COLONIAL PUBLIC HEALTH CAMPAIGNS AND LOCAL PERCEPTIONS OF ILLNESS

Case Study of the Gogo of Mpwapwa District, Central Tanzania, 1920-1950's

By
Beatrice Halii

M.A (History) Dissertation
University of Dar es Salaam
August, 2007

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A Dissertation Submitted in Partial Fulfillment of the Requirements for the Degree of Master of Arts (History) of the University of Dar es Salaam

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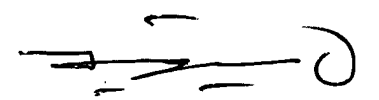
CERTIFICATION

The undersigned certifies that he has read and hereby recommends for acceptance by the University of Dar es Salaam a dissertation entitled: ***Colonial Public Health Campaigns and local Perceptions of Illness. A Case study of the Gogo of Mpwapwa District, Central Tanzania 1920s-1950,*** in partial fulfilment of the requirements for the degree of Master of Arts (History).



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DEDICATION

I dedicate this work to my parents, Edwin Halii and Clara Clemence, my husband Prosper Aloyce, and my daughter Consolata.

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ABSTRACT

This study had two main concerns. The first was to examine the influence of local perceptions of illness on the implementation of colonial public health directives. Secondly, it investigated the impact of colonial public health campaigns on local peoples' understanding of health and illness. To achieve its goals the study addressed Gogo perceptions of illness as an example and colonial public health campaigns in Mpwapwa district. The study integrated written and oral information in reconstructing the history of colonial public health interventions in Mpwapwa district.

The study found out that colonial public health campaigns were intended to make local people adopt the western practices of disease control and make them part and parcel of their social habits. Evidently, however, the introduction of colonial public health regulations was not an easy task. Local people tried to interpret the colonial innovations before adopting them. Their interpretation was strongly influenced by their previously held perceptions of illness and life as a whole. As a result, some innovations were accepted and some were neither accepted nor utilized. In the process some long-standing traditional conceptions were transformed while others persisted. Thus, the confrontation between local and western perceptions of illness did not result in the complete demise of local traditional system. Although in the long run the Gogo accepted some of the colonial principles regarding disease control, they maintained some of their local practices till the end. The study concludes that local perceptions of illness, taboos, social values and other social cultural factors played a major role in determining successes or failures in the colonial public health campaigns.

LIST OF ABBREVIATIONS AND ACRONYMS

CMS	-	Church Missionary Society
DDT	-	Dicholoro-Diphenyl-Trichloroethane
GEGGA-NUFU	-	Gender Generation and Communication in Times of AIDS, a NUFU- funded project
MEP	-	Malaria Eradication Programmes
TNA	-	Tanzania National Archives
UNICEF	-	United Nations Children Education Fund
UNO	-	United Nations Organization
WHO	-	World Health Organization

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CHAPTER ONE

INTRODUCTION

1.1 Background to the problem

Promotion of public health services was one of the functions of the colonial governments in Tanganyika. Both German and British colonial governments recognized some obligations to protect the health and safety of their subjects. Government public health interventions started during the German rule, but they were largely directed toward fighting epidemics in urban centres.[1] It was in 1925 when the British colonial government introduced Local Native Authorities to help the colonial government implement colonial policies in the district.[2] In the field of health the Native Authority Dispensary system was introduced in 1926[3], marking the first intensive attempt by the colonial government to attend to the health problems of rural African populations including those of Mpwapwa district.

The nature and scope of colonial public health campaigns changed over time due to both local and international forces. In German East Africa the early campaigns were initiated by the colonial state, and hence they were state campaigns. After the First World War, colonial public health campaigns were organized by the British colonial government and were internationally shaped by the League of Nations. In most cases these campaigns were preventive in character, aimed only at reducing or preventing the incidence of diseases, but not to eradicate them. After the Second World War public health campaigns underwent significant changes both in character and scope. The United Nations Organization and World Health Organization were involved in public health campaigns and the campaigns changed focus from the reduction of the incidence of disease to complete eradication of organisms which were believed to cause diseases. A good example is the malaria eradication campaign, which was undertaken in 1957 but abandoned in 1973 without much success.[4]A number of scholars have argued that the introduction of western explanations of diseases and healing in the African continent, including Tanganyika, was not an easy and straight forward process. According to Jan Vansina, in the period from 1880s to 1920's European officials used coercive measures to suppress African perceptions of health and illness. This involved persecutions of traditional healers and their

followers. During the 1920's and 1950's, apart from the use of coercive measures, colonial governments also started to distribute incentives like food, second-hand clothes, and shoes, to persuade Africans to accept health principles such as cleanliness, vaccinations, hygienic practices and spraying of insecticides.[5]

Different ethnic groups in Tanzania responded differently to the colonial public health campaigns. In some areas the campaigns were accepted positively, but in many cases they were rejected by the local populations. The majority of Africans saw no reason to adopt new health concepts in place of their own understanding of illnesses. This was contrary to the popular colonial official view that Africans looked forward to acquiring and implementing the colonial principles. In this connection, Juhani Koponen has noted that resistance to western medicine was stronger where traditional chiefs were resistant than where they strongly supported those new innovations. [6] People in the lake zone including Rwanda, Burundi and Shirati, fought bitterly against colonial medical missions but in Bukoba town populations offered considerable cooperation, and thus public health regulations were successfully introduced in the Haya community. Commenting on that situation, F. William, the colonial medical officer of Bukoba, stated that:

> ... Bukoba is the centre of a rich country inhabited by intelligent and progressive people, led by enlightened Sultans keenly interested in the health of the people. They always report any epidemic as soon as possible and institute a very strict quarantine on their own initiative, they made satisfactory arrangement for isolation, and the results of their precautions speak for themselves.[7]

From this example one can learn that not all Africans opposed colonial public health projects. Haya people, for instance, accepted the public health regulations, probably based on local forces. In addition to such receptive groups, there were some social groups, such as Christians, educated elites and government employees, who were among the first Africans to accept colonial public health regulations. Elsewhere, opposition or laxity dominated the scene. For instance in Mahenge district 250 labourers were issued with shoes which they refused to wear because they saw no advantages in using them.[8] Although in some districts colonial public health campaigns were pursued with considerable enthusiasm, the actual progress was slow. At the end of colonialism the campaigns did not yield as much fruit as anticipated.

1.2 Statement of the problem

Previous researches in Tanzania on public health have not adequately addressed two critical issues. First, they hardly explore the impact of colonial public health regulations on local communities' understanding of health and illness. Secondly, they lack emphasis on the influence of local perceptions of health and illness on the implementation of colonial public health campaigns. Many researches have presented colonial public health regulations as smooth and easily accepted interventions. [9] Other scholars have concentrated only on the impact of colonial public health principles on disease prevention.[10] Hardly any attempts have been made to examine the extent to which colonial public health programmes changed the African understanding of illness and the way Africans influenced the implementation of colonial public health campaigns. In view of these gaps in historical knowledge, this study examines the impact of colonial public heath campaigns in central Tanzania, specifically on the Gogo perceptions of illness and the influence of these perceptions on the implementation of colonial public health principles.

1.3 Research objectives, tasks and questions

The study had two main objectives. First, it examined the impact of colonial public health campaigns on Gogo understanding of health and illness. Second, it examined the influence of local perceptions of illness on the implementation of the colonial public health campaigns of the 1920's/1950s.

The study sets out three major tasks and questions to guide the whole process of researching for and writing a dissertation. The first and foremost task was to analyse local perceptions of illness. The guiding questions were: "What is health?" "How is it maintained?" "What is illness?" "What were the common afflictions in pre-colonial and colonial times?" "What caused those diseases?" "How was illness prevented or treated once contracted?" "How did authorities manage epidemics in pre-colonial and colonial times?" To answer these and related questions the researcher interviewed local people, the Gogo of Mpwapwa district, during a fieldwork conducted from December 2006 to the end of January 2007. Supplementary information was collected from the library of the University of Dar es Salaam, especially from ethnographic works.

The second major task of this study was to examine colonial public health campaigns. The guiding questions were: On what and whose ideas were the campaigns based? What did the colonial public health campaigns entail? What were the objectives of colonial public health campaigns? And what obstacles did colonialists face in implementing public health measures? In order to answer these questions the researcher visited Tanzania National Archives and consulted medical and sanitation reports. Other information was collected from University of Dar es Salaam library, especially in the science collection.

The third and final task of the study was to assess the influence of local perceptions in the implementation of colonial public health campaigns and the impact of colonial public health campaigns on Gogo understanding of illness. The questions posed were: How did different social groups perceive colonial public health campaigns? How did their perceptions shape their responses to the campaigns? What was the influence of nature beliefs, taboos and social norms in the implementation of colonial campaigns and how did colonial public health campaigns change local practices and perceptions of health and illness? Most of the information in this part was collected through oral interviews with local people during the fieldwork. Supplementary information was collected from Tanzania National Archives and from the library of the University of Dar-es-Salaam.

1.4 Significance of the Study

This study investigated the interactions between colonial policy and local social and ideological dynamics. As such, the study adds knowledge on the subject of disease and healing, specifically on the aspect of colonial public health interventions. Most publications on the topic of diseases are based on the biomedical approach or ecological theory or political economy. They did not go further in their researches to study the influence of local people on the implementation and sustaining of colonial public health campaigns. This dissertation therefore adds to the history of disease and healing by introducing into such a discussion of the local perceptions of illness and their implications on the implementation of colonial western health concepts.

Moreover, this study has tried to reconstruct the history of Africans. The role of rural Africans in shaping history is seldom acknowledged. They are often simply viewed as passive recipients of modernization pressure from

urban centres or directly from abroad. Thus the study shows how rural Africans interpreted and made sense of the colonial interventions before utilizing them.

The study may also have practical significance. The findings suggest the need for public health workers and others to be sensitive to local knowledge, ideas and social reality when introducing new ideas among rural communities. Finally, it is hoped that the study will stimulate further research on the following two critical issues: first, the contribution of colonial public health campaigns to cultural transformation, and second, the dynamism of interactions between colonial policy perceptions and local reality.

1.5 Theoretical Framework and Literature Review

Perceptions on health, diseases and healing have taken various theoretical points of departure in history. Some scholars have perceived diseases as human-induced phenomena, while others have seen them as products of the physical environment. Some analysts have considered diseases as purely a biological problem, while others consider them a social issue. Each of these theories had their implications in the evolution of public health programmes around the world. This dissertation builds itself around the strengths and weaknesses of the social constructionism theory of disease causation.

This theory emphasizes the importance of placing problems of diseases and illness within social, political and cultural contexts rather than viewing them as happening in a social vacuum. The theory maintains that diseases are largely caused by poverty, migration, malnutrition, ecological changes and economic distress. Scholars like Lesley Doyal, Y.Q. Lawi, Steven Feirman and John Janzen, Oswald Masebo, and Fredric Kaijage[11] have emphasized that social economic factors are arguably more important causes of disease than germs and natural environments. Consequently, the focus of public health provision should be on the reconstruction of the social relations of production. In addition to applying concepts of social constructionism, the study also attends to local perceptions, beliefs and ideas underlying local health practices.

The works of Cycle David[12] and Ann Beck[13] provide detailed historical descriptions of health services in Tanganyika during the colonial period. However, their descriptions were based on urban centres,

completely ignoring the role of central government in implementing colonial health policies in rural areas. Likewise the publications ignored local perceptions of illness which co-existed with Western medicine. According to David Clyde, medical and public health programs in Tanganyika started with German colonization in 1888. He claimed that "the pre-colonial people were held fast in the bondage of chronic diseases, were in constant fear of attack and enslavement by neighbours and strangers and were dominated in thought and deed by witchcraft."[14]

The gap in the development of public health services in rural Tanzania was somehow filled by the work of Van Etten[15], who deals with the development of rural health services in mainland Tanzania. One weakness of this publication is the generalization of rural Tanzania. Nsekela and Nhonoli's[16] work emphasizes the importance of placing colonial pubic health services in the broader context of socio-economic development policy of the colonial government. Although they acknowledged that colonialism brought a new era which changed the history of health and disease in Tanganyika, they were not interested in the transformation of local perceptions of disease caused by western approach to healing. Similarly, the publications did not acknowledge the role of Africans in influencing colonial public health interventions. David Clyde's study on malaria[17] and Eginald Mihanjo's[18] study on colonial policy of sexually transmitted diseases provide valuable but specific information about the particular campaigns, thus they limit the understanding of the colonial campaigns as a whole. Like many others, these writings did not show the dynamics of interactions between colonial experts and local people. Scholars such as Meredeth Turshen[19] and Randall Packard,[20] have provided critical analyses of the relationship between the colonial economy and diseases. They argued that colonial medical and health interventions were the response to diseases caused by colonial oppression and exploitation. These publications have two major limitations. First they provided a national analysis of disease and western medicines and hence they ended with general information. Second they did not show the position of Africans in influencing colonial policies.

According to Anitha Widding,[21] Steven Feierman,[22] Gloria Waite,[23] Jan Vansina,[24] Edwin Colson,[25] Christopher Robert,[26] Kar Arhem,[27] and Alan Harwood,[28] Africans had their own perceptions of illness. Diseases were viewed in forms of a perceived cause. Some diseases

were believed to be caused by natural factors such as rainfall, humidity, relief and temperatures; others were attributed to human-related forces. Another group of diseases was attributed to the breaches of social norms and taboos and poor nutrition. For the Safwa ethnic group for examples, disease was a result of the breaking or weakening of social relations. Disease, therefore, was an indicator of deviance in social relationships. Following that perception, the Safwa emphasized social cohesion as the first remedy for disease.[29] Although these publications acknowledged the presence of local perceptions of illness they did not show clearly the dynamics of local perceptions of illness in pre colonial and colonial times.

Gloria Waite's study of Central and Eastern Africa[30] went beyond that and showed clearly how Africans' perception of health and illness was distinct from Europeans' views. Although Waite acknowledged the coexistence of pre-colonial public health mechanisms and western medicine, she did not show how these two systems influenced each other. Critical evaluations of the impact of the coexistence of African and European understanding of diseases were done in the study by Steven Fiereman[31] and Jan Vansina.[32] They noted that, although Africans accepted some western ideas they did not shake off all their previous beliefs and practices. [33] Nevertheless, these publications did not go further to analyse the factors that shaped Africans' acceptance of certain public health regulations.

Scholars such as David Cycle, Anne Beck, Helmut Georgern and Krister Kueleker[34] attributed the failure of colonial public health campaigns to shortage of funds, poor administration, lack of political commitment and local people's opposition. They totally neglect the role of intangible factors. Margaret Read's study on health, disease and culture[35] has tried to show how the implementation of colonial health principles was influenced by socio-cultural factors all over the world. She successfully demonstrates this fact with examples from Latin America, India and Africa. Read goes further and suggests how to study local perceptions of health and disease in the traditional society before introducing any new health or welfare programme. Like other publications, the book is too general and hence it only provides a general framework on how colonial health principles contradicted local culture all over the world. It is out of these weaknesses of previous writings that this study was conceived.

1.6 Research Methodology

1.6.1 Research approach

The research for this study applied an interdisciplinary approach in collecting the needed information. The researcher selected this approach due to the nature of the topic. The study examines the impact of British public health campaigns on local perceptions and the influence of local perceptions on the implementation of colonial public health campaigns. The topic required an integration of information from various disciplines: public health, medical sciences, ethnography and social-cultural history, plus analysis of how colonial public health campaigns and local people's perceptions influenced each other.

The study was carried out among the Gogo of Mpwapwa district. This district was selected as a case study area for the following reasons. First, the researcher was familiar with the local language and other social cultural aspects of the society. Second, time constraint forced the researcher to conduct the study where she understood the environment and some aspects of people's experience. Third, Mpwapwa was selected because there is no detailed historical work on the district, especially in the area of social history. Scholars such as Peter Rigby, Gregory Maddox and Mathias Mnyampala[36] have written a general history of the Gogo of Dodoma region, including information about their cattle economy, kinship relations, population dynamics and rituals. The subject of health, illness and healing, however, did not feature in their studies.

1.6.2 Methods of data collection

Most of the secondary and primary data were collected from the library of the University of Dar es Salaam. Other primary data were collected from the Tanzania National Archives (Dar es Salaam), where Mpwapwa District Books as well as medical and sanitation reports were consulted. Fieldwork was conducted in Mpwapwa district, especially in Mpwapwa division. Oral data were collected using guided interviews and focus group discussions. Information was recorded in notebooks and on audio cassettes.

1.6.3 Data Analysis

Data analysis was guided by the stated research questions and objectives. The first task was to review the raw data as collected

from different sources. This helped to examine the depth and width of the data collected. The second task was to categorize the information according to the research objectives and questions. This step helped the researcher to compile all the information displaying a similar theme. The researcher also assessed the data and organized accordingly to examine whether the data was logically arranged to answer the research problem step by step. Data interpretation was another important task undertaken in this step. The data was subjected to a critical analysis enabling them to answer the research problem.

1.7 Limitation of the Study

The study was conducted between December 2006 and January 2007. This was the farming season, making it very difficult to find time with villagers as they were concentrating on farming activities. Thus most of the interviews were conducted in the late evenings when the majority of the respondents were already tired. Even then, some well-informed respondents hesitated to provide information especially that related to local perceptions of illness. The researcher had to educate them on the purpose of the research and convince them that it was beneficial to provide information. Some informants viewed the recording and collection of their information about disease and healing as academic theft rather than cultural promotion. It was difficult to have these particular people cooperate fully and provide reliable information. The researcher expected also to investigate parish records and registers at Dodoma and Mpwapwa CMS mission centres. Unfortunately, these records were not available since some had been taken to London and were thus not available in the mission centres.

1.8 Organization of the dissertation

The study is organized in five chapters. The first chapter is an introduction. It highlights the background to the study and the nature of the problem, the study's objectives, the theoretical framework and the methodology employed. The second chapter examines Gogo perceptions of illness in the late pre-colonial times. It shows that the Gogo conceptualized health and illness based on their local contexts. The third chapter examines the nature and character of colonial public health campaigns. The fourth chapter examines the influence of local perception on the implementation of colonial public health campaigns, as well as the impact of the articulation of

traditional and western perceptions of health and illness. The fifth chapter summarizes and concludes the study.

1.9 Conclusion

This chapter has identified gaps in the historiography of Tanzania, specifically with regard to disease and healing. Review of the existing literature has shown that most of the researches on the subject of disease and healing in colonial Africa tended to concentrate mostly on the medical aspects and dealt only in brief with public health issues. Studies on public health services are largely urban in outlook and devote comparatively little attention to the public health programmes in rural areas. In addition, most works on public health services have taken a broad perspective and by so doing they offer only general information. The other works on public health services have concentrated only on a single health campaign. This isolation of some parts of colonial public health campaigns limits the understanding of these campaigns as a whole.

Another major weakness of the publications reviewed is that they do not emphasize initiatives taken by rural societies to transform their perceptions and practices as an attempt to control new health problems and the challenges of epidemics in pre-colonial and colonial times. Most medical historians have tended to overlook initiatives taken by a rural society to transform themselves in every historical epoch. It should be noted here that up to the nineteenth century Africans had acquired a set of ideas, beliefs and practices on how to handle issues of disease and poor health. The next chapter will discuss this in detail.

NOTES

[1] David Clyde, History of the Medical Services of Tanganyika (Dar es Salaam: Government Press, 1962), 23, 41 and 53; Juhan Koponen, Development for Exploitation: German Colonial Policies in Mainland Tanzania 1884-191, (Helsinki: Finnish Historical Society, 1995), 470.

[2] Doyal Lesley, The Political Economy of Health (London: Pluto University Press 1981), 251.
[3] Ibid.

[4] Meredeth Turshen, The Politics of Public Health (London: Zed Books Ltd 1986), 121-151.
[5] Jan Vansina, A Clash of Cultures: African Minds in the Colonial Era in Philip Curtin et al, (eds), African History From Earliest Times to Independence (Singapore: Pearson Education Press, 1995), 469.

[6] Juhan Koponen, Development for Exploitation, 479.
[7] David Clyde, History of the Medical Services of Tanganyika, 165.

[8] Ibid.
[9] Ibid.

[10] Eginald Mihanjo, "Colonial Policy on Sexually Transmitted Diseases and other Infectious Diseases in Tanganyika, 1900-11960" in Yusufu Lawi and Betram Mapunda (eds.) History of Disease and Healing in Africa, (GEGCA-NUFU Publication Vol.7 Dar es Salaam, 2004).
[11] Doyal Lesley, The Political Economy of Health, (London: Pluto University Press 1981); Steven Feierman and J.M Janzen (eds.), The Social Basis of Health and Healing in Africa,(Berkely: University of California Press, 1992); Yusufu Lawi and Betram Mapunda (eds.), History of Disease and Healing in Africa.

[12] David Clyde, History of the Medical Services of Tanganyika, 1,11.
[13] Anne Beck, Medicine and Society in Tanganyika 1890-1930, A Historical Inquiry (Philadelphia, 1977), 9-13

[14] David Clyde, op.cit, p. 11
[15] Van Etten, Rural Health Development in Tanzania (The Netherlands: Van Goram & Co. B.V. 1976), 1.

[16] Nsekela Amon and Nhonoli Aloysius, Health Services and Society in Mainland Tanzania,2

[17] David Clyde, Malaria in Tanzania (London: Oxford University Press, 1967), 13.
[18] Eginald Mihanjo, "Colonial Policy on Sexually Transmitted Diseases and other Infectious Diseases in Tanganyika, 1900-11960" in Yusufu Lawi and Betram Mapunda(eds.) History of Disease and Healing in Africa, (GEGCA-NUFU Publication Vol.7 Dar es Salaam. 2004).

[19] Meredeth Turshen, The Political Economy of Diseases in Tanzania, (New Brunswick, Rutgers: University Press, 1984), 10.

[20] Randall Packard, "Industrialization, Rural Poverty, and Tuberculosis in South Africa" in Fierrman S, Janzen J.M.(eds.), The Social Basis of Health and Healing in Africa (Berkely: University of California Press, 1992), p.104.

[21] Anita Widding and David Westerlund (eds.), Culture, Experience and Pluralism: Essays on Africa Ideas of Illness and Healing (Acta Universitatis Upsaliensis: Uppsala, 1989),5-12.

[22] Steven Feierman, "Social Change in Colonial Africa" in Philip Curtin (et al), African History From Earliest Times to Independence (Singapore: Pearson Education Press 1995) , 491-493.

[23] Gloria Waite "Public Health in Pre-colonial East–Central Africa" in Fierrman S, Janzen J.M.(eds.), The Social Basis of Health and Healing in Africa(Berkely: University of California Press, 1992), 214-15.

[24] Jan Vansin, 'A Clash of Cultures,'470.
[25] Edwin Colson, "Spirit Possession among the Tonga of Zambia," in Beattie, J and Middleton.J (eds), Spirit Mediumship and Society in Africa (London: Rutgers University Press, 1969), 69-103.

[26] Chistopher Davis Robert, "Kutambua Ugonjwa among the Tambwa of Zaire" in Feierman S, Janzen J.M.(eds.), The Social Basis of Health and Healing in Africa (Berkely: University of California Press, 1992),376-392.
[27] Kaj Arhem, "Why Trees are medicine: Aspects of Maasai Cosmology" in Anita Widding & David Westerlund (eds.), Culture, Experience and Pluralism, 79-81.

[28] Alan Harwood, Witchcraft, Sorcery and Social Categories among the Safwa (London: Rutgers University Press 1970).

[29] Ibid.

[30] Gloria Waite, 'Public Health in Pre-colonial East –Central Africa', 228-231.

[31] Steven Feierman, 'Social Change in Colonial Africa,' 491-493.

[32] Jan Vansina, 'A Clash of Cultures: African Minds in the Colonial Era' in Philip Curtin et. al. (eds.), African History From Earliest Times to Independence (Singapore: Pearson Education Press, 1995), 469.

[33] Jan Vansina, A Clash of Cultures 469-485; Steven Feierman, Social Change in Colonial Africa, 491-493.

[34] David Clyde, History of the Medical Services of Tanganyika (Dar es Salaam: Government Press, 1962); Anne Beck, Medicine and Society in Tanganyika 1890-1930, A Historical Inquiry (Philadelphia, 1977); Goergen and Kueleker, The History of Health care in Tanzania,(German Agency for Technical Cooperation,GTZand National Museum of Tanzania 2000).

[35] Margaret Read, Culture, Health, and Disease (London: Tavistock Publications, 1966).

[36] Peter Rigby, Cattle and Kinship Among the Gogo : Semi Pastoral Society of Central Tanzania, (Ithaca: Cornell University Press 1974); Gregory Maddox, The Gogo History, Customs and Tradition, (London: M.E. Sharpe, 1995).

CHAPTER TWO

DYNAMICS OF LOCAL PERCEPTIONS OF ILLNESS AMONG THE GOGO OF MPWAPWA, 1800-1900

2.1 Introduction

Illnesses have been the problem of human beings since antiquity. However the patterns, prevalence and incidences of illnesses have been changing over time. Similarly, throughout history, human beings have been struggling to control illnesses by using various mechanisms. However, these techniques vary across societies overtime. This chapter discusses the changing perceptions of illness in the Gogo pre-colonial society as expressed in various forms of Gogo oral traditions. In this connection the chapter explores Gogo perceptions of epidemics and the practices used to control them. Before discussing the details of this process, the chapter dwells briefly on the geographical and cultural context of the pre-colonial Gogo society of Mpwapwa.

2.2 Geography and people

In the pre-colonial period, there was no place known as Mpwapwa. The area was called *Mahvwa.* The name was adopted from the River *Mahvwa,* which crossed the area and which had water throughout the year. According to local people, Germans failed to pronounce *Mahvwa,* and so they called the area *Mpwapua*, which the British latter changed to Mpwapwa which was easy for them to pronounce.[1]The first foreigners to establish a settlement in that area were the Arabs in 1830. The area was later occupied by the German East Africa Company in 1888. Mpwapwa was captured and occupied by the British in 1916, and it became a sub-division of Dodoma district until it was declared a full district in 1929.[2] Currently, Mpwapwa is one of the seven districts of Dodoma region. The other districts are Kondoa, Kongwa, Dodoma rural, Dodoma urban, Bahi and Chamwino. Administratively Mpwapwa district is made up of three divisions: Mpwapwa, Kibakwe and Rudi. The district has eighteen wards and eighty-four villages. It is bordered by Kilosa district of Morogoro region and Kongwa in the north, Iringa district of Iringa region in the south, and Dodoma rural district in the west. The major ethnic groups of the district are the Gogo, Kaguru, Tiriko and Hehe. The Tatoga and Maasai are pastoral groups that have migrated into the

district and settled in the southern plains around Mtera and Ruaha rivers. According to the 1967 census, there were about 170,275 people in Mpwapwa district. The Gogo numbered about 60,375; the Kaguru 41,208; the Hehe 33,466; Nyiramba 33,446; and the Sagara 12,043. Currently it is estimated that the district has a population of 235,690 people.[3]

Most parts of the district lie between 915 and 1200 metres above sea level. Mpwapwa district has an area of 7,479 square kilometres, constituting about 18.1% of the total area of Dodoma region. The climate of the district is more favourable than that of other areas of Dodoma region because of the influence of the Kiboriani and Rubeho Mountain ranges. Average annual rainfall is 715 mm. The rains begin in December and end in April. In mountainous areas like Kiborian, Wotta, Lufu, Mbuga and Mangaliza the rains are heavy, reaching up to 1200 mm per year. [4]

Map 1: Location of Mpwapwa District in the Map of Tanzania

Source: Adopted from Richard Titmus, Brian Smith and Arthur Williams (et Al.), *The Health Services of Tanganyika: Report to the government* (London:Pitman Medical Publishing Co. Ltd, 1964)

In the immediate pre-colonial period the Gogo had a very complex political organization. At the top there was *Kozeli Mazengo,* the head of the entire Ugogo region, who lived in Mvumi Makulu until 1960s, when the government abandoned chiefdoms. Under *Kozeli Mazengo* there were also w*atemi* of small political units scattered throughout Ugogo. The name *mtemi* came from the word *kutema* which means to open up new lands. The name reflects the major responsibility of the *mutemi,* which was to fight for and seize land and distribute it to his subjects. There were also people who were known as *ikutu dya mtemi* (spies of the *watemi).* These used to collect information secretly and deliver it to the *mtemi.* There were also *wapembamoto,* the political leaders of the division. Under the *wapembamoto* there were *wazenga tumbi,* the heads of the villages. At the lowest level of the hierarchy were the *wazenga kaya,* the heads of households, who were usually male. All these had a duty to implement orders from the *watemi.* This political set up survived until the beginning of colonial rule. It is reported that the colonialists found many *watemi* in Mpwapwa district. The best known among them are Sagia, Chipanjilo, and Ismail, who provided land to Europeans.[5]

2.3 Sources of Local Knowledge, Beliefs and Practices

Available oral and written information reflects that local knowledge develops from local people's experiences and initiatives. Carolyn Merchant and Michelle Wagner[6] have stipulated that local people perceive nature as an active object. In turn nature and culture shape human action and consciousness. This was true among the pre- colonial Gogo of Mpwapwa district. Their perceptions of illness clearly related to their perceptions of nature and culture. In other words, nature and culture were the major determinants of local perceptions of illness. According to Elikana Makasi, one of the major informants, the Gogo acquired skills, knowledge and values for controlling diseases through daily contact with the environment, including people. Local people also acquired knowledge through inheriting certain values, traditions and customs from older generations. Other skills for handling illnesses were acquired through apprenticeship, which involved staying with and learning from a competent traditional healer. In return, the learner agreed to work for the healer for a number of years as payment for the skills. Yet other knowledge and skills were gained through constantly reasoning, observing, and reflecting on social reality.[7] This confirms the long established understanding that ideas and knowledge develop out of interactions among people and between people and their natural environment. [8]

According to Monica Maganza, herself a traditional healer, Gogo elders strongly believe that children could inherit diseases but not knowledge on how to handle problems of ill health. Thus they felt responsibility for preserving such knowledge and skills in oral traditions and transmitting them to the younger generations. The transmission was through simple daily teachings, warnings and corrections. In some cases, elders induced fear as a way of teaching critical issues. There were also organized teaching programmes during rites of passage when community ceremonies were organized to accompany circumcision and *Unyago*[9] rituals. Apart from social orientation the youth were introduced to the world of spirits and their influence upon human survival.[10] All these teachings shaped their behaviour and their consciousness.

2.4 Gogo pre- colonial Perceptions of Illnesses and illness causation

Available oral and written information suggests that before the second half of the nineteenth century there were only endemic diseases in Ugogo, and these did not occur in epidemic proportions. Common afflictions mentioned in this era were leprosy, smallpox, relapsing fever, madness, infertility, impotency, diarrhoea, epilepsy, skin diseases, toothache and malaria. Available written information reports that before the second half of the nineteenth century diseases were localized, and their ability to spread was limited due to the low level of interaction with other communities.[11] They simply assumed that people stayed in small wandering groups of at most a few families which rarely came into contact with one another. Yet other scholars claimed that local people had developed biological adaptations to those diseases.[12] The Gogo for their part attributed the diseases patterns to stability, social cohesion, harmony and the isolation of the Gogo from other communities.[13]

The bulk of the historical information gathered during the fieldwork points to the fact that, among the Gogo of Mpwapwa, health had several meanings. It was not merely the absence of illness. It meant well-being in body and mind, beauty, happiness and fitness. Illness in the Gogo context was conceived as pain felt in some organ of the body, or inability to do work and other social obligations.[14] Perhaps Rehema Nchimbi's definition fits well the Gogo perception of health. She defines health as a state of complete well-being, in terms of being good in conduct and in abilities in relation to other members of the society.[15] Hence, in the African tradition in general, and among the Gogo in particular, the concept of health presumed a unity of body and mind. According

to Gogo oral testimonies, health status was influenced by several factors, such as the social relationship between the living and the dead, the relationship between the living and god or *Mulungu*[16] as well as contravention of taboos. To maintain health, individuals, leaders and the society as a whole had to undertake several activities, including rain making, isolation of the victims, offering of sacrifices to ancestors, observance of taboos, and commemoration of ancestors' names.

Contrary to the common assumptions among the colonial historians, that Africans attributed all diseases to witches, the Gogo considered witches to be only one of the causes of illness. Thus there was not a single explanation for illness; illnesses were explained differently depending on their type and nature. The first set of testimonies collected in Mpwapwa district suggested that some illnesses were believed to be caused by natural factors, such as temperature variation, rainfall, wind, humidity and general weather changes. Illnesses mentioned in this group included, diarrhoea, skin rashes, rheumatism, malaria and epilepsy.[17] Other testimonies claimed that some illnesses were the outcome of intended actions of human and superhuman agents such as *Mulungu,* nature spirits and witches. Gogo of Mpwapwa had oral narratives which explain the origin of smallpox. According to the story, after the creation *Mulungu* ordered all people to stay in harmony, peace and love. But some people learned how to harm others by bewitching them. This angered *Mulungu,* thus he decided to punish all the witches with smallpox. Although the Gogo believe that smallpox was special disease for witches they admitted that the diseases could attack innocent people by associating with victims. However they reported that when small pox attacked innocent people it became less virulent and could be cured by appropriate remedy.[18] The story above might be a fiction but it was very important in pre-colonial society as it reinforced the value of not harming others.

According to the local narratives, leprosy was also sent by *Mulungu* to a certain *Mtemi.* According to the story, long time ago there was a *Mtemi.* This *Mtemi* was very powerful. He managed to conquer weak societies and confiscated their land and other property which he distributed to his subjects. He had also the power to make rain. His subjects loved him. At one point in time the *Mtemi* started to feel more superior to any one else in the society. He started to treat people harshly. They were forced to carry him whenever he wanted to go. He killed people without any trial. When *Mulungu* saw the practices of *Mtemi* he became furious and decided to punish the *Mtemi* with leprosy. He ordered people to

expel the *Mtemi* to the bush and select another *Mtemi* in his place. According to the story, some people were afraid of expelling the *Mtemi,* and therefore they continued to associate with him, and thus many of them contracted leprosy. But the rest decided to evict the *Mtemi* and all who contracted the disease to the bush.[19] Although the story attributed leprosy to the magic power of *Mulungu* it also explains how the disease could be transmitted from one person to another. Direct or indirect the story suggests isolation of the victims.

Other diseases were associated with curse from a human being. According to Gogo local narratives, a long time ago, some children were going to the bush to collect firewood. On the way they found an older woman who was very dirty and ugly. These children started laughing at her. When the woman saw this she cursed the children and they suddenly paralyzed. From that time laughing at elders, disabled, ugly and poor people was declared a taboo. Children were taught to respect and help these categories of people.[20] It seems that in pre-colonial and even in pre-colonial period, the Gogo strongly believed that curse could bring diseases. And a curse often seems to follow the transgression of certain taboos and social norms. Thus, to maintain good health people were supposed to respect not only their parents but also other people of different kinds.

There is also a story which prohibits a friendly relationship between human beings and monkeys for fear of misfortunes such as illness. According to the story at creation human beings belonged to the family of monkeys called *mapuma*, which gradually changed into human beings. After the change, *Mulungu* ordered all human beings-male and female, to be circumcised, and all went for circumcision. The second order was to stay together in one place until the wounds healed. According to the story, some of them started to sever their adherence to the group and started leading an independent life. When *Mulungu* saw this he became angry at the disobedient human beings and cursed them. Soon after the curse they turned into monkeys again and they were forced to stay in the wilderness. In addition they were cursed with laziness, and so to survive they would have to depend on stealing crops from human beings. Finally, *Mulungu* declared enmity between human beings and monkeys.[21]

Problems relating to mental illnesses were attributed to nature spirits, called locally as *mhepo* and *machisi.*[22] The Gogo believed that these spirits

normally possessed human beings in order to shield them from sorcery. Paradoxically, they manifested themselves by making the individual sick or mad until he or she participated in a special dance of exorcism.[23]

Yet other illnesses were attributed to the actions of witches. Informants emphasized that diseases of this nature were very difficult to identify. However some of the characteristics associated with witchcraft included sudden sicknesses, headaches, aching of legs and paralysis.[24] As articulated by Monica Maganza, one of our informants:

> It was very difficult to know whether the cause of an illness was witchcraft due to the fact that they had the same symptoms as other diseases. Only the diviners were able to know the "bewitcher" and the reasons for being bewitched. Even white men could not distinguish these kinds of illnesses from the normal ones.[25]

When other people were asked how witches harm people, most of informants reported that witches used indigenous medicines and objects such as *soche, mapeli and kusonhela.*[26] According to oral testimony, a Gogo would often be heard saying *"Munhu nhendu yandalile cidole kululu, hamba lidole litali,"* meaning "a witch has pointed a finger at me, indeed with the longest finger". This was a serious accusation in Gogo society and was associated with suddenly death. One of the health problems believed to result from the victim stepping on *mapeli* was infertility and sterility. It was strongly believed that when the intended person set foot on *mapeli*, he or she was immediately afflicted, thus losing his or her reproductive power. According to local explanations, this followed from the effects of the viscous fluid of *mapeli* which would 'dry off' the reproductive capacity of the victims. According to Gogo narratives, *soch*e was the ghost of a previous victims used by witches to gain new ones. In general, witchcraft explanation for on diseases causation seemed to be employed to explain some kinds of awkward diseases mentioned above.

Elders and traditional healers interviewed during fieldwork also emphasized that there was a large number of diseases believed to originate from inside the person concerned. In this connection, it was believed that many deaths originated from *mahwele,* loosely translated as stress or fear of something. The belief is linked with a

mythical conversation between a snake and a rat.[27] According to the story, one day the rat asked the snake why human beings often fell sick and died. The snake replied that God had given them a long life and they were supposed to die in their old age, but *mahwele* made them die early. The rat was not satisfied with this reply. So he and the snake went to a distant forest to verify whether *mahwele* was the cause of human illness and death. When they were in the forest a man passed by and the snake went and bit the man and hid. The man looked around to see what had bitten him. Instead of the snake, he saw the rat. He did not mind at all and went on with his business as usual. After some time another man came and this time the rat went and bit the man and hid. The man looked around and saw a big black snake; he thought he had been bitten by it. He panicked and became mad, started to run and within no time he fell down and died.[28] This narrative reflects the Gogo belief that uncontrolled stress, wrong imaginations and anxiety could be a source of a fatal illness.

Many local testimonies point out that skin diseases and toothache resulted from the consumption of prohibited foods. These included certain types of animals or birds. However food taboos vary across Gogo clans. Every clan had its own restricted foods locally known as *mlongo*. Taking the Nyamzula clan, as an example, this clan was prohibited from eating frogs and they faithfully obeyed the taboo for fear of health problems associated with the breaking of it. The taboo was transmitted faithfully from one Nyamzula generation to the other through the following narrative. According to the narrative, during the immigration of their ancestors from the south to Ugogo they entered a waterless area and suffered from thirst. One of their dogs went off and came back with mud on its legs. Hence they decided to follow its footprints and found a waterhole with frog in it. From then on, the frog was made a symbol of Nyamzula clan. Hence the name Nyamzula was adopted from this episode.[29] This story shows how the clan adopted the frog as a totem, but these Gogo restrictions have much more to say than that. They helped in clan identification and also were one of the methods to avoid intermarriage between relatives. There are also biological implications one being the prevention of spread of hereditary diseases from one generation to the next.

In addition, the pre colonial Gogo observed a number of sexual taboos. They strongly believed that breaking of sex taboos could

result in certain types of illness. Among the Gogo it was prohibited to have sexual relationship with a woman who had miscarriage and between parents who have a nursing baby. Similarly, it was restricted to have sexual intercourse with a woman who is in menstruation period. Sexually transmitted diseases such as syphilis and diseases like general body malaise, frequent fever and diarrhoea for children were attributed to adulterous or sexual congress of parents during the nursing period.[30]

Records and local memories are rather silent on incidences of epidemics prior to the second half of the nineteenth century. According to Peter Rigby, before the second half of the 19th century the survival of the Gogo largely depended on cattle economy. The population was scattered and nomadic in character.[31] This kind of settlement pattern probably limited the level of interaction with other societies and hence prevented the eruptions of disease in epidemic proportions. Gogo traditions mention diseases like smallpox and leprosy as ancient diseases. However, Carol Sissons reports that the rate of occurrence and prevalence of these diseases changed significantly during the second half of the nineteenth century. She also reports the introduction of new diseases such as dysentery, measles and chicken pox in Ugogo society from the second half of the 19th century by slave caravans.[32] Many informants who were asked about the sources of the epidemics reported that their parents had told them that those epidemics had external origins. They believe that the diseases started among slaves in their slave markets or camps, where people of different localities met, and then the epidemics spread like bush fire to the nearby societies.[33]

In this case Gogo perceptions of epidemics coincided with one of the modern theses on disease causality. According to Oswald Masebo, the concentration of people in certain areas during the second half of the nineteenth century created ideal conditions for disease to spread in epidemic proportions.[34] In the case of Mpwapwa, both oral and written sources suggest that the caravans of long-distance trade, including those of the slave trade and porters passing through the district, acted as sources of the epidemics in Ugogo. When asked how illness spread in epidemic proportions most informants argued that illness could spread from one person to another through direct and indirect contact by sharing household utensils, bedding and other apparatus.[35] Edward Lwabe argued that:

> Illnesses such as boils, smallpox and sores, could be transmitted from one person to another, first by stepping on an infected person's apparatus hidden on a public path and also by touching the afflicted person's shoes. Sometimes, when a person stepped on or touched the infected things, the infections were transmitted to him or her and the one who implanted that illness was immediately cured.[36]

The above exposition suggests that the Gogo knew that illnesses could spread from one person to another, directly or indirectly, through natural inheritance, marriage relationship, through bodily contact, association with victims, or sharing household utensils, bedding and other infected things.

Furthermore, the Gogo attributed epidemics which erupted from the last quarter of nineteenth century with the decline of cattle economy. According to Helge Kjekshus almost 90 of livestock of the Gogo perished in the year 1890 following a rinderpest epidemic.[37] The Gogo reportedly felt, among other things, serious shortage of fat, meat, and milk, which were major sources of protein on their local diets. Similarly, the Gogo attributed diseases like flue, headache, general body malaise and frequent fever with the shortage of milk and were not cured by medicines but by the consumption of large amounts of fat and milk to reconstruct the body. Gogo oral testimonies emphasised that normally a person is required to take at least two litres of milk per day.[38] The eruption of malnutrition among the Gogo probably started in the last quarter of the nineteenth century following the rinderpest epidemic.

2.5 Gogo practices of disease prevention

Preventing the spread of diseases was one of the major functions of the Gogo local leaders. Political patrons, diviners, traditional healers and local elders all played a role in preventing illness. There were several ways of preventing diseases. It seems local authorities believed that it was simpler to prevent diseases than to cure them and so they played a critical role in helping their subjects to avoid diseases. One of these was performance of certain rituals. According to an informant, Elikana Makasi, the major function of rituals was to protect individuals and the society as a whole.[39] In other words, rituals were viewed as precautions to safeguard the

society. There were several rituals, but the common ones, and which involved the whole community, were birth, marriage and death rituals. Traditionally, the girl was to give birth at her parent's, and not her husband's homestead. According to recorded Gogo narratives, only maternal relatives, especially the mother of the expectant woman, could take proper care of her to ensure safe delivery. However, it is also known that, during such times, the husband was forced to finish paying whatever part of the bride price remained unpaid.[40] A newborn baby ordinarily inherited the name of an ancestor. A breach of this custom was believed to cause illnesses such as uncontrolled crying, eye diseases, and general body malaise.[41] Thus, ancestor names were to be perpetuated in the same clan. Giving a child an alien name was believed to be a potential threat to the child's health in the future. The remedy for this was simply to offer a sacrifice to the relevant ancestors and the adoption of the right name. Thus, among the Gogo of Mpwapwa district, naming children after clan ancestors was part and parcel of family efforts to ensure health and long life.[42]

Death rituals were also part and parcel of local mechanisms for maintaining health. It was taboo to inform children about the death of a relative. Similarly, it was strictly prohibited to incorporate children into the burial activities. Children were taken away to nearby villages, and when they asked about their departed relatives they were told "*Igongola limusola*[43]", which means that, the deceased had been taken to the wilderness by a very big animal. According to oral testimonies, the answer had two intentions. The first was to hide the fact of the relative's death. They believed that informing children and incorporating them into burial activities would bring serious health problems upon them.[44] Secondly, the answer was intended to create a phobia and make children afraid of entering a forest. After the burial ceremony the deceased's relatives would embark on a search for the causes of the death. This practice was known locally as *kujenda Mbeho.* Literally it means the movement from one diviner to another to find out the forces that interrupted the life of their relative.[45] This was also one way of maintaining health, as it created the fear of harming other people. As Steven Njamasi claimed," the practice of *kujenda mbeho* created fear to the people not to harm others with witchcraft, or poison; even though they would do it secretly at the end they could be caught and killed like animals."[46] However, some oral testimonies have pointed to the fact that these rituals gradually lost significance during the colonial rule. Christians, educated elites,

and government employees were the first social groups to violate these rituals as they preferred modern values over traditional ones.

Prayers for rain were part and parcel of the Gogo disease prevention practices. According to the local narratives drought was often accompanied with smallpox epidemic.[47] Every time they experienced a prolonged drought they resorted to conducting community prayers. The preferred site for these prayers was in the Rubeho ranges. *Mtemi,* or some selected priests clothed in black cloth, had to prepare a sacrifice, usually a black lamb. The sacrifice would be offered while the people danced, sang and "said" their prayers. According to Gogo narratives, *Mtemi* usually asked for the soaking rains to fall without much lightning or much wind, and to fall at the right time and to bless their crops. They also prayed for health so as to be able to cultivate in the rainy seasons.[48] The prayer proceeded as follows:

Wakoko na wa mama gwe mdigule Mlechele, chilima na humwezi wee Mdigule mlechele, Sukuma na takama Mdigule mlechele, chowana chikugaya mchidigulile Mvula mchidigulile.[49]	Our fore parents, grandfathers and mothers, open up for us, by your mercy, let rain come for us, East and West, North and South. Please let rain come for us, your children. We are suffering. (our own translation)

After the prayers, the *Mtemi* slaughtered a black lamb, and its blood was sprinkled on the land to make it "cool." The skin and meat of the lamb were burnt. The Gogo believed that the smoke from their sacrifices would make clouds which after a short time, would change into rain. In explaining this myth one informant, Steven Njamasi, claimed that "prayers and sacrifice were the only means to pursue our god to give us rain. *Mulungu* received our prayers and answered on time and rain fell soon after prayers and sacrifices, even before the participants arrived home".[50] The quotation above emphasizes that rains fell after the prayers. When the first heavy rain fell, people took a break from their daily activities to give thanks to *Mulungu* and the ancestors for answering their prayers. This resting day was locally called *udaha.* On this day of rest no one was allowed to work in the fields, and the prohibition was carried out faithfully for fear that *Mulungu* and the ancestors would be annoyed and cause a serious misfortune, such as illness.[51]

According to Gogo oral traditions, ancestor worship was widespread up to the 1930s. And was regarded as an important way of preventing misfortunes such as illness in Gogo society. It also symbolized social cohesion between the living and the dead in the family and society at large. According to available written and oral traditions, ancestor spirits had three major functions. They acted as a bridge between the living and *Mulungu,* advised the living people in times of serious family problems and indicated which healer to consult, and what medicine to use in certain cases of illness. Like parents or people with authority, ancestor spirits were believed to sometimes punish people for wrong doing. In most cases the punishment was in the form of illness.[52]

When asked how the Gogo traditionally prevented diseases from witches, most of the informants emphasized that it was through accusations of sorceress. Thus witch-hunting was an important mechanism for ensuring health in communities. Among the Gogo of Mpwapwa witch-hunting involved testing the accused by using boiling water. To prove his or her innocence, the accused would dip his or her hand into a pot of boiling water, trying to withdraw from it two stones. Informants submitted that sometimes the accused managed to do this without harm. In such cases the accused was given three cows. However, if the accused person suffered a burn, he or she was put to death by impalement.[53] According to informants, while belief in sorcery persists even today, witchcraft accusations began to decline after the colonization of Mpwapwa district. This was partly due to the British law which forbade all explicit sorcery accusations.[54]

Another preventive measure was the use of traditional community medicine, called *mavuo.* This medicine was made from a collection of portions of local medicines. Every member of the society had to drink a certain amount of this medicine and wash in it. The procedure of taking the medicine was supervised by *mzenga kaya.*[55] However, it has been submitted that, due to insecurity resulting from wars of conquest and resistance this practice disappeared in the early phase of colonialism.

2.6 Gogo Mechanisms of Epidemics Prevention

The complexity and devastating effects of epidemics from the second half of the nineteenth century forced elders and rulers to establish various strategies to control them. On the one hand these strategies

included restriction of the interactions between the Gogo and foreigners, such as Arabs and Europeans and also Africans from other societies. On the other hand, they restricted contacts among the Gogo, specifically the healthy and disease victims. The most strategy reported was isolation or social exclusion of the victims. According to the informants Monica Maganza, local authorities believed that those who contracted diseases like smallpox and leprosy had neglected the proposed strategies. Thus apart from being persecuted, victims were isolated in bushes. One remnant of such bushes is now called *Mbuyuni.* Victims' relatives hardly brought them any food or water. And it was reported that no-one was allowed to bury them for fear of contamination. The aim of these restrictions was to create fear among people so that they would avoid contracting disease by any means. Another method used to prevent smallpox was through inoculation of the healthy people with materials obtained from skin eruptions and scabs from infected persons. [56]

It is widely accepted that when epidemics erupted they resulted in high mortality rates among the indigenous population, and in the long run those who survived acquired natural immunity. This means normal life could return in the affected community. This was not the case with the Gogo, as those who survived leprosy and smallpox were not allowed to marry or even to have sexual intercourse with other people and even among themselves. When asked why these victims were restricted to such an extent, informants emphasized the need to prevent the spread of diseases. It was believed that children could inherit these diseases from their parents.[57] In the case of *iselenyenye* (measles) epidemic, elders did not permit anyone to leave or visit the affected homesteads. Likewise, it was strictly prohibited to bring into or to take away substances such as salt, fire or water from the infected household. In addition, a taboo called *nengulaulili* was applied as a cure for a child suffering from measles. This taboo prohibited sexual intercourse between parents when a child was suffering from childhood illnesses, especially chicken pox and measles.[58]

As pointed out above local people perceived epidemics to have originated from strangers, locally called *wakonongo.* For this reason, traditional rulers developed strategies to limit interactions between the Gogo and foreigners. These restrictions have been well documented by ethnographers. For instance, Carol Sissons has noted:

> The Gogo made every effort to control the spread of disease from the caravans to their communities. They did not allow the caravans to camp within their *tembe* as was the practice at some other points along the main routes. They insisted that the caravans have their own *boma* at a safe distance from their settlements.[59]

According to Anne Hore, traveler who passed in Ugogo through the 1870s, the Gogo also used coercive measures such as fines and prosecution of deserters who tried to move, or to shift their shelters from the *bomas* to new localities. She further claimed that it was difficult to pass near the Gogo settlements, and that in order to pass through Ugogo the caravans had to be escorted by guns. Hore also mentions tariff as an additional mechanism for checking the spread of diseases in Ugogo. She reports that the Gogo demanded very high tariffs from caravans passing through their territories so as to discourage the use of the central route during epidemics.[60] Richard Burton, a traveller who surveyed around East Africa in the 1860s argued that the dry air of Ugogo provided a healthy environment for the population and militated against the spread of diseases.[61] While this could have been the case, there is no evidence to substantiate the claim.

As pointed out above, unlike other societies which allowed the caravans to camp within their settlement the Gogo did not allow that. Thus, they were spared from some of the epidemics associated with caravans. In spite of avoiding contacts with aliens the Gogo became the major supplier of food to the caravans. Tariffs and tributes collected from the trade helped the Gogo to prosper at least up to the last quarter of the nineteenth century. Carol Sissons study in Ugogo reports that the Gogo experienced rapid population growth between 1860 and 1890.[62] She further claims that Gogo prosperity collapsed during the last quarter of the nineteenth century following the epidemics and other misfortunes of the 19th century. These included dysentery in 1889, smallpox in 1893, plague and rinderpest during 1895-1900, famine and wars of conquest.[63] Gogo narratives suggest that Gogo traditional healers reacted to the increased numbers of illnesses, epidemics and misfortunes of the last quarter of the nineteenth century by inventing a powerful traditional medicine called *dyang'ombe.* This medicine was made from a combination of traditional medicines. It was developed to protect people from both new and old diseases.[64] This medicine was popular from the late pre-colonial to colonial period because

many people used it. And it was reported that those who used the medicine never died hence had to be killed by their relatives after becoming too old. Monica Maganza, an old traditional healer still living in Mpwapwa, claimed that *dyang'ombe* was the most powerful medicine of all of the Gogo traditional medicines. She reports that the Gogo even tried this medicine against the invading colonial forces but in vain.[65] Although many of the rural Gogo still believe in the power of *dyang'ombe*, it is said that from the colonial period they did not use the medicine for several reasons. First, many feared it due to the belief that it prevented death even after several years of suffering until relatives of the victims decided to kill them. People found this to be a threat. Second, a person known to have used the medicine suffered from social exclusion, as he or she was viewed as a future burden to the family. Another reason given by informants was the influence of Christianity, which prohibited the killing of human beings. Thus many people refused to kill a person whose life was lengthened by the use of *dyangombe*. In a recent event narrated by informants, one person suffered pain after relatives decided not to kill him but to put him in a hut and destroy the hut by fire.[66]

2.7 Gogo pre-colonial Healing Practices

Illness is evidently one of the most feared conditions among the Gogo. This explains why they had so many mechanisms for preventing illness. Illness was a complex experience as it was viewed as an outward manifestation of the disruption of physical and moral standards, not necessarily of the victim but of the clan or society as a whole. Thus, together the maternal and paternal relatives discussed the cause of an illness when it occurred. If the discussions failed to establish the cause, the relatives usually consulted the diviner, *chisango,* who determined the cause through reflecting on the patient's social history reasoning, divination and intuition.[67] It was only after the identification of the cause that traditional healers, local priests or society elders could be consulted for medicine and appropriate rituals. Relatives were required to pay the diviner or traditional healers for their work. This means that the patient's relatives were involved in determining the causes of illness and in meeting the cost of treatment.

Among the Gogo healing practices did not focus on the symptoms, but rather on the suspected root causes of the illness. Illnesses that were believed to come directly from *Mulungu* were treated through prayers and sacrificial offerings to ancestral spirits (usually a black

lamb). These diseases were further prevented by observing the moral code of conduct believed to be sanctioned by *Mulungu* and by performing community prayers. According to oral testimonies, prayers were an integral part of the traditional rituals performed on any specific occasion. Prayers were performed for someone who had experienced a prolonged illness or during an epidemic. Community prayers to contain any epidemics were usually performed in special places like under big trees and along large valleys. They consisted of several activities, including singing and offering of animal sacrifices, especially cattle and lambs.[68] According to popular Gogo narratives some prayers were only performed in the case of prolonged illness and when all medicine had proved ineffective. A good example was the disease traditionally called *laho*.[69] Some members of the community interviewed associated this illness with the current HIV/AIDS because its symptoms resembled those of *laho.* Like HIV/AIDS, *laho* had no cure. Major reported symptoms of *laho* were frequent fever, prolonged illness of more than three years, general body malaise, diarrhoea and loss of weight. However, unlike HIV/AIDS, which attacks people of all age groups, *laho* was reported to attack only the adults.[70] So, for this kind of illness and the like, people opted for prayers to ask for help from ancestral spirits to cure the afflicted person or to take him or her after prolonged suffering. Edward Lwabe, whose father was a local priest, has reported one such prayer:

Anyu wanhu wa hasi, mumulechele ayu mwana yaputwe mbeho, nhaule mumugaza nhavi? Huno gwegwe koko mlela baba mwana adyu kumusaka yazekuki hoduu msole leche mgaza. Huno gwegwe koko mlela baba mwa adyu kumusaka yazekuko hoduu msole leche mgaza.[71]	You ancestors, we ask that you relieve this person of his / her suffering. Why torture him / her like this? If you are the grandfather, wishing to be with your grand child, better take him / her at once. Stop the torture. If you are the grandmother, you want this person, take him / her, and do not torture him / her. (our own translation)

The general picture we get here is the tendency of local people to use familiar experiences to explain the past, or the use of past to explain the present. For sure there is no relationship between *laho* and HIV/ AIDS. Local people compare HIV, AIDS with *Laho* probably to show

the acuteness of *laho* in pre-colonial Gogo society.

Gogo therapeutics sometimes involved special traditional dances known as *mwendeso.* Also, important community songs were performed at the beginning of each month, just before the appearance of the full moon. On such occasions all the people came from their homesteads and gathered together while singing songs asking for protection from illnesses associated with the coming of the new moon. They involved phrases such as "*bite bite na matamwa gako"* that is, "you (moon) go with your illnesses." This was usually done in mornings and evenings for two or three days until the moon appeared in full. In addition, the Gogo had a variety of traditional medicines for treating diseases, maintaining health and for removing a curse.[72]

2.8 Conclusion

From the preceding discussion one can draw a number of conclusions. First, people's perceptions of illness and illness causation emanate from historical and specific cultural contexts. Taking Gogo as a case study, their perceptions of illness reflected customs and beliefs they observed. Thus one can say with certainty that there is no universal perception of illnesses and illnesses causation. Yet, illnesses and illness prevalence differ from one place to another over time. For example Gogo perceptions of illnesses employed before the second half of the nineteenth century differed considerably from those used during and after the second half of the nineteenth century. In the former period Gogo conceptualized endemic diseases as having internal causes. But in the latter Gogo attributed old and new diseases which erupted in epidemic proportions to external forces such as slave caravans and the increasing inter societal integrations. Gogo perceptions of illnesses made sense to the traditional leaders and their subjects because they were close to concrete and thus limited cases of illnesses. Overall, it seems that the Gogo viewed diseases as a social problem which occurred in a certain social-economic and political contexts, and not a natural phenomenon.

Notes

[1] *Elizabeth Knox, Signal on the Mountain: The Gospel in Africa's Uplands before the WW1 (Wanniassa: Acorn Press 1991), 1-3; TNA, Guide to Provincial and District Commissioners Annual Report 1949, 23; Elikana Makasi, Interview at Vinga'we village 31.12.2006. Mahvwa is no longer a river, it remained as a big valley because of climatic changes.*

[2] *TNA, Guide to Provincial and District commissioner, 16.*

[3] *Ibid.*

[4] *Ndunguru Crescent, "Ujamaa: a Comparative Study of Perceptions and orientation in Kilosa and Mpwapwa districts" (M.A Dissertation. University of Dar-es-Salaam 1984),10; I.A Katunda, 'Mpwapwa District Comprehensive Council Health Plan for the year 2004,' January 2004, 3-4.*

[5] *Steven Njamas, interview at Igovu village, 13.12.2006.*

[6] *Carolyn Merchant, Ecological Revolution: Nature, Science and Gender in New England (The University of North Carolina Press, 1989), 5-26; Michele Wagener, Environment, Community and History Nature in Mind, in Gregory Madox et Al. Custodians of the Land: Ecology and Culture in the History of Tanzania (Dar es Salaam: Mkuki na Nyota 1996), 175-197.*

[7] *Elikana Makasi, interview at Vinga'we village, 31.12.2006.*

[8] *Maurice Cornforth, Dialectcal Materialism: Theory of Knowledge, Vol .III (London: Lawrence and Wishart Ltd, 1963),57.*

[9] *Unyago was organized teachings for young girls on how to handle their husbands and children after marriage.*

[10] *Monica Maganza, interview at Vingawe village, 31.12. 2006.*

[11] *Oswald Masebo, "Colonialism and the spread of Diseases" (M.A dissertation, University of Dar-es-Salaam,2002), 60.*

[12] *Richard Burton, The Lake Regions of Central Africa. Vol I (London: Longmans 1860), 297.*

[13] Elikana Makasi, interview at Vinga'we village, 21.12. 2006; Monica Maganza, interview at Vingawe village, 14.12. 2006; Carol Jane Sissons, "Economic Prosperity in Ugogo, East Africa 1860-1890" (Ph.D Dissertation, University of Toronto, 1984).

[14] Titus Mshana, interview at Mazae village, 9.1.2006.

[15] Rehema Nchimbi, "Health and Healing in processes of Beauty" in Yusufu Lawi and Betram Mapunda (eds), History of Disease and Healing in Africa, (GEGCA-NUFU Publication Vol.7 Dar-es-Salaam, 2004), 53-60.

[16] Gogo had the conceptions of Supreme Being known as Mulungu, the creator of universe and everything.

[17] Elikana Makasi, interview at Vinga'we village, 31.12.2006.
[18] Monica Maganza, interview at ving'awe village,8.01.2007; Steven Njamasi, interview at igovu village 11.12,2006

[19] Elikana Makasi, interview at vinga'we village,30.12.2006; Samson Chiuyo, interview at ving'awe village 17.01.2007

[20] Seven Njamasi, interview at Igovu village, 14.12.2006.

[21] Elikana Makasi, interview at Vinga'we village, 31.12.2006; Musa Musoloka, Interview at Igovu village,04. 01.2006.

[22] Gogo viewed mhepo as evil spirits which could posses any one but machisi were spirits which dominated and guided a specific clan.

[23] Edward Lwabe, interview at Igovu village, 14.12. 2006.
[24] Steven Njamasi, interview at Igovu village, 13.12.2006.

[25] Monica Maganza, interview at Vingawe village, 31.12. 2006.

[26] Monica Maganza, interview at Vingawe village, 31.12. 2006. Soche refers to the ghost of a previous victim used by witches to harm innocent people. Mapeli, according to Gogo narratives are pieces of euphorbia tree or wild sisal which were deliberately put down on the path where the victim was expected to pass. Kusonhela meant a witch pointing at the victim or at an object with the thumb or the index finger.

[27] Monica Maganza, interview at Ving'awe Village,14.12.2006, 31.12.2006; Robern Sabugo at Igovu village 15.12.2006; Penina Lwabe at Igovu Village14.12.2006, 30.12.2006.

[28] Pakshdadi Kashinde, interview at Idilo village 09.01. 2007; Steven Njamas, interview at Igovu village, 11.12. 2006; Monica Maganza, interview at ving'awe village, 15.1.2006.

[29] Penina Lwabe, interview at Igovu Village, 14.12.2006. 30.12.2006; Penina Lwabe at Igovu Village14.12.2006. 30.12.2006.

[30] Musa Musoloka, interview at Igovu village,04. 01.2006; Robern Sabugo, interview at Igovu village 15.12.2006; Esau Meshack, interview at Chamunye village 16.12.2006.

[31] Peter Rigby, Cattle and Kinship among the Gogo: Semi pastrol society of Central Tanzania (Ithaca: Cornell University Press, 1974).

[32] Carol Jane Sissons, "Economic Prosperity in Ugogo, East Africa 1860-1890" (PhD Dissertation, University of Toronto, 1984), 246-250

[33] Robern Sabugo, interview at Igovu village 15.12.006; Penina Lwabe, interview at Igovu Village,14.12.2006.

[34] Oswald Masebo, "Colonialism and the spread of Diseases" (M.A dissertation, University of Dar-es-Salaam,2002), 60

[35] Monica Maganza, interviw at Ving'awe Village, 14.12.2006, 31.12.2006; Robern Sabugo, interview at Igovu, village, 15.12.2006; Penina Lwabe, interview, at Igovu Village,14.12.2006.

[36] Edward Lwabe, interview at Igovu village, 14.12.2006.

[37] Helge Kjekshus, Ecology Control and Economic Development in East Africa History: The Case of Tanganyika, 1850-1950(London: University of California Press, 1977)

[38] Elikana Makasi, interview at Igovu village, 30.12.2006; Monica Maganza, interviw at Ving'awe Village, 14.12.2006; ACC.435/A2/ 38, Dodoma region Milk Supply,2

[39] Elikana Makasi, interview at Igovu village, 30.12.2006

[40] Esau Meshack, interview at Igovu village.

[41] Ibid.

[42] Steven Njamasi, interview at Igovu village, 30.12.2006.

[43] Musa Musoloka, interview at Igovu village,04. 01.2006; Robern Sabugo at Igovu village 15.12.2006; Esau Meshack, Interview at Chamunye village 16.12.2006.

[44] Ibid.

[45] Gregory Maddox, The Gogo History, 113.

[46] Steven Njamasi, interview at Igovu village, 11.12.2007.

[47] Elikana Makasi, interview at Vingawe Village, 31.12. 2006.

[48] Penina Lwabe , interview at Igovu Village14.12.2006. 30.12.2006.

[49] Ibid.

[50] Steven Njamas, interview at Igovu village, 13.12. 2006; Maddox, The Gogo History, 101.

[51] Ibid.

[52] Edward Lwabe, interview at Igovu village, 30.12.200; W.J Carnell " Symphathetic Magic Among the Gogo of Mpwapwa District" in Lewis E, Tanganyika Notes and Records Volume3, No. 15, 1943, 26.

[53] Elizabeth knox, Signal on the Mountain: The Gospel in Africas' Uplands before WW1 (Wanniassa: Acorn Press 1991).

[54] Meredeth Turshen, "The Political Economy of Health, the case study of Tanzania," Unpublished, PhD Dissertation, University of Sussex, 1975, 239.

[55] Samson Chiuyo, interview at Vingawe village, 17.1.2007.

[56] Monika Maganza, interview at Vingawe village, 31.12.2006; Juhan Koponen, Development for Exploitation: German Colonial Policies in Mainland Tanzania 1884-1914, (Helsinki: Finnish Historical Society, 1995), 472.

[57] Monica Maganza, interview at Ving'awe Village, 14.12.2006. 31.12.2006; Robern Sabugo, interview at Igovu village, 15.12.2006; Penina Lwabe, interview at Igovu village14.12.2006.

[58] ELikana Makasi, interview at Vingawe Village, 31.12. 2006; Monica Maganza, interview at Vingawe village, 31.12.2007;Steven Njamasi, interview at Igovu village, 13.12.2006.

[59] Carol Jane Sissons, "Economic Prosperity in Ugogo, East Africa 1860-1890" (PhD Dissertation, University of Toronto, 1984), 246.

[60] Anne, Hore , To Tanganyika in a Bath Chair (London: Sampson low 1886), 38

[61] Richard Burton, The Lake Regions of Central Africa. Vol I (London: Longmans 1860), 297.

[62] Carol Jane Sissons, Economic Prosperity in Ugogo, chapter four;Gregory Maddox, 'Environment and population growth in ugogo,' 43-61

[63] David, Clyde, History Of Medical Services of Tanganyika (Dar-es-Salaam: Government Press 1962), 4; Kjekshus, Ecology Control and Economic Development in East African History: The Case of Tanganyika (London: James Currey 1977), 127.

[64] Kezia Mwaka, interview at Igovu village, 03.01.2007.
[65] Monica Maganza, interview at Vingawe village, 31.12.2006.

[66] Ibid.

[67] Gilbert Madole, interview at Mwanakianga village, 13.12.2006.

[68] Ibid.

[69] Esau Meshack, interview at Chamunye village, 16.12.2006.

[70] Monika Maganza, interview at ving'awe village, 14.12.2006

[71] Edward Lwabe, interview at Igovu village, 14.12.2006.

[72] Monica Maganza, interviw at Ving'awe Village, 14.12.2006, 31.12.2006; Edward Lwabe, interview at Igovu village 14.12.2006; Penina Lwabe, interview at Igovu Village, 14.12.2006, 30.12.2006.

CHAPTER THREE

NATURE AND CHARACTER OF COLONIAL PUBLIC HEALTH CAMPAIGNS, 1890-1950s

3.1 Introduction

It would be recalled that the main intention of colonization was to fulfil the imperialistic demand for raw materials, markets and cheap labour. It was clear that these demands could be achieved through the introduction of a colonial economy which demanded a healthy labour force. Following this realization, colonial officials launched colonial public health campaigns with a view to changing local perceptions of illness and healing and introducing western knowledge. The articulated objective was to elevate Africans' awareness about diseases, specifically with respect to their transmission and prevention. Among other things, the campaigns emphasised immunization, hygiene, public sanitation and health education. However, until the end of colonial rule, it was doubtful whether the campaigns were successful, either in change local perceptions of illness or checking the incidences of illness. This chapter examines the nature and character of colonial public health campaigns in Mpwapwa district.

3.2 Public Health Programmes in Europe around 1900

During this period there were mainly three theories which guided public health interventions in Europe namely the contagion, miasma, and germ theories. Every theory had its implications for the evolution of public health programmes in Western Europe and later on in the colonies. The contagion theory was developed in 1546 by Fracastow, an Italian physician. The theory claimed that diseases arise within an individual and can pass from one person to another by direct or indirect contacts. According to the contagion theory, a disease can be prevented by destroying or expelling the seed of contagion using extreme heat or cold, or by evacuating the pollutants through urination, sweating or vomiting. With regard to public health services the theory suggested disinfection, quarantines, notification of the disease and the isolation of the sick during epidemics.[1]

The miasma theory of disease began in the middle Ages. It gained popularity in the mid-1800s when it was used to explain the spread

of diseases such as the Bubonic plague and cholera in London and Paris. According to this theory, diseases have external origins. They are caused by contaminated air that contains particles from decomposed matter. The miasma theory made sense to the English sanitary reformers of the mid-nineteenth century because it explained why disease, especially cholera, was endemic in places surrounded by contaminated water. Edwin Chadwick, the architect of the 1848 Public Health Act in Great Britain, was a miasmatic who believed that diseases arose from filthy conditions. Miasma theory helped Europeans to explain the relationship between poor sanitation and infectious diseases before the formulation of the germ theory of disease. This theory therefore informed the improvement of sanitation systems in European cities during the period in question which, in turn led to a reduction in the number of cases of cholera. Thus, the theory proved that sanitation and cleaning of the environment reduces diseases.[2]

The scientific researches of Louis Pasteur, Robert Koch and others during the 1860s and 1870s, which resulted in the discovery of the role of micro-organisms in causing diseases, opened up a new era in the science of health in Western Europe.[3] Following those discoveries, new procedures in sanitation emerged to ensure clean water supplies, clean foods, and adequate sewage disposal. The scientists also laid the foundations for the development of immunological weapons against diseases – vaccines, anti-toxins and anti-serums.[4] For the first time, European scientists developed powerful scientific techniques for controlling many of the epidemic diseases. It can be said that the Germ Theory provided a rationale for some existing practices which had been developed before its inception while it enabled others such as the use of vaccines, hygienic practices and public sanitation to be established through government action. On one hand, many of the nineteenth century techniques of disease control were revolutionized by the Germ Theory, resulting in a breakthrough of the public health policies developed around 1900. On the other hand it marked the institutionalization of some of the previous beliefs and practices. This is because the Germ Theory did not stamp out unscientific perceptions developed before it was developed.[5]

According to Steven Feierman, the discovery of the Germ Theory implied reorganizing people's way of thinking so that a disease could be seen as having an existence separate from an individual's experience of illness.[6] Diseases were to be viewed as something independent of

the person, something that exists outside of the person, something that exists as an identifiable thing even if individuals experienced it differently. The transition to the Germ Theory of disease produced a dramatic conceptual change because of its radically new view of disease causation. Diseases were thought to be universal. Symptoms and processes were expected to be the same at different historical periods in different cultures and society.[7] That being the case, colonial experts decided to use the same interventions used in Europe to solve the problems of Africans, regardless of Africans' perceptions of illness and the contexts in which diseases emerged in Africa. Contrary to African perceptions of illness, however Europeans and colonial historians viewed the diseases of Africans as natural phenomena, the outcome of the harsh tropical environment, the poor hygiene of Africans and lack of immunity to new diseases.[8]

3.3 The Introduction of Colonial Public Health Campaigns, 1880-1920

German colonization began soon after 1884. In the field of health in the 1880s the German medical policy directed efforts to the building of medical institutions like dispensaries and hospitals.[9] These medical institutions were to serve German personnel and soldiers. On a few occasions Africans also received medical attention. German medical services were organized according to race. There were separate services and wards for Europeans, Asians, and Africans, and it involved some kind of cost-sharing. Up to the end of the German rule there were about forty dispensaries and twelve hospitals scattered throughout the country. One among those forty dispensaries was situated in Mamboia near Mpwapwa district.[10] Apart from the building of medical institutions, the German colonial state conducted medical researches in Mpwapwa district. In 1908 the German colonial state erected a lymph laboratory, and lymph production started in the same year. The Mpwapwa laboratory continued to supply smallpox vaccine until the outbreak of the Second World War, after which supplies were obtained from Kenya. Apart from that, the German colonial state established Mpwapwa Veterinary Research Centre between 1898 and 1907 which was principally meant to produce serum so as to control rinderpest. Likewise, researches on the tsetse fly, the immunization of domestic animals, and research to examine the relationship between malaria and rainfall started in 1910. This went together with the establishment of cinchona plantations to provide raw materials for the manufacture of quinine.[11] The research most remembered among the local people was that of traditional medicine

conducted in 1895. This research involved collection and sending of various medicines to Germany for scientific investigation. This action led to a conflict between natives and Germans because the natives viewed it as deliberate theft of their medical knowledge.[12]

Other German public health interventions of the period under discussion focused on the control of epidemics in urban centres such as Dar es Salaam, Tanga, and Bagamoyo and on societies found along slave caravan routes like the Gogo of Mpwapwa district. The major interventions were the smallpox vaccination campaigns and plague, yaws and malaria control campaigns. In addition, the campaigns emphasized health education, sanitation and digging of wells to improve water supply in major towns and along caravan routes. [13] One of the major wells constructed during this period is well preserved in Mpwapwa near the current bus terminal, where caravans used to camp. Christian missionaries and the German colonial state functionaries were the most active forces against local practices of health during the 1880s and 1920s. On the one hand missionaries criticized local perceptions on the grounds that they presented pagan beliefs in magic and false gods. On the other, German colonial officials persecuted some traditional healers suspected of being a threat to the political system.[14] However, the outbreak of the MajiMaji resistance in 1905-1907 stopped German public health campaigns abruptly because at this point the German medical officers were enlisted by the military.

It was only after the end of the MajiMaji War that Dr. Mewixner, the Chief Medical Officer of Tanganyika, recognized the importance of local medical practices and the extension of public health services to rural areas. Thus the German colonial government changed its attitude towards traditional practices by recognizing traditional medicine in the health care system of German East Africa. At the same time, the German colonial state issued certificates to traditional healers specifying the illnesses they could treat and the localities where they could conduct such practice.[15] Using Tanganyika as a case study, Juhani Koponen[16] has argued that the Germans changed their policy after 1905 following the recognition of the economic importance of a healthy native population, which was then declining because of higher mortality rates. To the colonial state public health services were therefore very important to increase both the quantity of the natives and the quality of their working capacity. Because of that

recognition, the German state planned to expand its health services to reach the majority of people in rural areas. In this connection, Dr. Peiper claimed that:

> ... It is unthinkable to develop the colonies without indigenous people. In a climate that exhausts the white people's body very quickly...the most valuable good of our colonies, more than any precious metal, is the indigenous human being.[17]

Thus the intentions of the Germans in extending medical and public health services to the rural areas were to improve colonial gains. However, this idea was not implemented because of the outbreak of the First World War. In East Africa, Tanganyika was frequently the battlefield than other territories. The Germans were defeated and this marked the end of German colonial rule in Tanganyika. There were many health effects to African societies. It is reported that the general health of the population was very bad. Diseases like Spanish influenza, dysentery, smallpox, pneumonia, malaria and sexually transmitted diseases were wide spread. Thus in the period after WWI, the whole of Tanganyika apparently experienced a population decline[18] due to unhealthy conditions, diseases and famine of the 1920s.[19]

3.4 The First Phase of British Public Health Campaigns, 1920-1945

Problems of ill health and diseases associated with WWI forced the British government to divide the medical department into two sections namely medical and sanitation. The idea was to integrate curative and preventive functions. The latter was designed to oversee issues of hygiene and cleanliness, to initiate campaigns against communicable diseases and the training of both European and African staff that could assist with the implementation of public health directives. The sanitary department was put under the Director of Medical and Sanitary Services, headed by a doctor with public health qualifications. He was assisted by three health officers one in Tanga, one in Dar es Salaam and another was assigned exclusively to plague campaigns throughout the colony. [20]

The significance of colonial public health campaigns has been interpreted differently by various scholars. According to Lesley Doyal[21], colonial public health programmes were for Europeans and not for Africans. That is to say, the primary objective of colonial public health campaigns was to preserve the health of the European

community in the colony. Doyal supported his claims by the fact that most public health services were concentrated in towns and around European settlements, and commercial, military, and administrative centres. Similarly he argued that large portions of the available funds were directed towards health services and medical care in areas of white settlements only. And colonial European communities were also supported with low density accommodation, safe water, supplies, provision of sewerage disposal, and adequate dietary items. However this is rather overstatement the fact. White areas were a priority for sure, but some effort went to African areas to control contagion diseases. This is true because if the African areas remained unattended white areas would be infected as well.

On a slightly different note, Terence Ranger has claimed that the medical mission of Europeans in Africa was to change Africans unscientific outlook on diseases.[22] The colonial medical mission aimed therefore at initiating conceptual changes among Africans to persuade them to adapt the Western principles of hygiene and make them part and parcel of their own social habits. It seems that colonial experts believed that conceptual change could reduce the spread of disease in epidemics proportions. But one reporter noted in a colonial newspaper that "healthier labour could be obtained after several years of medical attention to the natives, to change their habits, their living customs, housing conditions and dietary behaviour, so that after two or three generations we may produce strong and healthy men."[23] This means that public health campaigns aimed to change Africans' behaviour, with the ultimate aim of fulfilling the economic imperative of colonization.

The British public health campaigns organized before the Second World War aimed only at the reduction of diseases to a level at which diseases were no longer considered as serious public health threats. As reckoned by Eginald Mihanjo, major public health problems in Tanganyika according to Ordinance No. 3 of the 1920 were: beriberi, cerebral spinal meningitis, chicken pox, cholera, diphtheria, fevers, continued influenza, leprosy, measles, mumps, plague, scarlet fever, sleeping sickness, smallpox, yaws and yellow fever. In addition to these diseases, there was sleeping sickness and malaria which were regarded as a principal menaces to Europeans in Tropical Africa.[24] At the micro-level the colonial public health campaigns emphasized, among other things, vaccination, isolation of victims, sanitary disposal

of sewage and other wastes, the erection of latrines, the building of standard houses, environmental cleanliness, and inoculations of people to stimulate the immune system to produce anti-bodies against particular diseases. At the macro-level the campaigns emphasized selection, training and deployment of African health workers to work as health and sanitary assistants.[25]

Dr. J.O. Shircore, Tanganyika's Deputy Principle Medical Officer in 1923, and Chief Medical Officer in 1924, emphasized the training of local people so as to gain acceptance by the majority of Africans. In explaining this Dr J.O Shircore argued that the African villager is one of the most conservative people in the world and nothing would be accomplished by sending alien inspectors, however well trained, to alter the habits of centuries.[26] This shows the racist bent of Dr. Shircore that Africans were to be trained only as assistants to change Africans habits which were generally generalized as primitive and unhealthy.

Thus between 1929 and 1939 a Native Development Act was passed to train some natives as medical and public health officials, because the number of European staff was insufficient. However, the Act failed to achieve its goal because there was a shortage of suitable candidates. Systematic training of the local people as dispensers, dressers, health and sanitary inspectors started in 1925 and was carried out by three medical officers. Dr. R.R. Scott trained local people in Dar es Salaam, Dr. A.I. Meek in Tabora, and Dr. Nixon in Tanga.[27] A special course of three months for District Sanitary Inspectors was conducted in 1925 on the mentioned urban centres. The contents of the course included knowledge of proper construction of houses, improvement in water and sewerage system, prevention measures against common infectious diseases and vaccinations.[28] Successful students in this training were posted to work as health officers in upcountry stations, including Mpwapwa district. In this way Africans were trained to propagate western ideas about health and illness into the farthest corners of the territory. British medical scientists believed that local health inspectors would be more accepted than European experts. However in reality, even African experts were not easily received by local communities. As one informant noted: "...it was really funny: They sent town boys to teach us about cleanliness and latrines. These youths knew nothing. They were not Gogo; and they ordered us to accept urban civilization and abandon our traditional practices..."[29]

Similarly, simple booklets prepared by the Director of Education and titled *Afya* were distributed throughout the country, to be studied by all pupils. As children grew older more advanced lessons in hygiene were added to the syllabus.[30] This reflects that British officers used health education to force African children to internalize the colonial principles of hygiene and health. Colonial officials believed that these children could carry those health principles into their families and hopefully teach their parents and the community at large the benefits of sanitation practices. Apart from health education there were measures such as notification, quarantine and isolation of victims of communicable diseases. It was compulsory for local authorities to report certain communicable diseases to colonial government officials. Native local authorities had to immediately notify the District Health Officers of any unusual disease occurring in their areas who in turn, reported to the administrators of the Central Province and eventually to the Director of the Medical and Sanitary services in Dar es Salaam. In most cases Native Authorities instituted quarantines after observing communicable diseases.

According to Gogo oral narratives Local people offered cooperation in the collection of smallpox victims and lepers abandoned by families in bush, and in funding their journey from Mpwapwa to either the temporary huts for smallpox victims or leprosy colonies which were located in Bihawana, Makutopora and Kilimatinde in the central province. However after 1925 a lot of complaints from colonial officials arose against isolation campaigns being imposed without good reason and resulting in inconvenience and unnecessary expense. Probably as a result of these complaints isolation of lepers was abandoned in 1927. From 1930 to the end of colonial rule policies on the control of leprosy changed from segregation or hospitalization to finding and treating cases within the community.[31]

Other diseases like yaws and malaria were prevented by using western drugs. Yaws campaigns were reported to be very successful among the Gogo of Mpwapwa district. The success was partly an outcome of the discovery of bismuth sodium titrate solution in controlling yaws through injection. The immunization reached a wide population around the 1920s. Treatment of yaws by bismuth, potassium and sodium won the British government quick acceptance by the local people. It is reported that natives travelled from far-off villages to follow the bismuth injection. [32]

The malaria campaign took various control approaches but in vain. In the early twentieth century the European understanding of diseases was influenced by the concept of racial differences and this concept was also employed in the formulation of approaches to malaria. Africans, except children under five years of age, were viewed as a race which had natural immunity to malaria. This assumption led to residential segregation. In the Mpwapwa district, European settlements were confined especially to the higher parts of hills and ranges, for instance around Rubeho ranges and Kiboriani hills. Other malaria control measures were chemotherapeutic mass campaigns using quinine instead of chloroquine, environmental cleanness and destruction of breeding grounds. Although local people responded slowly to the sanitation campaigns of the 1920s, in the 1940s they lost this supportive attitude as a result of the ineffectiveness of sanitation campaigns.[33] Likewise many written sources have reported that local people strongly opposed the quinine campaigns. For instance, David Clyde claimed that Africans were very happy with the Mohammedan's month of fasting because all pretended to be Muslims in order not to take it.[34] This complaint shows that Africans were not comfortable with the malaria control campaigns.

Another public health problem in Mpwapwa was the plague. The outbreak of the plague in the Central Province during the 1930s was attributed to poor housing conditions. The Gogo's houses, locally known as *tembe/ matembe,* sheltering livestock together with human beings were thought not allow sufficient ventilation. Thus, colonial officials' ordered the local people to build separate rooms for animals and to enlarge windows. In addition, the campaign emphasized the destruction of infected houses, clothes, beds and furniture and a change in their burial customs orders which resulted conflicts between natives and colonial officials.[35] In the 1940s the colonial state started plague vaccination campaigns along with an effort to eliminate rats. They persuaded local people to collect rats for a reward of ten cents per twenty rat tails. Because the local people were not educated on why they were forced to kill and collect rats, they started to breed rats so as to get tails needed by colonial health officials. And this became a strategy for getting money for tax obligations.[36]

Apart from the plague vaccination, there were also vaccinations against smallpox and measles. In the implementation of vaccination campaigns the vaccinators started with the traditional rulers and later

on their subjects. Vaccinations were also available in public avenues such as markets and old slave camps. Many written sources pointed out that smallpox vaccination was easily accepted but vaccination against measles was hardily accepted at all by some Gogo of Mpwapwa district.[37] It was reported that the vaccine was slowly accepted in the 1950s largely on account of fear of fines and persecutions.[38]

In general, the British public health campaigns organized in the period from 1920 to 1945 were beset by the following shortcomings. First, the colonial health ideas and practices were externally oriented, and thus did not exactly match the local health problems and needs. As pointed out earlier the ideas and beliefs of the colonial public health campaigns came from Europe; European scientists applied them in Africa the same way as they were used in Europe. But the contexts for disease causation were quite different. Europe was influenced by industrialization, where as Africa suffered colonial oppression and exploitation.[39] For a health policy to be effective, colonial experts needed to attack colonial oppression and exploitation, a strategy which was impossible under colonial regime. In this connection, for a health policy to be effective in Africa, knowledge of African circumstances was very important. The direct application of western ideas and practices and neglecting local ideas limited the chance for colonial public health campaigns to succeed. As Ann Beck claimed, it was difficult for sanitarians to succeed merely by applying their knowledge to tropical conditions.[40] In addition, local people complained that the public health programmes were directed from above. They also lacked continuity because they were impromptu and ad hoc.[41]

Lack of funds was another serious problem as it affected the availability of resources such as vaccines. It also limited the number of natives who could be trained and employed as assistants. For instance, the leprosy campaign was easily accepted by the natives but the campaign was constrained by limited funds for anti-leprosy work. In 1920 the CMS Church asked for more funds from the Leprosy Relief Association of the British Empire but in vain. The Church was given only £100 which was used for the erection of camps and for the treatment of lepers.[42] There was no fund for maintenance. The lepers were forced to provide labour for the building and maintenance of camps. This created an unpleasant image for the campaign, which in the long run rendered the collection of victims and recapture of run-a ways very difficult.

In the implementation of the ant- leprosy interventions, contradictions occurred between Africans, colonial administrators, missionaries and the Director of the Medical and Sanitation Services. It is worth noting that Africans and the Director of the Medical and Sanitary Services preferred the rigid principle of isolating the victims while administrators of the Central Province and missionaries wanted the abolition of the isolation practices. As the then Right Reverend Bishop of Central Tanganyika of Mpwapwa claimed:

> The policy of compulsory segregation was introduced to prevent the spread of disease but the system does not fulfil this... welfare of the lepers should be left in the hands of native authorities. Lepers have to be educated to be self-supporting people.[43]

J.D. Lawrence, Administrative Officer of the Central Province, shared this perspective when he complained against the isolation of lepers in the Central Province:

> Isolation of 100 lepers from 250,000 people had no serious influence on the incidence of the disease. We cannot stop this disease by isolation...isolation should cease and some alternative schemes should be substituted. The campaign is very expensive and heart- breaking.[44]

The administrators and missionaries challenged the leprosy campaigns because the campaign was very expensive. It required £60,000 capital expenditure and £100,000 recurrent expenditure, an amount that the British government failed to meet.[45] While male Africans feared infection from the lepers, this was quite different to women.[46] A good number of women interviewed reported that they preferred rigid isolation because they were afraid of the burden of taking care of lepers because some of them had lost their important organs and thus needed direct assistance with food, water, clothes and shelter. This means that the abolition of isolation could increase workload of women who had to take care of the family.

Another problem was lack of cooperation from the local people. Following the suspicious co-existence of natives and Europeans, local people rejected some colonial directives on disease control for fear of being killed or poisoned. Vaccinations, in particular, were resisted because of their side effects such as the occurrence of sores and

the painful experience of some injections. Inadequate education by the campaigners also contributed to negative responses. According to Adam Kusupa one of our informants, in most cases natives were not educated on why they needed to be vaccinated or why they were forced to take quinine tablets or dry out swamps. They were simply told that the programme would prevent eruption of diseases. [47]The paradox of cases of disease increasing despite the British public health campaigns was another problem, partly because it reduced the confidence of the local people in Western medical practices. Oral and written sources show that disease and ill health increased in the Mpwapwa district from 1930 to the 1940.[48] The major causes reported were the development of transport networks, taxation, famine, introduction of maize, increased societal interaction and labour migration.[49] The Great Depression of 1929- 1933, which was immediately followed by the Second World War in 1939, had serious impacts on colonial social services. The two events led to serious cuts in social services, health, education, water, housing and maintenance of infrastructures. For instance, medical expenditure for Tanganyika was reduced by approximately one third between 1930 and 1936, that is, from £275,000 to £186. Prices for agricultural commodities dropped, and taxes on Africans increased because public health programmes relied much on Africans taxes collected by Native Authorities.[50]

According to Gregory Maddox lives of the Gogo after the Second World War was disrupted by three forces, one being the increase of male migration to work on rubber and sisal plantations and the overloading of women who remained behind. The second point was the increase of cattle sales by the Gogo to pay for health care, education and food. It should be noted here that milk and meat were the main sources of protein for the Gogo. Thus excessive selling of cattle would have had negative impacts on the Gogo diet. The third factor was the introduction of maize production in the 1940s. [51] Maize replaced the traditional drought- resistant crops like sorghum and millet, as the result of which the district was heavily affected by famine and child malnutrition. Cicely Williams has reported that in the 1940s out of 967 births 503 died before reaching the age of five.[52] Thus, it can be concluded that British colonial officials failed to meet the intended goal, which was to reduce the number of cases of disease occurrence.

3.5 The Second Phase of the British Public Health Campaigns, 1945-1960

The post Second World War period constituted another phase of colonial public health interventions in Tanganyika. The era was characterized by the expansion of medical and health facilities, expansion of medical and sanitation budgets, systematic training of public health officials and intensification of campaigns on food and nutrition. John Iliffe[53] viewed these reforms as an innovative departure while Walter Rodney viewed them as the continuation of colonial oppression and exploitation, a deliberate plan to incorporate the majority of the African population into the capitalist system of production peacefully, willingly and even enthusiastically.[54] It seems that the main explanation for this change was economic, the need for a healthier labour force to carry out post- Second World War improvement programmes. It is clear that the colonized population was ill-fed, ill-housed and illiterate and hence it was difficult for such people to meet the needs of the new post-war-period, which required not only a qualified work force but also a healthier population.

The Public Health Bill of 1945 introduced some administrative changes in the sanitary aspect so as to increase the efficiency of the sanitary department. First, the bill emphasized the employment of highly qualified public health officials to administer public health programmes in rural areas. Second, the Bill emphasized the provision of courses of instruction and prescribed qualifications for health inspectors, sanitary inspectors and public health nurses. The bill put public health campaigns at the district level under the District Health Officer. In general, a District Health Officer had the following main functions: to promote the development of health services in the district, to initiate various health programs to protect the inhabitants from communicable diseases and to report at least monthly to the Regional Assistant Director. In addition he was given power to cleanse and disinfect houses, infected beddings, clothes, furniture and other infected apparatus.[55] From these changes one can deduce that the Director of Medical and Sanitation Services and his experts believed that only highly qualified personnel could facilitate the success of public health campaigns. This suggests total neglect of the local initiatives.

The period under discussion also witnessed the arrival of new international organizations in public health programmes, notably the UNO and WHO. These new international organizations arrived with

a new philosophy on public health which emphasized the complete eradication of diseases rather than the control or reduction of incidences. This would be done by absolute elimination of viruses, parasites and vectors by using powerfully insecticides and antibiotics drugs. The key proponent of the eradication campaign internationally was an American public health expert, Fred L. Soper, who had spent years working on diseases in America, North Africa and Italy. [56] The best example of such efforts on the global scale was the Malaria Eradication Campaign (MEP). In 1955, the Eighth World Health Assembly endorsed a world-wide programme for malaria eradication. In 1957, WHO took over the coordination of this activity and provided technical assistance. The malaria eradication campaign was based on the principle of systematic use of a new insecticide, DDT. This programme was launched in the late 1950s, but was abandoned less than 20 years later, partly because of internal and international complaints of the side effects of the DDT.[57] Internationally, the malaria eradication campaigns failed except in a few areas such as on the islands of Reunion, Sao-Tome and Principe, where malaria was eradicated.[58] Malaria campaigners therefore had to return to the strategy of reduction of cases. This involved continued attacks on the source of infections and breeding grounds, treatment of cases as well as using physical barriers such as mosquito nets.

Another campaign of this nature meant to eradicate yaws started in 1948. A global yaws eradication campaign was established by WHO together with UNICEF. This campaign emphasized mass treatment of people by using penicillin injections. It is reported that local people saw the healing "miracle" with their eyes and began to develop trust on Western medicine.[59] The discovery and use of penicillin after the WWII marked the end of yaws in the world, including Mpwapwa district in Tanganyika. Yaws eradication campaigns used case- finding techniques, which involved house- to- house searches of victims by yaws scouts. [60]

Another major change witnessed after the Second World War had to do with the content of colonial public health campaigns. Due to the forces exerted by the local people and the increased demand for food, the colonial officials in Mpwapwa initiated food production and soil conservation campaigns. This was known as the Gogo Development Scheme of 1952. This scheme intended to improve the local stock by reducing overstocking, and introduce famine relief for the Gogo.

In 1957 the major recommendations of the proposed scheme were implemented: cattle dips were constructed, by-laws to protect catchments areas were passed and water dams were constructed in various places around the district. In addition the scheme put new emphasis on the cultivation of drought-resistant crops such as cassava, as well the creation of food reserves in the district. [61]

The problem of malnutrition, especially of children, became a matter of international concern and so the district started to receive famine relief from UNICEF and from the USA. Complaints from Africans against the British neglect of medical and health services in the 1930s and 1940s resulted in the improvement of the medical budget from three percent in 1947 to fourteen percent in the 1950s.[62] Still the budget failed to eliminate diseases because funding was inadequate. In 1949, the British colonial government, through the Pridie Report entitled *Review of the Medical Policy of Tanganyika* for the 1950s, emphasized a balance between curative and preventive measures, training of the maximum number of doctors, health personnel and midwives.[63] However, the implementation of the Pridie Plan was crippled by limited funds. [64]

Another problem arose from the government tendency of after WWII to put great emphasis on the absolute elimination of vectors, viruses and parasites believed to produce diseases. As pointed out above the campaigners used strong insecticides like DDT. These measures created lasting negative consequences on the environment and for public health. In recognition of these dangers, from 1960 onwards a number of critics, including ecologists, attacked the whole idea of eradication of species in the name of public health.[65] Connected to this were problems associated with the over-use of antibiotics from 1945, whereby the world witnessed the re-emergence of infectious diseases with increasing antibiotic resistance.[66] Like disease control campaigns, disease eradication campaigns failed to reduce the incidences of disease, let alone eradicate diseases in Mpwapwa district. Thus it became apparent that worldwide eradication of diseases was not achievable. It remained a long term goal.

3.6 Conclusion

Critical scrutiny of the ideas and philosophies that formed the Western perceptions of illness leads to the realisation that western ideas and practices were not all that scientific. They integrated concepts of the

germ theory and ideas and practices developed before the inception of the Germ Theory. Yet colonial public health officials forced the Gogo to accept Western practices as a universally recognized approach to disease control. The historical experience of colonial authorities in Tanganyika has shown that there cannot be a single correct way of handling diseases. While experience in one instance may help, it cannot be taken as a panacea for every new situation. One can conclude that to handle diseases, colonial experts needed to apply not only Western orientation but also local perceptions of illness. As noted above colonial innovations often required recourse to local experience and other cultural norms.

Notes

[1] *Meredeth Turshen, The Politics of Public Health (London: Zed Books Ltd, 1989), 9-16.*

[2] *Lesley Doyal and Immogen Pennel, The Political Economy of Health (London: Pluto Press Ltd, 1989), 142, 144, 145, 147, 167, 239; Edwin Chadwick, Report on the Sanitary Conditions of the Labouring Population of Great Britain , 307; Meredeth, The Politics of Public Health , 127,138.*

[3] *Irving Gordon, World History Review Text, (New York: Amson School Publications, 1979),305; Turshen, The Politics of Public Health, 19-24.*

[4] *Doyal (et al), The Political Economy of Health, 142.*

[5] *Linda Nash, Inescapable Ecologies: A History of Environment, Disease,and Knowledge (London: University of California Press, 2006), 6*

[6] *Steven Feierman, "Culture, Technology and Poverty in the Making of Disease Entities" in Yusufu Lawi and B. Mapunda, (eds.), Healing History of Diseases and Healing in Africa. GeGCA- NUFU Publications (Dar es Salaam : University Press, 2004),3*

[7] *Ibid.*

[8] *John Illiffe, A modern History of Tanganyika (Cambridge: University Press 1979), 1, 12-13; David Clyde, History of the Medical Services of Tanganyik, (Dar es Salaam: Government Press, 1962), 1; W.O. Henderson "German East Africa 1884-1914" in Van Harlow and E.M.Chilver (eds.) History of East Africa Vol.2 (Oxford: Oxford University press, 1965), 123.*

[9] *Helmut Goergen, and Krister Kuelker, The History of Health Care in Tanzania (German Agency for Technical Cooperation, GTZ and National Museum of Tanzania, 2002),7.*

[10] *Juhan Koponen, Development for Exploitation: German Colonial Policies in Mainland Tanzania 1884-1914(Helsinsk: Finish Historical Society 1995), 462-467.*

[11] *Mpwapwa was among the German research centres, for instance where there was a lymph laboratory and Hammond medical laboratory. See David Cycle, History of Medical Services in Tanganyika, 16, 32, 36, 51 and 116.*

[12] *Elikana Makasi, interview at Ving'awe on 12.01.2007; Goergen and Kuelker, The History of Health Care, 4.*

[13] *Juhan Koponen, Development for Exploitation, 470.*

[14] *Goergen. and Kuelker The History of Health Care, 3.*

[15] *Ibid.*

[16] *Juhan Koponen, Development for Exploitation, 241-242.*

[17] *Dr. Peiper cited on Goergen and Kuelker The History of Health Care, 19.*

[18] *Gregory Maddox, "Environment and Population Growth in Ugogo" in Gregory Maddox (eds.) Custodians of the Land (Dar-es-Salaam: Mkuki na Nyota, 1996), 43-66 43-66 .*

[19] *Goergen. and Kuelker The History of Health Care, 12.*

[20] *Richard Titmus, Brian Smith and Arthur Williams (et Al.), The Health Services of Tanganyika: Report to the government (London:Pitman Medical Publishing Co. Ltd, 1964), 2.*

[21] *Doyal Lesley, The Political Economy of Health,241.*

[22] *Terence Ranger, "Godly Medicine: The Ambiguities of Medical Mission in Southern Tanzania 1900-1945" in Feierman and Janzen (eds.), The Social Basis of Health and Healing in Africa (Berkeley: California University Press, 1992), 256-282.*

[23] *Churusi. The African Observer News papers Vol 1: Tanganyika British or Foreign? May 193, 34.*

[24] *Pro.Col. 737, Vol.1 1910 Official Gazzette cited on Eginald Mihanjo, "Colonial Policy on Sexually Transmitted Diseases and other Infectious Diseases in Tanganyika, 1900-11960" in Yusufu Lawi and Betram Mapunda (eds.) History of Disease and Healing in Africa, (GEGCA-NUFU Publication*

Vol.7 Dar es Salaam, 2004).

[25] Helmut Georgern and Krister Kueleker, The History of Health Care10, 21, 22, 27.

[26] Annual Report of the Medical Department, 1925, 36.

[27] Titmus et al., The Health Services of Tanganyika, 6.

[28] Ibid, 32.

[29] Gilbert Madole, interview at Igovu village, 13.12.2006.

[30] Amon Nsekela and Nhonoli Aloysius, Health Services and Society in Mainland Tanzania (Nairobi: East Africa Literature Bureau, 1976), 33.

[31] TNA. ACC.450 File No.1/3 Lepers-Dodoma 1920-1950, 12.

[32] TNA, ACC. 450 File No 106 Plague in Central Province, 11.

[33] Gilbert Madole, interview at Igovu village, 13.12.2006

[34] David Clyde, Malaria in Tanzania, (London. Oxford University press, 1967),79

[35] TNA ACC 450, 106, Plaque in Central Province, 7.

[36] Ibid, 3.

[37] Monica Maganza, Interview at Ving'awe village, 31.12.2006.

[38] TNA ACC 450, 106, Plague in Central Province; TNA Central Province, Provincial Reports 1929, 23.

[39] David Stevenson et al., The Control of Diseases in the Tropics (London: HK Lewis and Co Ltd, 1989), 80; Doyal Lesley, The Political Economy of Health, (London: Pluto University Press, 1981), 142.

[40] Ann Beck, Medicine and Society in Tanganyika 1890-1930: A Historical Inquiry (Philadelphia: 1977), 23.

[41] *Monica Maganza, interview at Ving'awe village 31.12.2006.*

[42] *TNA. ACC.450 File No.1/3 Lepers-Dodoma 1920-1950, 3.*

[43] *Ibid, 3.*

[44] *Ibid, 7.*

[45] *Ibid,11.*

[46] *Charles Mamba,interview at Hazina village, 17.1.2007; Monica Maganza, interview at Ving'awe village, 31.12.2006; Penine Lwabe interview at Igovu village, 30.12.2006.*

[47] *Adamu Kusupa, Interview at Hazina Village 17.1.2007. Kezia Mwaka Interview at Igovu Village 3.01.2007. Maiko Mapuga, Interview at Igovu village 3.1.2007.*

[48] *Gregory Maddox, "Environment and Population Growth in Ugogo" , 43-66.*

[49] *Ibid.*

[50] *Doyal et al, The Political Economy of Health, 254; Maddox "Environment and Population Growth in Ugogo,"55*

[51] *Maddox "Environment and Population Growth in Ugogo," 43-66.*

[52] *TNA 184/ A3/ 31/ 1954-55/II. Draft of the Report by Dr Cicely Williams on the progress of food shortage and relief measures undertaken.*

[53] *John Illife, A modern History of Tanganyika (Cambridge: Cambridge University Press, 1979), 436-475.*

[54] *Walter Rodney, 'The Political Economy of Colonial Tanganyika' in M.H.Y Kaniki, Tanzania under Colonial rule, Longman, 1980,135.*

[55] *TNA ACC 450 File No. 1/3 First Draft Public Health Bill 1945.*

[56] *Meredeth Turshen, The Politics of Public Health,150-164.*

[57] *David Stevenson, The Control of Diseases in the Tropics,184-208.*

[58] Bruce Chwatt, Lessons Learned from Applied science Activities in Africa during the Malaria eradication era (New York: Amson School Publications, 1986), 19-20.

[59] Nsekela and Nhonoli, H ealth Services and Society in Mainland Tanzania, 24.

[60] David Stevenson, The Control of Diseases in the Tropics, op. cit, 302.

[61] TNA 42245/1 Gogo Development Plan, June 1953, 2.

[62] Doyal et al, The Political Economy of Health, op. cit, 254.

[63] Nsekela and Nhonoli, Health Services, 58.

[64] Helmut Georgern and Krister Kueleker, The History of Health Care, 16.

[65] Meredeth Turshen, The Politics of Public health,159-163.

[66] Ibid, 20-22.

CHAPTER FOUR

GOGO PERCEPTIONS OF ILLNESS AND THE IMPLEMENTATION OF THE BRITISH PUBLIC HEALTH CAMPAIGNS

4.1 Introduction

The preceding chapters outlined the Gogo perceptions of illness on the one hand, and the Europeans perceptions of disease on the other. Although one can deduce several similarities, in reality they differed to a large extent. It seems each has been shaped by its past experience and culture. The introduction of Western ideas and practices in Gogo society resulted in the mixing of Gogo and Europeans perceptions of disease. Contrary to the colonial officials' expectations that Africans could automatically abandon their established ideas, Africans on their part did not readily acquiesce to new innovations. This chapter discusses this complex phenomenon in detail. It examines local people's perceptions of colonial public health campaigns and discuses the various ways in which those perceptions shaped their responses to the campaigns. Similarly, it would be very important to examine if colonial public health campaigns had any impact on the Gogo perceptions of illness and on the Gogo society as a whole.

4.2 How the Gogo Perceived the Colonial Public Health Campaigns

Colonial public health campaigns were perceived and interpreted differently by local people in the Mpwapwa district. Some informants opined that colonial campaigns were unnecessary because the Gogo practices were enough.[1] As one informant claimed:

> We did not need colonial medicines, we had our ways of handling illness, and we had our ways of maintaining health. We had traditional medicines, rituals, prayers and sacrifices. Some diseases were easily avoided by isolation or by selecting an appropriate site for settlements.[2]

This means that some of the local people felt they did not need colonial interventions because they had some effective ways of preventing and controlling illness and maintaining health. Yet other informants pointed out that they did not want Western practices because they were irrelevant to their cultural settings. They complained that the Western ideas and practices conflicted their taboos, social norms, beliefs and

traditional practices employed over generations to maintain health effectively. They thought that the campaigns emphasised health principles from another society and were mistakenly brought to the Gogo society.[3] One respondent elaborated this position as follows:

> Colonial ideas and practices were very bad, they were destructive, and I don't like them. They forbade all ideas and practices from our ancestors. We were compelled to follow western medicines. This angered our ancestor's spirits. As a result, many people involved in the colonial medicine suffered adversely.[4]

This argument alluded to the popular notion that many people died or suffered from the side-effects of the colonial medication or other remedies taken without the permission of the Gogo nature spirits. In the Gogo context, such side-effects were viewed as punishment of the victims by nature spirits for accepting the remedies. In this regard, the informant Steven Njamasi argued; "We were the ones who were concerned, so we had to evaluate their thoughts to avoid creating havoc in our community. We tested one idea to see whether there is any truth in it before we adopted it.[5]" Local people were not passive receivers of new ideas championed by colonial experts. They evaluated those ideas before implementing them and after implementing them they also observed the outcome before proceeding further. As Adam Kusupa argued:

> When the white men told us that dirtiness causes diseases, I did not believe, and I decided to prove it. For a period of three months I slept on the ground. I did not take bath, but I did not become sick. I knew that white men were liars. I then attempted to fast for three months but after three days I became very weak. I therefore knew that food was more important for health than cleanliness.[6]

Other informants argued that there were a few local people who were interested in the innovations. They were the first ones to learn those innovations so as to increase their therapeutic knowledge. They initially believed that colonial ideas and practices could provide some of the missing solutions. Contrary to their expectations, problems increased after adopting certain practices, and thus they decided to abandon the innovations.[7] In this connection, Steven Njamasi claimed that:

> I became uncomfortable after locating a pit and latrine near my home because they resulted in a bad smell and the breeding of flies; they attracted rats which destroy my crops. I did not like them; they resulted in diarrhoea and dysentery in our community... Waste should be deposited far from human settlements.[8]

The quotation above demonstrates that local people were not taught how to construct and properly manage pits and latrines, hence the adverse affects reported here.

In addition, there was also the problem of misinterpretation of certain concepts embedded in the colonial public health interventions. Taking the campaign on public hygiene as an example, several informants[9] claimed that in the Gogo language hygiene meant a good moral posture, and not the physical cleanliness as emphasized upon by colonial officials. In the Gogo rural context, events believed to pollute the society were adultery, misbehaviour, a woman giving birth in the homes of her in-laws, sexual relations with a woman who had had a miscarriage and had not been purified, and sex between unmarried partners. Colonial hygienic practices such as cleanliness of the surroundings, boiling of drinking water, washing hands after visiting a toilet, and the like, were hardly accepted by the Gogo because they did not correlate with their perception of cleanliness as described above. The Gogo attributed diseases like diarrhoea, bilharzias and sexually transmitted diseases to the range of unacceptable behaviour mentioned above. Although local perceptions of public health hygiene contrasted sharply with colonial ideas, still these local ideas could have been used to educate the natives about the relationship between misbehaviour and diseases.

While ordinary men and women seemed to have a negative interpretation and attitude towards colonial experts and their campaigns, it has been reported that things were somehow different for the relatively small group of educated African, especially government employees, school teachers and Christians. Monica Maganza, one of the Gogo informants, complained that these people sided with colonial officials and even used traditional songs to mobilize the reluctant Gogo to accept new health regulations. She says that they were taught these songs in primary schools, and because they were children, they used to sing the songs without any reflection. The following is one of those songs taught by an African teacher:

Chiwaheshumu wazungu wachipele mwongozo wa afya,chikutuga sibitali,chiku pimwasakami,chikugundulik a matamwa mbalimbali chali sina ujuzi wayo wachilagila usafi wa vyoo na chila chinu chikali du nyuma, chijitahidi wose. [10]	Let us respect the white people, they have educated us on how to practice hygiene, they have built hospitals to test our blood and treat the diseases we had no knowledge to cure. They ordered us to clean our toilets and everything, we were still far behind.

The above song reflects clearly the tendency of colonial experts of using western education to legitimize Western ideas and practices.

4.3 Gogo Responses and Colonial Officials Reactions.

From the previous section one can learn that local people were not passive recipients of colonial ideas and practices pertaining to health. They tried to interpret the new innovations before adopting them. In general some of the colonial concepts were easily accepted right from the beginning, some were gradually adopted after long-term of contradictions and conflicts and many others, regardless of their importance, were either ignored or rejected completely. To show this varied nature of responses and colonial officials reactions let us examines varies categories of the campaigns.[11] The first group comprise the interventions which were not new but resembled old traditions. These were the ones which were easily accepted and local people participated materially and morally to implement the regulations. These included isolation of the victims, smallpox vaccination and campaign on compulsory wearing of shoes.

Starting with the lepers' isolation campaign, it was reported that local people played a great role in the identification of victims who were abandoned in the bush and in funding their transportation to the leper colonies because they were located in other districts of Dodoma region. Similarly smallpox vaccination was not a new phenomenon for the Gogo and thus it was easily received. In pre-colonial times they locally applied the principles of variolation which involved the inoculation of healthy people with matter obtained from the skin eruptions and scabs of the infected. This is contrary to Elizabeth Knox's claim that smallpox vaccination was readily received by the

Gogo of Mpwapwa because the natives were indeed in need of foreign interventions and that for a long time they used traditional medicines which aggravated the condition of the sick instead of curing it.[12] Like other colonial scholars, Knox underestimated the ability of Africans to handle smallpox. After all, few natives contracted colonial smallpox vaccinations before 1967, when WHO launched smallpox eradication after which no case of smallpox was reported.[13]

Wearing of shoes was also considered an old tradition. The Gogo were historically semi- nomadic people. Hence shoes helped them to walk over long distances while avoiding sunburn and thorns. Caravan raiders wore shoes because shoes facilitated fast running. Shoes were also important in traditional dances. For hunters, musicians, rulers and animal keepers, wearing of shoes was part and parcel of their daily practice. What was new was the idea that shoes could prevent hookworm infection. Yet, not everybody wore shoes in the Gogo society.[14] In explaining why some Gogo did not use shoes during the colonial rule informants have noted that the Gogo did not have money to buy shoes because they there were so many social obligations which required money. This point was elaborated on by one informant, Steven Njamasi:

> It is an insult to claim that colonialists taught us the importance of shoes; shoes are our traditional heritage from our fore fathers. But during the colonial rule some people were afraid not only to wear shoes, but even good clothes. Women did not decorate their bodies as they used to do, for fear of being questioned by colonial masters. Yet, the majority could not afford to buy shoes because they had to pay for their children's education, health services, food, clothes and taxes. Shoes became a luxury item.[15]

This is to say that what prevented some of the Gogo from using shoes was poverty, not ignorance or other social- cultural factors. The demands for money exceeded what they actually earned from selling their labour, livestock or crops. Informants noted that it was difficult to obtain shoes during the colonial rule because most makers were taken as labourers to work on Mbori pawpaw plantations or on sisal plantations in Tanga and Morogoro. The impacts of Gogo migration is well-documented by Gregory Maddox's study on environment and population growth in Ugogo.[16] Maddox has succeeded in showing how poverty increased among the Gogo as the result of colonial operations.

The second category of campaigns involved new practices regarding diseases control. This group comprises campaigns such as domestic waste management, use of latrines, building of standard houses, measles vaccination and compulsory child and maternal clinics attendance. When asked if *bwana afya* (public health officer) visited them to give an orientation on the implementation of these new public health directives, the respondents seemed to have a negative attitude towards these experts. Many respondents complained that these officers regarded the locals as people who knew nothing about illness, and themselves as people who know everything there was to know about health. Local people complained that these officers did not educate them about new ideas but they were very harsh in forcing them to implement the directives. Elikana Makasi elaborates:

> ...when we were informed that health officers would visit us, the whole community became unhappy. We got confused and so we became busy, cleaning up our compound and digging latrines. Their main duty was inspection, and whoever was found not having one had to pay a fine. Some of us were even beaten.[17]

It seems that colonial experts taught new health concepts merely by orders, because they viewed local people as passive absorbers of their innovations. They did not motivate participation because they did not require local people to engage in the programme rationally. By the end of colonial rule many colonial officials had realised that introducing innovations by using this mode was an ineffective means of policy implementation, regardless of the brilliance and skills of the experts.

Starting with waste management campaigns, during the colonial period the Gogo were forced to put domestic waste into pits just around their homesteads. However, the Gogo were not comfortable with this regulation. When asked the reasons behind their displeasure, many informants claimed that staying near wastes increased cases of diseases and other social problems.[18] According to the Gogo, they used to throw waste away from their homes or into the nearby bushes which limited direct and continuous contact with human wastes.[19] Even shifting cultivation probably limited the concentration of wastes in the pre –colonial period; so they did not suffer from the effects of waste as it happened in the colonial period.

The unpopularity of latrines campaigns among the Gogo is also clearly acknowledged by official sources. The Provincial Commissioner's Report on Central Province 1931-1933, for example, noted that compulsory building of latrines near homesteads was very unpopular, and that the Gogo, especially adults, were very reluctant to use toilets.[20] However, these sources have little to say in explaining the causes of local people's resistance against such innovations. The Gogo on their part provided some explanation. According to Gilbert Madole, the latrine campaign was formulated without any consideration of local culture. Thus, it contradicted social norms and Gogo taboos. Madole claimed that in Gogo culture it was not socially acceptable for parents to attend natural call in places that were known or visible to their children. Children were not even expected to know that their parents attended the call of nature. It was fear of persecution and colonial fines that made some Gogo adults build toilets, but they did not utilize them. For a long time they continued with the old practice of using nearby bushes as toilets. However around 1950 some of the Gogo started to use latrines so as to avoid colonial disturbances and fines.[21]

Colonial regulations on housing also resulted in conflicts between colonial experts and local people. Local people were ordered not to share rooms with their animals and to enlarge their windows.[gn] Although Gogo explain that relapsing fever is transmitted by ticks, in their opinion the solution was not abandoning their cattle far from their homes, and thus exposing them to Maasai raiders. Rather they used elevated traditional beds known as *ulili* made from poles and ropes to limit interaction with ticks. It was for fear of fine of about 6 cents that some Gogo modified their houses as colonial officials directed.[23]

Another government action in Mpwapwa district during the 1920 involved the selection and training of girls to work as midwives. However, the policy resulted in grievances among women and it affected the efficiency of the child and maternal health campaigns conducted around this period. Various colonial officials reported that maternal health campaigns of the 1920s had not won the confidence of the Gogo of the Mpwapwa district.[24] When asked about those complaints, almost all women informants claimed that they were not comfortable with the maternal clinics for several reasons. The first one was the use of young girls and sometimes

male nurses to attend their pregnancy or child birth problems. To this end an informant Monica Maganza claimed that:

> ... Attendants were children, some were not even married, and they lacked practical experience. How could they help us? If we were not wise we would allow them to attend us, but then this would mean exposing these young people to curse and disgrace. To show children your private parts is to curse them. [25]

As a response to women complaints the colonial government in 1940s started to train and employ traditional midwives at newly established maternity and child welfare clinics, such as at Kongwa Mission, St. Luke Mission and at Mpwapwa General Hospital.[26]

In addition to that, colonial experts, in collaboration with missionaries, introduced annual baby show competition.[27] The competition motivated women from different villages to attend a programme at a nearby clinic, where every woman displayed her child to show her competence in feeding and cleaning the baby. The winners were given material prizes like clothes and food. When asked about the baby show competition organized by the maternal clinics, informants expressed a negative attitude. Kezia Mwaka for instance noted:

> We attended because we needed goods like milk, soap and clothes. But we did not like the show as it increased children's mortality rates. The shows were very bad. They exposed children to people of all kinds including witches and people with evil eyes. As a result children who won the competition did not stay long. They passed away.[28]

Apart from this the success of child and maternal clinics was constrained by the well established Gogo conceptions on childhood diseases. Childhood diseases were believed to result from adulterous relationships of the parents. It was considered a shame, and parents used to hide those children suffering from illnesses associated with the breakage of sexual taboos. According to informant Kezia Mwaka, many people believed that children's diseases, such as measles, chickenpox and kwashiorkor, could not be prevented by attending child and maternal clinics, but rather by observing cultural taboos.[29] For instance, in the case of measles,

the society had to observe a number of taboos. These included restricting visitation, avoiding taking things like salt and fire from the affected household, avoiding taking hot meals, avoidance of injections, and parent restraint from sex[30] They also believed that taking the measles vaccine without the approval of the nature spirits would result in serious health problems and other misfortunes for the child who inherited the ancestor's name.[31] It would probably have been better for the colonial experts to educate the society about the causes of childhood diseases instead of wasting their money and energy in building maternal and health clinics.

According to David Clyde, villagers in Mpwapwa started to respond positively to maternal health campaigns in the 1950s. Taking Tubugwe village as an example, it is reported that every villager contributed to a clinic fund, and about £80 was raised for the purpose of building a new maternity clinics. [32] While it might have been true that towards the end of colonialism some Gogo started to accept colonial public health practices, it must be emphasized that many of them still resisted some aspects of colonial practices.

Another campaign which was very important but resisted by local people was the malaria campaign. The malaria campaign was viewed by the local people as meaningless. Colonial experts tried to approach malaria by using different techniques including, the use of malaria chemoplaxis, environmental cleanliness and use insecticides. However all these failed. One medical expert, Dr. Mantenfel, described Africans response to these campaigns as follows: "The adult African is much more inconvenienced by a quinine cure than by his malaria...He knows how to take advantage cleverly of his circumstance to influence his employer against the measures of malaria."[33]

Gogo on their part viewed malaria as a normal fever caused by wet weather or rainfall, and thus it passes with time. In connection with that they complained against malaria eradication campaigns and especially the negative side effects of insecticide which included accidental killing of their pets such as dogs, cats and chickens. So they feared it could harm human beings as well. They also bitterly complained against the unnecessary disturbances brought about by the campaigns. In this connection, Gilbert Madole argued that "spraying was very bad. It killed domestic animals. It greatly increased bed-bugs. It made the house smell bad and it involved a lot of inconveniences, including moving furniture in and out;

cockroaches also increased as a result of spraying."[34] In general malaria interventions in Mpwapwa district was one of the colonial public health interventions that failed. Malaria continues to be a public health problem in Mpwapwa and elsewhere in Tanzania.

4.4 The Impact of Colonial Public Health Campaigns

4.4.1 Changes of the meaning of illness

Although it is difficult to document the complete history of transformations in the Gogo conceptions of illness following the colonial public health campaigns, it is clear that they did bring about many changes. Colonial experts challenged the Gogo explanation of disease causation, which was based on sorcery, ancestral spirits, natural factors and breach of taboos. Thus, some of the approaches, such as belief in sorcery, spirits and *Mulungu*, gradually lost their popularity. However, most Gogo still believed that breach of taboos and weather changes could lead to health problems and diseases. They also acknowledged the role of poor sanitation and malnutrition in the eruption of diseases. According to Steven Njamasi, diseases are caused by breakage of taboos, poor sanitation and the shortage of milk in the local diet.[35]

Other changes were reported in healing practices. Pre-colonial healing practices among the Gogo varied widely depending on perceived causes of illness. During the colonial period the Gogo categorised diseases into two groups; diseases that responded to Western therapies and diseases that responded to African therapies. The diseases believed to respond to Western therapies such as smallpox, yaws and leprosy, were labelled as Western diseases. Other illnesses which were believed to come from sorcerers or the transgression of taboos were labelled as African diseases. Monica Maganza claimed that:

> Today we have two categories of diseases. Diseases of Africans and diseases of Europeans; diseases of Africans are caused by the weakening or disturbed social relationship and can not be treated in the hospitals. Diseases of Europeans are natural ones caused by unknown forces and can only be treated by western therapies.[36]

It has been noted above that colonial officials discouraged most of the local ideas and health practices. Colonial officials claimed that local ideas and practices were a product of barbaric beliefs. Some of the traditional health practices and traditions were eventually abandoned as a result of these challenges and criticisms. For instance, the tradition of burying people inside homes and of abandoning people suffering from smallpox and leprosy disappeared during the early years of British rule. Gilbert Madole, one of our informants, reported that:

> It was difficult to surrender our relatives in the wilderness. But burying people inside homes made people to suffer continued fear when entering the room. When the British government allocated burial sites in remote areas, the Gogo responded positively. They willingly started asking for burial permits.[37]

According to Steven Feierman, each time a new disease appeared it challenged the local categories of diseases and initiated discussion about its classification.[38] This was true among the Gogo of Mpwapwa district because the rise of new diseases like influenza, cholera and venereal diseases during the colonial rule resulted in the development of new conceptions about illness. The new conceptions attributed diseases that erupted during the colonial period to operations such as taxation, migration, poor diet, selling of cattle, urbanization, and development of transportation and communication facilities. [39] In this view, healing could only be achieved by either getting rid of colonial oppression and exploitation or by rejecting the modernization pressure. The impact of modernization of transportation was well articulated by our informants as follows:

> In Gogo society we did not have many illnesses. We experienced new and dangerous diseases during colonial rule. These diseases were brought to us by buses from the coast. When we saw buses coming from the coast we were unhappy because they carried many diseases.[40]

Along similar lines Gilbert Madole noted:

> It is true that sexually transmitted diseases increased during the colonial period. These came from towns. In towns many people did not observe traditional values; they participated in prostitution, they lived with partners without formal marriage and often had many lovers. They did not consider the cleansing of women who have miscarried. Towns were very bad places because people abandoned all social norms.[41]

Thus the local people understood that the integration of the Gogo society into other societies as the result of the development of transport facilities increased the importation of diseases from the coast. In this context the coast or towns represented Tanga, Morogoro and Dar-es-Salaam, where some Gogo men worked as labourers. This being the case, it was rational for the local people to conclude that buses brought diseases to their area. In reality labourers were indeed exposed to new diseases in plantations, and when returning to their communities some must brought and spread new diseases.

4.4.2 Persistence and the Consolidation of Traditional values

The functionalist anthropologists of the 1950 viewed Western medicine and Christianity as the greatest forces for shaking off 'primitive' explanations of disease. They predicted the demise of the pre-colonial non-scientific perceptions. Contrary to these expectations, however, many local traditions in relation to health and illness did not disappear. Some of the core beliefs and values of the society adapted to new situations and challenges. What changed was the mode of their performances. In the pre-colonial period, those practices were performed openly and communally. During the colonial times some of these went underground so that colonial officials would not notice. These included ideas and practices relating to sorcery accusations, rituals, prayers and sacrifices, commemoration of ancestors, and the observation of sexual taboos. For example, the Gogo in Mpwapwa held on to a belief that breach of sexual taboos resulted in health problems. In explaining how sexual intercourse brings illness, the informant Steven Njamasi stressed that:

> It is not socially accepted to have sexual intercourse with a nursing woman; because the act produced dangerous heat that affects the growth of the baby we called *kubemenda.* Parents are supposed to avoid sexual intercourse until the baby grows to the extent of being able to graze animals and to fetch water.[42]

From the quotation above one can reflect that the weaning period was too long. This was probably because Gogo as livestock keepers could not manage toddlers because of the frequent movements. The persistence of values was also connected with the influence of beliefs on nature or ancestor spirits. According to Gogo oral testimonies, before attending a hospital for treatment a patient's relatives, consulted diviners or ancestors' spirits in order to discuss the root cause of the illness and to suggest appropriate remedies. This practice made it difficult for the Gogo to accept colonial public health regulations, for they did not discuss with colonial experts, who were not conversant with the Gogo perception of the role of non-physical reality. In explaining this dilemma, Mdala Malogi, one of our informants noted:

> ...I have lived for so long and I have never gone to hospital. My ancestral spirits forbade me to go to hospital; if I go I will die. I don't boil water for drinking and I rarely take bath. I do not remember when I took bath for the last time.[43]

It seems failure of colonial therapeutics to provide correct answers to all the problems of local people also contributed to the consolidation of some traditional values. Today some Gogo strongly believe that diseases associated with witches and the breach of taboos can not be treated in hospitals or controlled by using hygienic practices. These diseases have to be attended to by traditional healers. In emphasizing this dichotomy the informant Monica Maganza noted:

> White men's medicine failed to treat all diseases in our community. Some diseases were treated only by local people, such as diseases caused by fears, stress, curses and witches. It was widely recognized that western medicine could only help to stabilize the conditions of people suffering from such illnesses. [44]

Similarly a male informant, Gilbert Madole, emphasized that:

> Colonial medical officers were capable only to explain how diseases were transmitted from one person to another, but they could not explain why a certain person was ill at a certain time and not another. Only traditional healers could answer that question.[45]

It is somewhat surprising that while ordinary local people discovered the weakness of Western therapies immediately after it was introduced, the educated ones viewed them as a panacea for Africans' health problems. This can be attributed to the western education they received. However public health experts and WHO officials have admitted openly that in certain instances Western medicine has failed to provide correct answers for African health problems and so strongly recommended the use of local remedies.[46]

4.4.3 Demographic Impact of British Public Health Campaigns

Many scholars of population dynamics agree that populations in Africa and Tanzania in particular started to grow slowly in the 1930s and increased rapidly after the Second World War.[47] However, the main interest has been in the implications of dynamics for the environment, poverty and economy. The question on the reasons for the increase of population has received relatively little attention. Thus it would be interesting to examine the extent to which colonial public health campaigns contributed to population increase. A recent study conducted in Ugogo by Gregory Maddox[48] reports that, during the British colonial rule from 1916 to 1961, population of Mpwapwa district grew quite substantially.

Table 1: Showing Patterns of Population change in Ugogo: 1913-1967

	Gogo	Ugogo	Dodoma	Manyoni	Mpwapwa	Old Dodoma
1913	124,814					299,400
1921	118,500					270,890
1928	166,233	211,687	128,126	44,912	38,649	
1931	182,114	211,322	130,349	43,563	37,380	
1948	278,755	369,522	218,800	52,600	100,673	268,849
1953		371,300	221,200	55,500	94,600	
1957	299,417	409,766	236,152	58,829	114,785	
1967	360,131	553,371	297,180	80,157	176,034	

Sources: Censuses of Tanganyika and Tanzania 1913-1967 as cited in Maddox, et Al *Custodians of the Land: Ecology and Culture in the History of Tanzania.* (Dar es Salaam: Mkuki na Nyota 1996), 44

Accordingly to Maddox, the rate of population increase of Mpwapwa was higher compared with other districts in Dodoma (see the table.1 above). Maddox has argued that this population growth was mainly due to immigration of people from outside the area. Many colonial scholars have simply attributed population growth to colonial medical interventions, which is said to have slowed mortality rates and improved fertility rates. Wrigley[49], for example, attributed population growth in Africa to improved health care and sanitation campaigns introduced during the colonial rule. This argument probably carries a grain of truth but it seems the contribution of medical intervention has been exaggerated. Activities like smallpox vaccination, the use of antibiotics in controlling infectious diseases and eradicating diseases like yaws, the distribution of anti-malarial drugs along with sanitation campaigns might have contributed to population increase to some extent. However this study did not find strong evidence to support the view that public health intervention contributed to the decline of mortality rates or population increase among the Gogo of the Mpwapwa district. This is because the district experienced high mortality rates almost throughout the colonial rule. Many people died because of new and old diseases like influenza, plague, cholera and venereal diseases. Also, Mpwapwa district suffered repeated famine throughout the colonial period as a result of the introduction and commercialization of maize production. Therefore, there is a need to

conduct further research to examine the extent to which colonial public hygiene and sanitation altered mortality rates and hence contributed to the population increase in Tanzania.

4.5 Conclusion

The preceding discussion has shown that colonial experts strongly believed that Africans needed Western ideas and practices so as to be free from the problems of poor health and illness. In contrast to this belief, however, there is much evidence that the task was difficult and its implementation often heart- breaking on the part of colonial administrators and experts. The study has found that social responses to colonial innovation followed a process of interpretation of colonial ideas and practices, because the indigenous population did not merely absorb the lessons embedded in the British public health campaigns. Rather, they interpreted those ideas in the light of their culture. Furthermore, local people's interpretation of colonial public health principles was influenced by social realities, past experiences, and socio-cultural factors such as taboos, religion, myths, values and beliefs. This chapter has demonstrated that in the long run local people accepted some aspects of the campaigns. However, other colonial orders were ignored and hence never utilized by local people. As a result, some of the traditional conceptions were transformed while others persisted or became even stronger than they were as a result of the weaknesses of colonial innovations.

Another reflection from this chapter has to do with the emergence of a new perception of illness causation. The colonial social economic contexts and the emergence of new diseases made local people attribute diseases of the colonial period to colonial operations and processes. This illustrates how local perceptions of illness underwent significant changes, not only in pre-colonial but also in colonial times. It has been concluded that, even though the Gogo eventually accepted certain modern practices, they did not abandon some of the old traditions. This was contrary to the basic expectation of colonial experts, namely that their interventions would totally transform African perceptions of illness and ways of handling diseases.

Notes

[1] *Monica Maganza, Interview at Ving'awe Village, 15.01.2007. Titus Mshana interview at Chamunye village, 09.01.2007. Dr. John Musumula interview at Mpwapwa Hospital, 16.01.2007. Tito Chamwihala interview at Ving'awe village, 17.01.2007.*

[2] *Elikana Makasi, Interview at vingawe village, 30.12.2006*

[3] *Monica Maganza, Interview at Ving'awe Village, 14.12.2006. Steven Njamasi, interview at Igovu village, 13.12.2006. Kezia Mwaka, interview at Igovu village, 30.12.2006.*

[4] *Mdala Malogi Interview at Igovu village Mdala 30.12.2006.*

[5] *Steven Njamasi, interview at Igovu village, 13.12.2006.*

[6] *Adam Kusupa, interview at Hazina village 17.01.2007.*

[7] *Monica Maganza, Interview at Ving'awe Village, 14.12.2006. Steven Njamasi, interview at Igovu village, 13.12.2006.*

[8] *Steven Njamasi, Ibid.*

[9] *Elikana Makasi, Interview at Ving'awe village, 13.12.2006, Esau Meshack interview at Igovu village 16.12.2006. Penina Lwabe, interview at Igovu village, 14.12.2006.*

[10] *Monica Maganza, Interview at Vinga'we village, 31.12. 2006.*

[11] *This is my own categorization of colonial public health campaigns to simplify the analysis.*

[12] *Elizabeth Knox, Signal On the Mountain: The Gospel in Africas' Uplands Before the WWI1, (Wanniassa: Acorn press, 1991),17.*

[13] *Helmut Georgern and Krister Kueleker, The History of Health Care in Tanzania, 28-29.*

[14] *ACC.450/ 968, Foot Wear for Africans Natives 1939, 1.*

[15] Steven Njamasi, interview at Igovu Village, 13.12.2006

[16] Gregory Maddox, "Environment and Population Growth in Ugogo" in Gregory Madox et. Al. Custodians of the Land: Ecology and Culture in the History of Tanzania. (Dar es Salaam: Mkuki na Nyota 1996).

[17] Elikana Makasi, Interview at Vinga'we village, 31.12. 2006

[18] Steven Njamasi, interview at Igovu Village, 13.12.2006.

[19] Ibid.

[20] Tanganyika Territory Provincial Commissioner' Report, Central Province, 1931-33, 47.

[21] Gilbert Madole, Interview at Mwanakianga village,13.12.2006.

[22] TNA ACC 450/ 106, Plague in Central Province, 3.

[23] Esau Meshack, interview at Igovu village, 14.12.2007

[24] TNA Central Province, Provincial Reports 1929, 23.

[25] Monica Maganza, Interview at Igovu village, 31.12.2006.

[26] Justine Njamasi, interview at Igovu village, 14.12. 2006

[27] M1/6 – Maternity Clinics Midwives and Babies Show, 1939-53, 1

[28] Kezia Mwaka, Interview at Ving'awe village 15.01.2007.

[29] Kezia Mwaka, Interview at Mwanakianga village, 13.12.2006

[30] Robern Sabugo, interview at Igovu Village 15.12.2006, Penina Lwabe, interview at Igovu Village. 30.12.2006

[31] Nyendo Masumbuko, interview at Kisokwe Village.09.01.2007.

[32] David Clyde, History of the Medical Services of Tanganyika, 98.

[33] David Clyde, Malaria Control in Tanganyika, p, 79

[34] *Gilbert Madile, Interview at Mwanakianga village.13.12.2006.*
[35] *Steven Njamasi, interview at igovu village, 14.12.2006*
[36] *Monica Maganza, Interview at Vinga'we village, 08. 01. 2007*

[37] *Gilbert Madole, Interview at Mwanakianga village, 13.12.2006*

[38] *Steven Feierman and John Janzen (eds), The Social Basis of Health and Healing in Africa, (Berkeley: University of California Press, 1992), 12.*

[39] *Gilbert Madole, Interview at Mwanakianga village, 13.12.2006. Steven Njamasi, Interview at Igovu village, 14/ 12/ 2006. Monica Maganza, Interview at Ving'awe village, 31.12.2006.*

[40] *Steven Njamasi, interview at Igovu village, 14.12. 2006*

[41] *Gilbert Madole, interview at Igovu village, 13.12.2006*

[42] *Steven Njamasi, Interview at Igovu village, 14/ 12/ 2006.*

[43] *Mdala Malogi, interview at Igovu village, 30.12.2006. Kezia Mwaka, interview at Igovu village, 30.12.2006.*

[44] *Monica Maganza, Interview at Ving'awe village, 31.12.2006.*

[45] *Gilbert Madole, Interview at Mwanakianga village, 13.12.2006.*

[46] *Olayiwolo Akerere" Traditional Medicine programme –World Health Organization" in Charles Mgone,(ed), Tanzania Medical Journal Special Issues, (Arusha: Tanzania Medical journal press 1984),3-7*

[47] *R.R Kuczynski, Demographic Survey of the British Colonial Empire: Vol.II: East Africa. Oxford: oxford University Press, 1970, 98-99; Steven Feierman " Social Change in Colonial Africa" in Philip Curtin et. al, African History From Earliest Times to Independence, (Singapore: Pearson Education Press 1995), 504-508; Gregory Maddox, "Environment and Population Growth in Ugogo" in Gregory Madox et. Al. Custodians of the Land: Ecology and Culture in the History of Tanzania. (Dar es Salaam: Mkuki na Nyota 1996).*

[48] *Gregory Maddox, 'Environment and Population Growth,'43-61.*

[49] *Quoted in Gregory Maddox, Environment and Population Growth,'4.*

CHAPTER FIVE

SUMMARY AND CONCLUSIONS

This dissertation had two major objectives. The first objective was to gain clues on the influence of local perceptions of illness on the implementation of colonial public health regulations. The second objective was to understand the impact of colonial public health campaigns on the Gogo understanding of illness. In order to achieve these goals there was a need to have constant references to both sides, the side of local people with their preconceived ideas, and that of colonial experts with their modern or western orientations on health and disease. Following these concerns the dissertation has addressed local perceptions of illness, colonial public health campaigns, contradiction between local people and colonial experts' perceptions and consequences on both sides.

The dissertation started with a survey of the available literature on the subject of disease and healing. The following three issues have been noted. First, many publications seem to show that pre-colonial Africa had no mechanisms for dealing with health problems. Thus, these scholars have presented Western medicine as if was introduced to an empty society. Second, a few scholars have tried to show that Africans had their own perceptions of illness, but they did not show the dynamics which resulted in the changes in local perceptions of illness in the pre-colonial and colonial period. Thirdly, Very few scholars have attempted to show the influence of local perceptions of illness and other social- cultural factors on the implementation of colonial public health directives. Yet the comprehension of that aspect is very important. It helps to understand some unexplained areas of scientists' failure in the colonial public health campaigns.

The dissertation proceeded with an analysis of local perceptions of illness as embedded in various forms of Gogo cultural expressions and practices in the late pre-colonial period. These included rituals, prayers, beliefs, taboos, initiation rites and traditional ceremonies. Gogo perception of illness has been found to be very broad as they integrated ideas emanating from interaction with social, natural and spiritual worlds. In general, their approaches to disease control involved the participation of people from different categories: society elders, traditional healers, diviners and spiritual and political leaders. This multifaceted approach to diseases shows the complexity and the importance

of well-being in local contexts. The dissertation has underscored the fact that in many cases this approach provided satisfactory answers for health problems and illnesses. Local perceptions of health and illness were not the outcome of mere imagination and intuition. They were rather a product of specific historical circumstances and experiences.

The information provided in chapter two shows that local perceptions were embodied in the changing social, economic and political systems of the society, so that when society changed, the perceptions also changed following the changing nature of the society. This confirms what is underlined in the Marxist approach to understanding society. According to which forces such as ideas, knowledge, rituals and philosophies form the superstructure of the society and are not independent of the basic structure of the society, namely its economic processes and production relations.[1] It is clear that, while diseases existed in pre-colonial African societies, each community developed unique perceptions that guided the development of preventive and curative practices. This reality coincided with the Linda Nash argument that diseases and healing practices are inseparable from their localities.[2] Thus illness and healing have to be understood only on their specific contexts. The broader derivative of this is that, although up to the 19th century Africans had not yet achieved a profound scientific revolution as was the case in Western Europe, Africans had some ways of maintaining health and controlling diseases. Up to now there has been no evidence supporting the colonial contention that before colonial medical intervention Africans were subjected to extreme problems of poor health and illness. On the contrary there is ample evidence showing that colonialism aggravated health problems in Africa. This is true despite the extensive public health campaigns pursued by colonial administrations.

It can be said that, even though local perceptions of epidemics could be regarded as unscientific, the perceptions made sense to the local authorities and their subjects because they reduced the number of epidemics. Local people managed to establish a direct relationship between interactions and epidemics. From the local perceptions of illness one can deduce that epidemics are social events which occur in certain social-economic and political contexts and are not a natural phenomenon. This study explores just a part of local perceptions of epidemics, but still the topic needs further researches to investigate socio-economic changes brought about by epidemics and, more specifically, the impact of epidemics on demographic change.

After this discussion on the dynamics of local perceptions of illness and healing, the study proceeds with an overview of colonial perceptions of health and illness as manifested in the colonial approaches to disease control. The material presented and discussed in chapter three demonstrates that colonial experts, even of African origin, were oriented toward western perceptions of diseases. The chapter shows that, unlike Gogo perceptions, which drew ideas from social, natural and spiritual worlds, colonial experts had two ways of acquiring medical knowledge. First they formulated certain ideas from the findings of laboratory research performed here in Tanganyika. Second they directly imported some ideas from Western Europe. Colonial actions in this respect show that they found nothing to learn from Africans. It can be speculated that colonial experts ignored local people's knowledge for the reason that it did not came from a laboratory, and was therefore un-scientific. It is clear in the various colonial records that only Western perceptions were viewed as rational. Therefore, following the established idea that the diseases of Africans were the white man's burden, such perceptions had to be inculcated in the minds of colonised Africans.

Chapter four discusses the problems that arose from the implementation of the colonial public health interventions. Contrary to colonial experts' expectations, the exercise turned out to be very difficult and disappointing for both Africans and colonial officials. Africans, who were viewed as passive objects, proved difficult to treat as simple objects. They did not rush to embrace modern ideas. They accepted new ideas only after a period of interpretation, evaluation and experimentation. Their interpretation revolved around common local perceptions of nature and culture. They would often try to observe any qualitative changes after adopting certain new ways, and if they found no changes they immediately abandoned the idea. In response to Africans negative reactions to colonial interventions, colonial experts employed various techniques to persuade and sometimes threaten Africans using tactics such as coercive measures, giving incentives and ideological manoeuvring. However, some of the colonial ideas were either ignored or rejected outright.

Paradoxically, colonial public health campaigns sometimes strengthened some traditional values. This happened when, for example, western knowledge failed to provide answers to major problems facing local people. A good example of this is when western medicine failed to cure illnesses that were locally associated with witchcraft and breach of taboos. Such failure strengthened the belief that some illnesses could only be attended to by traditional healers. It can generally be said that the colonial public health

campaigns failed in many aspects. One can propose two major reasons for this failure. The first was that colonial experts addressed the secondary forces behind diseases causation namely vectors and germs. They focused on elimination of diseases without addressing the core problems of poverty and other predisposing factors. It is worth noting that, according to the social constructionism theory, the fundamental basis for disease emergence and spread are social, economic and political determinants of health.[3] These relate to problems of inequality, poverty, exploitation and capitalist oppression. One can say with certainty that it is impossible to control diseases without improving the health conditions of the people concerned. The second reason was the neglect of local people's accumulated knowledge, which would have been a good foundation for the implementation and success of colonial public health intervention. We have demonstrated that colonial health experts overlooked the role of local perceptions and practices in the implementation of their public health initiatives. This is not to suggest that local practices were naturally preferable to scientific knowledge. Local perceptions were limited in scope and some of the related practices were undesirable. However, many of them provided viable solutions in a society where advanced technology and specialised knowledge of disease and healing was lacking. It was therefore inappropriate for the colonial government to reject all local ideas and practices regarding disease control.

Another major weakness connected with the neglect of local ideas was that colonial experts disrupted even some of the established and rational practices of maintaining health and controlling illness. In the discussion we have shown how some of the practices shared the logic of scientific practice. Practices such as indigenous inoculation, isolation of the infected and proper feeding of the ill were in line with western ideas and practices. Yet these ideas were not used in the implementation of new colonial health programmes. Adoption of some of the relevant local ideas and practices would have increased the possibility of acceptance of some of the colonial innovations. This is to say, the colonial government would have increased the chances of succeeding in achieving the goal of their public health campaigns if they had modified their innovations to make them socially and culturally acceptable.

Connected with these problems was the issue of methodology or practical approach to the promotion of public health. The methodology used created a social gap between experts, who pretended to know everything, and the local people, who were viewed as ignorant and not competent to contribute anything to public health promotion. This presents racism not very different

from that of Hegel who called Africans *tabularasa* as far as reasoning is concerned. Hegel viewed Africans as objects to be analysed and understood, they are not to be involved in the discourses.[4] Accordingly, the main task of the public health official, popularly known as *bwana afya,* was to teach and order local people to implement the directives even if the latter saw no any advantages in doing so. When local people rejected the imposed measures they were seen as stubborn and ignorant villagers. This study has revealed that far from being simply stubborn and ignorant, local people always thought rationally in accepting or rejecting imposed regulations. They always wanted to satisfy themselves that they were doing a useful thing.

To concretise on this, let us take the example of the disease malaria, which has remained a leading cause of morbidity in Tanzania despite numerous colonial and post-colonial government interventions. Many scholars have attributed the failure of these interventions to factors such as inadequate funds, the resistance of mosquitoes to pesticides and resistances of malaria parasites to curative medicine. However, it is now clear that the story would have been different if the campaigners had utilized some of the relevant local concepts and practices in formulating remedial actions. The Gogo, we have seen, viewed malaria as a normal fever associated with rains. Because of these conceptions about the cause of malaria, they rejected the chloroquine therapy. One would argue that the anti- malaria campaigns would have had a better impact had they put emphasis on environmental sanitation rather than on the quinine therapy.

Similarly, the Gogo had ideas on how diseases could spread from one person to another. They believed that diseases were transmitted from infected persons to healthier ones, directly or indirectly. They believed that marriage, and other ways of associating with victims could transmit disease. They also believed that touching or even stepping on infected things could transmit diseases. Colonial experts could have built on these conceptions when dealing with threats of infections, instead of unilaterally destroying homes and personal belongings, such as in the case of plague. This would have reduced misunderstandings and resistance on the part of the colonial subjects. Colonial experts often misconstrued what was happening in the local set up. For example, when they saw local people busy cleaning or digging latrines, they considered these as signs of local people's understanding of the health principles behind them. It is evident that this was sometimes not the case.

In the final analysis, it is clear that colonial public health interventions generally failed to provide sufficient and correct answers to health problems among the colonial subjects. The key factor behind this failure was the colonial experts' conservative and racist view of Africans. Having found no reason to build on Africans' accumulated wisdom and experiences, they formulated public health principles based only on the evolving western scientific knowledge. Although this knowledge was in itself useful, it could not work in the specific social and cultural contexts of Africa without consideration of the dynamics of local culture and consciousness.

Notes

[1] Maurice Cornforth, Dialectical Materialism: Theory of Knowledge ,Vol. III, (London: Lawrence and Wishart Ltd, 1963), 68

[2] Linda Nash, Inescapable Ecologies: A History of Environment, Disease ,and Knowledge (Berkeley, Los Angeles, London: University of California Press, 2006), p. 49.

[3] Doyal Lesley, The Political Economy of Health, (London: Pluto University Press 1981) Steven Feierman and J.M Janzen (eds.), The Social Basis of Health and Healing in Africa,(Berkely: University of California Press, 1992) Frederick Kaijage, "Disease and Social Exclusion: The African Crisis of Social Safety nets in the era of HIV and AIDS" in: Yusufu Lawi and Betram Mapunda (eds.), History of Disease and Healing in Africa (GeGGA-NUFU Publication Vol. 7 Dar-es-salaam, 200), 116.

[4] G.W.F. Hegel, Philosoph of History (Newyork: Dover Publications, 1956), 91-93

BIBLIOGRAPHY

A: Published Secondary Sources

Adiel, M (1998), *Affordability of Cost Sharing in Public Health Services A case study of Kilombero Valley,* M.A Dissertation, University of Dar es Salaam

Beck, A (1977), *Medicine and Society in Tanganyika 1890-1930, A Historical Inquiry,* Philadelphia, Philadelphia press

Byron, J (1994), *Medicine, Rationality and Experience in Anthropological Perspective,* Cambridge, Cambridge Press

Clyde, D (1962), *History of the Medical Services of Tanganyika,* Dar es Salaam, Dar es Salaam Government Press

David,S (1989), et al *The Control of Diseases in the Tropics,* London, HK Lewis and Co. Ltd.

Doyal, L (1981, *The Political Economy of Health,* London, Pluto University Press

Feierman S & Janzen J.M (eds), (1992), *The Social Basis of Health and Healing in Africa,* Berkley, C.A. University of California Press

Kjekshush, H, (1996), *Ecology and Economic Development in East African History: The Case of Tanganyika, 1850-1950.* Dar es Salaam, Mkuki Na Nyota

Koponen, J. (1995), *Development for Exploitation: German Colonial Policies in Mainland Tanzania: 1884-1914*, Helsinki, Finish Historical Society

Lawi, Y.Q. and Mapunda, B. (eds), (2004), *Healing History of Diseases and Healing in Africa,* GeGCA-NUFU Publications, University of Dar es Salaam Press

Lawi, Y.Q. (2000), "May the Spider web bind witches and wild Animals: Local knowledge and the Political Ecology of Natural Resource use in Iraquw Land" Ph.D Thesis, Boston University

Chapter of Books

Vansina, J (1995), "A Clash of Cultures: African Minds" in Curtin, P *African History from Earliest Times to Independence,* Singapore, Pearson Education Press, pp470-485

Mihanjo, E. (2004) "Colonial Policy on Sexually Transmitted Diseases and Other Infectious Diseases in Tanganyika, 1900-1960 in Lawi, Y.Q and Mapunda, B (eds), *History of Disease and Healing,* Dar es Salaam, Dar es Salaam University Press, pp 90-108

Packard, R (1992), "Industrialization, Rural Poverty and Tuberculosis in South Africa" in Fierman, S. *The Social Basis of Health and Healing in Africa,* Berkeley, University of California Press, pp 104-130

Rodney, W. (1980), "The Political Economy of Colonial Tanganyika" in Kaniki, M.H.Y., *Tanzania Under Colonial Rule,* Longman, Longman Press, pp. 128-163

Maddox, G (1996), "Environment and Population Growth in Ugogo" in Madox, G. *Custodians of the Land: Ecology and Culture in the History of Tanzania,* Dar es Salaam, Mkuki na Nyota, pp 43

Kaijage, F (2004), "Disease and Social Exclusion" in Lawi, Y.Q and Mapunda, B.B *History of Disease and Healing in Africa,* Dar es Salaam, Dar es Salaam University Press, pp 116-128

Waite, G (1994), "Public Health in Pre-colonial East-Central Africa" in Fierman, S. *The Social Basis of Health and Healing in Africa,* Berkeley, University of California Press, pp 212-233

Ranger, T.O (1994), "Godly Medicine: The Ambiguities of Medical Mission in South Eastern Tanzania 1900-1945" in Fierman, S. *The Social Basis of Health and Healing in Africa,* Berkeley, University of California Press,pp 255-284

Journals

Akerere, O. (1984), "Traditional Medicine Programme", *Tanzania Medical Journal Special Issues,* Arusha, Tanzania Medical Journal Press, Vol. 3, No. 2.

B: Archival Sources Consulted at Tanzania National Archive

ACC. 450. 106 Plague in central province, 1930-1940

ACC. 450. 925 Smallpox in central province, 1920-1950

Acc. 450. 4/1 First Draft Public Health Bill 1945

ACC. 450. 1/3 Lepers – Dodoma 1920-1930
ACC. 450. 120/5 HED Small pox in central province, 1940-1950

ACC. 450/ 208 Medical and Sanitation Complaints 1955/1958

ACC.450/ 968 Foot Wear for Africans Natives 1939

ACC.435/A2/ 38 Dodoma Region- Milk Supply

Tanganyika Territory, Provincial Commissioner's Reports, Central Province 1931-1933

Tanganyika Territory, Annual Report of Labour Department 1927

M1/3 – Medical reports, 1920-1930

M1/6 – Maternity Clinics Midwives and Babies Show 1939-53

Appendix 1: Key Informants Consulted during the Field Work in Mpwapwa District.

S/No.		Age	Village	Date	
1.	Adamu Kusupa	77	Hazina	17.1.2007	
2.	Bezaleli Madege	70	Igovu	8.1.2007	
3.	Charles Mamba	72	Hazina	17.1.2007	
4.	Edward Lwabe	38	Igovu	14.12.2006	30.12.2006
5.	Elikana Daniel Makasi	70	Ving'awe	14.12.2006 21.12.2006 12.1.2007	30.12.2006 8.1.2007
6.	Esau Meshack	28	Chamunye	13.12.2006	16.12.2006
7.	Gilbert Madole	60	Mwana Kianga	13.12.2006	16.12.2006
8.	John Musumuki	55	Mpwapwa Hospital	16.1.2007	
9.	Kezia Mwaka	63	Igovu	3.1.2006	30.12.2006
10.	Maiko Ismail Mapuga	67	Igovu	3.1.2006,	30.12.2006
11.	Mdala Malogi		Unknown	30.12.2006	18.1.2007
12.	Monica Maganza	72	Ving'awe	14.12.2006 30.12.2006	8.1.2006 31.12.2007 15.1.2007
13.	Musa Msokola	59	Igovu	4.1.2006	
14.	Nyendo Masumbuko	101	Kisokwe	9.1.2006	
15.	Pakshadi Rashinde	73	Idilo	9.1.2006	
16.	Penina Lwabe	34	Igovu	14.12.2006	30,12.2007
17.	Rubern Sabugo	98	Igovu	15.12.2006	15.1.2007
18.	Samsoni Chiuyo	84	Ving'awe	17.1.2007	
19.	Steven Njamasi	74	Igovu	13.12.2006 30.12.2006 14.12.2006	11.12.2006 31.12.2006
20.	Tito Chamwihala,	65	Ving'awe	17.1.2007	
21.	Titus Mshana	60	Mazae	9.1.2006	