to reach the rural areas where the majority of Africans lived.248 The Moravian church requested £96, from which it would use £50 for buildings and

246 Ibid.
247 Ibid.
248 TNA 450/178/3 Grants to Missions 1927 – 1939.
equipment and £46 for the living expenses of the nursing sisters.²⁴⁹ DMSS Shircore did not approve the grant, arguing that “the priority for the grant created by the government (lay) in supporting education in schools, in the training of African welfare workers, and in the preparation of instructional materials and pamphlets that pupils in schools and welfare workers could refer to.”²⁵⁰ Shircore’s response reflected his evolving vision, articulated in 1927/1928, demanding government financial resources to be used by its Medical and Sanitation Department to build its own presence and legitimacy among Africans instead of depending on the medical missions’ agency. His response to the church’s request that the government could fund school education, training of African welfare workers, and preparing learning materials revealed the extent to which the colonial government was willing to support mission activities which would ultimately aid the government in its own agenda of directly reaching Africans through welfare interventions. For example, through education in schools, children would receive basic knowledge of hygiene, nutrition, infant care, and health. Welfare workers trained through mission efforts could potentially be employed by the government in its own welfare activities. Finally, the instructional materials and pamphlets produced by missionaries could be used in government welfare interventions and learning institutions. An important point to note in Shircore’s response is the refusal to fund the actual running and expansion of the mission medical work, in this case, construction of buildings, buying equipment, and paying nurses’ salaries. This refusal was in line with the government’s new effort to undercut and displace the influence of medical missions in

²⁴⁹ TNA 450/178/33 Moravian Mission (Moravian Church), 1927 – 1932
²⁵⁰ TNA 450/178/33 Moravian Mission (Moravian Church), 1927 – 1932. This government position is also stated in TNA 450/178/3, Grants to Missions 1927 – 1939.
welfare interventions so that it could build its own presence and justify its activities among Africans.

The government’s refusal to fund certain activities of medical missions was part of the shifting government priority which favored providing financial support for the training of African welfare workers at the expense of funding the actual running and expansion of mission health clinics. The government was ready, however, to fund missions’ training of African welfare workers who could potentially be employed in the government’s own welfare work. Communications between the British Church Missionary Society (CMS) and the British Colonial Medical Service provides evidence of these shifting priorities. In February 1936, Reverend Briggs, the Secretary of the CMS, asked Ralph. R. Scott, Shircore’s successor as the Director of Medical Services, to fund a grant-in-aid of £150 per annum to expand the mission health services to reach greater numbers of African patients. Scott’s response to Briggs’s request was emphatic:

… I think it more important from our point of view to develop the work at your central training [centres] … rather than to expand the general medical work of the mission at distant stations. The intention behind the grants which are made towards the provision of nurses is to obtain a supply of native midwives; and there is no doubt in my mind that this can be better accomplished at larger training centres where more clinical material and supervision are available than is possible at small isolated centres.251

Scott thus acted consistently with the policy that his predecessor, John Shircore, had established in the late 1920s. Scott made it clear that the aim of the government grant was not “to expand the general medical work of the mission.” The government’s unwillingness to fund this aspect of mission work aimed to limit the resources available

251TNA 450/ 108/22 Letter from Scott to Briggs, 19th may 1936, reference 108/22/86.
to missions for pursuing medical work among Africans. In addition, it is evident from Scott’s response that the fundamental objective of the government’s support was in the training of African midwives which Scott valued. The significance of the mission’s preparation of midwives is that the colonial government could ultimately employ some of them in its own welfare initiatives. This support to medical missions potentially enhanced the government’s own interest in building the basis of reaching African men and women in their homes and communities. In the ongoing communication concerning subsidies, Briggs was not convinced by Scott’s response. He wrote back asking whether the government would provide a £75 grant to serve the purpose. In his second letter, Briggs wrote:

I have no desire to be wearisome to you over this matter, but after consultation with the Bishop it has become increasingly clear that the mission can not drop the medical work it has been doing … without weakening to a dangerous extent the other missionary work …. I have suggested that as Native Authority (can not provide) the sum of £150 per annum, they might perhaps be able to make a smaller grant, and I have mentioned £75. May I venture to hope that although you felt the larger sum was not warranted, you will be able to approve of this lesser amount.252

Briggs’s letter suggests that medical and welfare work was critical not only for enhancing the welfare of Africans, but also for enhancing conversion of Africans to Christianity. For Briggs, medical and welfare work made it easier for Africans to accept the missionary message. This welfare work made Christian missions influential and grounded in the daily concerns of African communities. Indeed, Shircore’s and Gilks’s views (on medical missions reaping credit and influence from government financial support at the expense

252 TNA 450/108/22 Letter from Briggs to Scott, 26th May 1936, reference 108/22/98.
of the government) demonstrated their desire to undercut this growing missionary influence and power since it undermined the government’s own effort to build legitimacy and acceptance among Africans. Acting consistently with this new orientation, Scott refused again, acknowledging:

I note that the mission find that the medical work … can not be dropped, but I regret that I do not feel justified in asking the Native Authority to contribute to the extent you mention. \(^{253}\)

Briggs persisted, requesting that Scott rethink his refusal. In his third letter to Scott, Briggs wrote:

It would be a pity if maternity and child welfare work … had to be dropped so soon after its inception, and in the event of the mission being unable to continue supervision without financial assistance the situation should again be reviewed. \(^{254}\)

Scott’s subsequent reply restated his refusal, but also clarified the new direction being taken by the colonial government from 1928. He wrote:

My view is that more effective results can be attained by concentrating personnel in such a way that they can be used for training native hospital workers rather than in opening or maintaining small centres where the energies of highly trained European staff tend to be dissipated on minor work which can adequately be carried by native trained workers. I do not wish to criticize policy in this connexion, but the same principles apply to our own work, and we feel now that it is more important to lay sound foundations for future development by training Africans to the fullest extent possible rather than to expand the number of small stations served by non-native personnel. \(^{255}\)

Scott’s reply highlighted the colonial priority of training African personnel rather than opening new mission health centers or supporting their actual running. The reply reinforced the educational foundation that defined government welfare work during the

\(^{253}\)TNA 450/108/22 Letter from Scott to Briggs, 2\(^{\text{nd}}\) June 1936 reference 108/22/101
\(^{254}\)TNA 450/108/22 Letter from Briggs to Scott, 15\(^{\text{th}}\) June 1936, reference 108/22/103
\(^{255}\)TNA 450/22 Letter from Scott to Briggs, 14\(^{\text{th}}\) July 1936, reference 108/22/104.
late 1920s and in the 1930s. He made it clear that government funding would not support
the missions in opening new institutions of health or for expanding existing facilities. The
foundation for future development, evident in Scott’s letter, lay in training Africans on
welfare related matters. The thrust of this welfare work included teaching school children
about hygiene, infant care, and nutrition; training welfare workers who could be
employed not only in medical missions, but also in government institutions and
initiatives; organizing mothercraft classes; and in preparing instructional materials for
school children and for adults. The communication between Scott and Briggs, therefore,
reflected a shifting government priority towards funding the training of Africans to work
in the government welfare interventions rather than towards funding the actual running
and expansion of medical missions.

The government’s shifting priority was evident in its willingness to provide financial
support for the preparation of teaching and instructional materials by missionaries. For
example, two missionary sisters, Thecla Stinnesback and C. Archer Wallington, received
financial support to produce instructional materials for pupils which remained central
references in both government and mission schools. Stinnesback’s book, titled *Utunzaji
wa Watoto Wachanga (Infant Welfare and Mothercraft – Swahili)*, paid particular
attention to hygiene, infant care, and domestic science.256 The book was intended to
address socio-cultural influences on infantile illnesses, underlining that most infantile
illnesses and deaths stemmed from poor hygiene, filth, and parental ignorance on proper

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care and feeding. It aimed to teach children domestic sciences, such as cooking, gardening, hygiene, housekeeping, food preparation, and infant care. The idea behind domestic science was that training pupils on the cleanliness of the home, the compound, the latrine, a clean water supply, infant care, and nutrition would empower them in the future to maintain healthy homes, to bring up healthy children, and to prepare nourishing food. Commentators on children and women in the 1930s, such as Mary Blacklock, believed that domestic science of cooking, infant care, housewifery, mothercraft, character formation, and household management should be the foundation of health education in primary schools. Domestic science would help girls “… to consider wifehood and motherhood as noble occupations” and it would give boys and young men “… a higher idea of marriage and of the respect and consideration to be given to their wives.” Additional financial support went to Sister C. Archer Wallington who in 1943, published *Maarifa Yawapasayo Mama Katika Kutunza Watoto (Swahili: A Series of Lessons in Mothercraft).* Wallington’s assumption was that women were the bedrock of infant care and growth and that not only would the girls receiving that education turn out to be good mothers, but that they would also increase the pool of candidates from which to choose trainees for infant welfare work and nursing. The government, therefore,

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257 Three years after the publication of Stinnesback’s work, the colonial government released a syllabus for primary schools entitled *Muhtasari wa Mafundisho (Syllabus of Instruction)* in 1935. See Government of Tanganyika, *Muhtasari wa Mafundisho (Syllabus of Instruction)* (Dar es Salaam, Department of Education, 1935).


looked at the educational work of the medical missionaries as important for its own agenda of reaching men, women, and children, and was therefore willing to provide financial support to missionaries on this front.

The government’s objection to providing the medical missions with grants-in-aid indicated a shifting set of government priorities in relation to the provision of welfare services to the African population, including infant survival interventions. The government’s priority from the late 1920s privileged the training and educational component of medical missions rather than the actual running and expansion of mission medical centers. Reflecting on the statements and positions held by John Shircore, John Gilks, and S. Scott, together with the communications between medical missions and the government, we learn that the relationship between the colonial government and mission societies during the interwar period was limited to the government’s subsidizing missions in three activities only. First, the government was willing to subsidize medical missions in the training of African midwives and welfare workers, some of whom would eventually be employed in the government infant welfare interventions. Second, the government was willing to provide financial support to meet the cost of publishing Swahili literature on public health, hygiene, and infant care because these could also be used in the government education system. Third, the government was ready to provide missions with grants for education in primary and secondary schools because the government, like the mission, believed that the education of children would eventually result in the production of better mothers in the future: mothers who understood the
basics of infant care and growth.\textsuperscript{260} Historians have used these grants as evidence for a positive relationship and cooperation between the government and medical missions.\textsuperscript{261} However, as the examples of the Moravian Church and Christian Mission Society suggest, these grants disguised the important fact that the government was not willing to provide medical missions with the financial support for buildings, equipments, drugs, salaries, and the expansion of mission centers. The colonial government’s funding priorities worked to undercut missions’ influence and power among Africans. Subsidizing missions in the actual running of welfare centers, and thus empowering missions to reach deeply into African homes and communities, would undercut the government’s efforts to do the same in the period when the government intended to build its presence and acceptance among Africans, even in the rural areas. The government wanted to be physically present in rural communities and in homesteads by meeting with Africans in the social sphere that supported the foundation of African families and societies: the realm of infant survival. Jean Allman and Victoria Tashjian have aptly characterized the nature and character of this social sphere as “the world where children were born, the sick were healed, meals were cooked, babies were bathed, marriages were negotiated, deaths were mourned, and the next world was pondered.”\textsuperscript{262} The government could no longer leave this important field of public health in the exclusive hands of medical missions if it wanted to reach African homes and communities in the rural areas.

\textsuperscript{260}TNA 450/178/3 Grants to Missions 1927 – 1939.
\textsuperscript{261}See for instance the work of Allman and Tashjian, “I Will Not Eat Stone;” chapter 5. Vaughan, Curing Their Ills, Chapter 3; Bruchhausen, “Practising Hygiene and Fighting the Native Diseases;” Gaitskell, “Getting Close to the Hearts of Mothers;” Zucchelli, Medical Development in Tanganyika; Clyde, History of the Medical Services of Tanganyika; Schulpen, Integration of Church and Government Services in Tanzania.
\textsuperscript{262}Allman and Yashjian, I will Not Eat Stone, p.184.
It had to weaken and displace medical missions so that it could become the sole purveyor of these interventions.

3.4 Conclusion

The Tanganyikan colonial government produced its first infant welfare policy in 1925 as a means of reaching homes and communities and of building its own presence and acceptance among Africans. The policy reflected colonial assumptions which defined the problem of poor infant survival to be a product of maternal ignorance of proper infant care, feeding, and hygiene. Consequently, the government proposed educational interventions as the ultimate solution to alleviate the problem, and thus to set conditions for improving infant survival. There were larger motives behind the government’s interest in improving infant survival. First, the government sought to increase African populations to ensure a constant supply of cheap labor in colonial economic investments. This motive supports the position of Marxist and materialist scholars who have stressed the economic reasons for colonialism in Africa.²⁶³ Yet, by narrowing all explanation of colonialism to economic terms, these theories have failed to take seriously other factors at play, which I have discussed in this chapter. This chapter demonstrates that the colonial efforts to define the infant survival problem as rooted in maternal ignorance, and its proposed maternal education meant to transform African women from supposedly primitive to modern qualities, were integral to colonial efforts to impose medical and welfare hegemony in African colonial culture, and to impose European “scientific” ideas and practices on Africans. While recognizing the economic basis of colonialism in

²⁶³ See for instance, Doyal and Pennell, *Political Economy of Health*; Turshen, *Political Ecology of Disease*
Africa, this chapter reveals that the government’s intentions to build its own presence and acceptance among Africans motivated it to embark on infant welfare interventions.

For the government to use infant welfare programs to build its legitimacy and acceptance among Africans, it had to redefine its relationship with medical missions which had pioneered and dominated the field and on which the government had depended to provide health services to the majority of Africans, especially those living in the rural areas. The government redefined this relationship by refusing to provide financial support for the actual running and expansion of mission medical work because such support enhanced medical missions’ popularity and acceptance among Africans at the expense of the government. Refusal to provide these types of grants was part of the government’s plan to reduce medical missions’ popularity and influence among Africans. The government, however, did not stop all forms of financial support to medical missions. It continued to provide missions with funding for activities which directly benefited the government’s own welfare interventions, activities such as the training of welfare workers who could also be employed by the government, the education of children who learned the basics of mothercraft, hygiene, infant care, and nutrition, and the publication of teaching-learning materials which could ultimately be used both in medical missions and government institutions. In chapter four, I examine how peasants perceived the infant welfare workers and interpreted the colonial infant survival programs.
Chapter Four

Negotiating the Viability of Early Colonial Infant Survival Interventions, 1920 - 1940.

4.0 Introduction

This chapter examines how peasants engaged with the early colonial infant welfare programs that were exclusively preventive in the 1920s and early 1930s. Chapter three has shown that colonial government officials explained the infant survival problem in terms of maternal ignorance. In contrast to colonial officials’ views, peasant men and women perceived the problem in terms of the effects of colonialism in the 1920s and 1930s. The oral recollections reveal that peasants explained the infant survival problem in terms of increasing nursing mothers’ workloads, witchcraft, diseases, as well as periodic food shortages. They thought that increased workloads due to the absence of migrant men meant that mothers spent more time in agricultural fields than in nursing and breastfeeding infants at home during the day time. This development forced infants to rely on porridge as a primary source of nutrition. In addition, peasants pointed out that periodic food shortages affected maternal nutrition and reduced the amount of breast milk that mothers generated for their infants.

Peasants also claimed that witches affected the health and welfare of infants. They argued that the implementation of colonial Witchcraft Ordinances in the 1920s and 1930s, which outlawed witchcraft accusations, made it easier for witches to pursue their malicious acts against infants. Finally, peasants linked infant survival to diseases that brought premature
deaths, including malaria and pneumonia. For them, the absence of curative medical services in rural areas meant that parents had limited options when infants contracted diseases for which there were no effective indigenous medical cures. Taken together, these perspectives suggest that peasants considered the colonial governments’ focus on maternal ignorance as an insufficient explanation for the infant survival problem because it failed to consider the effects of maternal workloads, food shortages, witchcraft, and diseases.

This chapter argues that the different lenses through which peasants and colonial government officials saw the infant survival problem were manifestations of negotiations over the perceived causes of poor infant health and the viability of the early colonial welfare programs that were meant to tackle the problem. Peasants’ interpretations and critiques of the early colonial interventions formed the basis for their negotiations with welfare workers and chiefs in the 1920s and 1930s. This argument builds on chapter three to highlight the negotiated character of the early colonial infant survival interventions in the 1920s and 1930s.

The cumulative and mediated memories of African men and women who witnessed the implementation of the infant welfare programs as children or youths form the main evidentiary basis for understanding African engagement with welfare workers and chiefs. In addition, these reminiscences provide glimpses into the tensions and varied experiences within African communities and households, such as those between local chiefs and commoners over witchcraft, between migrant men and wives over household
labor, between older mothers and young welfare girls, and between civil servants and poor peasants over food security. These tensions and variations reveal that Africans were not homogeneous.

This chapter has three sections. The first section briefly describes the political economy of southwest Tanzania during the 1920s and 1930s. This period was a time of consolidating British colonial rule through the creation of indirect rule, the development of labor migration, and peasant production of coffee and rice. Periodic food insecurities were also common during these decades. Understanding these political, economic, and social developments is important because they formed the lenses through which peasants interpreted the viability of early colonial welfare programs. The second section examines how the colonial government used welfare workers to implement infant welfare policies in rural communities. It analyzes the social composition of the workers, their training, the medical advice they propagated, and how peasant men and women perceived them. The third section examines peasants’ critiques and evaluations of the early welfare programs. Through these critiques and evaluations, the section uncovers the social relationships between peasants, welfare workers, and chiefs that evolved during the 1920s and 1930s.

4.1 Historical Context of the 1920s and 1930s

The 1920s and 1930s were decades characterized by the consolidation of British colonialism in Tanzania. This section outlines the political, economic, and social developments that shaped peasants’ interpretation of the early welfare programs.
Politically, the colonial government buttressed the position of local chiefs and made them their agents in implementing welfare policies. As I underscored in chapter three, the colonial government organized African communities into “tribes” and placed each under its chief in order to engage Africans in the administration of colonial affairs and as propaganda for democratic governance. Chiefs held executive and political functions. Chiefs collected taxes from subjects, oversaw the native courts, and administered rural development projects such as peasant agriculture. Moreover, chiefs implemented various laws, including the controversial Witchcraft Ordinances that I will discuss in the third section of this chapter. Finally, the colonial government charged the chiefs with the daily oversight of welfare workers in their areas of jurisdiction.

Economically, the 1920s and 1930s witnessed the development of labor migration and peasant production of coffee and rice as commercial crops. Opportunities for colonial labor migration began in the early 1920s with the opening of the Lupa goldfields in the southern highlands, the need for more labor in the sisal plantations on the coast of Tanzania, and the influx of labor recruiting agents for copper fields in Northern Rhodesia and mining in South Africa from the 1930s. According to the Rungwe District Annual Report for 1923, for instance, approximately 700 men were recruited from Rungwe to the Lupa goldfields; and 2123 people were recruited by Messers Bird Company of Pangani sisal plantations on the coast. R. de Z. Hall, who investigated local migration in Rungwe district, noted that in 1932, almost 34% of migrant laborers at the Lupa

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264 TNA, Rungwe District, Annual Report for 1923, p.18
goldfields were men from Rungwe district; and that by 1939, laborers from Rungwe to the Lupa goldfields and coastal sisal plantations were about 25,000 or 77% of the 33,000 tax payers in the district.265 These figures imply that around 25,410 men out of 33,000 traveled outside the district, thus leaving only around 7000 male tax payers.266 Apart from this internal migration within Tanzania, people from Rungwe participated in international migration to the copper fields in Northern Rhodesia and to the mining complexes in South Africa and in Southern Rhodesia. The Political Officer of Rungwe district estimated that about 15,000 men traveled to Northern Rhodesia and South Africa, excluding those who traveled independently without being officially counted.267

Labor migration was sex selective, and it favored men. In their four-year extensive ethnographic research in colonial Rungwe district in the 1930s, Monica and Godfrey Wilson witnessed the imbalance between men and women as a result of the formers’ absence due to labor migration, concluding that “[a] characteristic of the Nyakyusa population, at least since 1931, has been the preponderance of women.…”268 While many women in Zimbabwe, Angola, and Zambia followed their husbands to the mining or plantation centers or migrated on their own initiatives,269 women in colonial Rungwe

265 Reported in TNA, Rungwe District Book, 1939, MF 2.
267 TNA 18/L1/20. Rungwe District, Correspondences.
268 Monica Wilson, For Men and Elders, p.75
district remained in the rural areas, and no evidence for female labor migration has been identified to date. As Monica Wilson noted in the 1930s, “…Nyakyusa women, other than prostitutes, rarely traveled: indeed for a man to insist on his wife accompanying him abroad was regarded by Nyakyusa women almost as a ground for divorce.” Women remained at home.

Peasant commodity production of coffee and rice also began in the late 1920s. The colonial administration promoted coffee production among Rungwe and Bundali highland and required each household to cultivate them. In the plains of Lake Nyasa, the government promoted rice production for export to the Lupa goldfields. These colonial campaigns made rice and coffee the major peasant cash crops produced in colonial Rungwe district during the interwar period. The absence of men due to labor migration meant that the production of coffee and rice depended on women’s labor. Work in coffee and rice farms diverted the labor needed for food production. According to one of my interviewees, Steven Mogha, women labored on coffee farms, producing crops whose


271 Wilson, For Men and Elders, p.18. Wilson, however, acknowledged that this pattern was shifting towards women’s migration by the 1950s. It is not clear from her work why this shift happened.
fruits were inedible. Moreover, coffee was only useful in terms of generating cash for meeting tax obligations.\textsuperscript{272} Another informant, Nikubhuka Kashiliiliki, pointed out that although rice is a food crop; its commercial value meant that after harvesting, people sold most of the rice they harvested, exposing themselves to periodic food shortages.\textsuperscript{273} Coffee and rice helped people meet the colonial government’s tax obligation, but had adverse consequence for ensuring food security. Jengapho Kamwela argued that “women coped with increased workload through \textit{imbalila} (work parties), use of child labor, and use of relatives whenever possible, but these initiatives did not eradicate the basics of increasing workload that women experienced due to absence of men.”\textsuperscript{274}

Periodic famines and food insecurities also dominated the interwar period. Colonial nutrition studies conducted in Tanganyika during the 1930s, for instance, showed that many households lacked enough food to sustain them throughout the year, that the local diet was poor in basic nutrients, and that undernourishment was a common experience in many households.\textsuperscript{275} The government reports on food shortages in southwest Tanganyika found that families faced acute food shortages during the last months before the new

\textsuperscript{272} Steven Mogha, Interview at Kafule, July 30, 2006.
\textsuperscript{274} Jengapho Kamwela, Interview at Ngumba, September 3, 2007
\textsuperscript{275} The following studies made these observations; R.R. Scott, \textit{Preliminary Survey of the Position in Regard to Nutrition among the Natives of Tanganyika Territory} (Dar es Salaam, Government Printer, 1937); Veronica Berry, ed. \textit{The Culwick Papers 1934-1944: Population, Food and Health in Colonial Tanganyika} (London, Academy Books, 1994). See also the study by Marylin Little, “Native Development and Chronic Malnutrition in Sukumaland, Tanganyika, 1925-1945” (PhD Dissertation, University of Minnesota, 1987).
harvests, especially from December to March. These reports, which investigated both the famine and non-famine years in the 1930s and 1940s, noted that the perpetual conditions of food shortages made many men leave their families to go to the coastal sisal plantations to get money for buying food. Food insecurity, nutrient deficiencies, and hunger in many households received attention in the colonial reports of the late 1930s.

The political, economic, and social developments that I have charted set the background for understanding peasants’ interpretations of the colonial infant welfare programs. These developments were lenses through which peasants evaluated the contextual relevance, significance, and viability of the programs and their social relationships with local chiefs, welfare workers, and colonial government officials. Before I examine these negotiations, I will analyze the colonial government’s implementation of the early policy programs and examine the tensions that developed between the welfare workers and elder pregnant women and nursing mothers.

4.2 Taking the Colonial Policy into African Homes and Communities.

This section examines government’s implementation of infant welfare policies in rural homes and communities. Because of the small number of European medical personnel in the colony, the government depended on the work of trained African welfare workers to

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276 Tanganyika Territory, *Native Affairs* Vol 1; TNA File 22546 Vol. 1 (1934-36) and Vol. 11 (1942-50), Food Shortages in Iringa Province.
278 Tanganyika Territory, *Native Affairs* Vol 1; TNA File 22911 Vo. 1(1935) and Vol. 11 (1940), Native Diet and Rural Sanitation. For similar conditions in the early 1940s, see Tanganyika Territory, *Native Affairs*, TNA File 30071 (1941-46), Annual Reports on Native Food Supply.
implement welfare programs. These workers advised mothers on infant care, feeding, and hygiene in the welfare centers as well as in the homes of expectant and nursing mothers.

The challenge in implementing infant survival interventions concerned getting the right candidates to run the welfare centers and to elicit the confidence of African women, whom colonial authorities had perceived as ignorant, timid, and conservative in the early 1920s. Colonial government officials considered the young, western-educated girls who could read, write, and follow the instructions received during training to be better candidates to pursue infant welfare work than the older women. N. H. Maynard of Shinyanga, for instance, argued that

… any venturing along this line should be through girls who are not yet deeply contaminated by native customs, as are all mature women. These girls will soon be women and in the meantime can have inculcated in them a measure of proper care of mothers, as well as infants and young children…. 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.

Maynard's argument underlined the colonial perception that the ignorance of African mothers was the cause of poor infant survival. Maynard thought that girls were a reasonable option precisely because, unlike older women, they were “not yet contaminated by native customs.” Maynard emphasized that despite the youthful age of these girls, women would respect them because of the skills and training they would acquire.

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280 TNA 10409, Training of Native Midwives, Village and Welfare Workers, 1927, vol.1
281 Ibid.
Colonial archival records indicate that other colonial officials supported Maynard’s proposition. For example, A. H. Owen, the acting Director of Medical and Sanitation Services, echoed Maynard’s proposition by arguing that girls’ training would give them social standing and power “to overcome the opposition of the grandmothers and the older members of the tribe.” An anonymous colonial official supported the idea of training girls by pointing out that

…it is far better to train girls, many of whom we admit may not agree to continue the work when they are married but at any rate they will become useful mothers and if we do fail to retain the services of all of them we can at any rate console ourselves with the fact that some useful and intelligent mothers have been given to the community.

Thus, colonial officials viewed the training of girls, not older women, as a foundation for improving maternal infant care and alleviating an infant survival problem.

The colonial government officials produced three directives that set the groundwork for infant welfare work. The first directive involved starting instructional programs to train “native” girls in the art of child rearing where a certain number of girls from each district would be sent to undergo a simple course for a few months. The other was that as soon as these girls were proficient in the ordinary elementary principles of child rearing, they would be employed in instructing and assisting mothers in child care in their natal

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282 TNA 450/108/10 Acting Director of Medical and Sanitation Services to Chief Secretary and Provincial Commissioners, 5/4/1927, p. 3. Same document found in TNA 10409 Training of Native Midwives and Village Welfare Workers, 1927-1929

283 TNA 10409: Training of Native Midwives and Village Welfare Workers, 1927-1929

284 Actually it was H.C.Stiebel who first proposed these arrangements and then the colonial government adopted them. See H.C.Stiebel to Director of Medical and Sanitation Services. This letter, written in 1923, is filed in TNA 450/108/9 Maternity and Child Welfare General, ref. 93/2/1 that generally has documents from 1928 to 1936.
The third arrangement required local chiefs to keep statistics of births and deaths and submit returns monthly. The areas in which deaths did not decrease would be visited and inquiries instituted by a member of the more skilled medical staff. By placing local chiefs in the infant welfare programs, the colonial government situated the welfare interventions within the politics of indirect rule that, as I mentioned in the previous section, took shape in the 1920s.

In colonial Rungwe district, the District Officer worked with local chiefs to identify suitable girls who could attend the training for three months at the district hospital in Tukuyu. The first batch of candidates consisted of three girls: Tupilike Mshani from Malangali aged seventeen, Tusumigwe Mwakatumbula from Kapugi aged nineteen, and Ipyana Mwandemele from Kyela also aged seventeen. These candidates shared certain characteristics: they were still girls, they read and wrote in Kiswahili, and they had already attended some schooling. In addition, they were fluent in the local languages, Kindali and Kinyakyusa, allowing for easy communication with mothers. Colonial officials believed that these biographic qualities would enable women to accept them.

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285 Ibid.
286 Ibid. Throughout my research, I was unable to locate records that chiefs may have prepared in response to this directive.
287 TNA 10501, Circular on Training Welfare Workers, 26th May, 1927, p. 6
288 TNA 450/108/9 Maternity and Child Welfare General, ref. 93/2/16
The training took place from January to March in 1927 at the district hospital in Tukuyu. The main theme of the training concerned infant care, feeding, and hygiene.\textsuperscript{290} The training integrated theoretical and practical instruction. Occasionally, the trainers borrowed babies, whom they used for practical demonstrations of skills such as bathing, caressing, and protecting them from cold.\textsuperscript{291} Other practical training included preparing food for children, maintaining hygienic homes, and personal cleanliness of mothers, including the necessity of washing breasts before allowing the baby to suck. They also received training on the use of weighing scales to monitor the progress of infants and how to keep records on the children.\textsuperscript{292} An important point to note about this training is that it prepared welfare workers in basic preventive medical interventions. The training did not prepare these girls to practice curative medicine or engage in elementary diagnosis and treatment of illnesses and diseases.

Effective implementation of the infant health policy in the rural communities began in 1927/1928 with the opening of three infant welfare centers: the first at Kapugi in the highlands of Rungwe; the second at Mwaya in the plains of Lake Nyasa; and the third which opened in 1928 at Malangali in the Bundali highlands.\textsuperscript{293} In 1935, the District Political Officer reported that the total number of welfare centers was nine, and that a total of twenty-three girls had received training.\textsuperscript{294} The Officer pointed out that some of these girls did not have a particular welfare center, and that they advised expectant or

\textsuperscript{290} Ibid.
\textsuperscript{291} Ibid.
\textsuperscript{292} My efforts to find records that welfare workers may have kept was not fruitful.
\textsuperscript{293} TNA 27/3, H. MacAllan, District Political Officer of Rungwe to PC Iringa Province.
\textsuperscript{294} Ibid.
nursing mothers by visiting them in their homes.\textsuperscript{295} The physical structures of these welfare centers were simple, and although they were similar to the houses of surrounding communities in architecture, they had relatively bigger windows than indigenous houses to enhance ventilation.\textsuperscript{296} The architectural similarity between infant welfare buildings and the ‘native’ houses was a product of the vision of John Shircore, the Director of Medical and Sanitation Services in the territory. Shircore proposed that infant welfare centers be built according to the model of locally existing buildings as a strategy of making them more acceptable to the indigenous population than if they were constructed in the modern European style. In his justification for this structural design, Shircore argued that “[t]he 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 (European style buildings).”\textsuperscript{297}

A number of my interviewees witnessed welfare workers advising mothers on infant feeding, hygiene, and other preventive medical programs necessary for healthy child development. Elizabeth Kajange, for instance, recalled one incident,

I was present when Tupilike [Mshani] came to our home. She came home the first day that my mother gave birth to Ndondwa, my young sister. She was accompanied by a person whom we were told was a person of the government [African chief]. She talked so much about holding an infant, and bathing a baby. She also talked about cleaning the house all the time, removing all the dust,

\textsuperscript{295} Ibid.
washing hands before holding a baby, and keeping the baby warm. When she finished talking with my mother, she weighed the baby on a machine.298

Other recollections on the work of these welfare workers came from Tumulikeghe Swilla. She recalled,

Mothers took infants to the centers. Welfare workers showed them how to bathe their children. They also practiced how to prepare porridge for infants who were old enough to eat food. And then Tupilike would weigh all the infants, record the weight in the paper. She would be angry if the weight was less than the preceding recorded weight. She would report you to the chief. Mothers were afraid to be reported to the chief.299

These interviews reveal that advice on infant feeding, home cleanliness, and personal hygiene were important components of the instructions that mothers received from infant welfare workers during the implementation of early infant welfare programs. Kajange’s reminiscences reflected welfare work in the homes while those of Swilla were about work in the welfare centers.

Welfare workers’ practical demonstrations of infant care have left marks in the reminiscences of men and women I interviewed. Sikanyagha Kibona, for instance, recalled that welfare workers “called upon mothers to wash infants in the basins instead of simply pouring water onto the baby, to bathe infants with soap and not with water alone, and to apply ointment to infant bodies after bathing them.”300 She emphasized that “sometimes, welfare workers made practical demonstrations on how best to use basins,

298 Interview with Elizabeth Kajange, Kafule, May 5, 2007. Recall that Tupilike Mshani was one of the first infant welfare worker in colonial Rungwe who opened Malangali infant welfare center in Bundali.
300 Sikanyagha Kibona, Interview at Kafule, May 29, 2007
soap, and ointments.” Commenting on these welfare demonstrations and advice, Mwamuleghe Kamwela reflected,

…. Today everybody can buy soap, ointments, powder, and other necessities for infants. But in the past it was not easy to get them. Following this advice was expensive. Parents did not have money to buy the things they advised. Unfortunately, welfare workers discouraged people to use *inyemba* [this was a locally made ointment, made from fruits called *ishunguti*] which people used as ointment after bathing infants. They [welfare workers] said that *inyemba* were dirty and unhygienic for infants. Mothers listened to their advice, but they did not have the money to buy those goods.

While Mwamuleghe underscored that it was expensive for parents to buy the basins, soap, or ointment, Kaswashi Pwele indicated that buying them was not a big issue for some households. He reminisced,

People who had money, like the teachers, chiefs, and court clerks could easily buy them. They could buy soap or ointment on a regular basis. But what about the poor people who were struggling to find food or to pay taxes? It was difficult for the poor to have money to buy these needs. It would have been easy if welfare workers distributed those needs to every family. Then it would be very easy to implement the advice. Mothers listened to their advice on buying ointments, but many mothers who were not able to buy them continued to use *inyemba*.

Pwele, therefore, highlighted social differentiations and variations in how households holding different socioeconomic positions had different chances of implementing the advice that welfare workers propagated. For him, it was easier for the rich, such as teachers, to buy materials that welfare workers advised than for the poor parents who struggled to meet the basic subsistence needs of their households.

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301 These sorts of medical demonstration were also common in the colonial welfare work among the Asante in colonial Ghana, in West Africa. See for instance, Jean Allman and Victorian Tashjian, “I Will Not Eat Stone:” *A Women’s History of Colonial Asante* (Portsmouth, Heinemann, 2000), pp.186-208
302 Mwamuleghe Kamwela, Interview at Kafule, May 23, 2007
303 Kaswashi Pwele, Interview at Kapelekesi, September 5, 2007
The oral recollections further suggest that weighing infants and keeping weight records was important work that welfare workers performed. As Tumulikeghe Swilla emphasized,

Weighing machines in the welfare centers was a new method introduced during these programs. Welfare workers used them to track the weight of infants. They put an infant on the weighing machine, read the measures, and wrote down what they saw. They put much emphasis on weight.\textsuperscript{304}

Another interviewee, Mwamukono Kajange, argued that the weighing machine was a new method of understanding how infants were growing. He recalled that before the introduction of the weighing machines, “parents tracked the progress of infants by observing their changing body physique” and that “the physical emaciation of infant body and general body weakness were signs that the child was not in a good condition.”\textsuperscript{305}

Nevertheless, parents did not simply look at the physical appearance of infants as Kajange suggested. As Erika Kibona argued,

People possessed a knowledge that allowed them to look at an infant and to diagnose whether it was happy, unhappy, or sick. They observed an infant’s movements, smiles, cries, and laughs. They could tell from these actions whether an infant was well or not. Later on, the Europeans brought the weighing machines and welfare workers read the progress of infants in the machines.\textsuperscript{306}

While Kibona presented a romantic description of the ability of Africans to monitor infant progress, she also hinted at the introduction of weighing machine in the rural communities.

\textsuperscript{304} Interview with Tumulikeghe Swilla, loc.cit.
\textsuperscript{305} Mwamukono Kajyange, Interview at Chija, May 11, 2007.
\textsuperscript{306} Erika Kibona, Interview at Lupembe, May 22, 2007
Some Colonial officials were concerned with the ability of infant welfare workers, who had attended three months of training, to manage welfare work in remote areas without adequate supervision from qualified European nurses or doctors. The Political Officer in Rungwe lamented in 1929 that due to transport problems it was difficult for a District Medical Officer or Sanitary Inspector at Tukuyu district hospital to regularly visit the infant welfare centers located away from the district headquarters, citing Malangali welfare center as an example.\(^\text{307}\) The Provincial Commissioner (PC) of the Northern Province showed similar concerns when he informed the Director of Medical and Sanitation Services an the Acting Chief Secretary that he could not view without apprehension an institution (infant welfare center) of this nature which was not under adequate professional supervision. The PC pointed out that the work was so important for the future of the “indigenous” population that it could not be left to “natives” without close supervision of well trained European nurses.\(^\text{308}\) In particular, the PC called for the possibility of stationing European qualified nurses to supervise these infant welfare centers, instead of leaving them to “native” welfare workers alone. The Chief Secretary, however, was against the idea of stationing European nurses in the remote rural areas, arguing that

To send a European lady to live in a temporary house remote from other Europeans whose work would be entirely amongst natives would in many cases be nothing less than cruelty and would probably result in a complete nervous and mental breakdown. The only ladies suitable for work of this nature are those who have lived for sometime in Africa and have acquired a knowledge of the native,


\(^{308}\)PC of Northern Province to DMSS and Acting Chief Secretary, TNA450/108/10 Mbulu Maternity and Child Welfare Clinic, 1927.
his language and customs and who like working amongst them. I believe that even the missionary societies do not station sisters in any station alone.\textsuperscript{309}

The Chief Secretary’s argument means that the colonial government relied on African welfare workers to propagate its ideas and practice of infant care in the rural areas. As Megan Vaughan has noted in her study of colonial medicine in Eastern and Central Africa, “(t)he agents of public health encountered by most villagers were not the white medical officers (of whom there were very few), or even the white administrators (though these did make an appearance when a crisis occurred) but rather African agents of the colonial sanitary state.”\textsuperscript{310} Vaughan’s argument resonated well with the experience of medical interventions in colonial Tanzania where rural communities received the welfare programs through the work of African welfare workers.

The responsibilities that welfare workers shouldered raise an important question: how did pregnant and nursing mothers in the 1920s and 1930s perceive welfare workers? Oral recollections suggest that their perceptions were not uniform. Asked how mothers thought about the welfare workers, Malita Masebo, who attended Malangali center soon after marriage during the Second World War, responded,

Welfare workers were doing an important job. The instructions were good and useful for the lives of mothers, infants and family. We had learned some of the things they were teaching us in the schools as girls. Going to welfare centers was like going to school. We liked them. Not using their services was a sign that you were still ignorant and uneducated. We did not want to appear as ignorant.\textsuperscript{311}

Bomani Kibona echoed some of Malita’s reminiscences by pointing out that

\textsuperscript{309} DMSS to PC Notrthern Province, TNA450/108/ 10 Mbulu Maternity and Child Welfare Clinic, 1927.
\textsuperscript{310} Megan Vaughan, \textit{Curing their Ills: Colonial Power and African Illness} (Stanford, Stanford University Press 1991), 43
\textsuperscript{311} Malita Masebo, Interview at Kafule, May 28, 2007
Some people felt very proud talking to welfare workers. They followed their advice. Following the advice of welfare workers indicated that you were a modern woman [mwanamke wa kisasa] and an up-to-date mother [mama wa kileo]. It was a sign of civilization [kustaarabika] and that you were educated. People liked to appear that way.\(^\text{312}\)

A close reading of these memories shows that a particular segment of African women, notably those who had attended some schooling, perceived the welfare workers positively. For Kibona and Masebo, talking to the welfare workers or following their advice was an indication of being educated, of being a modern woman, and of being a civilized person. As Sindondile Swilla recalled, “people who had gone to school liked welfare workers whose advice resonated with education that they had learned schools.”\(^\text{313}\)

While the educated Africans looked at welfare workers as an indication of modernity in their communities, some of my interviewees emphasized that welfare workers were not popular among African Christian converts. Christians preferred missionary nurses who combined preventive services with the treatment of infantile illnesses in medical missions’ welfare work. Many people recalled the missionary nurse called Elise Scharf, whom they nicknamed Tusekile [meaning we are happy with you].\(^\text{314}\) Another missionary nurse, Imgard Wolf, joined Scharf to continue with social welfare and evangelical works in the 1930s.\(^\text{315}\) According to Bomani Kibona, these missionary nurses built friendly relations with Christians at Isoko, visited Africans in their homes, treated patients at the

\(^{312}\) Bomani Kibona, Interview at Kafule, July 4, 2006
\(^{313}\) Sindondile Swilla, Interview at Isoko, July 3, 2007
\(^{315}\) *Ibid.*
dispensary, and committed their lives to the care of children and mothers.316 For Christian converts, following missionary advice and instructions on infant welfare “was part of religious faith” on issues that [Elise and Imgard] advocated.317 Another interviewee, Agnes Kashililika, pointed out that

Christian mothers internalized infant welfare work within the Christian religious life, believing that God would protect infants and make them immune from the dangers that witchcraft, sorcery, and the wrath of ancestors posed. Christian mothers thought that government’s welfare workers was not anchored on the power of God and thus lacked the ability to protect enhance the welfare of infants.318

In addition, Mbokile Swilla echoed Kashililika’s recollections,

Christian women could not value welfare workers in the same way that they valued the missionary nurses because for them, missionary nurses combined welfare advice and religious teachings of God that were necessary for the welfare of infants. This made Christians perceive missionary nurses as more superior than government welfare workers.319

These oral memories reveal that Christian mothers were less comfortable with the government welfare workers because, unlike European missionary nurses, they did not integrate medical work with religious belief in enhancing the welfare of infants.

A third category of Africans perceived welfare workers in terms of their age. Although the colonial government thought that young girls were appropriate for implementing the welfare programs, one of my oral interviewees, Elizabeth Mogha, indicated that some African mothers questioned the welfare workers’ young age to deal with the intricacies of childcare. She recalled,

316 Bomani Kibona, Interview at Kafule, July 4, 2006.
317 Ibid.
318 Agness Kashililika, Intervie at Isongolo, June 26, 2007
319 Mbokile Swilla, Interview at Isegelo, September 25, 2007
... The problem is that welfare workers were young girls, not married, without any experience with what it meant to give birth when you did not have a husband to help you. They did not know the sufferings of mothers.\textsuperscript{320}

Tufingene Swilla echoed these memories when she pointed out that

The welfare workers were inexperienced with matters of children. You see, they were just young girls. They were not even married. They did not have the experience of being married, of giving birth, of raising children. How could elders take them seriously? Until someone is married, she is simply a child. Can a child provide advice on raising children to her mother? It was astonishing to have these girls advising their mothers.\textsuperscript{321}

Another oral interviewee, Fumbachisu Songa, reminisced,

They were young girls. People had to listen to them because they were brought by the government and they were usually in the company of chiefs or chiefs’ assistants. That is why people listened to them and attended the clinics. The government required people to participate in the welfare work. But people did not think that those young girls were the persons to advise them on how to take care of children.\textsuperscript{322}

Taken together, these recollections raised two interrelated issues. First, welfare workers and the message they propagated were somehow detached from the daily lives of women and mothers in the households and communities of colonial southwest Tanzania in the 1920s and 1930s. Secondly, welfare workers were young girls, inexperienced, and unaware of the challenges that women and nursing mothers faced in the 1920s and 1930s. The reminiscences reveal that mothers were uncomfortable with young girls advising them on intimate questions of pregnancy, giving birth, and the raising of children. Mothers’ concerns must be understood in a historical context. Theodor Meyer’s and Duncan Mackenzie’s ethnographic works in the late nineteenth century and early twentieth centuries indicate that midwives who performed reproductive and procreative

\textsuperscript{320}Elizabeth Mogha, Interview at Kafule, September 16, 2007
\textsuperscript{321}Tufingene Swilla, Interview at Kafule, June 1, 2007
\textsuperscript{322}Fumbachisu Songa, Interview at Isegelo, September 16, 2007
roles in the communities during this historical period were usually older women, experienced, and respected members of the communities. Understood in this context, my interviewees showed that women of the 1920s and 1930s considered the practice of the colonial government to use young girls in infant welfare work as inappropriate and unacceptable.

4.3 African Engagement with Colonial Infant survival Interventions in the 1920s and Early 1930s

This section examines how peasant men and women engaged with the message that welfare workers propagated in their communities, and how this engagement revealed negotiations and tensions within peasant communities. Peasants evaluated the viability of infant welfare programs through three lenses: the implementation of Witchcraft Ordinances in the context of indirect rule, periodic food shortages, and women’s growing labor burdens due to men’s labor migration.

Africans were skeptical of the colonial welfare interventions pursued simultaneously with the government’s implementation of the Witchcraft Ordinance. The British colonial government issued the Witchcraft Ordinance in 1922. The Ordinance, which essentially made witchcraft accusations illegal, defined witchcraft as nothing more than evidence for the barbarous, superstitious, primordial, and illusory nature of African beliefs. One of its articles stated that “Whoever … names or indicates any person as being a witch or

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wizard by imputing to him the use of witchcraft with a malignant intent to cause injury or misfortune to any person or class of persons or to cause injury to any property shall be guilty of an offence against this Ordinance.”

In 1928 the government revised the ordinance and stipulated that it would “punish anyone who declares someone else to be a witch acting with intent to cause injury, with seven years imprisonment and a fine of two hundred pounds.” The government required African chiefs to implement the Witchcraft Ordinance by tracking people who accused others of being witches in their areas of jurisdiction.

For some African men and women, the colonial implementation of the Witchcraft Ordinances compromised the viability of the government’s interventions to bring improvements to infant survival. As Ngubhombeleghe Swilla recalled,

The Europeans were bad. They said that witchcraft was an illusion. They prohibited accusing other people of witchcraft. They imprisoned or fined people who accused others of bewitching children. People were now afraid to deal with cases of witchcraft. Now, how can you regard people who defend witches and sorcerers as helping to protect children? They (the Europeans) were actually a problem.

Swilla’s reminiscences blamed the government for outlawing witchcraft accusations which Africans used to check malicious activities of witches. Likewise, Kuchoto Mogha interpreted the ordinances as evidence that the colonial government protected the witches. He pointed out that “outlawing witchcraft accusations entailed mutual collaboration and

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325 Tanganyika Territory, An Ordinance to Provide for the Punishment of Persons Practicing or Making Use of so Called Witchcraft, No.39 of 1922.
327 Ibid.
partnership between the colonial government and witches.”329 Another interviewee, Menani Ndimbwa, amplified this argument by claiming that

The problem with the colonial government is that it was against the practice of publicly identifying and accusing witches. Accusing witches in public was a very important method which our forefathers used to protect children from the harming effects of witches. And then these colonialists came and said it was illegal to accuse other people of witchcraft. When they did that, they increased the dangers for infant health.330

These recollections show that the government’s implementation of the Witchcraft Ordinance undermined the potential of colonial interventions to improve infant survival because they increased the freedom of witches to act against children. Numenye Mwotela highlighted this perception in her recollections that “people used witchcraft accusations to check malicious activities of witches that harmed children” and therefore “the implementation of the laws that prohibited people to expose and accuse witches reflected the government’s failure to address long held fears that witches were responsible for illnesses and deaths of infants.”331 Furthermore, these reminiscences reveal that the colonial government and Africans held different views over witchcraft. Whereas Africans considered witchcraft a threat to infant survival, the government denied its existence. These differences were not unique to colonial Tanzania. Karen Flint has shown that in South Africa, “African communities sought to discover and expose those who practiced [witchcraft], while whites aimed to protect the accused and prosecute accusers.”332

329Kuchoto Mogha, Interview at Chija, June 22, 2007
330Menani Ndimbwa, Interview at Isongole, October 8, 2007
331Numenye Mwotela, Interview at Isongolo, June 26, 2007
The disturbing part of the implementation of Witchcraft Ordinances for some peasants was that fellow Africans, particularly local chiefs, helped to enforce them. As Mbonisye Kashililika argued,

People understood that one of the significant dangers to infant survival was witches and sorcerers believed to have interest in tender infant flesh and blood. Before the white men came, people had a mechanism to deal with witches. Witches could be accused, and the chief could ensure that an ordeal was administered to prove whether the accused was innocent or guilty. Witches could not freely harm infants as they lived in constant fear of their malicious acts being discovered. But when the British came, they made witchcraft accusation illegal. They prohibited witch-finding, they criminalized healers who administered ordeals, and the malafyale (local chief) was required to report witchcraft-related accusations so that legal measures could be processed. Outlawing witchcraft accusations produced a fertile ground for witches and sorcerers who endangered the lives of infants because they began to operate without fear.333

The changing role of chiefs in relation to handling witchcraft under British colonial laws was also evident in Mwatabhika Swilla’s memories. Swilla recalled,

Even before colonialism our chiefs were the guardians of the welfare of infants. One of his responsibilities was to protect his subjects from the malicious actions of witches. Chiefs handled witchcraft accusation cases and administered mwafi to prove whether the accused suspect was innocent or not. But now chiefs were cooperating with the colonial government to protect witches. There was no one to protect children or adults. The chiefs became puppets of the colonial government. People did not like the actions of chiefs.334

Taken together, these reminiscences reveal that the chiefs’ implementation of the colonial Witchcraft Ordinances was a departure from what peasants had historically expected local chiefs to do in relation to witchcraft. People expected their chiefs to coordinate meetings for trying suspected witches to establish whether they were innocent or guilty. Swilla’s and Kashililika’s recollections uncovered uncertainties on the role of local chiefs in safeguarding the welfare and health of infants in the context of the colonial

334 Mwatabhika Swilla, Interview at Kafule, May 20, 2007
implementation of witchcraft legislations. In addition, they reveal tension between chiefs and their subjects as the later questioned the engagement of the former in implementing colonial prohibition of witchcraft accusations.

African mothers thought that the early welfare programs failed to address the threats that witchcraft posed to the welfare of their infants. As Numenye Mwotela recalled,

> Welfare workers talked extensively about hygiene, cleanliness, and good nutrition for infants. They emphasized that these brought many infant deaths. They talked about these problems every time they met mothers in welfare centers, in streets, and even in funeral ceremonies. However, mothers were very much worried with witches who ate infant flesh and blood, who suffocated infants to death. But welfare workers never talked about witches. Saying publicly that witches could cause infant illness and death was illegal.\(^\text{335}\)

Fumbachisu Songa echoed Mwotela’s reminiscences when he pointed out that

> …the government would be helpful if it did not interfere with our methods of dealing and disciplining witches. The nurses talked about infant care, but how can good care help if you do not have a way of protecting infants from witches. Witches had spiritual powers and they preferred small children who could not complain of illnesses. The colonial government was protecting them. It reached a point even our own chiefs were helping the colonial government to protect witches. They were difficult times.\(^\text{336}\)

These memories reveal the debates over the causes of infant survival problem between peasants and the welfare workers. While welfare workers and colonial officials emphasized the role of maternal ignorance in producing the problem, peasant men and women thought that witchcraft was an equally important determinant of infant health.

\(^{335}\) Numenye Mwotela, Interview at Isongolo, June 29, 2007.
\(^{336}\) Fumbachisu Songa, Interview at Isegelo, September 20, 2007
Periodic food shortages were also at the center of my interviewees’ skepticism over the viability of colonial measures to improve infant survival. Two famines occupied the memories of men and women on infant survival. The first famine struck the region from 1923 to 1924 as a result of rain failures during the planting season. This famine warranted only a passing reference in the Rungwe District’s Annual Reports, but it remains a central recollection for African men and women’s interpretation of colonial infant survival interventions. Elders in the region remember this famine as isala jya ngungula (the famine of coroms) because people depended on banana coroms as the staple diet during this time. Kwikoshi Masebo, who experienced this famine as a young boy, produced the following recollection of the famine of coroms.

It was a difficult time. Rain did not fall and so people did not plant maize, beans and finger-millet. Planted seeds did not germinate and crops dried out. There was neither grain nor vegetables. Even bananas did not bear fruit. People depended on the coroms of bananas as the main diet. They dug the coroms of banana plants, cut the coroms into small pieces, dried them, and grinded them to make flour. This was used to make stiff porridge. This became the only reliable diet for all people, including infants.

Kwikoshi Masebo also remembered the taste of coroms as follows:

We ate coroms because we had no alternative food. We did not like them and they tasted bitter. I was still young, but I remember the bitter taste of coroms. Even infants drank porridge made from coroms because there was no finger-millet or maize to grind.

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337 The report for the 1924 mention in passing that Rungwe district faced the problem of famine in the 1923/24 season, but it provide no details that would help us to imagine its gravity. See TNA, Rungwe District, Annual Report, 1924.

338 Kwikoshi Masebo, Interview at Kafule, May 27, 2007. Other people who remembered stories on isala jya ngungula even though did not experience it in person were Mwatabhika Swilla, Interview at Kafule, May 20, 2007; Andembwisye Kashililika, June 28, 2007; Sindondile Swilla, Interview at Isoko, July 3, 2006.

339 Ibid.
His recollections reveal that famine years were difficult for men, women, and children when they struck households and communities. Parents thought of corms as an emergency-only food, something that they had to feed to their children and which they knew compromised their health. The second famine struck the region from 1933 to 1935. According to Rungwe District Agricultural Officer’s narrative, the famine began with the invasion of red locust in November/December 1932: the months marking the onset of the new agricultural calendar and planting of new crops. The swarms of red locusts destroyed food crops and vegetative cover to make 1933 and 1934 difficult and marked by famine. The Agricultural Officer noted that the locust invasion of 1934 was most severe, and predicted that the district faced a grim prospect of even more serious hunger for 1935. Kwikoshi Masebo, whose reminiscences I have pieced together to make sense of these famines, described it as isala jya pashi umukesefu (the famine of red locust). He characterized this famine as follows:

The famine of red locust came when I was older than when famine of corms came. I remember the red locusts. They ate all the food in the farms and all of the leaves. Sometimes we caught and ate these locusts. The situation was bad. They had eaten all our food; and people caught and ate them in return. We did not have food. Some people died from hunger. Some people got very sick because of hunger. It was bad. Sometimes children cried, but there was nothing to give them. If the government intended to improve child health, it could buy food and distribute it to infants, children, mothers, and other people. The government had the ability to do so. But it did not do all these things.

340 Rungwe District, Annual Reports by the Agricultural Officer for the year 1933, p.6; 1934, pp. 2-3.
341 Interview with Kwikoshi Masebo, op.cit. Also, these recollections, though with less details, shared by Lyojyo Swilla, Interview at Ngumba, September 3, 2007.
Explicit in Kwikoshi Masebo’s memories is the recognition that famine years generated extreme food scarcities that undermined the nutrition of infants. Lyojyo Swilla reiterated some of the concerns raised by Kwikoshi Masebo, arguing that “the welfare workers were talking about preparing good food for children in households which had no food supplies” during the famine stricken years. In addition, Tufingene Swilla, who experienced the famine of red locusts as a young girl in the 1930s, recalled:

I did not witness the hunger of corn but our parents talked a lot about it. If you threw out food leftovers, they warned us that you will eat corns. This was a way of teaching us the good practice of keeping and storing food. But I remember the hunger of red locusts after locusts had destroyed food crops. There were big swarms of locusts roaming around. Sometimes we caught and ate them because there was no other food. It was difficult for young children. Mothers had no milk to breastfeed their babies because they were hungry themselves. Cows had no milk which could be used to feed infants because locusts had destroyed grasses. Some infants died. I remember it. Sometimes we stayed hungry the whole day. Welfare workers did not talk about these problems. They could not give people food. How could you prepare good food for children when there was no food to prepare? They advocated breastfeeding. But they also knew that mothers had no milk because of poor nutrition in those years.

The memories of Tufingene Swilla and that of Lyojyo Swilla indicate that famine and extreme food shortage generated hunger, infantile illnesses, and deaths. These memories are also explicit criticisms leveled against welfare workers whose advice to mothers failed to consider the condition of food supplies in the households and communities.


343 Interview with Lyojyo Swilla, loc.cit
344 Tufingene Swilla, Interview at Kafule, June 6, 2007.
Another interviewee, Bomani Kibona, reinforced these commentaries when she recalled that

Infants would be crying because they were hungry and thirsty. Mothers would feed them with water instead of milk as their breasts were dry. Mothers’ breasts were dry due to their own under nutrition. But welfare workers did not have a solution to these problems. They spoke a lot about good care and nutrition. But there was no food.\(^\text{345}\)

Kibona’s reminiscences indicate that mothers’ poor nutrition hindered their breastfeeding potential. By locating the infant survival problem in the context of food insecurities, she challenged colonial explanations which narrowly defined infant survival in terms of maternal ignorance.

The extent to which people’s experience with the effects of food insecurity among mothers and children during the 1920s and 1930s shaped their interpretations of early colonial infant welfare programs was also evident in Sindondile Swilla’s reminiscences. She recalled:

The problem (during the interwar period) was not simply about the proper ways of feeding infants. The problem was not simply that of observing hygiene in preparing food. The problem was also about the availability of food for infants and all members of the family. You can preach a lot about proper feeding of infants. It will not help if mothers do not have food to prepare. It is easy to tell women to breast feed their babies. But it will not help if these mothers are hungry. You must begin with making sure that there is enough food in households.\(^\text{346}\)

Similarly, Menani Ndimbwa reminisced,

Food scarcity brought enormous problems. Breast milk was not plentiful. Without breast milk, infant survival was in danger. And many infants were thin. People praised mothers whose infants were fat because that was the sign of healthy

\(^{345}\) Bomani Kibona, Interview at Kafule, July 4, 2006.
\(^{346}\) Sindondile Swilla, Interview at Isoko, July 3, 2006.
growth. Mothers who generated plenty of breast milk were praised. But when government workers talked about infants, they never talked about the problem of food. They only talked about how to breast feed infants and how to ensure that homes were clean.³⁴⁷

Taken together, these recollections did not discredit the significance of colonial educational interventions. Rather, they revealed people’s skepticism of colonial interventions which failed to integrate educational interventions with initiatives to ensure food security in the African homes and communities. The problem of food insecurity was critical because, as Tufingene Swilla emphasized, “food shortages during famine years constrained the ability of mothers to generate breast milk for feeding their infants, and caused infantile deaths.”³⁴⁸ Her claim meant that food shortages affected maternal lactation, and without the sufficient generation of breast milk, “the lives of infants were endangered.”³⁴⁹

The effects of food shortages were not uniform for all children and households in the communities. Elias Mandala has convincingly argued that privileging extreme famines due to environmental crises of drought and locusts disguises a larger problem of periodic food insecurities, seasonal variation of food supply, and unequal distribution of food based on gender and age within and between households.³⁵⁰ His research in Malawi, for instance, found out that within households, men enjoyed better access than women and

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³⁴⁷ Menani Ndimbwa, Interview at Isongole, October 8, 2007.
³⁴⁸ Tufingene Swilla, Interview at Kafule, June 6, 2007.
³⁴⁹ Ibid.
children to nutritious stew that is consumed with stiff porridge.\(^{351}\) Like Mandala, my own research suggests that the effect of food shortages and insecurities varied across households. According to Elizabeth Mogha, food shortages hit some households harder than others. She distinguished between *abhapina* (the poor) and the *abhatalamu* (the civil servants/the rich) in drawing attention to the way in which households differently experienced food shortage and infant feeding. She noted,

> You know, the peasants were poor; they sold food to pay tax and buy other necessities. They depleted granaries before the next harvests were due. They had problems feeding their infants. Their infants are the ones who suffered most. But other people were rich and they had money to buy food. Teachers, nurses, and other workers could buy food every month when they received a salary. Their infants were safe. They enjoyed better feeding than infants of poor peasants.\(^{352}\)

Elizabethi Mogha’s observations underscored social differentiation in which infants from civil servants’ households stood a better chance of survival than those born in the poor peasants’ families. The question of varied access to nutrition was also central in Jengapho Kamwela’s reminiscences. He recalled,

> You think every infant suffered from food shortages in the society? Chiefs and *amafumu* [assistants and advisors to chiefs] had lot of food. They produced lot of food because they used the labor of commoners. Sometimes they would distribute food to people who were in dire need, but not always. Chiefs and *amafumu* were privileged and rich. Their wives did no go hungry. They enjoyed good nutrition and had no problem breastfeeding their infants. Children born in their families were safe. They did not suffer from hunger like children of the poor families.\(^{353}\)

Clearly, Kamwela introduced the households of chiefs and *amafumu* as another social category among Africans who could afford to meet the basic needs of infants even during

\(^{351}\) *Ibid.*, pp.221-225
\(^{352}\) Elizabeth Mogha, Interview at Kafule, September 16, 2007. Other interviewees who hinted on family differentiations on the experience of infants included Bomani Kibona, Interview at Kafule, July 3, 2006; Fumbachisu Songa, Interview at Isegelo, September 3, 2007
\(^{353}\) Jengapho Kamwela, Interview at Ngumba, September 3, 2007.
moments of food insecurities in the society. Jamuson Swilla amplified the differentiations among children as follows,

It was common for some families to send their older children to wealthier family friends or relatives in order to reduce the number of people they fed. They remained with the youngest. But when the older children went to the relatives, they worked hard there. They increased the labor force in the host families. Their labor helped host families to produce more food than their natal families whom they left home. So wealthier families continued to fare better in food security and in feeding their children while poor families continued to be burdened with food insecurities and inability to effectively care for and feed their children.  

Taken together, these recollections mean that we can not homogenize the effect of food insecurity on infants. They reveal the variations among infants belonging to households with different levels of socio-economic standing. In particular, infants from relatively higher incomes families like those of chiefs, amafumu, teachers, nurses, and other colonial civil service employees fared better in terms of care and feeding than those born in the poor households of the peasants.

The oral recollections on periodic food insecurities that I have analyzed above did not refute the significance of preventive educational interventions that colonial welfare workers propagated in homes and communities in the 1920s and 1930s. Rather, they challenged the narrow focus of the programs on maternal ignorance. These challenges were the means through which peasants engaged with African welfare workers over the importance and viability of the early colonial welfare interventions to improve infant welfare. In addition, these oral recollections reveal the variations among children belonging to households occupying different social positions in the communities.

354 Jamuson Swilla, Interview at Isegelo, September 12, 2007
Children from poor peasant families were more vulnerable to food insecurities than those raised in the households of chiefs, amafumu, teachers, nurses, and other colonial civil servants.

Increase in women’s workload during the interwar period, exacerbated by the beginning and development of labor migration from the 1920s, which I introduced in the first section of this chapter, was another development that shaped peasants’ engagement with the early colonial infant welfare interventions. While welfare workers emphasized the role of maternal ignorance on infant welfare, African men and women argued that women’s increasing labor burden undermined the regularity of breastfeeding and maternal care. To better understand the relationship between women’s increased workload and people’s interpretation of colonial infant welfare interventions during this period, a brief note on the gendered division of labor before the mid 1920s is necessary.

Before the institutionalization of labor migration in the 1920s, a gendered division of labor defined men’s and women’s responsibilities in the family. Theodor Meyer, a German Moravian missionary who observed the gendered division of work in southwest Tanzania from the 1890s to the onset of the First World War, noted that women and men had defined roles to play.355 According to Meyer, women performed most of the household related works such as cooking, caring for children, gathering firewood, and fetching water, as well as caring for the sick, the elderly, and the disabled in the

household. In addition, women made pots and mats, cleaned the house, and carried thatching grasses. Women also participated in agricultural duties such as sowing, weeding, and harvesting.\textsuperscript{356} On the other hand, men did agricultural work such as farm clearance, tilling, and weeding. They performed most of the construction work, such as house building and thatching. They also completed labor related to the livestock, especially cattle keeping, grazing, and milking.\textsuperscript{357}

Gender roles, however, were always in flux. Meyer noted that that in certain instances, men and women crossed this gendered line by participating in work which would normally appear to belong to the opposite sex. Men, for instance, could help in sowing, in harvesting, and in caring for the sick and elderly. Likewise, women could participate in finding thatching grasses and in digging.\textsuperscript{358} This lack of rigidity in gender roles suggests that they could be fluid at particular moments, drawing men and women into unending relations of cooperation as they managed their daily social and economic concerns. These practices would be sorely tested when labor migration began shaping household and community labor relations in the mid 1920s. As the discussion below underscores, these changing gender and labor relations brought by men’s labor migration also influenced people’s interpretation of early colonial infant welfare interventions.

\textsuperscript{356} \textit{Ibid.}, p. 166
\textsuperscript{357} \textit{Ibid.} Duncan Mackenzie made similar observations on the gendered division of work in the region in the early 1920s, although his expositions on these divisions are not as clearly articulated as is the case with Meyer. See Mackenzie, \textit{The Spirit-Ridden Konde} (Philadelphia, Lippincott, 1925).
\textsuperscript{358} Meyer, \textit{Wa-konde}.
My oral interviewees recalled that in the absence of men due to labor migration, many women became household heads, continuing to perform their traditional responsibilities as well as those usually held by the now absent men. Elizabeth Mogha, who witnessed these laboring women in the 1930s, recalled that

Women’s workload increased tremendously in the absence of men. Women began doing much of the work which men did in the past. They had little time to rest due to the busy schedules they endured. Men came back from the mines to impregnate their wives and then went back to the mines. It was difficult for pregnant and nursing mothers. Their husbands were absent when they needed them most.\(^{359}\)

Elizabeth Mogha’s recollections underscore the sort of changes associated with the growing prevalence of labor migration which transformed household reproductive and productive work from being a shared duty between men and women towards being a nearly absolute female responsibility. For example, apart from the traditional responsibilities of caring for children, collecting firewood, or fetching water, women now needed to perform all farm duties such as clearance and preparation, cultivation, weeding, harvesting, and all other duties that enhanced livelihood in the household.\(^{360}\) Elizabeth Mogha’s recollections also indicate that migrant laborers in the mines offered little or no support to women remaining in the rural communities. Her point that men come back in the villages to “impregnate” their wives before they retreated back to the centers of their wage employment may be interpreted symbolically to indicate the ways in which she perceived migrant laborers as generally irresponsible.

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\(^{359}\) Elizabeth Mogha, Interview at Kafule, September 7 and 16, 2007.  
\(^{360}\) Ibid.; Nikubhuka Kashililika, Interview at Chija, June 8, 2007; Fumbachisu Songa, Interview at Isegelo, September 20, 2007; Tufingene Swilla, Interview at Kafule, June 6, 2007; Sijeghe Masebo, Interview at Mukela, July 12, 2005
Mogha’s recollections indicated that pregnant women or nursing mothers suffered more than other women from the absence of their husbands. Pregnant and nursing women performed productive labor in the agricultural fields simultaneously as they channeled their labor in the reproductive process they were going through. Nikubhuka Kashilika, who worked on the Zambian copper belt for almost six years without returning home during and after the Second World War, reflected on the condition his wife experienced in ways that echoed Elizabeth Mogha’s recollections.

It was difficult for her. I was in Zambia for almost six years. I did not have enough money to send to her at home. Whenever she met someone traveling to Zambia, she always sent messages to me complaining that she was tired of all the work she did in my absence. She always complained that I did not send money she could use to hire laborers. She also complained that without my support, she was having difficulties looking after the children and securing food for the daily household needs.\textsuperscript{361}

Kashilika’s memories highlight the stresses that his wife faced in the rural areas. For her, the gendered division of work no longer existed in the household as she fulfilled productive, reproductive, and care-giving responsibilities without support from her husband. In this particular example, Kashilika made little effort to provide financial support for his wife to maintain the household back home. His reminiscences show the tensions between migrant men and their wives left at homes because of the perceived irresponsibility on the part of former. Taken together, the recollections by Elizabeth Mogha and Nikubhuka Kashilika indicate that it was children of migrant fathers who suffered most from the increasing maternal labor burden, further revealing social differentiations of the children in the rural areas.

\textsuperscript{361} Nikubhuka Kashilika, Interview at Chija, June 8, 2008. Similar sentiments shared by Bomani Kibona, Interview at Kafule, July 4, 2006
Women’s increased agricultural workload reduced the frequency with which mothers breastfed their infants. Kujoberane Kamwela recalled how migrant men changed labor relations,

Before the beginning of labor migration to Tanga [coastal sisal plantations], Rhodesia, and Jon [Johannesburg for South Africa], pregnant and nursing mothers spent time at home performing ordinary roles of child care, cleanliness, cooking, and other household duties. Men assumed major duties of performing agricultural work, and in helping their wives in the manner that made the transition from pregnancy to infant care less stressful for mothers. Pregnant and nursing mothers did not engage in farming. However, when the majority of men began traveling for wage employment away from home, many women lacked the support of husbands that women enjoyed in the past. They had to do the work that husbands did previously.\textsuperscript{362}

Kamwela’s recollections emphasized that before the development of labor migration, pregnant and nursing mothers devoted most of their time in raising infants and that fathers assumed most of the roles that mothers would do had they not been nursing. However, with the onset of labor migration, these relations changed as wives of absent husbands took over the duties that their husbands did. Sindondile Swilla revealed the effect of this change on breastfeeding as follows,

With their husbands gone to the coast or to the mines, it was now common to see pregnant women and nursing mothers whose husbands had gone away for wage employment collecting firewood, clearing farms, digging, weeding, and doing all the necessary duties to ensure the livelihood of their families. They spent most of their day time in the agricultural fields. The problem with this development is that mothers could no longer breastfeed their infants regularly, because, often, they left their infants home.\textsuperscript{363}

\textsuperscript{362}Kujoberane Kamwela, Interview at Isegelo, September 8, 2007

\textsuperscript{363}Sindondile Swilla, Interview at Isoko, July 3, 2006.
For her, therefore, growing women labor burdens affected the regularity of breastfeeding, particularly during the peak of the agricultural season: the most demanding for women’s labor. During this period, Sijeghe Masebo emphasized, “pregnant or nursing mothers had no alternative but to spend most of their time in the agricultural fields from morning to evening.” Another interviewee, Sikanyagha Kibona, reminisced that “some mothers who had young girls and boys assigned their older children the role of looking after infants and feeding them porridge as they labored in the fields” and that “elderly women increasingly assumed the roles of infant caregivers while mothers labored in the fields.” However, Kibona acknowledged that using older children was not a readily available option because most children during this period were going to schools.

The strategy of using alternative infant caregivers made the introduction of supplementary feeding in early infant life an inevitable option. Mwatabhika Swilla pointed out that “porridge made from maize or bananas substituted for maternal breast milk for many infants during the day, as mothers were working in the fields.” Another oral interviewee, Numenye Mwotela, argued that “because mothers left infants at home as they labored in the agricultural farms, the destruction of the regularity with which infants needed to be breastfed was inevitable.” In addition, Erika Kibona recalled the effects of increasing maternal workload in the following terms,

Women’s workloads in the farms forced some mothers to leave infants at home during the day. Leaving infants behind meant reduced the frequency with which

364 Sijeghe Masebo, Interview at Mukela, July 12, 2005
366 Mwatabhika Swilla, Interview at Kafule, May 19, 2007
367 Numenye Mwotela, Interview at Isongolo, June 26, 2007
mothers could breastfeed infants during the day. The effect of this development is that mothers were forced to introduce supplementary feeding of porridge to their infants earlier in life.368

A careful and critical reading of all these recollections reveals that feeding infants with supplementary food was probably a new development, a coping strategy that mothers adopted in the context of overwhelming labor demands. Her thinking about feeding and the introduction of supplementary feeding differed from that of colonial officials. As Chapter Three has indicated, colonial officials observed these supplementary feeding practices in the 1920s and 1930s and concluded that mothers were feeding infants hard food due to ignorance, and that these feeding practices epitomized supposedly “primitive” African cultural ideas and practices on infant welfare.

Oral recollections show that the issue of increased maternal workloads influenced mothers’ skepticism toward the viability of colonial infant welfare programs. Tumulikeghe Swilla’s recollections of the work of Tupilike Mushani, the first welfare worker who worked in Bundali from 1928, revealed this skepticism,

Tupilike Mushani was hard on mothers. She lamented that mothers were not breastfeeding infants enough. She complained that mothers did not know the importance of breastfeeding infants. She used to threaten mothers that she would report them to the chief because they failed to breastfeed their infants. But it was difficult for mothers to follow Tupilike’s advice. Could mothers remain at home breastfeeding infants? Or could they continue working in the fields? If they did not, the children would suffer from hunger. You could not always take infants to the fields. You left them at home. Tupilike did not understand why mothers did not stay home to breastfeed infants. 369

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368 Erika Kibona, Interview at Lupermbë, May 22, 2007
369 Tumulikeghe Swilla, Interview at Ikuyu, June 12, 2006.
Tumulikeghe Swilla’s reminiscences provide glimpses into both colonizer and colonized ideas unfolding amidst the implementation of infant welfare interventions. They reveal that welfare workers such as Tupilike perceived mothers as negligent, careless, and irresponsible by their failure to devote enough time to their infants. Choosing to leave at home infants who needed regular breastfeeding in favor of working in the agricultural fields was for Tupilike an indication of this maternal negligence. Her complaints that “mothers did not know the importance of breastfeeding infants” resonated well and tended to reinforce the colonial assumptions that maternal ignorance was the root cause of poor infant survival, a point that Chapter Three has already underscored. Yet, in Tumulikeghe Swilla’s recollections, we also see a story of how Africans interpreted the ideas propagated by welfare workers. She offers a sense that rather than viewing the low frequency of breastfeeding in this period as an ill-informed African practice, as colonial interventions envisaged, it must be seen as a difficult but strategic choice mothers made in the context of their extraordinarily high labor burden. I look at her reflection as an example of the local interpretation that colonial interventions failed to take seriously the nature of rural socioeconomics and labor relations that resulted in a drastically increased workload for women: a condition which inevitably disrupted the rhythm of breastfeeding. She meant that in the context of mothers assuming reproductive and productive duties in the midst of men’s absence due to wage employment outside the district, Tupilike’s advice on breastfeeding were impractical because they neither engaged with nor reflected the realities of women’s work in the rural communities.
Although conventional wisdom would be for mothers to carry their infants with them to the food and cash crop fields, or as they engaged in duties such as firewood collection, water fetching and others, oral sources indicate that the dangers associated with this strategy outweighed its advantages. As Erika Kibona recalled,

…. They [welfare workers] were angry with giving infants porridge. They said infants were too young to drink porridge. They wanted infants to live on breast milk only. It was difficult during the agricultural season because this was also a period of heavy rains, cold weather, and many insects. Mothers did not want to expose babies to these dangers. Mothers left infants home to protect them from cold. They had to drink porridge. But this was not acceptable to them [welfare workers].

A careful reading of Kibona’s memories, like those of Tumulikeghe Swilla, reveal that leaving infants at home, and feeding them with porridge, was not a symptom of maternal ignorance as defined by welfare workers, but was an inevitable preventive strategy meant to protect infants from being exposed to heavy rains and cold weather. Likewise, Sindondile Swilla reminisced that infants who accompanied mothers to the agricultural fields often became ill:

During the agricultural season, mothers carried babies who had not yet begun drinking porridge with them to the field. That way, they could breastfeed their babies while working in the fields. But these were also rainy and windy seasons, especially from December to May. Taking babies to the fields exposed babies to rainy conditions and cold winds and made them vulnerable to health problems during the peak agricultural season. Chest problems were one of the serious problems at this period.

While it is difficult to discern the challenges embodied in “chest problems” in these recollections, they may have been afflictions such as whooping cough or pneumonia identified by colonial authorities in the 1930s as some of the common afflictions

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affecting infants in the region.\(^{372}\) Considering the risks of taking infants to the fields in order to meet the colonial advice of breastfeeding, mothers would take their infants to the field only in circumstances where it was impossible for them to leave infants at home.

Taken together, Erika Kibona’s and Sindondile Swilla’ recollections are important in two ways. At one level, the recollections uncover the material world in which infants were born and raised in the 1920s and 1930s. At another level, these recollections reveal the local interpretations of colonial infant survival interventions. Central to this interpretation is people’s perception that what welfare workers were doing, and the issues they emphasized in their advice and instructions on infant feeding, failed to take into consideration those material conditions they deemed important influences on infant survival, especially breastfeeding.

Increasing women’s workload reduced the time mothers spent to care for their infants. The inverse relationship between women’s work and infant care was evident in the oral reminiscences. As Jopho Kibona recalled,

Because mothers spent more time performing work such as farming, planting, weeding, harvesting, collecting firewood, and fetching water, they spent less time being with their infants. Mothers spent less time with infants during the day. Only during the night was there a guarantee that a mother would be caressing and nurturing her infant in her lap.\(^{373}\)

\(^{372}\) Mentioned in TNA, Rungwe District Books for the Years 1930, p.8; 1932, pp.3-4; 1932, p. 6 1936, p.10; and 1938, pp. 16-17.

His recollection indicated that the closeness between mothers and their infants was insubstantial during day-time as mothers worked in the fields from dawn to night to support their families. Another interviewee, Namwasa Kajuni, produced similar reminiscences as follows,

Mothers worked hard during pregnancy or during nursing because they had little support. Few men remained in the villages. Welfare workers wanted mothers to spend more time with their infants. They wanted mothers to love their infants. But mothers had to work too. Otherwise, children would have no food.374

Kajuni’s recollections acknowledge less maternal care in the 1920s/1930s, but emphasize that women’s increased labor burdens were responsible for undermining this maternal infant care as well as the closeness that you would expect between mothers and their infants. Indeed, as Chapter Three has argued, colonial officials in the 1920s and 1930s attributed poor infant survival to maternal ignorance, and they defined this ignorance as reflecting a larger problem of primitive African cultural ideas and practices on infant welfare. Kajuni’s reminiscences offer a way of looking at the problem of maternal care in the 1920/1930s that goes beyond maternal ignorance to take into account the changing socioeconomic relations ushered in by labor migration. Her reminiscences also reveal that people drew on their knowledge of the relationship between increasing women’s workload and infant care to comment on colonial infant welfare interventions. It seems from her reflections that welfare workers’ urging that mothers spend more time caring for their infants and showing maternal love was an indication that these workers, and thus colonial welfare interventions more generally, failed to understand the difficult balance


women were striking between the complex processes of work, livelihood, and child care. Kajuni thought that the colonial government failed to consider this important equation in their creation and implementation of infant survival interventions.

4.4 Conclusion

The analysis of the oral recollections reveals that peasant men and women interpreted the early infant welfare programs as lacking the viability of improving child health because they were narrowly focused. According to these recollections, colonial officials simplified the complex issue of infant survival into the exclusive problem of maternal education. Because of this narrow focus, colonial officials failed to take into consideration problems of witchcraft, food insecurity, and women’s labor burden that peasants thought were important determinants of child health.

Furthermore, the analysis of these recollections shows that Africans were not homogeneous: they held different social positions and the relationships that evolved between them as they grappled with the colonial infant welfare programs generated tensions between commoners and chiefs, young welfare workers and older mothers, wives and migrant men, and between the poor and the rich African households. The next chapter moves the discussion to later forms of negotiations that focused on the incorporation of curative medicine in the colonial welfare policies. Peasants demanded this incorporation as a necessary condition for dealing with diseases such as malaria and pneumonia that claimed the lives of many infants in the rural areas.
Chapter Five

Negotiating the Incorporation of Curative Medicine into the Infant Welfare Interventions, 1930-1950

5.0 Introduction

This chapter examines later forms of negotiations and agendas that focused on the incorporation of curative medicine into infant welfare interventions. Its central argument is that multisided negotiations between peasants, local chiefs, health officials, and political administrators were integral components of this incorporation. These negotiations appeared in multiple forms. They included peasants demanding the incorporation of curative medicine in the welfare programs, local chiefs mediating between peasants and the colonial administration, and the government transforming welfare centers into dispensaries. Other negotiations appeared in the form of training dressers in preventive and curative medicines, and conflicting ideologies among colonial officials over the accommodation of peasant demands. These social relations brought peasants and local chiefs in the villages together with government officials at the district, provincial, and territorial levels into engagement with each other as they grappled with infant health and colonial welfare programs. Although colonial government officials initiated and implemented infant welfare policy in the 1920s, it was the complex negotiations with peasants, chiefs, and dressers that ultimately resulted in the change from exclusive preventive programs of the 1920s and early 1930s to measures that integrated preventive and curative medicines in the late 1930s and 1940s.
Participants in these negotiations had specific interests and agendas that they intended to achieve. For instance, peasant men and women demanded that the colonial government include curative medicine in order to expand medical resources for dealing with infant medical challenges. Their negotiation strategies included refusing to pay taxes that colonial officials did not utilize to improve medical provisions in their rural communities, boycotting to attend the government welfare centers that excluded curative medicine, and using their local chiefs to communicate their demands and concerns to the colonial administration. By contrast, the interest of local chiefs in the welfare programs lay in consolidating their political power as representatives and spokespersons for peasants and the colonial administration in the rural communities. Local chiefs mediated between peasants and government officials by articulating peasants’ demands and communicating them to the colonial administration through letters. Through these mediations, chiefs strategically cemented their intermediary position by making their work important for both peasants and the colonial administration.  

The agenda of the colonial government was to utilize infant welfare programs to extend its reach into the rural African homes and communities. As Ralph Scott (the Director of Medical Services) argued, the incorporation of curative medicine in the infant welfare

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programs enabled health officials and political administrators to “maintain touch with various elements of the [African] population in the furthest corners of the territory.”\textsuperscript{376} He thus saw the welfare programs as essential to the success of building the presence of the colonial government throughout the colony. In addition, Patrick Malloy has argued that the extensive rural dispensaries that Africans demanded, which numbered over 300 by the end of the 1940s in the territory, were “the most distributed networks of the government” that colonial officials utilized in “the political administration of the territory.”\textsuperscript{377} These networks served administrative roles because the government used them as conduits for spreading its medical ideas and culture among rural Africans.

The African dressers participated in the colonial welfare programs in order to expand livelihood opportunities. To accommodate peasants’ demands, the colonial government trained dressers in both child preventive and curative medicines and prepared them to work in the rural dispensaries. For these dressers, practicing medicine in the rural areas became a source of salaried income which they used to meet their subsistence needs.

The targeted population of the medical policy shifted as negotiations unfolded. Initially, and as chapter three has documented, the early government medical policy targeted infants. As a result of this target, welfare interventions in the 1920s and early 1930s attempted to improve infant health using preventive programs. The incorporation of

\textsuperscript{376} Quoted by David Clyde, \textit{History of the Medical Services of Tanganyika} (Dar es Salaam, Government Press, 1962), pp.119, 143.

curative medical policy in the late 1930s and 1940s, however, expanded the target population because the resulting medical services catered to infants, older children, youth, and adults alike. Thus, the medical policies that targeted infants in the 1920s expanded in the late 1930s as the African dressers in rural dispensaries provided medical care to all age groups in rural communities. Because of these shifts, the policy documents and oral recollections that I analyze in this chapter occasionally make reference to both infants and the general population. The references reflect the effects of negotiations over incorporating curative medicine that was available to infants and older populations.

The government’s implementation of African demands was not a smooth process. Rather, intense negotiations fraught with conflicting debates among colonial government officials characterized this process. For example, political administrators such as the district/provincial commissioners and some health officials like Dr. Arthur Keevill supported the inclusion and expansion of medical care in rural areas because this inclusion would make both the government and preventive medical measures popular among Africans. Other health officials such as E. Jackson and Paul Alfred T. Sneath disagreed with the evolving practice, arguing that there were insufficient financial and human resources to provide quality medical care in the rural areas. These conflicting debates suggest that colonial government officials did not hold homogenous ideas.

This chapter is significant for two reasons. First, it reveals that although colonial government officials initiated preventive infant welfare policies in the 1920s, the
incorporation of curative medicine in these programs resulted from the multisided negotiations between peasants, local chiefs, government officials, and dressers. Second, the examination of officials’ conflicting ideologies over the incorporation of curative medicine reveals that the colonial government, as an institution of the state, was a contested and negotiated terrain.378

5.1 Locating Negotiations in the Dynamics of Infant Survival Interventions

The absence of curative services for infantile illnesses in the early colonial infant welfare programs of the 1920s and 1930s initiated struggles between peasants, chiefs, and government officials. This absence resulted from officials’ understanding that preventive medical programs were the best strategies for addressing the challenges of infant survival. The welfare centers that the colonial government created during the implementation of these early programs provided advisory and instructional services on infant care and feeding, not the diagnosis and treatment of diseases. The programs followed the British model of welfare work in the early twentieth century which, according to Jane Lewis, was “strictly educational: health visitors and infant welfare clinics were not permitted to offer medical treatment and confined themselves to instructing mothers on infant hygiene.”379

A critical reading of oral recollections suggests that peasant men and women perceived the early programs as having little viability to improve infant welfare because they excluded curative medicine. As a result of this perception, the major form of negotiation in the 1930s focused on peasants demanding that the colonial administration incorporate curative medicine in the existing welfare programs. Andembwisye Kashililika produced the following recollections to highlight these negotiations.

You know, people appreciated the value of advice that welfare workers offered. At the same time, they were dissatisfied with the failure of the colonial government to make the welfare centers as places for treating diseases that infants contracted. When infants contracted illnesses such as malaria, welfare centers offered no treatment services to deal with such infections. People demanded their local chiefs and the colonial government to ensure that curative medical services were available in their local communities.\(^{380}\)

Kashililika emphasized that peasant men and women demanded the availability of medical services to treat diseases that affected infants in their communities. Common diseases in the 1920s and 1930s included malaria, diarrhea, chest problems, respiratory diseases, pulmonary diseases, whooping cough, and pneumonia.\(^{381}\) According to Steven Mogha, peasant men and women believed that upgrading welfare centers to provide curative medical services would help them to deal with these diseases. He recalled,

Many people were disappointed with the absence of centers which could not treat diseases affecting infants. Infant suffered from fevers, from chest problems, from respiratory problems, from diarrhea. People began demanding centers capable of

\(^{380}\) Andembwisye Kashililika, Interview at Isongolo, June 28, 2007.

\(^{381}\) TNA, Rungwe District Books for the Years 1930, p.8; 1932, pp.3-4; 1932,p. 6 1936, p.10; and 1938, pp. 16-17. These diseases also mentioned by Monica Wilson, *For Men and Elders: Change in the Relations of Generation and of Men and women among the Nyakyusa-Ngonde People, 1875-1971* (New York, Africana Publishing Company, 1977), 75-76; Menani Ndimbwa, Interview at Isongole, October 8, 2007; Mwatabhika Swilla, Interview at Kafule, May 20, 2007; Anosisye Masebo, Interview at Maketa, September 14; 2007.
treated diseases which endangered infant lives. They wanted medicine for ailing infants, not simply advice.\footnote{382}

In another interview, Mogha reminisced,

The welfare workers were doing everything that was humanly possible in advising mothers, in visiting them at home, and in teaching them. Unfortunately, they would do nothing when infants were sick. And they tended to advise against consulting local medicine men [or women]. They emphasized that if mothers observed their advice, infants would not get sick. It was difficult for people to understand this.\footnote{383}

Taken together, Mogha’s memories suggest that the demand for the inclusion of curative medical care in the pre-existing preventive interventions were a logical consequence of difficulties rural peasants experienced in dealing with afflictions such as fevers and respiratory problems that claimed the lives of infants. In contrast to Kasihililika and Mogha who generalized the problem to all residents in the region, Kaswashi Pwele argued that the absence of curative services in the colonial welfare interventions was not a big issue for Africans living in Tukuyu town because they had access to the district hospital housed there. For him, the problem was critical for people living away from the district headquarters. He recalled,

For us, living far away from Tukuyu, where we had to walk two or three consecutive days to reach the hospital, this was a big problem. Carrying a sick person to Tukuyu was not easy. If the colonial government wanted to help us, it would have built the hospital here. People were always wondering why they did not bring doctors to treat children when they were ill.\footnote{384}

\footnote{382} Steven Mogha, Interview at Kafule, July 12, 2006.\footnote{383} Steven Mogha, Interview at Kafule, July 30, 2006. Concerns about colonial infant survival interventions lacking the curative component for infantile illnesses were also expressed by Saligwe Kamwela, Interview at Isongolo, June 21, 2007.\footnote{384} Kaswashi Pwele, Interview at Kapelekesi, September 5 and 11, 2007. Similar views expressed by Gideon Swilla, Interview at Isegelo, September 15, 2007; Filingison Kajange, Interview at Chija, June 11, 2007; Jengapho Kamwela, Interview at Ngumba, September 3, 2007.}
Menani Ndimbwa’s reminiscences of his childhood supported those of Pwele. He narrated,

My parents told me that I had serious chest problems when I was very young. My parents carried me to the Europeans [Elise Scharf] at Isoko for treatment. The journey took two or three days and the Bundali Mountains were difficult to climb [It is almost eighty kilometers from Bulambya to Isoko]. Unfortunately, when we arrived at Isoko, the European was away. My parents had to carry me another two days from Isoko to Tukuyu. That is where I got treatment. I would not be alive today without that. My parents endured so many troubles with my ailing condition. It was very difficult for then. That is why our parents struggled so much to make sure that the government brought medical services here.  

For Pwele and Ndimbwa, therefore, the creation and provision of both preventive and curative medical services in the rural villages, equivalent to those provided at Isoko mission and at Tukuyu district hospital, would have helped people to tackle diseases that infants contracted. Moreover, and as Mwamukono Kajange emphasized,

People saw a mission dispensary at Isoko offering medical care [for infants and adults]. Yet, the government center at Malangali, for which they paid taxes, was not offering them. And people knew the government could provide these services in the same way that it provided them at the district hospital built at Tukuyu [colonial Rungwe District administrative headquarters]. Those who lived close to the mission could easily access medical care. For those who lived away from both the mission and from the district hospital, they traveled long distances to find these services. People wanted to end this difficult.  

According to these reminiscences, peasant men and women wanted the colonial government to ensure that the medical care available for the residents of Tukuyu town or at Isoko mission were also available in their rural communities in return for the taxes they paid. There were many medical developments from the 1920s to the 1940s that may have influenced peasants’ demands for the incorporation of curative medicine into the infant

385 Menani Ndimbwa, Interview at Isongole, October 8, 2007.
welfare programs. For example, the 1920s witnessed district hospitals implementing the
government campaign to eradicate yaws through Bismuth Sodium Titrate (BST)
injections, which proved capable of suppressing open sores and ulcers that afflicted yaws
patients.\textsuperscript{387} The 1930s saw the penetration of sulfa drugs and by 1939, for instance, the
sulfa drug known as Mary and Bakers 693, popularly known as M.& B., was extensively
distributed in the territory and widely used in dealing with illnesses such as
meningococcal meningitis, pneumonia, gonorrhea, and other bacterial infections.\textsuperscript{388} In the
1940s new anti-malarial drugs such as mepacrine, chloroquine, and proguanil joined
quinine and became common prescriptions in many hospitals.\textsuperscript{389} In addition, antibiotics
such as penicillin appeared in many parts of colonial Tanganyika.\textsuperscript{390}

Peasants negotiated for curative medicine because for them, integration of preventive and
curative medicine was a necessary condition for effective infant welfare interventions.
According to Bomani Kibona,

> People had always used medicine to improve health. Healers always gave some
form of medicine to drink, or to bathe in, or to rub on the body, or to tie anywhere
on the body. Illness is eradicated by medicine, unless it is caused by ancestors. So
it was very difficult for people to understand that infants could survive without
medical care [by maternal educational advice alone].\textsuperscript{391}

\textsuperscript{387} Clyde, \textit{A History}, p.113. The popularity of bismuth injection in southern Tanganyika has also been
documented by Terence Ranger, "Godly Medicine: The Ambiguities of Medical Missions in Southeastern
Tanzania", in Steven Feierman and John Janzen, eds., \textit{The Social Basis of Health and Healing in Africa}
\textsuperscript{390} See Iliffe, \textit{East African Doctors}, pp.133-135, for discussion of these developments. That Africans were
aware of the potential benefits of these western medical technologies and traveled long distances to follow
them is also documented by Ranger, "Godly Medicine."
\textsuperscript{391} Bomani Kibona, Interview at Kafule, July 3, 2006.
Filingisoni Kajange reiterated Kibona’s recollections when he argued, “people believed that individual medical care for sick children was a practical means of ensuring that they did not succumb to premature death, and they expected the same from the [colonial] government.” When we read the recollections of Kajange and Kibona alongside chapter two, we learn that peasants’ struggle for the incorporation of curative medicine in the 1920s and 1930s was not a new development: it was part of long history of infant welfare ideas and practices dating from the pre-colonial period.

Peasants’ negotiation strategies with local chiefs and the colonial administration changed over time. Initial strategies involved boycotting to attend the government-run welfare centers that offered no treatment services for the sick children. Fumbachisu Songa memories indicated that women, particularly mothers, were central actors who staged this strategy. He emphasized,

Mothers were not interested in taking children to Malangali [government center] because they could not depend on it when they [children] were sick. They preferred Isoko [mission center] which cared for sick children as well. Mothers avoided going to Malangali before it began offering treatment services.

In addition, Tumulikeghe Swilla’s reminiscences highlighted that mothers boycotted government-run welfare centers in opposition to the early preventive interventions. She recalled,

Mothers went to Isoko mission which offered medicine as well. They wanted to build a relationship with nurses at the mission and to become acquaintances. When they were sick, or when their children were sick, they would send them to the mission. Nurses at Isoko cared for the healthy and the sick children alike.

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392 Filingisoni Kajange. Interview at Chija, June 4 and 9, 2007.
393 Fumbachisu Songa, Interview at Isegelo, September 20, 2007.
They were good and kind at taking care of children because they knew the mothers. Mothers really had no interest of using government services that had no medicine to deal with illnesses.\textsuperscript{394}

It seems from these memories that mothers used medical missions as a buffer to exert pressure on the government. That is, they preferred to get welfare advice from medical missions that also treated infants who contracted diseases. Swilla emphasized that peasant mothers’ preference for medical missions’ welfare work was a strategic move to build close relationships with nurses. Mothers thought it advantageous if they had acquaintances with nurses who worked with infants when they were healthy and when they were sick. Furthermore, an interview with Namwasa Kajuni reinforced Swilla’s recollections by arguing that

Mothers’ preference over medical missions’ welfare work was a conscious move to build relationships with nurses that were necessary in getting the attention of nurses when infants were sick. They told the chiefs that it was better for them to use missions because they help us when our children are sick.\textsuperscript{395}

Swilla, like the preceding interviewees, made references to mothers as she recalled the acts of boycotting attendance at the government-run welfare centers. It was women, particularly mothers, who exerted influence on local chiefs and the government by choosing medical missions’ welfare work over that of the government. In addition, these reminiscences indicate that mothers did not oppose the message of preventive health embodied in the early welfare programs. Rather, they criticized the failure of government to provide treatment services for sick children. For these women, the government needed

\textsuperscript{394} Tumulikeghe Swilla, Interview at Isongolo, June 12, 2006.
\textsuperscript{395} Namwasa Kajuni, Interview at Kafule, May 28, 2007
to follow medical missions’ precedence of providing both preventive and curative medical services in its infant welfare programs.

Peasants’ later bargaining strategies combined boycotting to attend government welfare centers with withholding taxes to exert pressure on local chiefs and colonial administration. An interview with Jopho Kibona indicated that peasants were unhappy with the realization that colonial government used their taxes to provide curative medicine at the district hospital in Tukuyu town, but not in their local communities. He reminisced,

> You know, chiefs collected taxes with the promise that money would be used to provide treatment services in their communities. And people paid taxes because they knew they will benefit from them. As they continued paying taxes, they realized that there were no efforts to build hospitals here. When people or their children were sick, they continued traveling long distance to Tukuyu. People did not like this. They thought that their taxes were benefiting residents of Tukuyu town who could easily access the district hospital. They did not want to pay taxes which benefited other people. You see. They refused to pay taxes in order to force their chiefs and the colonial government to listen and implement their demands. Withholding taxes began when they [peasants] were demanding curative medical services.\(^{396}\)

Kibona highlighted that rural peasants were not willing to pay taxes that did not contribute to improving medical provisions in their communities. His reminiscences revealed that peoples’ refusal to pay taxes was a bargaining strategy for influencing local chiefs and the colonial administration to address their demands and concerns. Another interviewee, Sindondile Swilla, recalled,

> Here people told *malafyale* Musomba that we are not paying taxes because we do not see the benefit. Yes, they refused to pay. They did not see the benefit of taxes.

\(^{396}\) Jopho Kibona, Interview at Isoko, July 3, 2006.
There was no dispensary where they could get treatment. It was difficult for *malafyale* Musomba because he had to submit taxes to the government.\(^{397}\)

Like Kibona, Swilla clearly indicated that peasants used taxation to exert pressure on their chiefs and thus to push their agenda for the incorporation of curative medicine in the welfare programs. Finally, Kaswashì Pwele’s memories provided more glimpses into these peasant struggles. He reminisced,

> People were angry with the chief. They blamed the chief that he was not doing enough to make sure that the government brought health services here. They complained that chiefs were getting salaries and other advantages but they did not fight for their people. They began refusing to pay in order for chiefs to fight for their interests. It was difficult for the chiefs. Failure to collect taxes jeopardized the positions of the chiefs. They would lose their jobs.\(^{398}\)

For Pwele, therefore, using taxes as bargaining strategy was a peasants’ calculated move they devised to influence chiefs and government officials. He emphasized that “[this strategy] was critical because failure to collect taxes was a sufficient reason to demote the chief from his position.”\(^{399}\) Since no chief would be comfortable to relinquish his privileged political position, this strategy subsequently forced chiefs to exert pressure on the colonial administration.

The above discussions indicate that rural peasants’ demand for the colonial government to incorporate curative medicine began with the pressures they exerted on chiefs. As stated in chapter three, local chiefs were part of an indirect rule political system that the British colonial administration institutionalized in the 1920s. The chiefs articulated peasants’ demands and communicated them to colonial government officials through the

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\(^{397}\) Sindondile Swilla, Interview at Isoko, July 3, 2006  
\(^{398}\) Kaswashì Pwele, Interview at Kapelekesi, September 5, 2007  
\(^{399}\) *Ibid.*
letters they wrote to the colonial administration. A careful reading of these letters confirms many of the claims embodied in the oral recollections concerning peasants’ demands, negotiations between peasants and chiefs, and negotiation strategies peasants used to achieve their agenda. For example, a letter that Malafyale Musomba of Bundali wrote to Philip Huggins (the District Officer of Rungwe District) illustrates these issues. Musomba wrote,

My people demand medical treatment at Malangali welfare center. They are tired of carrying the sick children [and adults] to Tukuyu to seek medical treatment. Those who live close to the Isoko mission dispensary think it is better to pay tax to the mission which provides them with the services they like. It is becoming difficult to collect taxes. They do not want to pay taxes, complaining that the money is not used to solve the problem of medical care in the area.  

Like the oral recollections that I have examined above, Musomba’s letter pointed out that his subjects demanded that the colonial government provide medical treatment of children in their local communities. The statement in the letter that his subjects thought it more logical to pay taxes to the medical mission means that peasant men and women used medical missions as a yardstick through which they evaluated and challenged the colonial government officials. In addition, this letter reveals the role of local chiefs in the negotiations over infant welfare programs. By informing the colonial administration that his subjects withheld taxes to push for the inclusion of curative medicine in welfare interventions, Musomba acted as the medium of communication between peasants and colonial government officials.

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400 The letters were written in Kiswahili. Translations in English are mine.
401 TNA 18/22/6 Musomba to Philip Huggins, DO Tukuyu, 2/10/1934.
The issue of peasants’ resistance to paying taxes also formed the main content of a letter that *Malafyale* Mwangamilo sent to the district officer. He wrote,

> Every time we go to collect taxes we meet resistance. They ask us, why should we go to Tukuyu when we are paying the taxes? Why should we be carrying the sick children all the way to Tukuyu? Why should we carry people [adults] to Tukuyu. They complain of the difficulty of carrying the sick all the way to Tukuyu, and carrying the corpses back home for those who died. They want the government to begin providing them with the services here. It will make it easy for us to collect the taxes….³⁰²

Mwangamilo’s letter articulated his subjects’ demand for the colonial government to provide medical care for ailing children and adults. Mwangamilo highlighted the painful and difficult process of carrying children on their backs or adults in the stretchers [*ifipimbilo*], to and from Tukuyu, when they were sick or when they died. According to him, these difficulties would end if the government offered treatment services in their local communities. Like Musomba’s letter and the oral recollections I have analyzed, Mwangamilo’s letter expressed the difficulties that he experienced collecting taxes. People found no reason to pay taxes when the government did not use to improve medical services in their communities. The letter is thus significant for revealing negotiations between peasants and chiefs, the formers’ bargaining strategies, and the chiefs’ role in mediating between peasants and government officials.

While Musomba and Mwangamilo focused on taxation, *malafyale* Mwakiembe’s letter to the district administration addressed how his subjects boycotted the government-run welfare centers. He wrote,

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³⁰² TNA 18/22/11 Chief Mwangamilo to Philip Huggins, DO Tukuyu, 2/3/1935
It is really becoming difficult to convince people to send their children to government centers. They want treatment services. They complain that the government is favoring people at Tukuyu. Some do not want to pay tax. They think the government does not like children and that is why it can not provide curative services. They prefer to attend a mission dispensary for advice where they also get medical treatment. We had a meeting last week at which they kept asking [:] what are the taxes doing if there are not even medical services? … They complain [:] why should we go to [government welfare] centers if they can not provide individual medical care for sick children?403

Mwakiembe’s letter emphasized that peasants boycotted government centers as a negotiation strategy for the inclusion of curative medicine into infant welfare programs. Mwakiembe’s claim that his subjects perceived the failure of the government to offer curative medical care as an indication of dislike for children is pertinent. A reading of this claim in conjunction with the oral recollections I have analyzed above indicates that Mwakiembe’s claim was quite widespread. The claim makes sense because even before colonialism, rulers’ legitimacy depended on how they helped to mobilize both preventive and curative medical interventions to deal with existing and emerging infant medical challenges, as chapter two argued. Likewise, Steven Feierman’s study of peasants in northwest Tanzania noted that the legitimacy of political rulers was tied to health and was central to the political pact between people and their rulers.404 Mwakiembe’s assertion that people were willing to give their tax money to missions can be interpreted that peasants were creatively using their own ideas of what constituted a legitimate authority to engage with the colonial rulers.

403 TNA 18/22/19 Chief Mwakiembe to DO Tukuyu, 18/9/1934. Almost seventy years after this letter was written, Nakasebeta Kabage echoed the same feelings during an interview when shed pointed out that “even if the government claimed that it cared for children, failure to offer treatment services for sick children indicated that it cared less about their health.” See, Nakasebeta Kabage, Interview at Maketa, September 18, 2007.

404 For an excellent study on the relation between political authorities and subjects on questions of health and social wellbeing, see Steven Feierman, Peasant Intellectuals: Anthropology and History in Tanzania (Madison, The University of Wisconsin Press, 1990).
The strategy of chiefs mediating between the interests of peasants and colonial administration was necessary for them to safeguard their political positions. As Nakasebeta Kabage pointed out,

> Chiefs needed to listen to the needs of their people [subject population] in order to remain in their positions. If they did not do so, the subject population would rebel against them. They would riot against them. There would be chaos in their [chiefs’] areas of jurisdiction. The colonial government would not tolerate them. The government would demote them. If people rebelled against chiefs, and chaos reigned, they could lose their positions. So, chiefs built a good relation with the people they represented and with the colonial administration in order to remain in their chiefly positions.\(^{405}\)

Kabage’s memories meant that by working as spokespersons for rural peasants’ demands and concerns to the colonial administration, local chiefs cemented their position as their representatives in the local communities. Another interviewee, Mbakisye Kamwela, amplified this point as follows:

> Local chiefs had to do what their subjects and the colonial administration expected from them in order to maintain their positions. They portrayed themselves as diligently working for the course of their subjects. When they met colonial officials, they presented themselves as advancing the interests of the colonial administration. They had to understand the needs and interests of their subjects and the colonial administration and made sure they were accepted by both. Otherwise, they would not remain in their positions.\(^{406}\)

Kamwela’s reminiscences reveal that local chiefs strived to understand the concerns and interest of their subjects and colonial administration as a precondition for maintaining their political positions. That is why their role in the negotiations between peasants and the colonial government were so crucial during the struggles over the incorporation of

\(^{405}\) Nakasebeta Kabage, Interview at Maketa, September 10, 2007.  
\(^{406}\) Mbakisye Kamwela, Interview at Isongolo, June 24, 2004
curative medicine into the infant welfare interventions. Through the letters that they wrote to the colonial administration, chiefs were “intermediaries [and] interpreters” who made possible the transactions between the government officials and peasants in the rural communities. Chiefs straddled the African and European worlds of colonialism in ways that served their own personal agenda of cementing their political positions. Their ability to negotiate the interests of peasants and the colonial administration alike was critical for pushing peasants’ agenda of incorporating treatment of infant diseases in the welfare programs.

The letters expanded the boundary of negotiations and dialogue between peasants and local chiefs in the rural communities by engaging district and territorial colonial government officials. A close reading of the letters that Philip Huggins, the Rungwe district administrative officer, wrote to Ralph Scott, the Director of Medical Services in Tanganyika, in 1936 illustrates this point. Huggins wrote that “Native women demand that welfare centers should be treating sick children… [and] they complain of having no immediate help for their sick children….” This statement is important for revealing Huggins’s engagement with women’s demands, and thus the unfolding negotiations between peasants, chiefs, and government officials over the incorporation of curative medicine in the welfare interventions. In these engagements, Huggins was particularly concerned by the realization that attendance in the mission welfare centers for both

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407 The quoted words are from the title of the book by Lawrence, Osborn, and Roberts eds., Intermediaries, Interpreters, and Clerks.
408 TNA 18/27/3 Huggins, DO Tukuyu to DMS, Dar es Salaam, 10/6/1936.
expectant mothers and children exceeded the attendance recorded in the government centers. He produced the following table to illustrate the variations in attendance.

**Table 1: Attendance of Children in Mission and Government institutions.**

<table>
<thead>
<tr>
<th>Year</th>
<th>Attendance in Government Centers</th>
<th>Attendance in Mission centers</th>
<th>Total Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1931</td>
<td>212</td>
<td>863</td>
<td>1074</td>
</tr>
<tr>
<td>1932</td>
<td>146</td>
<td>1401</td>
<td>1546</td>
</tr>
<tr>
<td>1933</td>
<td>1096</td>
<td>3011</td>
<td>4107</td>
</tr>
<tr>
<td>1934</td>
<td>1214</td>
<td>3620</td>
<td>4834</td>
</tr>
<tr>
<td>1935</td>
<td>1200</td>
<td>4833</td>
<td>6033</td>
</tr>
<tr>
<td>1936</td>
<td>1105</td>
<td>4219</td>
<td>5324</td>
</tr>
<tr>
<td>Total</td>
<td>4973</td>
<td>17,947</td>
<td>22,920</td>
</tr>
</tbody>
</table>

The table illustrates that from 1931 to 1936 three times as many parents took their children to mission centers than to government centers. A total of 17,947 children attended mission centers compared to only 4,973 children who attended government centers. Although the available evidence sheds little light that can allow us to analyze variations in attendance from one year to another, these numbers reflect and reinforce the popular discontent expressed in the letters written by chiefs and in the oral recollections I have analyzed above. In particular, this table provides evidence that some rural peasants boycotted government welfare centers in favor of those run by medical missions. As Huggins himself wrote,
Few mothers send children at the government centers but they flood the mission centers where they can get inspection, advice, and medical care during sickness. If we want to reverse this trend, we must provide treatment services which they demand.\textsuperscript{409}

An interesting point to note about the letter is Huggins’s assertion that implementing African demands would make government programs appealing to African mothers, who would in turn reverse their preference for medical mission services. Huggins’ stipulation that “if we want to reverse the trend [of boycotting government-run centers], we must provide treatment services which they [Africans] demand,” reinforces this chapter’s proposition that the development of colonial welfare programs was not a creative work of government officials alone. Rather, it was a product of negotiations between government officials, peasants, and local chiefs.

Huggins’ letter raised an equally important point concerning dwindling revenues due to the unwillingness of Africans to pay taxes that did not help to improve medical provision. He wrote that “revenue collections are dwindling as natives are not cooperative in paying taxes…[and t]he explanations I have received from the local authorities [chiefs] attribute the decline to natives’ dissatisfaction with medical care.”\textsuperscript{410} Unfortunately, Huggins did not back up dwindling revenues with statistical evidence,\textsuperscript{411} as he did with attendance of children in government-run centers. Thus, it is not possible to understand the extent to

\textsuperscript{409}Ibid.
\textsuperscript{410}Ibid.
\textsuperscript{411}The issue of dwindling revenues from taxation may also have raised concerns within the colonial administration because as Meredeth Turshen and Crawford Young have argued, taxation was the major source of financing and sustaining the operations of the colonial government and other institutions of the colonial state like armies, police, courts, and prisons. See Meredeth Turshen, \textit{The Political Ecology of Disease in Tanzania} (New Brunswick, Rutgers University Press, 1984), pp.33-35; Crawford Young, \textit{The African Colonial State in Comparative Perspective} (New Haven and London, Yale University Press, 1994), pp. 124-133
which revenues were decreasing as a result of these peasants’ dissatisfactions. We are also not able to know the actual number of people who resisted paying taxes. However, Huggins’s explicit reference to the content of local chiefs’ letters to support his statements on the dwindling revenues suggests that rural peasants’ demands, grievances, and pressure reached relevant colonial authorities. Quite significantly, the reference offers evidence that complex negotiations between chiefs, peasants, and government authorities were at the center of the struggles over the incorporation of curative medicine in the welfare programs.

Huggins’ letter to Ralph Scott tied local politics and negotiations to the territorial stage. Scott responded to Huggins’s letter by writing that

We are at present not able to provide funds for upgrading infant welfare centers into dispensary-like centers for dealing with sick children. However, if native authorities are capable of shouldering the operational costs of running the dispensaries, I have no problem with that development…. If mothers are not willing to send infants for advice unless there were curative services for the sick children then we should provide medical treatment. The problem is that at the moment, there is no manpower to do that. We must change our training programmes so that we prepare native dressers for welfare work and for elementary treatment of illness. We can not afford to lose the trust that natives are bestowing upon us.\(^\text{412}\)

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\(^{412}\) TNA 18/27/3 Ralph R Scott, the DMS to Huggins, Tukuyu DO, July8, 1936. By delegating the responsibility of funding the running of rural tribal dispensaries to Native Authorities, these colonial officials shifted the cost burden to rural peasants because Native Authorities operated through taxes that peasants paid. The unwillingness of the central government to shoulder all the costs rural native dispensaries in the 1930s and 1940s may have been due to the consequences of the Great Depression and the Second World War, which undermined the financial capabilities of the colonial government. This period witnessed colonial economies and governments suffering from the unfolding impact of the Great Depression (mostly from 1930-1935), followed by the Second World War three years later (1938-1945). These capitalist crises might have made the colonial government hesitate to expend its scarce financial resources to expand medical care from the urban centers to the remote rural communities where the majority of Africans lived.
Scott’s claim that “we can not afford to lose the trust” reveals that colonial government officials did not implement the welfare programs in splendid isolation. Rather, implementation required government officials to enter into relationships with Africans and local chiefs, as well as to address the interests and demands of African mothers. Specifically, colonial officials recognized that the success of their welfare agenda required building the trust and confidence of African mothers. In addition, Scott’s stipulation that “if mothers are not willing to send infants for advice unless there were curative services for sick children then we should provide medical treatment” further illustrates that infant survival interventions were about negotiations, and in this case, they involved government officials accommodating African demands. Apart from Scott, Dr D.A. McKenzie, a senior medical official in the medical department, also noted that implementation of infant welfare policies benefited from the interactions between Africans and colonial government. McKenzie wrote,

…. [I]t was the African who requested medical services. He demanded more than the government could give him. He wanted individual treatment and personal concern with his health problem… To respond to the new demands, the government trained tribal dressers.\footnote{TNA 12606, D.A.McKenzie, 'The Native Authority Dispensaries}

Mackenzie wrote explicitly that the initiative to incorporate curative medicine was an agenda that Africans put forward.

Taken together, the writings of Huggins, Scott, and Mackenzie were responses to the questions, concerns, and demands that Africans had put forward in their efforts to see improvement in the colonial government’s welfare services. These writings highlighted
the multisided nature of the negotiations that involved peasants, local chiefs, medical missions, and government officials. They also underlined the multileveled nature of these negotiations, as they drew together power relations in rural communities, the district, and the territory to grapple with infant welfare programs.

Scott and Mackenzie noted that implementation of peasants’ demands necessitated the training of a cadre of “native” dressers in basic preventive and curative medicine. Colonial officials envisioned this training to prepare dressers to “live in a village or district, and be able to diagnose simple and common diseases; to perform simple operations; give injections; minister to the health requirement of the village; look after the sanitation; and dispense stock mixtures.”\textsuperscript{414} Local Authorities under the chiefs proposed the candidates to undergo training and the District Medical Officer examined their qualifications for approval. To qualify for this training, the candidates had to possess sufficient general education (usually standard five or above) that could enable them to follow medical instructions. In addition, candidates had to read and write Kiswahili sufficiently well to be able to send reports to higher authorities.\textsuperscript{415} The colonial government required dressers to be employed in their home districts because they understood the customs and language of their own people.\textsuperscript{416} Training schools for dressers started at Tukuyu, Tabora, Mwanza, Bukoba, Musoma, and Tanga and by 1937,

\textsuperscript{414} Quoted in Clyde, \textit{History}, p.143
\textsuperscript{415} Clyde, \textit{History}, p.118
\textsuperscript{416} Note that this was the same arrangement for the cadre of welfare workers who were also required to work in their natal communities for the same reasons.
a total of ninety-two dressers were being trained in these schools.\textsuperscript{417} Training lasted eighteen or twenty-four months and prepared dressers on preventive health, hygiene, illness diagnosis, and elementary treatment.\textsuperscript{418}

The training would allow the dressers to integrate preventive and curative services in the rural dispensaries. The \textit{Memorandum of Health Policy} of 1938 emphasized this training and work of dressers by stating that “[t]he preventive outlook must at all cost be inculcated into the … dresser[s], although [their] first duties are curative; [they should be encouraged to … keep their people well, instead of using all the resources of the dispensary to cure the sick.”\textsuperscript{419} The reference book for these skills was \textit{Kitabu Kidogo Cha Madressa (Instructions for Dressers)} that offered guidelines on basic aspects of dressers’ training such as diagnosing diseases, drug mixing, needle sterilization, hygiene, drug prescription, dosage, and using needles/injections, to mention a few.\textsuperscript{420} In addition, dressers received training in preventive medicine. The major reference for this training was Ralph Scott’s \textit{An introduction to the Study of Preventive Medicine}.\textsuperscript{421} Emphasis was on nutrition, hygiene, digging/using latrines, and cleanliness. Furthermore, dressers’ basic training concerned disease causation, especially parasitic diseases. The basic textbook for

\textsuperscript{418} Relevant works on this cadre of workers includes Iliffe, \textit{East African Doctors}; Malloy, “Holding [Tanganyika] by Sindano.”
\textsuperscript{419} Medical Department, \textit{Memorandum of Medical Policy} (Dar Es Salaam, Government Printer, 1938), p. 8
\textsuperscript{420} Tanganyika Territory Medical Department, \textit{Kitabu Kidogo Cha Madressa (Instructions for Dressers)} (Dar es Salaam, Government Printer, 1935).
\textsuperscript{421} Ralph Scott, \textit{An Introduction to the Study of Preventive Medicine} (Dar es Salaam, Government Printer, 1935).
this learning process was *Magonjwa Yaletwayo na Vimelea na Matibio Yake*.\(^{422}\) Finally, they learned the basics of using a microscope in illness diagnosis. In 1938, Sister M. Thecla Stinnesbeck published a book on the use of microscopes in disease diagnosis.\(^{423}\) An important point to note is that the training that native dressers received was more complex than that of welfare workers whom I analyzed in the previous chapter. While the training of welfare workers focused only on basic preventive care, that of dressers integrated basic preventive and curative medical practices.

Although the rural dispensaries started in the context of Africans demanding that the colonial government improve infant survival interventions by including curative medicine, the resultant medical services were available to both children and adults. For instance, the *Kitabu Kidogo cha Madressa* had the following guideline for using quinine to treat fever:

- For a child still in its parent’s arms, the measure of medicine is two teaspoons.
- For a child of middle age the measure of medicine is four to six tea spoons.
- For a teenager or adult the dose is one ounce.\(^{424}\)

This guideline indicates that native dressers were expected to deal not simply with infants still in their parents’ arms, but also with other children and adults. Thus, the effects of rural peasant’s struggles that began in the form of improving child welfare spilled over to touch all age groups in the rural villages. By 1938, eight rural dispensaries and African

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\(^{422}\) Noel Chilton, *Magonjwa Yaletwayo na Vimelea na Matibio Yake: A Description of the Common Parasitic Diseases of East Africa with Notes on their Diagnosis and Treatment for Swahili-Speaking Rural Dressers* (Dar es Salaam, Government Printer, 1936). New editions for this book were published in 1942 and in 1946, suggested that it was probably a valued textbook in the training programs.


\(^{424}\) *Kitabu Kidogo Cha Madressa* op.cit, p. 15
dressers were operating in Rungwe district, serving approximately 195,062 Africans. The number of dressers increased to 15 by 1946.\textsuperscript{425} They worked in native dispensaries in Bundali, Bulambya, Kyela, Lutengano, Kapugi, Ibaba, Mwakaleli, and Ntebele. Steven Mogha recalled that mothers were happy sending children to Malangali dispensary to get medical care.\textsuperscript{426} Kaswashi Pwele enthusiastically pointed out that rural dispensaries relieved people from walking the long distance to Tukuyu district hospital or to Isoko mission, unless the medical condition was too serious to be dealt with by dressers.\textsuperscript{427} In addition, Mwamuleghe Kamwella claimed that people were happy to be able to get medical care at the dispensary, and that the frequency of youth carrying sick people in \textit{ifipimbilo} [locally made stretchers] decreased.\textsuperscript{428} Both children and adults could access medical care offered by the expanding rural dispensaries in the rural communities.

Archival records reveal the medical tools and gear that dressers used in the rural dispensaries. The tools included cotton wool, scissors, thread, thermometer, soap, canvas bags, drugs, syringes, razors, scalpels, bandages, dissecting forceps and other utensils.\textsuperscript{429} Dressers dealt with medical conditions such as malaria, fever, constipations, bronchitis, ulcers, asthma, convulsions, venereal disease, stomach complaints, parasitic worms, bone setting, and wounds. They sent serious cases of patients to the district hospital, including the slides of blood, stool, or bloody diarrhea for illnesses they could not diagnose.\textsuperscript{430}

\textsuperscript{425} Rungwe District, Annual Medical Report for 1938, p.7; Rungwe District, Annual Report for 1946, p.12
\textsuperscript{426} Interview with Steven Mogha, op.cit.
\textsuperscript{427} Interview with Kaswashi Pwele, op.cit.
\textsuperscript{428} Mwamuleghe Kamwella, Interview at Kafule, May 23, 2007
\textsuperscript{429} Rungwe District, Annual Medical Reports for the Years 1929, 1943, 1947. For more discussion on dressers’ resources in Tanganyika, see Malloy, Holding [Tanganyika] by Sindano,” p.209-213
\textsuperscript{430} Ibid.
Although sending the slides to the district hospital was a plausible instruction, the remoteness of some dispensaries from the district hospital made it difficult to do so regularly.\textsuperscript{431} For remote areas, therefore, the only option for complicated cases was to carry the patient to the hospital.

The working conditions and resources necessary for dressers to discharge their work effectively were not always adequate. In 1944, the District Medical Officer complained that there were no drugs at Malangali rural dispensary, and there was no money to buy new supplies. At Kyela, he noted that drugs were in short supply and the dressers did not have razors and soap. Finally, he noted that the dispensary at Kapugi was in bad shape.\textsuperscript{432} These observations suggest that dressers worked in difficult conditions and with scarce medical resources.

Through their preventive and curative medical practices in remote rural communities, dressers integrated remote rural communities into colonial medicine. As Patrick Malloy has pointed out, “…among those African men and women who received some form of training for work in the colonial medical system, it was the “Native Dressers” who carried biomedicine farther afield into the rural areas of Tanganyika, beyond the district centers with their hospitals.”\textsuperscript{433} In addition, John Iliffe has argued that the status and respect of dressers increased significantly and that over time; they “were outpacing

\textsuperscript{431} TNA 152B, Letter from MO, Rungwe District, to PC, PMO, Southern Highlands, 3/7/1947
\textsuperscript{432} TNA 10654, The Welfare of Native Population in Rungwe District
\textsuperscript{433} Malloy, “Holding [Tanganyika] by Sindano,” p. 202
schoolteachers and clergymen as protagonists of enlightenment as they practiced medicine in the rural communities. Through these dressers, “[t]he health services would thus be brought to all those people living in areas previously distant from treatment centers, and would no longer be restricted in the main to government officials and the population of the larger towns.” By “treating minor medical cases, rendering first aid for medical and surgical conditions, and promoting the elementary principles of hygiene,” the native dressers offered the services that rural peasants demanded and pressured the colonial government to provide in their communities.

Dressers’ medical work enhanced the presence of the colonial government in rural areas. Ralph Scott characterized the work of native dressers and dispensary organization as follows,

“These men carried western ideas of medicine and hygiene into the furthest corners of the territory …. The tribal dispensaries constructed and maintained by the native authorities provide the furthest outposts of medical work in the districts and it is our constant endeavour to improve the efficiency of this intimate link with the people …. Thus, the Medical Department of Government, through its provincial and district medical staff who are responsible for the technical supervision of the tribal dispensaries, and by collaboration with the missionary organization, maintains touch with various elements of the population in the furthest corners of the territory.”

Scott’s argument that the medical work of native dressers provided a “critical intimate link with people” and allowed the colonial government to “maintain touch with various elements of the population in the furthest corners of the territory” reveals that the

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434 Iliffe, *East African Doctors*, p.49
435 Ibid., p. 117
436 TNA 13350, Rural Health Services; Beck, *A History*, p. 213
437 Quoted by Clyde, *History*, pp. 119; 143. My emphasis
significance of medical interventions lay in allowing the colonial administration to penetrate from urban areas to remote rural communities through the intimate realm of health, healing, and illnesses. In addition, Ann Beck has noted that rural dispensaries raised the morale of the people they served because it made them feel that the colonial government authorities cared for their own health. For her, these medical interventions simultaneously allowed rural peasants to have access to both preventive and curative medicine in their vicinities and allowed the colonial government to interact with Africans directly in their communities.

The incorporation of curative medicine that native dressers were implementing in the remote rural areas was fraught with intense negotiations among medical officials. As the above discussion has indicated, some medical officials such as Scott supported peasants’ demands for the incorporation of curative medicine in welfare programs. Their support needs to be situated within a broader context of the development of colonial infant welfare initiatives. Scott had practiced medicine in colonial Tanzania from the end of the First World War and thus he was part of the British colonial establishment for two and a half decades when he retired in 1945. He was the deputy director under John Shircore when the colonial government formulated infant survival measures in the 1920s as a tool of legitimizing its presence within African communities, especially in the rural areas. When he eventually became the Director of Medical Services in the 1930s, Scott played a role in undermining the competitive advantage of the medical mission by cutting subsidies, as shown in chapter three. When rural peasants pushed the colonial

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government to include curative medicine in the 1930s, Scott was part of the negotiations and social engagements that culminated in the incorporation of curative medicine. Scott, as discussed above, believed that the incorporation was politically necessary in order to win the confidence and trust of Africans.

Some medical officials did not support the incorporation of curative medicine in the rural welfare work because by the 1930s and 1940s there was no infrastructure that could ensure the provision of quality curative services or the supervision of dressers in the remote rural areas. For example, P.A.T. Sneath, who succeeded Ralph Scott as the director of Medical Services in 1945, challenged the incorporation of curative medicine that began in the late 1930s. Sneath arrived in Tanganyika for the first time in 1944 as the deputy director under Scott, whom he succeeded in 1945. As a new comer to the territory, he was thus not part of the negotiations that culminated into the integration of preventive and curative medicine that he witnessed when he arrived in the territory. More specifically, he was not part of two decades of the effort of the colonial government to exploit medicine as a political resource of legitimating colonialism. After taking charge of the medical department, Sneath toured the territory in order to understand the nature and character of health services being provided in the territory, including maternal and child health. One development puzzled him, as his tour report revealed,

I think we must carefully avoid the perpetuation of the idea that the major purpose of [dispensaries] is to relieve medical officers of clinical concern with sick outpatient women and children.... In my opinion we can not perpetuate the confusing doctrine that the treatment clinic may lend itself to a physical combination with a “preventive and health” clinic. What I am interested in “getting across” is that pregnant mothers should seek advice and guidance before
the complications of pregnancy occurs, and that well babies may be kept from getting sick. …. When sickness occurs, the sick mother and the child should be referred to another clinic or to the general dispensary service.\textsuperscript{439}

Sneath’s discovery that child welfare programs engaged with treating diseases instead of focusing on preventive educational work alone puzzled him. He arrived in Tanganyika with the notion that child welfare work was limited to preventive and educational interventions that would keep infants from getting sick. His views reflected the ideas that informed Shircore’s formulation of infant welfare policies of the 1920s and early 1930s. For Sneath, the treatment of illnesses was the responsibility of hospitals and dispensaries, and that sick children ought to be taken there. Sneath was in effect proposing having two different types of facilities for children: facilities specializing in health promotion and facilities for dealing with sick children.

Sneath asked medical officials in the districts and provinces to study and compile reports on maternity and child welfare work in their respective areas. Specifically, he wanted to solicit their ideas on the ongoing trend of merging preventive and curative services in programs supposedly meant to improve child welfare. One response came from E. Jackson, the medical officer of Tabora. In an extensive letter to Sneath, Jackson wrote:

The modern stress on the purely educational role of ante-natal and child welfare clinic appears to have been absent… and (the clinics are) filled with purely obstetrical duties and the outpatient treatment of sick women and children. Work along curative-preventive lines with a natural starting point in the ordinary out-patient department appears still to have been the policy nine years ago; to organize on purely preventive and educational lines was considered impossible…. [A]nd firmly as I am convinced that prevention of disease in children is of infinitely more value than patching up sick children and mothers, I consider that it

\textsuperscript{439} The quotes are in the original text. TNA 450/108/1. Maternity and Child Welfare, ref. 62A/45/9/5 dated 27/5/1946
is essential to find some compromise in order that we may not alienate the familiarity and beginning of trust which Africans are starting to have in western medicine. This compromise can only be devised by people with experience of modern western welfare clinics combined with real knowledge of Africans among whom they work. With my English background I am most impatient of a practice of giving a dose of medicine of some kind to every woman and child attending the clinic, but most people who have much experience of African women consider that to be necessary .

Clearly, Jackson was against the integration of preventive and curative medicine as an integral component of welfare work in rural areas. Like Sneath, Jackson believed that preventive interventions were sufficient to improve infant welfare. That is why he was “most impatient” with the practice of giving medicine to mothers and children every time they came to the clinic whether they needed it or not. Jackson, like many other medical practitioners in the territory had an “English background” not only in nationality, but also in his intellectual and professional training. The premise of this training was that empowering mothers with preventive and educational skills formed the foundation for raising healthy children. The practice of medical treatment of children which Jackson and Sneath were observing in Tanganyikan child welfare measures was thus an antithesis to this foundational assumption.

While Jackson supported Sneath’s position, there were also opponents, as Dr Arthur. J. Keevell’s response to Sneath’s critique illustrates. Keevill responded,

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\(^{440}\) Emphasis (underlined sentence) in the original. TNA 450/108/1 Maternity and Child Welfare. Letter to The Director of Medical Services, ref. 11/1/362, dated 21/12/1946

You will remember that the first place you visited was what you designated “The Maternity Centre” and what we usually refer to officially as “The Maternity and Child Welfare Clinic.” … It appears to me that unless designations have altered since I was home last time, the work done here is a little more than one would expect in a maternity center…. If we “cannot pretend that we are offering an Infant and Child Welfare Service” until it is one hundred percent efficient, then we should apply the same yard-stick to the whole Medical Service. The hospital buildings of the Territory are merely caricatures of “hospitals” by British or American standards … Even if I could prove with mathematical accuracy that malaria is a great “killer” during the first year of life (a conviction born of experience) what can we do about it except to dose infants with Totaquina? … When you write “… we can leave the hospitals to deal with the sick of all ages” do you mean that so-called Clinics should be interested only in healthy infants? If so, [this thinking] does not make sense …. It is quite natural that the African mother should take her infant, when sick, to the people who have been interested in it when healthy. Otherwise how can we get to know what happens to the infant? …. So that, in my opinion, if all sick infants are forbidden to attend the Clinics and must attend only the hospital as members of the general native population, that would be the end of even the present poor attempt at arriving at some idea of “what reduces infant and child life.” … I believe that treatment of infants pays a better dividend than much time spent over chronically diseased and incapacitated adults.442

Keevill opposed Sneath’s proposition that clinics should be serving healthy infants alone, and that sick infants should be sent to general hospitals for treatment. He strongly believed that such curative services were critical ingredients in infant survival improvement efforts. For Keevell, investing in the treatment of infants was the best strategy for winning the confidence of mothers. He reasoned that this investment would increase the interest and confidence of mothers to utilize welfare services if they learned that the medical practitioners were interested both in healthy and in sick infants.

On 20th February 1947, Sneath responded to Keevill’s criticism in the following manner.  

442 TNA 450/108/1 Maternity and Child Welfare. Letter to The Hon. The Director of Medical Services, dated February 6, 1947.
You may be assured that I am as disinterested in fame and fortune as you are, or I wouldn’t be here. However, I am satisfied that the Tanganyika Medical Service needs a spur to provide a better quality of services not at a wider range in which we stretch our resources beyond their physical capacity. I am disturbed by the production line diagnosis and issues of medicine that goes in the name of treatment of disease, and I am appalled at the ignorance and inertia of the public in realization of what they themselves can or could do to reduce the burden of sickness…. [T]he … practice of medicine (must) lose the aura of another kind of the magic and become less a weapon of political barter and more the demonstration of the honest purpose that most of us envisaged when we first became students of medicine. ⁴⁴³

Sneath was thus reinforcing his earlier position that privileging curative medicine was not the right strategy for infant welfare improvement, and that what was needed were aggressive efforts to address the ignorance of the public on what they could do to reduce the burden of sickness. He challenged the political uses of medicine to appease Africans which privileged quantitative considerations at the expense of quality. In addition, he was concerned that political considerations of appeasing Africans compromised the “honest purpose” of practicing medicine. Sneath’s opposition to the multiplication of centers that combined preventive and curative medical services throughout the territory was based on medical considerations and his professional dedication. This dedication was implicit in his claim that he joined the medical profession because he thought medicine served the “honest purpose” of ensuring that people received quality care that reflected the level of science and resources available.

Sneath employed his executive position as the Director of Medical Service to voice his disagreement over the tendency of defining treatment of children as a central component

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in infant welfare interventions. He articulated his position in Medical Department Circular No.760 of 1947, titled *Maternity and Child Welfare Clinics*, which he distributed to all Provincial Medical Officers, Medical Officers, Surgeons, Matrons, Health Visitors, and Nursing Sisters. In this Circular, Sneath wrote,

> In the course of my various tours I find that much of the co-called Maternity and Child Welfare effort, consist solely in affording facilities for confinements. These have become so popular, that the purpose of ante-natal, post-natal and child welfare have either been lost or have never been incorporated in the programme. Infant and child welfare work, where such is to be found in conjunction with maternity work, appears in the majority of instances to consist in the treatment of sick infants and children. The argument I have met in defence of this, has been that mothers require that medicine be provided or they will think they are not getting anything for their effort. I would submit that the treatment of the sick is a hospital responsibility and to follow this course as part of an infant and child-welfare function, is to perpetuate in a malleable community, all of the inequity and fraud of our own kind, whose views of treatment may be erected upon the shrine of the bottle and the syringe. I believe the time has come when the African mother should be “weaned” from this worship of false gods, and that Infant and Child Welfare should be made an integral part of the whole Maternity Scheme. To popularize ante-natal efforts and competent institutional or domiciliary deliveries of African women, as we have in some regions in this Territory, and to fail in making it clear to the mothers thus benefiting, that their part in the programme is to raise a healthy child and ours to provide facilities for guidance and direction to that end, is to waste efforts and miss the target.\footnote{TNA 34303. Medical Department Circular No.760 on Maternity and Child Welfare Clinics. Emphasis (require) in the original.}

Sneath’s Circular is significant in its acknowledgement that many colonial officials in the territory explained the transformation in infant survival interventions, which witnessed the inclusion of curative services to the pre-existing purely preventive interventions from the late 1930s, in terms of the demands from Africans, especially women. The government officials’ acknowledgement that Africans, especially mothers, “required” this inclusion to make welfare interventions meaningful as they perceived them,
underscored the extent to which Africans were part of the negotiations that shaped the evolution of medical policies and practices. Sneath was skeptical that emphasis on the treatment of infants and the uncontrolled expansion of western medical treatment centers would improve African health, including the welfare of infants. His characterization of the whole process of privileging western curative practice in welfare interventions as “fraudulent,” “worship of false gods,” and “shrine of the bottle and the syringe” reveal this skepticism. Sneath’s conviction was that focusing on prevention rather than curative medicine was the most viable option for improving the welfare of children within the colonized population.

There were also negotiations between government departments, particularly between the medical and administrative department over the incorporation of curative medicine in infant welfare programs. Sneath criticized the administrative political officials, who favored the integration of preventive and curative medicine, for using medicine politically to appease “ignorant” Africans. In a letter that he sent to the Chief Secretary of Tanganyika territory, he wrote,

The African public does not really distinguish between the benefits of medical competence and incompetence. … What inducement is offered when they are satisfied that all is needed is scattered buildings where medicines may be doled out and injections, irrespective of need or content there of, may be given, by a person with from six months to 2 years training? I regret that this, in my opinion, is a fraudulent imposition on an ignorant people. Expediency in the past, for good or bad reasons has created an appetite for this “appeasing treat.” These are the reasons for opposing the multiplication of these facades … [which meet] the local demand for a substitute for the local “medicine man” or for the vendors of patent medicines.  

445 TNA Secretariat 12602, Village Dispensaries.
Although Sneath’s language was paternalistic and he looked at Africans as ignorant and primitive, his continuous reference to “African demands” further revealed negotiations between Africans and colonial government officials over the incorporation of curative medicine in the infant welfare programs. He opposed the colonial administration for succumbing to Africans who could not “distinguish between the benefits of medical competence and incompetence”\(^{446}\) and whose demands were thus informed by what he thought of as sheer ignorance. For him, the government’s implementation of Africans’ demands constituted “a fraudulent imposition on an ignorant people.”\(^{447}\) The use of colonial medicine to “appease” Africans, Sneath thought, undermined the purpose which medicine was intended to serve. He thought that the absence of qualified manpower who could meet the standards of medical practice undermined the quality of medical care being practiced. He characterized such medical practice as a “façades” having little potential for improving African health.

Colonial officials in the administrative department responded to Sneath’s propositions by reaffirming their continued support for the incorporation of curative medicine. The extract from the report of the District Commissioners Conference expressed their concerns of the Medical Department’s new direction that Sneath articulated,

> The District Commissioner, Nzega, expressed keen dissatisfaction with present medical policy, and stated he did not agree with the principle that until facilities had reached 100% efficiency, they should be completely withdrawn. He felt strongly that priority should be given to the need of the vast majority of the population for elementary treatment rather than that of the few for specialized medical facilities. Tribal dispensaries, low as their standard might be, were better

\(^{446}\) Ibid.  
\(^{447}\) Ibid.
than native “dawa” and witchcraft. Whatever was the opinion of the Director of Medical Services [Sneath], the requests of the general public should be considered, who in spite of poor medical facilities in the past, still clamoured for more. The District Commissioner, Tabora, said he endorsed District Commissioner, Nzega’s views completely. He wished to go further – and in this he felt he had the support of all District Commissioners present – in requesting that a public statement on present medical policy be called for and Government asked whether it accepted the Director of Medical Services’ policy as there was widespread discontent among the people at this lack of and withdrawal of facilities in rural areas. Medical policy was definitely the business of the Administration. Provincial Commissioners at the last Conference had not approved of the policy outlined to them by the Director of Medical Services, and the difference of opinion between the Medical Department and the Administration should be solved by Government.

This extract further reveals interdepartmental negotiations and contested opinions. District Commissioners, who were part of the colonial administrative branch, were against the Director of Medical Services for trying to limit the provision of health services not only because they served an important role in meeting “elementary treatment” needs of many Africans in the rural communities, but also because it was necessary to satisfy “the request of the general [African] public” who “clamoured for more” of these services. The claim in the quotation that “the requests of the general public should be considered” provides further revelation that negotiations among colonial officials and between colonial departments were part of the complex negotiations with Africans and local chiefs that shaped the development of welfare interventions.

This extract is also valuable for the way it reveals power struggles within the colonial government over the control of health services. While the Director of the Medical

448 TNA 480/108/13 Extract from the Minutes of the District Commissioners’ Conference held at the Provincial Office, Tabora, on 17th April, ’1947. Emphasis (italicized and underlined) in the original.

449 Ibid.
Department wanted to exert total control on matters pertaining to health services in the
territory, the political administrators thought that determining medical policies was their
responsibility. These conflicting ideologies suggest the extent to which, as Sara Berry has
argued, colonial states, and colonialism more generally, were terrains of contradictions
and fragilities between colonial officials who held different ideas, strategies, and
motivations for running state institutions; and that states were arenas within which social
groups struggled to advance their interests.450

The Director of Medical Services defended his position, arguing that political pressures
to provide curative medicine in the rural welfare programs could not improve health
because there was no infrastructure for ensuring the provision of quality services. He
argued,

The [administrative department’s] alternative means that the standard of service
given everywhere will be of a very low order, that few if any of the recent
developments in medicine can be applied in such a manner as to give any real
benefit to either the individual or to the community as a whole and finally that we
will not be able to study the effects of modern medicine in improving the
admittedly poor condition of the African and so will have to postpone indefinitely
the application of a social medical policy that alone can affect him on a territorial
basis….. It is realized that the success of western medicine has made the African
anxious to have its newest benefits easily available everywhere and that there are
political reasons why we should attempt to satisfy his not unreasonable demands.
Unfortunately we are at present quite unable to fulfill them and any such attempt
will only provide him with a sham service which will be of little use beyond the
ignorant pride of possession. Especially during recent years medicine has made
considerable strides, each stride has necessarily involved greater care in

450 Sara Berry, “Hegemony on the Shoestring: Indirect Rule and Access to Agricultural Land” Africa: Journal of the International African Institute, Vol.62, No. 3 (1992): 327-355, p. 238. See also Sara Berry, No Condition is Permanent: The Social Dynamics of Agrarian Change in Sub Saharan Africa (Madison, University of Wisconsin Press, 1993), chapter 2. For my discussion, I am particularly interested in the complex and contested nature of a colonial government, which was one of the institutions of the colonial state.
examination and treatment of the individual. We are frankly unable with our present staff to keep pace with the advances of medicine unless we steadfastly refuse to extend medical department facilities beyond a reasonable radius from our main stations….451

The sentence that I have underlined reinforces the chapter’s central proposition that the incorporation of curative medicine in the rural welfare programs resulted from negotiations between many social actors, and this quotation mention three of them, political administrators, health officials, and Africans. The Director of Medical Services accused the colonial political administrators for haphazardly responding to African demands in order to achieve political gains. He argued that political considerations resulted in “sham [medical] service which [had] little use beyond the ignorant pride of possession.”452 These services lacked the quality that would enable them to bring the intended welfare improvements.

The negotiations among colonial officials and between government departments in colonial Tanzania drew the attention of the Colonial Office in London. The Colonial Office supported the colonial administration’s position of combining preventive and curative services in child welfare improvement strategies, and wrote favorably about that. The Office articulated this position in the annual reports that it submitted to the United Nations on the administration of Tanganyika. Characterizing child health services being offered in Tanganyika in the report for 1947, the Office wrote that “Child health clinics are mainly concerned with the care and treatment of sick children, although a number of

451 TNA 480/108/9 Extract from Agenda for P.M.O.’s Conference, 1.3.1947. This quote is from the section on Matters Arising on Maternity and Child Welfare. P.M.O is shorthand for Provincial Medical Officers. The emphasis (the underlined sentence) is mine.
452 Ibid.
these clinics undertake teaching and propaganda work in regard to the prevention of
disease and in the instruction of positive measures." Indeed, in the report for 1949, the
Colonial Office claimed that integration of preventive and curative interventions was
inevitable, arguing that

There is some difficulty in drawing a clear distinction between the curative and the
preventive services. In the present stage of development of the territory many
individual members of the service must be prepared to deal with a complexity of
problems and many medical officers are concerned with both the prevention and
the cure of disease. This argument was important because it entailed that the perceived distinction between
the preventive and curative interventions was an illusion; that the two forms of
interventions were so intertwined that distinguishing between them made little sense.

Drawing on this important conceptual understanding, the Colonial office made a point
that it was necessary that anybody aspiring to work in the colonial service in Tanganyika
had to be prepared to assume both the preventive and curative interventions for
improving the welfare of colonial subjects, including infant survival. The position taken
by the Colonial Office, which seemed to favor the integration of preventive and curative
medicine in the colony offer glimpses that the Director of Medical Services was failing to
reverse the integration of curative and preventive medicine in welfare interventions.

453 Great Britain Colonial Office, Report by His Majesty’s Government in the United Kingdom of Great
Britain and Northern Ireland to the Trusteeship Council of the United Nations on the Administration of Tanganyika for the Year 1947 (London, His Majesty’s Stationery Office, 1948), p. 133. The Office almost
reproduced this characterization in its 1948(page163) report, where it stated that “[c]hild health clinics are
mainly concerned with the care and treatment of sick children, but at a number of them teaching and
propaganda work in regard to the prevention of disease and the introduction of positive health measures is
undertaken.”

454 Great Britain Colonial Office, Report by His Majesty’s Government in the United Kingdom of Great
The Tanganyikan colonial government reviewed its medical policy in 1949 which further reinforced the integration of preventive and curative services. That review was based on the recommendations made by Dr E.D. Pridie, the Medical Officer to the Colonial Office, who evaluated health services in the territory. The Legislative Council of Tanganyika ratified the recommendations in a policy document titled *A Review of the Medical Policy of Tanganyika*. The document stated explicitly that “Although preventive and social medicine have more lasting effects, it is essential under African conditions to have a well-balanced medical service as curative medicine is demanded by the people and its popularity makes preventive medicine acceptable to them.” Through this document, therefore, the Legislative Council emphasized that curative services had to be promoted not only because they facilitated the dissemination of preventive medicine to local populations, but also because that is what Africans wanted. The fact that the government was responding to these African demands illustrates further that the development and dynamics of infant welfare programs involved negotiations.

The positions expressed by the administrative department, Legislative Council, and Colonial Office in London indicated clearly that Sneath could do little to reverse the integration of curative and preventive medical cares in rural areas. This was evident in the language he used to write the *Sessional Paper* as he streamlined the Legislative Council’s medical review into his medical department. He wrote,

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Although preventive and social medicine have more lasting beneficial effects it is essential under African conditions to have a well balanced medical service as curative service is demanded by the people and its popularity makes preventive medicine acceptable to them. The hospital and dispensary system must be brought up to a minimum standard of efficiency at once, to provide adequate curative facilities for as many as possible …“456

This Sessional Paper indicates that Sneath was under pressure from the colonial administration, and thus he softened the uncompromising position that he had maintained since he became Director of Medical Services in 1945. Possibly, Sneath was now coming to terms with the prevailing opinion within the colonial administration that meeting Africans demands was necessary for political reasons, and that there was little he could do to change the condition. An interesting point to note is that Sneath’s stance softened just before he retired in 1950. John Iliffe claims that the colonial government forced him to retire.457 All the same, Sneath’s disagreement and debates with the political administrators during his directorship reveal not only the contested nature of medical provision in the territory, but also the extent to which he was more of a spokesperson of ideals of medical practice than an agent of the colonial administration.458

Sneath’s opposition to the incorporation of curative medicine in rural welfare programs needs to be understood within the context of potential harm that colonial medical cures could bring to patients. As stated earlier, Sneath opposed the incorporation because, among other reasons, dressers were incompetent, medical provisions frequently produced positive harm to patients, and dressers in remote areas lacked close supervision from

457 Iliffe, East African Doctors, p. 45
458 Ibid.
qualified medical practitioners. Medical evaluations of the 1930s and 1940s enhance the
validity of his claims. One of these evaluations reported,

There was an ever present tendency on the part of eager local authorities, supported by the administration, to put up more and more small dispensaries made of mud and wattle, whether or not the dressers staffing them could be properly supervised. It seemed a simple answer to public demand to erect an inexpensive building and employ a Tribal Dresser whose salary as a learner was only twenty shillings a month, increasing by stages to sixty shillings after nine years service. But without regular and frequent inspection by the few qualified medical officers, many of these dressers soon lost interest and forgot their training, or went to the other extreme by attempting to undertake overly ambitious methods of treatment. One example of what could happen was reported by Dr H.G. Calwell, who visited a dispensary in Singida District. The building appeared clean, the man in charge intelligent and neatly dressed, and the confidence the local people had in him was obvious from the large numbers awaiting treatment. But when asked to produce his records, he explained that none had been kept since the dresser had gone sick two months before; he himself was only the untrained sweeper who could neither read nor write.459

This evaluation is important for two reasons. First, it acknowledges that the incorporation of curative medicine was a negotiated process, highlighting that the political administrators supported local authorities (the chiefs) to meet the demands that Africans put forward. In particular, the evaluation acknowledged that the colonial government’s expansion of curative health services in the rural areas resulted from local demands. Second, the evaluation raised serious questions about the qualifications of the dressers to practice curative medicine, particularly the problem of medical supervision in the dispensaries. For instance, the guy manning the dispensary on that day was not even a dresser! He was just supposed to keep the place clean, but he was, in his own and in locals peoples’ eyes ‘practicing medicine.” This was outrageous for those trained in

459 Clyde, History of the Medical Services of Tanganyika, p.121
western biomedicine like Dr Calwell or Sneath. Another evaluation by Medical Department in 1947 complained that the system of using dressers

[w]as in practice failing to fulfill even the elementary purpose for which it had first been intended. A few dressers were doing useful work, but the majority were overreaching themselves. Misdiagnosis was leading to wastage and sometimes to positive harm…

Close supervision of dressers could help to alleviate the problems of misdiagnosis and to monitor the effects of medical cures that dressers offered in rural dispensaries. Unfortunately, the remoteness of most of the dispensaries from the district headquarters, the transportation problem, and the absence of sufficient financial resources to support frequent medical officials’ visits meant that many native dressers performed their duties without close supervision.

In addition, Sneath’s opposition was valid because until the 1940s, many medical cures lacked efficacy, contained poisonous elements, and produced side-effects that harmed patients. For example, many drugs in the 1920s and 1930s were arsenic compounds such as atoxyl used in the treatment of diseases such as yaws, syphilis, and sleeping sickness. Dr Maclean noted in the 1930s that arsenic based drugs for sleeping sickness resulted in cases of blindness among patients in colonial Tanzania. Furthermore, Malloy’s research found out that in 1935 four patients died in Biharamuro because a “bottle containing Bismuth Soldium Tartare (BST) was mistaken for the required calcium chloride. The former, when injected intravenously, as is calcium chloride, is poisonous.

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460 TNA 12602, History of the Tribal Dresser System, 1947, p.4
461 TNA 12602, History of the Tribal Dresser System, 1947, p.3-8
462 G. Maclean, Sleeping Sickness Notes (Dar es Salaam, Government Printer, 1933), p.3-4
All four of the patients were to receive intravenous injections of calcium chloride; all four individuals died as a result of the mistake.” He also recorded another incident in which twenty six people died because of errors in preparing the solution for injecting patients.

What these examples suggest is that health care required well trained medical workers to monitor these potential dangers. It is possible that Sneath was skeptical about rushing to expand curative medical care in the remote rural areas because he understood the potential dangers of contemporary medical cures.

Sneath’s concerns about the dangers of taking medical practices for granted were not unique to colonial Tanzania. Marynez Lyons’s study of sleeping sickness in the former Zaire found that the consequences of treating patients with atoxyl only increased mortality rates, citing an example of an area called Ibembo where nearly one third of patients admitted at the lazaret died. She also pointed out that “there was a dreadful side-effect with atoxyl injections- up top 30 percent of those treated became blind as the drug atrophied the optic nerve.” In colonial Kenya, John Carman pointed out in his *A Medical History of the Colony and Protectorate of Kenya: A Personal Memoir*, that the practice of medicine brought positive harm, and could kill. He narrated his personal experience with an anti-plague campaign as follows,

When we had been at it for a week, all the roads and fields began to be deserted, for the brand of Haffkine plague vaccine put out by the Medical Research Laboratory looked rather like pea soup and gave rise to such formidable reactions.

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463 Malloy, p.154
that by the time our campaign was finished all the people lay groaning in their huts, wondering which was worse, bubonic plague or the sirkali’s dawa (Government medicine).  

Incidences of the harmful effects of colonial medicine were also evident in West Africa. Writing about the Haffkine anti-plague vaccine in Dakar, Myron Echenberg noted that it “was dangerously potent and even toxic” and that it produced painful abscesses, soreness at the point of inoculation, fever, painful swelling of the lymph nodes in the groin or armpits, diarrhea, and insomnia. In addition, he noted an incident in which “breast-fed children were found to have vomited the night following the inoculation of their mothers.” These examples suggest that many parts of colonial Africa experienced the negative side-effects of medical cures. Medical practice required well prepared and qualified health workers who could prescribe medicines and monitor the progress of the recipients of these medical cures.

Situating Sneath’s position in the context of a sample of medical cures’ side-effects that I have outlined above suggests that Sneath clearly understood the state of the art of the field of colonial medicine, the strength and limitations of the existing medical infrastructure, and wanted honesty in the provision of medical services, including infant welfare interventions. Sneath may have lost the battle, but his loss, his arguments, and his positions reveal important insights that this chapter, and thus this dissertation, uncover. The battles, arguments, and losses were manifestations of the contested and negotiated

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467 Quoted by Osaak Olumwullah, *Dis-Ease in the Colonial State: Medicine, Society, and Social Change Among the AbaNyole of Western Kenya* (Westport, Greenwood Press, 2002), p.184

character of the development of welfare programs in colonial Tanzania. In particular, they reveal negotiations among colonial government officials and the way in which these negotiations resulted from their interactions and social relationships with peasants, chiefs, and medical missions during the 1930s and 1940s. Equally important, they confirm that the colonial government was a contested and negotiated social terrain of the state.469

5.2 Conclusion

Negotiations between peasants, local chiefs, health officials, political administrators, and dressers produced the dynamics of the infant welfare interventions from exclusive preventive programs of the 1920s and early 1930s to those that incorporated curative medicine. Peasants demanded that the local chiefs and colonial government include the treatment of infant diseases, and they negotiated and engaged with them by refusing to pay taxes and by boycotting the government-run welfare services. Local chiefs, malafyale, articulated and communicated peasants’ demands and pressure to the colonial administration. Their role in mediating between peasants and colonial officials further made the inclusion of curative medicine in the pre-existing preventive interventions a dialogical and negotiated process. As the colonial government began implementing

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469 By uncovering the negotiations and contestations within the colonial government, this dissertation reinforces the formulation of John Lonsdale and Bruce Berman that colonial states were full of contradictions, complexities, and ambiguities as different entities with the state struggled to define their positions or contest entities that did not enhance their positions. Writing particularly about Kenya, Lonsdale and Berman argued that the colonial state was full of complexities and contradictions since it was a meeting ground for contending economic and political interests: such as interests between settler capital’s priority for independence and cheap supply of labor, metropolitan interests, and the colonial government’s interest to legitimate its rule among Africans. While their research focused more on the political economy of colonial Kenya, their formulation resonates well and shed light into the contested and negotiated nature of the development of medicine in colonial Tanzania. See Lonsdale and Berman, “Coping with the Contradictions”; Berman and Lonsdale, “Crises of Accumulation, Coercion and the Colonial State”; John Lonsdale, “States and Social Processes in Africa.”
peasants’ demands, dressers became central actors in the negotiation process. They received training in preventive and curative medicine that prepared them to deal with the medical challenges of infants, children, and adults in the rural communities. Dressers’ work extended curative medicine in the remote villages and disseminated the ideas and practices of western medical culture among rural inhabitants.

Negotiations were multileveled, connecting the rural villages, the districts, and the territorial headquarters in Dar es Salaam, and the Colonial Office in London. For instance, the writings of Scott, Huggins, Mackenzie, and the local chiefs suggest a line of communication that allowed dialogue and negotiations to move across these levels. A chain of communication was as follows. Peasants in the rural villages put forward their demands to the colonial administration through their local chiefs. Local chiefs who lived with peasants in the rural communities articulated local grievances, demands, and pressures and communicated them to the district administrative officer at Tukuyu, Mr Huggins. Huggins himself communicated these demands to higher territorial authorities in Dar es Salaam. This pattern of communication allowed peasants’ demand for the inclusion of curative services in rural infant survival interventions to reach the district headquarters in Tukuyu and, subsequently, the territorial administration in Dar es Salaam and the Colonial Office in London. The colonial government’s implementation of peasant demands suggest that negotiation and influence went both ways, and that as actors engaged each other, they changed as they accommodated the ideas that other actors put forward.
The incorporation of curative medicine in the infant welfare interventions generated divisions and conflicting ideologies within the colonial government. The political administrators favored this development because it was in line with their own agenda of building African legitimacy and acceptance: an effort intended to increase the popularity of the colonial government among Africans. Within the medical department, there were divisions. Some medical officials supported the inclusion of curative services in infant welfare interventions, together with expansion of dispensaries in remote areas. Other medical officials, most notably the Director of the Medical Department, vehemently opposed this development, arguing that it was an ineffective strategy. He was concerned that there were no resources to ensure the quality of services being provided, that emphasizing treatment of sick infants as integral to welfare work was wrong, and that the medical department did not have enough resources to supervise health services in the rural areas. Sneath wanted the medical department to exert total control of medical issues in the territory. Debates, conflicting ideas, and tensions between individuals and departments suggest the extent to which the colonial government, as an institution of state, was a negotiated terrain.
Dissertation Conclusion

This dissertation has examined the development of colonial infant survival interventions from purely preventive programs in the 1920s and early 1930s to initiatives that integrated preventive and curative medicine in the late 1930s and 1940s. It has argued that the development of these interventions in colonial Tanzania was a negotiated process between government officials, peasants, chiefs, welfare workers, dressers, and medical missions.

The dissertation reveals that negotiations over infant welfare programs changed over time. Earlier negotiations, particularly those of the 1920s and 1930s, focused on the causes of poor infant health and on the viability of the policies that the colonial government formulated to alleviate the problem. Colonial government officials explained the infant survival problem in terms of maternal ignorance and proposed preventive medical interventions to alleviate the problem. Peasants, however, challenged the narrow focus of government officials’ views, arguing that they failed to take into consideration the importance of witchcraft, maternal work, food insecurity, and diseases in undermining infant survival. Later negotiations, evident in the mid 1930s, focused on the incorporation of curative medicine in the welfare programs. These negotiations unfolded as peasants, through their local chiefs, demanded that the colonial government incorporate treatment of diseases as part of welfare interventions. Eventually, the government began implementing peasants’ demands in the late 1930s. Taken together,
the earlier and later forms of negotiations indicate that the dynamics of infant welfare programs in colonial Tanzania resulted from negotiations between many social actors, including government officials, peasants, chiefs, and dressers.

This dissertation is significant because it brings infant welfare into the study of African history. Although historians have produced important studies on men, women, youth, gender, families, or nations, a historical understanding of infant welfare remains a significant gap in African history. This gap is surprising because the generational continuities of African societies that historians have been studying in the past five decades depended (and continue to depend) on the development of infants into adults. Understanding how households and communities invested in the welfare and survival of infants is thus an important topic of historical inquiry.

This dissertation also offers a way to compare infant welfare initiatives in Africa and those from other continents. In contrast to African history, histories of Europe, America,

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475 Gregory Maddox and James Giblin (eds.), *In Search of the Nation: Histories of Authority and Dissidence in Tanzania* (Oxford, James Currey, 2005).
Asia, and Latin American have witnessed the growth of studies of infant welfare since the 1980s. Studies of child welfare in these regions have suggested that the development of infant welfare programs resulted from the initiatives of elite men and women. On the contrary, this dissertation has shown that the evolution and dynamics of infant welfare interventions did not result from the creative visions of elite colonial government officials alone. Through their critique of early welfare programs and their demand for the incorporation of curative medicine in the interventions, the illiterate peasants were part of the negotiations that shaped the development of these medical programs. For this reason, the illiterate peasants were not passive recipients of colonial welfare initiatives. Rather, they were important agents who, together with colonial officials, chiefs, and welfare workers, and dressers, shaped the dynamics of the infant welfare policies.


This dissertation has shown that specific agendas motivated colonial government officials, local chiefs, peasants, and dressers to engage in infant welfare programs. British colonial government officials, for instance, utilized infant survival initiatives to enhance the legitimacy of their emerging government among Africans. These welfare programs helped the colonial government to extend its presence in the rural communities where the majority of Africans lived. For the African dressers, work in preventive and curative medical practice was a livelihood opportunity. They utilized their incomes to buy basic needs for themselves and their families. In addition, medical practice improved their social standing and status in the society because they joined the cadre of educated colonial subjects that included teachers, clerks, and other colonial civil service employees. In contrast, the agenda of peasants was to expand available medical resources in the rural communities. Western curative medicine complemented existing indigenous preventive and curative medical technologies for meeting the medical challenges of children and adults alike. Peasants were particularly interested in ensuring that the colonial government made curative western medicine an integral component of the welfare programs. This inclusion was necessary in dealing with diseases such as malaria that claimed the lives of infants. Finally, the agenda of local chiefs was to cement their economic and political positions as local authorities in the rural areas. Their facilitation of the mediations between peasants and colonial administrators was part of their effort to consolidate their positions as local representatives of peasants and the colonial government.
The colonial imposition of western medical ideas and practices in the form of infant survival interventions did not displace African understandings of infant welfare. Even before the 1920s, Africans understood that efforts to improve infant survival had to necessarily and consciously incorporate preventive and curative medicines. Africans mobilized preventive and curative medical interventions to tackle spiritual, social, and environmental threats to infant survival. These interventions included conducting rituals, sacrificing to ancestors, practicing hygiene, and seeking curative medicines for infant illnesses and diseases. In the 1920s and 1930s, peasants drew on these understandings and practices to evaluate the viability of the evolving government interventions and noted that they lacked viability since they excluded curative medicine. This evaluation became the basis for peasants’ demand that the colonial government incorporate curative medicine in its welfare programs, as shown in chapter five.

The examination of negotiations over infant welfare interventions reveals tensions among Africans and differentiations in the way households met welfare needs of infants. As the examination of early and later forms of negotiations has underscored, tensions loomed large among Africans, such as those between African welfare workers and pregnant or nursing mothers because of the young age of the workers, between commoners and local chiefs over the implementation of the Witchcraft Ordinances, and between wives and migrant men over labor relations. The dissertation has also uncovered inequalities in the experiences of infants, depending on the socioeconomic background of their parents. Thus, infants born in the households of the rich (such as the chiefs and their assistants)
had the potential to receive better care and nutrition than those born and raised in the families of poor peasants. Indeed, the very system of colonialism increased inequalities among Africans by creating stable incomes for civil servants such as teachers, nurses, clerks, and dressers. These employees enjoyed expanded opportunities of livelihood and had a better chance of meeting the basic needs of infants because of their higher incomes. On the other hand, colonialism constrained the economic opportunities of peasant households who lacked stable incomes, were burdened with taxes, and lost manpower through labor migrations and thus limited their ability to fulfill the basic needs of infants.

Like Africans, the colonial government officials were also not homogenous, and they did not always agree on the direction of the infant welfare programs. The most contentious area related to the incorporation of curative medicine in welfare interventions. As chapter five made clear, some medical officials, such as Ralph Scott, supported the incorporation, arguing that it enhanced a positive relationship between the colonial government and colonial subjects. For them, the interventions were necessary for building the legitimacy of the colonial government among Africans, and that accepting African demands was a route towards this end. There were colonial officials, such as P. Sneath, who opposed the integration of preventive and curative medicine. They feared that the level of infrastructure in the 1930s and 1940s was inadequate to ensure quality provision of curative medicine in the rural areas. Understanding these divisions and contestations among medical officials is an important example of instances indicating that the colonial
government was negotiated from within by its own officials and from outside by social actors such as peasants and chiefs.

Although this dissertation has contributed a historical understanding of infant welfare to African history, many questions remain unexplored in the history of infants and children in Africa. Some of these questions include the historical agency of infants and children, child welfare in colonial and post-colonial Africa, and changing socialization of infants and children. While exploring these questions is part of my future research agendas, I hope that this research will stimulate the interest of other historians to explore the many dimensions of child histories in Africa.
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Oral Interviews

Interviews at Kafule

Andimile Masebo: 2007: May 1; May 2; May 15
Sikanyagha Kibona: 2007: May 2; May 4; May 5; May 29
Ezelina Masebo: 2007: May 4; May 10; May 11; May 16
Amulike Masebo: 2007: May 8; May 9; May 10; May 20
Steven Mogha: 2006: July 6; July 8; July 12; July 30
Mwatabhika Swilla: 2007: May 19; May 20; May 25
Tufingene Swilla: 2007: June 1; June 6
Elizabeth Mogha: 2007: September 2; September 3; September 7; September 16
Bomani Kibona: 2006: July 1; July 3; July 4
Jotam Masebo: 2005: August 3; August 8; August 21
Mwamuleghe Kamwela: 2007: May 22; May 23
Kwikoshi Masebo: 2007: May 27; May 28
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