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Seniority in Midwifery in Tanzania: Medical Local Practices Between Colonial Medicine and Postcolonial Modernization

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Abstract

Concepts of seniority and elderhood were important structuring elements in many societies of precolonial Africa and were connected with social status. This changed with the European colonization of Africa, and strongly affected traditional cultures of elderhood and seniority. On a general level, this societal change took place through efforts at 'modernization', in the field of midwifery and maternity mainly through mission education and the introduction of Western medicine. The impact of colonialism continued in the postcolonial era when the former emphasis placed on old age as a structuring factor for societal hierarchies was partly replaced by other factors such as political power, monetary wealth (in the new capitalist economy), or the level of education, including access to scientific knowledge. These changes were certainly not always as linear as often portrayed in earlier historical research. In the case of traditional midwifery, several studies have shown its transformation through the process of medicalization and the decline of traditional midwives. However, in this paper, we will look at medical practice and analyse how – since colonial times – the attempts to end or transform traditional midwifery have been contested, had setbacks, and been full of varying, sometimes antagonistic developments. Using Kilombero in Tanzania as an example, we show how the services of traditional midwives continue to be sought, even in independent Tanzania. In this respect, the concept of age and seniority play a key role. Besides strong external influences, internal cultural interplay still favours the concept of elderhood, leading to the survival of traditional midwives.

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1 Introduction

Why are age and seniority key questions in midwifery? Age remains an important concept in which various systems of societal difference are anchored. In precolonial East Africa, age was the basis upon which various roles were assigned. This particularly applied to midwifery, where women could only act as midwives when they had reached a certain status and age. While age and seniority are widely used concepts in our day-to-day lives, a closer analysis demonstrates that the two concepts are loaded with differing interpretations and meanings. In pre-colonial Africa, for instance, age was not only meaningful in terms of chronology but also in the form of experience. For instance, childbearing meant a certain status for women that also made them eligible to be midwives. Such lifetime markers were important to one's seniority status.

Defining age and seniority for sub-Saharan Africa certainly remains difficult. It relates to the problematics of defining the concept of time in Africa, which has been addressed by various scholars (Mbiti 1969; Widlok et al. 2021). Time and seasons in Africa were marked by events and activities that were in the living memory of the people. Without overgeneralizing the concept of time, it can be argued that in many precolonial African contexts, age was a fluid but important concept. 'Old' was not strictly defined by numerical years but also by significant life events, such as rites of passage (Kimani 2015), and by time measured through certain cycles (Sims 2015).

In this paper, we do not adhere to one concrete definition and meaning of age or seniority. Seniority cannot be defined only chronologically or biologically; a definition has to include more difficult-to-measure concepts such as "psychological age, mental age and emotional age". (Laslett, quoted in Malik and Edwards 2011, 25; Kalla 2006). We look at age and seniority as closely related concepts and focus on the social status and meaning that one would receive during a lifetime as a result of age – both biologically, in terms of years, and socially, depending on one's positionality in society (Kalla 2006).

Chronologically, increased age was, and still is, often associated with reduced strength; communities worldwide have portrayed the fear and disadvantages of ageing using different paroemia. However, in many parts of Africa, local cultures had a way of providing a balance to that perception, such that ageing was not seen as the ultimate decline (Stroeken 2002, 89). Everyone, right from childhood to old age, played a certain role in society; this arrangement was often seen as signifying the completeness of life. Thus, while reduced bodily agility and strength were associated with age(ing), wisdom acquired through life experiences was also believed to peak in old age. In many traditional societies in Africa, respect for seniority was recognized and portrayed through speech, as well as through body language when talking to older persons. Indeed, political and social positions were assigned largely according to seniority.

In many traditional cultures in Africa, the young were expected to respect the old because age was seen as a gift from God and was believed to be connected with other abilities, such as the ability to bless or to curse, and with wisdom, experience, and insight (Makoni and Stroeken 2002, 4). Age was also a determining factor in political leadership, a sphere mostly dominated by men. In centralized communities, kingship was hereditary and often passed from the father to the eldest son, while decentralized communities were often ruled by groups of elders who based their status on seniority. In Tanzania, for instance, many precolonial societies were ruled by a council of elders. Generally, the role of elderly men and the differentiation between ages of men in various African precolonial and (post)colonial societies have attracted much research, particularly in ethnography and anthropology (see e.g. Evans-Pritchard 1940; Wilson 1951; Kulet 1972; Jones 2006).

Seniority among African women was also an important social structure. Many feminist studies focus on the social, biological, psychological, and economic lives of women in relation to ageing (Svetieva 2003; Twigg 2004; Malik and Edwards 2011; Freixas et al. 2012), concentrating on the consequences of aging in general. However, not many studies address the concept of seniority among African women. Despite the limitations that came with age, elderhood also gave African women access to status (Foner 1984). Indeed, there were many female roles and responsibilities in African society which also followed gerontocratic principles, meaning the general rule of elders in a society. In some areas of specialization, women were able to give certain services to the communities. Midwifery is an important example of such an area, as women who performed these duties were mostly elderly and had already given birth themselves. Young women were not seen as socially 'qualified' to perform such services[1] (Thomas 2003). Furthermore, in many local African cultures, midwifery involved secrets, which were believed to be safe only in the hands of elderly women, as will be demonstrated in Section 3 below. In many African societies, pregnancy and childbirth themselves were connected with manifold taboos and rules that had to be obeyed. (Stephens 2013, 151). Thus, having experienced such rites of passage made women gain a certain status of seniority.

With the advent of colonialism, African societies experienced many societal transformations. In Eastern Africa at the end of the 19th century, and in some regions since the advent of missionary activities in the 1840s, forms of Western medicine were introduced as new concepts from Europe (Clyde 1962, 1). Basic forms of Western medicine offered by missionaries and their wives became an important point of contact with the African population. It was one of the areas that the missionaries identified as an entry point into African lives, potentially yielding a transformation and achieving the goals of Christianization, 'civilization', and cultural change (Vaughan 1991, 55–76). Though some of the services were very attractive to the local population, conflict between Western and African understandings of medicine was inevitable. While it was common for Africans to seek remedies for their maladies from traditional healers, many missionaries and colonial officials initially strove towards a total departure from what they perceived as 'primitive' African medicine (Tilley 2011, 26; Langwick 2011, 39). Yet medicine has to be seen as a social institution, comprising a set of beliefs and practices that only work when carried out and used by members of a certain society (Ackerknecht 1942, 545).

Ideally, any cultural change should occur through invention, discovery, or diffusion (Idang 2015, 107). In the case of Western and African medicine, forms of diffusion quite clearly took place. However, the interaction between Western and African medicine occurred not from a point of equality where the parties involved intentionally borrowed what was beneficial to each of them. It was rather a process of imposing upon Africans the practices and beliefs of Western culture which the colonizers and missionaries brought with them and believed to be superior. The interaction of Western and African medicine often became a conflict zone, especially regarding the status of certain traditional expert groups such as healers and local midwives. The colonizers sought to achieve their goals of 'modernizing' the African population, including through 'civilizing' medical practices and beliefs, excluding them from the influences of 'witches' and 'diviners' (Ranger 1981, 261). Midwifery was one of the target areas for the missionaries, the Germans, and later the British colonial government, and remained so even in the newly independent Tanzanian state.

[1] Letter from the District Medical Officer, Kongwa to Cecily Williams, Director of Medical Services on Training of Village Midwives, , WHO Archives, Geneva.

Furthermore, after independence in 1961, the question of age also became instrumental for modern planning. Life expectancy in Tanzania was estimated to be forty years in 1961. This meant that many infants and children died from infections and other diseases and never reached adulthood, therefore lowering the average life expectancy. When people had reached adulthood, they could mostly reach an average age of 60 or 70. Increasing the average life expectancy to fifty emerged as a significant concern of the new state and was reflected in the objectives of the First Development Plan (1964–1969). To increase life expectancy, it was essential to reduce the early deaths of infants and children. The new government therefore also had to address childbirth and midwifery (United Republic of Tanzania 1964).

In this paper, we look at German East Africa from the 1880s, which then came under the British mandate as Tanganyika Territory after World War I (WWI), finally becoming independent in 1961. We discuss how the concept of age and seniority remained pivotal for the role of midwives and how it helped the practitioners of traditional African midwifery to survive the societal changes during and after colonization in rural Tanzania. The midwife was seen as being able to hold the necessary secrets surrounding childbirth and was expected to be full of expertise that was acquired over a long period. Such a persistent perception helped the traditional midwives to maintain their status and role in a changing society.

The paper first gives a short overview of the development of maternity services and midwifery under German and British colonial rule in the region of today's Tanzania, before analysing the continuities of traditional midwifery in Tanzania, focusing on Kilombero District, located in Morogoro Region in Southern Tanzania, from the colonial to the postcolonial era. The Kilombero area was impacted by mission influence from 1911 onwards when German Benedictine monks from St. Ottilien in Southern Germany came to Ifakara. However, they had to leave during WWI when the Belgian troops took over the region, so the Benedictines could hardly have had a lasting impact. The Baldegg Capuchin monks from Switzerland then reopened the Ifakara station in 1922, and the Baldegg Sisters followed in 1925, opening the first dispensary. Their efforts culminated in the establishment of St Francis Hospital Ifakara in 1931 (Müller 1997; Frei 1997). Furthermore, Ifakara was a centre of Swiss medical research operations, with the Rural Aid Centre[2] growing into a research hub from 1956 to the present[3] (Freyvogel and Tanner 1997). Therefore, one would expect to find a strong influence of Western biomedicine in the region from the 1920s onwards. However, forms of traditional midwifery persisted equally until today. The paper will show how these traditions were constantly contested but were still able to continue.

Taking a historical approach, using data from printed sources, archives, and interviews conducted in different wards such as Ifakara, Mang'ula A, Mangula B, and Kidatu, all located in Kilombero District,[4] the paper argues that seniority played a major role in the resilience of this practice. The paper also analyses the social, economic, and political changes that occurred over time in the field of midwifery, as, even with their long-time expertise, traditional midwives were expected to learn new and different techniques.

[2] It later became the Medical Assistants Training Centre (MATC) in 1972, and in 1978 it was renamed Ifakara Centre.

[3] Staatsarchiv Basel-Stadt ED-REG 1. Rural Aid Ifakara, 1959–1964

[4] A purposeful and snowballing sampling method was used to locate specific respondents relevant to the study in different wards the specific villages in the wards were Viwanja sitini, Uwanja wa ndege, Lipangalala, Katinduika, Lumemo and Mlambani, Msolwa Ujamaa,Mtaa wa Njokamoni, Mtaa wa kota, Sanje and Kidatu A.

2 Midwifery during the German and British colonial era in Tanganyika

In 1884, German East Africa was recognized as a German territory. During the first years after Germany occupied the region, German colonial medicine was primarily concerned with the well-being of the small white population, mainly consisting of a few European soldiers and administrators (Curtin 1996, 100; Eckart 1997, 299). Colonial medicine focused on combating tropical diseases to allow Europeans to govern the African territories (Bruchhausen 2003, 87–88). The health of the African population, and even more so the field of maternity and midwifery, was not of great concern for the colonial administrators until the beginning of the 20th century. As one can see from the Medizinalberichte über die Deutschen Schutzgebiete ('Medical Reports on the German Colonies'), the combating of tropical diseases such as malaria and sleeping sickness stood at the centre of attention.[5]

If facilities were provided at all, it was by the missions. The missionaries offered rudimentary Western medical services to their African 'brethren', who were to be proselytized (Lindner 2014, 212). The British Church Missionary Society and the London Missionary Society, for example, had been active in several regions of Tanzania since the 1870s.[6] After the German occupation, most of the British missions had to leave the region, and stations were taken over by German Protestant and Catholic missions that came to the new colony, such as the Catholic Benedictine mission and the Protestant Leipzig and Berlin missions (Lindner 2011, 104–105).

Generally, all missions paid attention to mothers and children much earlier than the colonial administrations did. The missions saw it as their aim to combat the 'pagan and unhealthy customs' of the African population, especially in practices around childbirth that were assumed to be dirty and barbaric, and to introduce European family models and morals. Missionaries were generally keen to intervene in the areas of sexuality and reproduction. Furthermore, they perceived Western medicine as a useful aid in their fight for the Christianization of Africans. Local people found these offers attractive and attended mission stations to gain access to treatment (Vaughan 1991, 61).

However, German East Africa was a huge country and mission stations could only reach a fraction of the population. Furthermore, in the colonial cities, the few hospitals were only meant to assist the white colonizers. The Medical Report for German East Africa for the year 1903/1904 stated: "Only rarely do the natives seek the advice of the white doctor in gynaecological and obstetric cases. Accordingly, observations were sparse" (Kolonialabteilung 1903/4, 93).[7] Therefore, midwifery and childbirth were mostly in the realm of traditional midwives, i.e. old, experienced African women, who had given birth themselves and who practised midwifery in accordance with traditional beliefs and customs.

This was also the case in the Kilombero Valley region, where Catholic missions arrived only at the end of the German colonial occupation. In contrast, the Southern Highlands had been a centre of both Protestant and Catholic mission activity since the 1880s. There, missions had opened many dispensaries offering basic biomedical aid, but the missions did not move into the Kilombero Valley, as accessibility and transport were highly problematic, especially during the rainy season. Some areas were isolated for up to nine months of the year

[5] See e.g. the 1905 report *Medizinalberichte über die Deutschen Schutzgebiete für das Jahr 1903/04*. Pages 1–121 cover German East Africa and only half a page is devoted to maternity and birth, whilst almost all the remaining pages deal with infectious tropical diseases.

[6] History of Church Missionary Society in German East Africa, May 1, 1902, CMS G3 A8 O 1900–1903. University of Birmingham Special Collections.

[7] German original: "Nur selten sucht der Eingeborene in gynäkologischen und geburtshilflichen Fällen den Rat des weißen Arztes. Dementsprechend waren auch die Beobachtungen nur spärlich."

(Jackson 2021, 507). The Catholic missions of the St. Benedictines had established a mission station in the Mahenge Highlands south of the Kilombero Valley around 1900; however, they only proceeded into the valley in 1911 (Green 2003, 36).

During the first two decades of German colonization, the south of the colony and the Kilombero Valley were seen as a highly productive region with great economic potential. Successful rice production had been established long before the German conquest; furthermore, the region was rich in the natural occurrence of rubber, which could be collected. Tax revenue for the German colonialists had been particularly high in this region (Monson 1991, 244–247).

However, this changed after the devastating Maji Maji war broke out in 1905. Several communities and societies in the south of German East Africa rebelled against the exploitative policies of the German colonial rulers. During the war, from 1905–1907, hundreds of thousands of Africans were killed (Wimmelbucker 2005). The Kilombero region, being a centre of the Maji Maji uprisings, suffered greatly from the consequences of the war. The German military used a scorched earth tactic as revenge for the uprising, destroying the livelihood of whole areas, which suffered from horrible famines; this was commented upon and condemned by contemporary observers such as the neighbouring British Missionaries from the Church Missionary Society and the British consul of Zanzibar, Basil Cave.[8] People moved away and the population declined. Afterwards, the region was no longer viewed as an asset of the German colony and became rather marginal (Green 2003, 22–23).

The Germans viewed the declining population with some concern, as they needed a strong workforce to have an economically successful colony. This now led to a growing interest in maternity within the colonial administration. The aim was to reduce infant mortality amongst the African population. Therefore, the field of midwifery reached the attention of colonial officials around 1910 (Lindner 2014, 216). For the first time, the Medical Report for German East Africa for the year 1911/12 referred to infant mortality in the African population and gave some statistical material (Kolonialabteilung 1911/12, 180). A shrinking population was now seen as a threat – the productivity of the East African colony was anchored in cash crop production by African peasants and in plantation agriculture, equally dependent on African labour. German administrators and colonial experts expressed their concern about an allegedly sinking birth rate; however, they never discussed the grave consequences of the war and their own role in it (Peiper 1910; Burgt 1914). To reduce infant mortality, the German colonizers in East Africa and later the British administration of Tanganyika Territory saw an urgent need to control maternity issues. The Germans were already collaborating to some extent with the missions in the field of maternity; the British colonial government continued that practice. The colonial administration strove to improve hygiene and the allegedly bad birthing conditions (Dreier 2015; Kallaway 2020, 39). Both the German and the British colonial medical experts blamed the African rural population and especially the 'bad habits of mothers' for high infant mortality and population decline (Meixner 1914; Lindner 2014, 216). Research has shown clearly that a substantial population decline in East and Central Africa around 1900 was caused by the impact of the colonial wars and the new work regimes the colonizers implemented; however, these topics were not addressed by contemporary experts (Feierman 1985).

As already discussed, maternity still belonged mainly to the sphere of local midwives,

[8] Baylis an Rees, November 24, 1905, G3 A5 L9, University of Birmingham Special Collections, Church Missionary Society; Cave, Zanzibar to Lansdowne, Foreign Office, September 20, 1905, PRO, CO 533/8, Nr. 332. The National Archive London.

who were seen as the experts in the field by the local population. This was increasingly perceived as a danger and as one of the reasons for the high infant mortality. Therefore, the German colonial government and missionaries alike sought to medicalize and modernize maternity and bring it under the control of Western medicine, including by seeking to train African people in Western medicine (Malowany 1997; Kanogo 2005). The process became a major conflict area, as most of the local people were certainly not willing to follow the new attempts of the colonizers and missionaries to medicalize childbirth. Besides that, if we look at German East Africa, the colonial government only operated very few medical facilities for the African population and these were not able to offer adequate services (Kolonialabteilung 1903/04, 1–2; Kolonialabteilung 1904/5, 1–2).

The missions had long combated the traditional customs of midwifery and childcare. Missionaries had started quite early, in some regions of Tanganyika in the last decades of the 19th century, to train young Christianized girls in midwifery, as they were thought to be less 'spoilt' by traditional customs. However, this was hardly successful. Generally, the young local girls were not accepted as midwives by women giving birth, as they had no standing in the local society and were seen as inexperienced. To give another example of cultural conflicts between missionaries and local women: to be attended by missionaries at birth, women were to renounce key cultural issues not only during the act of birthing but from conception onwards until long after delivery. For instance, the use of charms, which were usually tied around the wrist of a child, was prohibited by the missionaries. Women were forced to remove the amulets and denounce their faith in order to be attended to in a mission hospital (Respondent E (RE), interview, September 25, 2023). African women had learned how to manoeuvre around these rules: they would remove the amulets during the treatment, but wear them again afterwards. This also shows that most of the missionaries hardly understood the concept of medical pluralism practised by many Africans, who were used to seeking solutions from several sources, ranging from the physical to the spiritual. Malowany's study on medical pluralism is a good example of how Africans on the Kenyan Coast juggled between Islamic, Ayurvedic, African, and Western medicine (Malowany 1997).

However, even if medical practice was often a mix of some aspects of both Western biomedicine and local customs, most missionaries would not see pluralism as a solution. For example, Protestant missionaries among the Sukuma in Tanzania were strongly against old traditional midwives in the 1920s. They saw them as 'contaminated' by native customs and were convinced that there would be too much 'to train out' of older women (Bruchhausen 2003, 105). Missionaries from the University Mission even described old midwives as the "last fortress of Satan" (Vaughan 1991, 67) – old women in midwifery were perceived as a literal thorn in the flesh of missionaries' work. The quotation is again illustrative of the fact that age was highly important for practising midwifery.

Despite the attempts of missionaries and government officials to "reform" maternity and childbirth, the combination of partial services provided by the missions, with most births being attended by local traditional midwives, remained the same after the British took over the colony in 1916. It was then administrated, as a British mandate, as Tanganyika Territory from 1920 onwards. Governor David Cameron, who came to Tanganyika from the British colony of Nigeria in 1925, implemented the system of indirect rule first developed in Nigeria by Frederick Lugard. Indirect rule was seen as most suitable for a mandated territory, with its stress on African traditions, a focus on so-called 'tribal institutions', and administration through Native Authorities (Eckert

2007, 42). Such a system of colonial administration left considerable leeway for African cultures and traditions, which also applied to the realm of maternity and midwifery. In the medical services, Dr Owen Shircore, the first Medical Officer of the colony, played an important role in shaping future medical services in Tanganyika (Beck 1970, 81). He was keen to train Africans in healthcare and to establish a better rural health service. He also meant to integrate experienced older African women into training for maternity issues. However, since Tanganyika Territory did not have sufficient training facilities, a substantial part of medical training remained in the hands of the missions. Still, the colonial government invested considerably in these trainings; this was even discussed in the British Parliament. As recorded in Hansard on 12th December 1929, the Duchess of Atholl asked the Undersecretary of State for the amount of grants given towards the training of African women as midwives between 1921 and 1928 in East Africa, thereby showing the involvement of the government in the matter.[9]

The training was not as successful as the colonial government had hoped for. The missions still preferred young girls in the field of maternity and midwifery, although they were hardly successful (Iliffe 1998, 42; Lindner 2014, 224). Additionally, most of the so-called 'tribal dressers', or African health inspectors, who trained either in missions or in the few government institutions during the 1920s, were men and were therefore not able to work in the field of maternity and midwifery, as they were rejected by African women.

If we now look at the region of the Kilombero valley, the Swiss Capuchin Fathers began evangelical and medical interventions in the area in 1921, taking over the station the German Benedictines had to give up when Belgian forces conquered the region during WWI. In 1937 they opened a ward specializing in obstetrics, led by Sr. Arnolda Kury (see Figure 1), who was called "the Mama of Ifakara" (Frei 1997, 143–144). She served in the hospital from 1928 to 1962 and was respected as an experienced nurse and midwife by local women who were about to give birth.

The missions remained important actors in the field of rural health services and in the provision of Western biomedical services for pregnant women and mothers – alongside the traditional midwives who still served the majority of the population. This arrangement was also to be found in the Kilombero Valley. Some women in the neighbourhood of Ifakara could attend the antenatal clinics of the Baldegg sisters or go to their hospital to give birth; however, most women in the valley had to rely on traditional midwives and their support (focus group discussion at Lipangalala, Ifakara, September 23, 2023).

In the 1930s, the missions succeeded in forming the Tanganyika Mission Council (TMC), bringing together most of the Protestant missions and creating a representative organization that could negotiate more effectively with the colonial state. The TMC received grants from the colonial government to provide health services from the 1930s onwards and remained a prominent actor in the field of health until independence (Jennings 2016, 159–162).

After World War II, with the implementation of the National Health Service (NHS) in the UK in 1948, there was obviously some enthusiasm in Tanganyika Territory for reforming the health services run by the colonial government as well. The Chief Medical Adviser of the Colonial Office, Dr Pridie, visited Tanganyika in 1949 and was rather critical of the then-current standard of health provisions. He recommended again the training of more African staff and better cooperation between the different services in Tanganyika.

[9] Hansard, UK Parliament (House of Commons), December 12, 1929. Accessed September 23, 2024. https://hansard.parliament.uk/commons/1929-12-12/debates/aad51566-eee2-40e6-976a-9e2ff2dfdab2/EastAfrica(Midwives,Training)

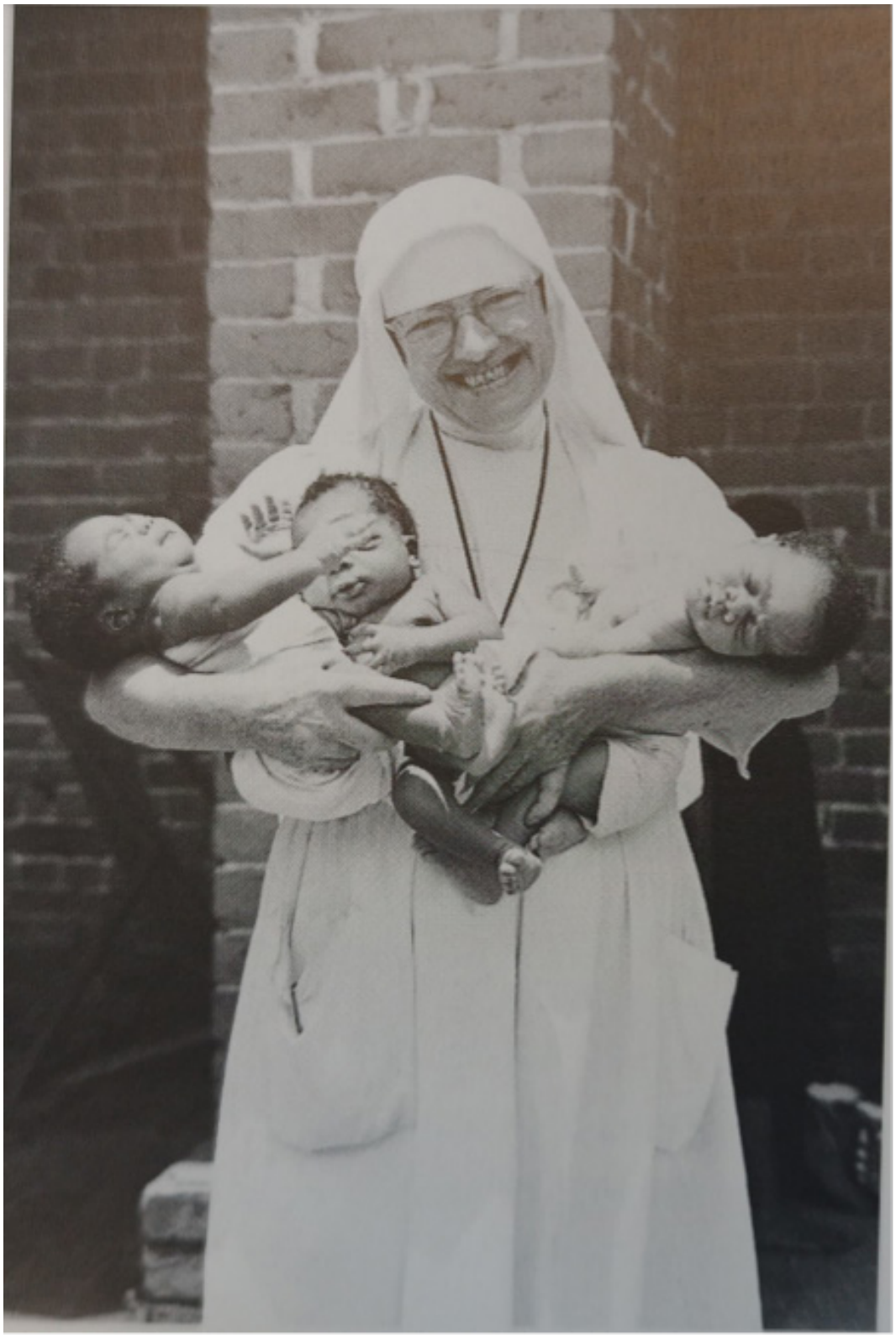

Figure 1: Photo of Sr Arnolda Kury, "the Mama of Ifakara". Photo from Frei Markus (1997, 144).

Additionally, a tighter integration of mission hospitals into government services was seen as essential – similar to the development under the NHS in the UK that had integrated the voluntary hospitals into the state health service (Webster 1988, 16–34). However, with regard to training, there was no medical school in Tanganyika in the 1940s and too few young people had a general education that was deemed satisfactory for entering into medical training (Beck 1970, 162–163). As for the reduction of missionary medicine, even in 1961, the year of independence, the missions still provided more beds in hospitals and clinics than the state hospitals and treated almost the same number of outpatients as state institutions (Jennings 2016, 169).

In the field of midwifery, the problems and conflicts around the training of suitable staff continued to shape the provision of health services in the 1950s. To give an example: Cecily Williams, a world expert in infant and maternity issues, who had worked for the British Colonial Service and the UN, and was now Senior Lecturer at the London School of Tropical Hygiene (Craddock 1983), undertook a tour of Tanganyika in 1953/54 to inspect the training of village nurses who should also act as midwives. She openly reported on the problems of age when trying to find women for village nurse or midwife training.[10] After her travels in Tanganyika Territory, Williams also collected material on maternity and midwifery in Tanganyika that clearly shows the ongoing conflicts around the age and the status of midwives. For example, a female British development worker wrote a report on the Moshi district and the Chagga society, where she was supposed to organize women's clubs and initiate training for assistant nurses and midwives. In the revealing report from 1955, she writes the following, also touching on problems related to staff, age, and seniority:

> So far, the search for married women as staff has borne no fruit whatever. Local feeling is much against making a married woman mobile, even if she is able to be away from home. Widows appear to have more, not fewer, responsibilities. All divorced or separated women interviewed so far have a reputation making them unacceptable to a part of the population. Also, older Chagga women often do not have the necessary standard of education. Consequently, our staff are likely to be young girls, who (unless they have teaching qualifications) do not enjoy much prestige among married women and who of course cannot have the knowledge of the world so desirable for their type of work.[11]

She also referred to the "power of the grandmother", and stated the strong influence of old women in the field of midwifery:

> Perhaps one of the most important figures from a social development point of view in any African society – due to her leading part in circumcision rites, midwifery, medicine and child welfare – the grandmother is particularly important in Chagga society because she so often has charge of the weaned child.[12]

Again, the young girls trained as nurses were hardly acceptable as midwives by the local

[10] Report on visit to Tanganyika, Kenya, Uganda, Johannesburg, Gold Coast, Gambia, December 1953–April 1958, PP/CDW/E 2/4, London School of Hygiene and Tropical Medicine, Contemporary Medical Archives Centre. Colonial Office, funded by Nuffield Fund.

[11] Background Papers Tanzania 1955/56, Annual Report July–December 1955 Moshi District, p. 4, PP/CDW/E 2/1. London School of Hygiene and Tropical Medicine, Contemporary Medical Archives Centre.

[12] Background Papers Tanzania 1955/56, Annual Re-

populations; married women, who seemed to be the most acceptable to the colonial health services and experts, would not undergo training in Western medicine outside their local villages; and the older Chagga women, who would have been available and who might have been traditional midwives, were seen as a danger and as not educated enough.

In general, one can see that the cultural conflicts around maternity and midwifery remained throughout the colonial period and also persisted into the postcolonial period.

3 Midwifery in postcolonial Kilombero: A mix of faith and secrecy – not for the young

3.1 Midwifery immediately after independence

Despite the growing popularity of Western medicine after independence, many aspects of traditional African medicine remained an important part of the day-to-day routine of African people, especially in rural areas. As we have seen in the earlier paragraphs, the effort by the colonial state to medicalize maternity achieved little success. While it was believed that Africans would be weaned off traditional medical practices with the development of health facilities, different writers have shown the resilience of traditional medicine even after many campaigns for biomedicine and the postcolonial government's development of hospitals and clinics. In the case of midwifery, African women continued to seek services from traditional midwives (El Kotni 2022, 454; Musie et. al 2022, 87). How was the situation in Kilombero? To understand the dynamics of the medical situation in postcolonial Tanzania, we aim to analyse medicine holistically and thus consider, especially, its social dimensions, which are affected by politics and societal factors (Ackerknecht 1942; Feierman 1985).

In 1961, when Tanzania became independent, the clarion call from the president was to eradicate poverty, ignorance, and disease (Nyerere 1973). The government was committed to improving health services, particularly maternal and child welfare (MCH) (Tanganyika Ministry of Health and Labour 1961). Just as it had been in the colonial days, maternal and child welfare was a gateway to accessing women and children, which also enhanced the political legitimacy towards the ruling party (Kimani 2024). However, the health sector was still rudimentary, and the government was not in a position to provide medical care to everyone, leaving most people to rely on traditional medicine and missionaries, who had dominated the medical field (Kallaway 2009; Jennings 2006, 2016). This also applied to midwifery, where most women sought the services of traditional midwives and herbalists (Musie et al. 2022; Langwick 2011). One of the challenges of the health system of the newly independent state was the shortage of health workers (Nhonoli and Nsekela 1976; van Etten 1976; Iliffe 1998), often associated with the fact that colonial education relegated Africans to the bottom, where they would ostensibly be equipped with practical skills (van Etten 1976; Mbilinyi 1980). Secondly, throughout the colonial period, social welfare for Africans was not the priority but the colonial economic venture (Zeleza 1997, 223; Kallaway 2009, 2020, 41). The long-term impact of this policy was significant during the initial years of independence: Only a few Africans were qualified to pursue medical-related courses. Furthermore, there was no medical faculty in Tanzania; people had to travel to Makerere in Uganda and other countries for medical training. Of the 403 doctors in the country in 1961, only 12 were of Tanzanian origin (Titmuss et al. 1964; Nhonoli and Nsekela 1976; Gish 1975). Another challenge can be attributed to the vast size of the country – at the time of

port, July–December 1955, Moshi District, p. 25, . London School of Hygiene and Tropical Medicine, Contemporary Medical Archives Centre.

independence, the majority of people lived in rural areas, whereas the few medical facilities were concentrated in urban areas (Bech et al. 2013, 67).

Furthermore, many of the new politicians ignored the holistic nature of the African understanding of medicine. Even where there were facilities offering Western medicine to pregnant women, there is considerable evidence from the oral interviews shown below that, as in many regions, the majority of the women in Kilombero preferred the services of a traditional midwife over those offered in a medical facility. In Kilombero, as already noted, the Swiss missionaries started medical services in the 1920s (Dirr et al. 1997; *The Citizen* 2021). Yet even the long contact with Western medicine and the efforts of the missionaries, colonial and postcolonial governments were unable to eradicate traditional midwives. A close analysis shows that local midwives were preferred because of their expertise, experience, and integration of the cultural knowledge that they had acquired in their lifetime. The data collected from Kilombero shows that the older the midwife, the better skilled she was believed to be in her work. Therefore, seniority was crucial when women chose someone to help them during birth. It was not formal education in Western medicine that was seen as trustworthy, but a long-term apprenticeship with gradually acquired expertise by traditional midwives. In that way, also different forms of knowledge acquisition were contrasted with each other.

3.2 Continuity of the expertise of the old midwives in Kilombero

The *mkunga* (midwife), as she was referred to by the local population in Tanzania in the Swahili language,[13] was and still is a respectable figure in society. The importance of *mkunga* was evident in the daily language transmitted through local lore and paroemia such as *usitukane mkunga uzazi ungalipo* 'do not insult the midwife, while you still procreate'. It is important to mention that in Swahili there is a differentiation between the traditional *mkunga wa jadi* and the modern or hospital-trained *mkunga wa Kalamu* midwife.[14] The knowledge of *ukunga* 'midwifery' is believed to be acquired throughout one's life (Dietsch and Mulimbalimba-Masururu 2011, 326). This knowledge, however, is believed to be a gift and favour from God (Dietsch and Mulimbalimba-Masururu 2011). One of the interviewees at Lipangalala, Ifakara, here labelled respondent A (RA), narrated how she acquired her knowledge of traditional midwifery through a dream (RA, interview September 21, 2023). Though this was her personal experience, such dreams were often embedded in African cosmology and connected the living, the living dead, or the ancestors.[15] However, even with her calling and experience, RA noted the importance of cooperation among midwives, where they

[13] Though there are many language communities in Kilombero and Tanzania more generally, Swahili is the language that is widely used by the majority. Although the Wandamba, Wahehe, Wambena, and Wapogoro were the earliest to settle in the area, the first president, Nyerere, encouraged the use of Swahili as the national language after independence, and also the free movement of people within the country. Kilombero attracted many people because of its rich diversity, which allowed farming and fishing. Later on, the construction of the TAZARA railway and the Kilombero Sugar Company led to the migration of more people to Kilombero. Thus, even though the people use local languages, Swahili is universally used in Kilombero and across Tanzania.

[14] Focus Group Discussion with Women at Lipangalala, Ifakara, on September 21, 2023. For more on the definitions and terminologies in medical studies, such as the meanings of the terms traditional, modern, and alternative medicine, see Bruchhausen (2018, 32). For healers, herbalists, spiritual, and physical medicine, see Adu-Gyamfi and Anderson (2019).

[15] In many African belief systems, the hierarchy of beings recognized the existence of the living dead, meaning those who have died not long ago, such that they are still within the living memory (*sasa*), and the ancestors who died a long time ago (*zamani*). For a detailed analysis of the *sasa* and *zamani* hierarchy of beings, spirits, living dead, and ancestors, see John Mbiti (1969, 83).

exchanged knowledge and learnt from each other.

Likewise, another interviewee, respondent B (RB), reported that her role as a traditional midwife and healer was a calling. Her expertise in the use of roots was inherited from her grandfather, who was also a healer; as a young girl RB used to help him dig for roots in the forest. For RB, inheriting medical knowledge as a healer came after the death of her grandfather, which, according to her, caused a serious affliction (RB, interview September 30, 2023). She interpreted this illness as the ancestors communicating to her that it was now time to engage in healing practices. This occurrence was followed by rituals that enabled her to take on the role of midwife and herbalist. Being a healer and a midwife was an important combination. Although her grandfather had not been a midwife but just a healer, RB was called by the ancestors to take up midwifery. This is an illustration of how gendered the role of midwifery was, both in RB's community and across Tanzania. The transfer of knowledge from an old man to RB was indicative of how age and experience were interconnected.

In addition to being called, apprenticeship was another way of learning midwifery. An experienced midwife would teach one who was interested and willing to learn. Here, the role of age was clear, for it was through a long period of practice that the midwife would become a mentor. The procedure of becoming a midwife involved many secrets, as RB said in the interview. The rites and ceremonies that were conducted were indicative of the seriousness of the task that was ahead. While these rites were conducted to usher a woman into the practice of health and healing, midwifery demanded more than that. From the experiences shared by RA and RB, it follows that only a woman of an age old enough to have delivered a baby herself – as a form of initiation into motherhood – could become a midwife. Thus, both biological and social age were important, because most midwives had to reach a certain biological age and acquire a certain social status in order to be accepted by society as qualified. It is difficult to capture age in numbers in a strict sense, but there were markers of both social and biological age in any given community. It is important to note that age was and still is also a consideration in biomedical practice, where old doctors are believed to have acquired the expertise. Nevertheless, in cases where new knowledge, new methods and technology are considered, younger doctors may emerge as experts. This is also reflected in the changes that have occurred through the transformation of the perceptions towards midwifery over time. As respondent E noted, as a young Maternal and Child Health Aide (MCHA), she was accepted by some women as their nurse despite her age (Respondent E, September 25, 2023). This shows that, just as society is not static, ideas on midwifery are not fixed but are shaped by constant transformation.

The practice of traditional midwifery necessitated the knowledge of traditional herbs that were crucial in the birthing process. Musie et al. note that pregnancy-related complications such as backache, indigestion, and nausea were treated by use of herbs (Musie et al. 2022, 90). Knowing what herbs to use when and where was a preserve of the few who had taken not only time and interest to learn, but also had the ritualistic power that was often associated with elderly women (Foner 1984). These herbs were also important for emergencies such as excessive bleeding, and for protection from bad omens. This was made apparent during the fieldwork in Kilombero, because both RA and RB had small gardens behind their houses. To a novice, the plants and shrubs looked nothing more than weeds, but their importance to the local practices of midwifery became evident once the midwives shared the medical importance linked to the plants. The presence of the gardens was also proof that their trade was alive. In addition, the

practising traditional midwives were widely known in the villages.

How did the midwives maintain their relevance in Kilombero? In most parts of Africa, deep cultural values and beliefs were linked to the birthing process (Ankasor 2017, 40–41; Bruchhausen 2018).[16] This holds for Kilombero as well, where certain rituals usually accompany the delivery. One important similarity between the cases in Kilombero and in other regions in Tanzania, as well as in several places in Ghana, and also in Asia, is the fact that, culturally, no young woman is qualified to conduct the rituals performed in midwifery (Nguyen 2010; Ankasor 2017).

In Kilombero, midwifery entailed the prescription of a traditional herbal medicine referred to as *kilala*, which was applied or fed to the baby and the mother immediately after birth (focus group discussion, September 21, 2023). *Kilala* acted as a protective charm, dug as roots, then, through experience and knowledge, prepared in a powdered form by the midwife. After birth, during the seclusion and breastfeeding period, a woman was not allowed to have sexual contact with her husband. However, it was silently assumed that, during the seclusion period, the husband was likely to have another partner. It was believed that if a man engaged in sexual contact outside marriage, it would bring a bad disease not to the woman but to the child. This infirmity was described as *kubemenda* 'delayed milestones.' The women in Kilombero had a metaphor for the condition, with which they described the affected child as *fundi wa viatu* 'shoemaker'[17] (focus group discussion, September 21, 2023). The metaphor of the shoemaker denotes immobility, which translates to delays. This made the *kilala* ritual popular, because it was believed that if it was applied or fed to the baby as a drink, it would protect him or her from the mischief of the father. If this ritual did not happen and the child was sick, it was the midwife who was able to diagnose and treat the problem (RB, interview, September 30, 2023).

The popularity of this medicine resonates with Bruchhausen's and Sempebwa's notion that African religion and medicine are intertwined (Sempebwa 1983; Bruchhausen 2018). It is important to acknowledge, however, that various belief systems have brought about transformations not only in medicine but in the general lifestyle. While delving into whether midwives and their clients adhere to other belief systems like Islam or Christianity is beyond our scope here, it is notable that in Kilombero, and in East Africa more broadly, individuals commonly embraced different forms of therapies, including traditional, biomedical, Islamic, and Ayurvedic, among others, without necessarily compromising their faith, with the primary objective of achieving wellness (Malowany 1997).

Generally, the process of birthing was guarded as a secret. The story of another respondent, here labelled Respondent C (RC), gives an interesting example. RC had eight children with the help of traditional midwives. According to RC, the midwives used *udongo mwekundu* 'red ochre' on the babies to protect them from *surua* 'chickenpox' and other ailments. According to RC, young women were not allowed to come near the delivery place, as they were believed not to be able to keep secrets. RC explained how traditional medicine was applied to the back of the hand of the newborn, and every woman present was to have her eyes touched by the hand of the baby (RC, interview, September 29, 2023). This was to signify that whatever one had seen in the process of delivery had been erased from their

[16] This was also the case among the Indo-Chinese societies. Rituals had to be conducted to protect the baby and the mother. For the Vietnamese, the *ba'mu* 'midwife' performed rituals to ward off the evil spirits from the infants by communicating with the metaphysical world (Nguyen 2010, 138).

[17] The meaning was twofold: the child will either have delayed milestones, denying him or her mobility, or the problem, if untreated, will follow the child into adulthood, where he or she will be a person of little regard.

mind, thus maintaining secrecy amongst the women present at birth.

Traditional midwives knew what to do in many different circumstances during labour. If a woman in labour had to walk to the midwife's place of delivery, then a medical ritual called *ngata* was used. Traditionally, in Kilombero, women carried loads on their heads. To keep the load balanced, a piece of cloth was rolled up several times and placed on the head where the load would rest *(ngata)*. The same *ngata* was placed on the woman in labour and a stone was placed on the *ngata*; she was to concentrate on the stone so that it would stay in place. This was a way of making sure that the woman in labour would not deliver on the way (focus group discussion, September 21, 2023). Another group of women noted that a stone would be knotted into a *kanga*[18] and only when it was untied would the woman then deliver (focus group discussion, September 25, 2023). While the general public, especially women, was aware of the existence of the *ngata* ritual, only the traditional midwife knew the specific mechanism by which it prevented women from delivering prematurely. It was believed to be *dawa* 'medicine', which was known but not necessarily understood by the general public, only by the midwife.

Furthermore, it was the role of midwives to advise and help women with family planning. Contrary to the common perception of European missionaries and the colonial government, family planning was not a new concept in Africa. Some authors have described the way Africans used different methods of family planning, such as prolonged breastfeeding or abstinence (Kennedy 1990; Kigondu 1993). These methods were also embedded in various cultural practices. However, there were other traditional methods which were still in use in the postcolonial era. Because of the secrecy of midwifery, these methods were rarely known to the general public, especially because they only involved the individual woman and the midwife present at birth and after – not unlike modern doctors, who are obliged to hold the details of their patients in confidence. The midwives had a secretive way of helping women to space out their children.

Women in Kilombero described how they would take their monthly period blood to a midwife (focus group discussion, September 21, 2023). The traditional midwife would prepare *dawa*, mix it with the blood, place the mixture inside a snail shell and then seal it. The mixture was given to the woman to hide in a safe place. The preparation of the herbal mixture underscored the importance of the midwife's experience and expertise. Over the years, the accumulated knowledge of herbs and their applications became a crucial aspect of a midwife's seniority. Other women described how, where this snail shell method was not used, the mixture of menstrual blood and herbs was tied in different knots in a *kanga*. For instance, if a woman wanted to prevent conception for three years, three knots were tied. After three years, the knots were untied and then she would conceive. In all these narratives, the process involved secrecy and sacredness. Thus, the midwives performed both moral and religious tasks. To be able to undertake such rituals, one must have reached the level of societal acceptance whereby age was key. Therefore, as noted above, an older woman who was not a mother herself would not be considered qualified for midwifery.

In the postcolonial era, some women still chose to visit the traditional midwives rather than be attended by the *watoto*[19] 'the young nurses' in the hospitals (RA, interview, September 21, 2023). In the 1960s, the first decade of independence, it was clear that the role of traditional midwives could not be over-emphasized. However, just like the colonial governments, the new government of independent Tanzania aimed at training the traditional midwives in some aspects of

[18] A light fabric used by East African women as clothing or wraps.

[19] *Watoto* (Swahili) is the plural of *mtoto* 'a child'.

clinical medicine. The implementation of such a plan proved difficult. It was hard to convince the women to train (Tanganyika Ministry of Health 1962), as many of them ascribed primarily to the traditional concepts of living and healing. Secondly, the ideas of clinical medicine were opposed to some of the cultural values which were connected to the well-being of the whole society, such as the use of rituals, charms, and amulets (Swantz 1990, 147; Musie et al. 2022). Moreover, while birthing was a woman's affair, women's reproductive and productive roles were mainly controlled by men (Cattell 2002). Thus, in patriarchal societies such as those found in Kilombero, the majority of the men would support what was in line with the cultural affairs of the community.

It was not until the late 1970s and early 1980s that the government of Tanzania began to integrate traditional midwives into the health system. Seminars were organized in collaboration with NGOs. In Kilombero, Plan International was mentioned by the respondents as having helped to organize such seminars. Respondent D, who was about 71 years old at the time of the interview, confirmed that the government and various NGOs organized these seminars. In these seminars, traditional midwives were trained alongside the newly recruited *wakunga wa kalamu*,[20] the majority of whom were in their 20s, and they exchanged ideas (Respondent D, interview, September 20, 2023). Respondent A, a traditional midwife who is an octogenarian, confirmed having attended these seminars (Respondent A, interview, September 21, 2023).[21] During this period, the seminars were successful because it was the time when HIV/AIDS had become a scourge in the medical sector and fear of contracting it was high. Thus, many traditional midwives attended these seminars to educate themselves about the new disease.

In addition, the cooperation between the traditional midwives and hospital services was encouraged. This was in line with the WHO Alma Atta Declaration of 1978, which called for the involvement of traditional health practitioners as allies of the medical sector (WHO and UNICEF 1978). Consequently, traditional midwives were taken on as partners to aid in the development of hospital services, but not as independent practitioners. Although this gave traditional health workers recognition and triggered policy shifts in defining and regulating traditional medicine, it failed to recognize the holistic nature of traditional medicine, particularly of the rituals, which people continued to seek, in line with their cultural beliefs. Therefore, one can observe a continuation of the significance of traditional healers and old midwives in the case of midwifery.

4 Conclusion

Age and seniority played and still play a key role in East African socioeconomic and cultural life. Despite the impact of colonialism since the end of the 19th century, with its paradigm of 'modernization' that contradicts principles of seniority in general, seniority and elderhood continue to structure many societies in East Africa. Especially in the field of medicine, seniority signified experience and understanding of various maladies and their remedies in many African societies. However, European colonizers and missionaries interpreted African medicine partly as 'magic' or 'witchcraft', often calling it 'primitive', and hence not scientific enough to warrant any recognition, even if the actual boundaries between Western biomedicine and indigenous medicine were often fluid. The conflict between African and Western medicine was particularly prominent in midwifery. African midwives, traditionally older women with much experience and

[20] *Mkunga wa kalamu* loosely translates as 'the midwife of the pen', which is used to refer to the midwives who have been trained in biomedicine in a school of medicine or a hospital, and to differentiate them from *mkunga wa jadi* (traditional midwife).

[21] Respondent D is a retired *mkunga wa kalamu*, while Respondent A is a *mkunga wa jadi.*

traditional knowledge, were seen as problematic by the colonial administrators and midwives. However, they were respected by local communities. Removing traditional midwives was not as easy as the missionaries, the colonial administrators, and even the post-colonial government thought. Traditional midwives were respected as mothers and women of experience with secret knowledge. They carried the traditional secrets of womenfolk, from which the young girls who were trained by missions and by European doctors and nurses were alienated. While Western medicine was able to transform and medicalize midwifery to a great extent, it was not able to remove the traditional midwives. This paper has shown that they remained key actors in the reproductive processes of African women, especially in rural areas, and even after independence. While some have argued that the scarcity of health facilities was the main reason for the perseverance of local traditional midwifery, this paper has established that even women who lived close to Western health facilities, as was the case in Kilombero, chose to be attended by traditional midwives. An essential reason for their persistence was the respect the community accorded them due to their experience and status that they had achieved, a reflection of respect for seniority within the social-cultural fabric of the African society, without which the case would have been different.

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Interviews

Respondent A, interview by Veronica Kimani and Luoneko Kaduma, Lipangalala, Ifakara, September 21, 2023.

Respondent B, interview by Veronica Kimani, Mang'ula B, September 30, 2023.

Respondent C, interview by Veronica Kimani, Kidatu, September 29, 2023.

Respondent D, interview by Veronica Kimani and Luoneko Kaduma, Viwanja sitini, Ifakara, September 20, 2023.

Respondent E, interview by Veronica Kimani and Luoneko Kaduma, Uwanja wa Ndege September 25, 2023.

Focus group discussion at Uwanja wa Ndege, Ifakara, September 25, 2023.

Focus group discussion at Lipangalala, Ifakara, September 21, 2023.