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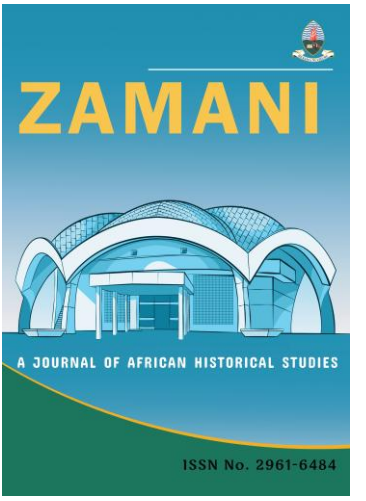

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Research Article: Nurturing Traditional Midwifery and Medicine: The Entangled Path of Health Integration in Post-Independence Kilombero, Tanzania.

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Nurturing Traditional Midwifery and Medicine: The Entangled Path of Health Integration in Post-Independence Kilombero, Tanzania.

VERONICA KIMANI

Abstract

This paper focuses on the Tanzanian government's ambitious endeavour to enhance health, particularly midwifery services following independence. The initial strategy by the government involved promoting Western medicine by establishing healthcare facilities and training medical personnel. However, the strain of a burgeoning population and limited resources soon became evident, prompting the government to recognise the need for the incorporation of traditional medicine, previously overlooked. This integration posed its own set of obstacles, as the focus on herbal remedies overshadowed crucial aspects of conventional midwifery, such as rituals. While research has shown the resolve of the government towards medical integration between different players, this paper shows that incorporating other actors such as voluntary agencies and traditional health workers proved a formidable task for the post-independent government. Using examples from Kilombero District, this paper examines the complexities and setbacks of government planning in this context, highlighting how the intended path to improvement took unexpected turns, failures, and detours, leading to a re-evaluation of strategies and priorities on the part of the government, while the people embraced a hybrid of medical therapies.

Keywords: Midwifery, maternal health, traditional medicine, biomedicine, health hybridity, health futures, Tanzania.

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Introduction

The healthcare landscape in Africa is entrenched in formidable challenges. Maternal and child health (MCH) provides a good example, as evidenced by

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persistently high maternal and infant mortality rates in many African countries. This enduring struggle highlights the ongoing difficulties confronting healthcare systems in the region, reflecting a historical pattern of arduous endeavours to address these issues. Despite concerted efforts by governments in Africa to enhance MCH, the process of improvement has proven to be immensely challenging, with many of the established goals remaining unattained. Efforts enshrined in the Safe Motherhood Initiative (SMI), launched in 1987, Millennium Development Goals (MDGs) from 2000-2015, and Sustainable Development Goals (SDGs) from 2015-2030, underscore a prioritization and will towards the transformation of overall health and maternal well-being, but the stark reality of conditions in Africa remains dire.[1]

Transforming medicine, midwifery and MCH in Africa is not a new endeavour. Every African society has its unique and culturally accepted principles concerning medicine and midwifery, which are ancient and multifaceted, spanning human history. These ideas concerning medicine were constantly transformed through interactions such as trade, intermarriages, and raids. Thus, the African concept of medicine was dynamic and evolving. The colonial powers and missionaries, however, were committed to introducing 'better' health systems in Africa. Western civilisation was often regarded as supreme to the others, and therefore, African medicine was treated as inferior to Western medicine. As a result, the process of transforming medicine intensified after the inception of colonialism. Medicine was used as tool of advancing the influence of the empire.[2] Midwifery was especially significant because women served as a gateway to the family, offering a more accessible route to achieving the desired change. Across Africa, from the German, French and British colonies, interest in having control over midwifery and child health has

[1] Chibuike O. Chigbu, "Maternal Mortality and Near Miss Events: The African Perspective," in *Maternal Child Health: Interdisciplinary Aspects Within the Perspective of Global Health*, edited by Uwe Groß and Kerstin Wydra (Göttingen: Universitätsverlag Göttingen, 2013), 3; The United Nations, UN Documentation: Development, https://research.un.org/en/docs/dev/2000-2015 accessed August 20, 2022.

[2] Helen Tilley, *Africa as a Living Laboratory: Empire, Development, and the Problem of Scientific Knowledge, 1870-1950* (Chicago: University of Chicago Press, 2011).

been documented.[3] Between 1921 and 1928, for instance, the British colonial government gave money towards the transformation of midwifery practices in East Africa.[4] The missionaries alike preached against traditional practices such as rituals and the use of amulets on pregnant mothers and children.[5]

After independence, many African governments embarked on improving the health sector. The same colonial attitude towards medicine recurred under the postcolonial governments, the attitude that underscored the hegemony of Western medicine. In Tanzania, the post-colonial government advocated for the use and embrace of Western medicine despite the slow development of health facilities and the lack of qualified medical personnel.[6] This was in line with the modernisation

[3] Walter Bruchhausen, "'Practising Hygiene and Fighting the Natives' Diseases': Public and Child Health in German East Africa and Tanganyika Territory, 1900-1960," *DYNAMIS* 23 (2003): 85-113; Nancy Rose Hunt, "'Le Bebe en Brousse': European Women, African Birth Spacing and Colonial Intervention in Breast Feeding in the Belgian Congo," *The International Journal of African Historical Studies* 21, no. 3 (1988): 401-432; Ann Beck, *A History of the British Medical Administration of East Africa, 1900-1950* (Massachusetts: Harvard University Press, 1970); Anna Davin, "Imperialism and Motherhood," *History Workshop* 5 (1978): 9–65; Tabitha Kanogo, "The Medicalization of Maternity in Colonial Kenya," in *African Historians and African Voices: Essays Presented to Professor Bethwell Allan Ogot on His Seventieth Birthday*, ed. Elisha Stephen Atieno Odhiambo (Basel: Schlettwein, 2001); Ulrike Lindner, "The Transfer of European Social Policy Concepts to Tropical Africa, 1900-50: The Example of Maternal and Child Welfare," *Journal of Global History* 9, no. 2 (2014): 208–231.

[4] In the parliamentary proceedings of December 12, 1929, the Duchess of Atholl wanted to find out from the Undersecretary of State the amount of money that had been used to train East African women as midwives from 1921 to 1928. See United Kingdom, Hansard, December 12, 1929 in https://Hansard.Parliament.Uk/Commons/1929-12-12/Debates/Aad51566-Eee2-40e6-976a-9e2ff2dfdab2/EastAfrica Accessed September 23, 2024); Letter from C. Davies to Dr Cecily Williams on Village Midwives, February 27, 1956 in WHO Archives, Geneva, 'Health H/8/6 PP/CDW/E.2/4.

[5] Debby Gaitskell, "'Getting Close to the Hearts of Mothers': Medical Missionaries among African Women and Children in Johannesburg between the Wars," in *Women and Children First: International Maternity and Infant Welfare 1870-1945*, eds. Valerie Fildes, Lara Marks, and Hilary Marland (London: Routledge, 1992), 178-202; Marcel Dreier, "Health, Welfare and Development in Rural Africa: Catholic Medical Mission and Configuration of Development in Ulanga, Tanzania, 1920-1970" (PhD diss., University of Basel, 2015).

[6] Richard M. Titmuss et al., The Health Services of Tanganyika: A Report to the Government (London: Pitman Medical Publishing, 1964); Gerardus Maria van Etten, *Rural Health Development in Tanzania* (Assen: Van Gorcum & Comp. B.V., 1976); John Illife, *East African Doctors: A History of the Modern Profession* (Cambridge: Cambridge University Press, 1998); Margunn M. Bech et al., "Changing Policies and Their Influence on Government Health Workers in Tanzania, 1967-2009: Perspectives from Rural Mbulu District," *The International Journal of African Historical Studies*, 46, no. 1 (2013): 61–103.

strategy which was interpreted to mean that development in Africa should mirror development in the Western industrialised nations. Any other form of medicine was seen as subordinate to Western medicine.

Midwifery was identified as one of the key areas that most post-colonial governments had to improve. It was imagined that to improve the health of the people, concerns about one's health had to start from before birth. MCH had been a key concern to the colonial government and missionaries, and because post-colonial policies largely followed colonial patterns, maternity became a key consideration in the post-independent era.[7] Blinded by the urgent need to catch up with the industrialised world, most post-colonial governments overlooked the reality at the time. Thus, in most cases, many African government policies were not aligned with the culture and expectations of the people, where, despite a record of increased demand for Western medicine, the majority largely relied on conventional therapies.

Evidence points to a hybrid or transculturation of medical solutions even in the pre-colonial era. In midwifery, for instance, the majority of African women in Tanzania and the Kenyan coast continued to consult the services of traditional midwives, and religious bodies in addition to the services they received in medical facilities.[8] The concept of hybridity in medical studies is not only complex but highly contested as it highlights a set of polarities of, and within, biomedicine and traditional medicine, both in terms of practice and terminology.[9] This portrays an 'in-between space' that shows continuity with the past and an engagement with another idea as described by Homi Bhabha.[10] The differences between biomedicine and traditional medicine encompass different issues ranging from methodological, epistemological, ethical, and cultural. This challenges the notion of any type of medicine as a single unit or a rigid, uniform, and

[7] Veronica Kimani, "Maternal Healthcare and Health Policy Planning in Tanzania, 1961–1970s," *Africa Development* 49, no. 2 (2024): 89–118.

[8] Maureen Malowany, "Medical Pluralism: Disease, Health and Healing on the Coast of Kenya, 1840-1940" (PhD diss., McGill University, 1997); interview with Hassan Zuhura, September 21, 2023, Lipangalala.

[9] Rebecca Marsland, "The Modern Traditional Healer: Locating 'Hybridity' in Modern Traditional Medicine, Southern Tanzania," *Journal of Southern African Studies* 33, no. 4 (2007): 751–765.

[10] Homi Bhabha, *The Location of Culture* (London: Routledge, 1994), 1.

unchanging category. Even what was commonly referred to as 'Western medicine' was not uniform, as the nature, structure, and organisation were largely determined by its country of origin.[11] Similarly, African traditional medicine is not a single, rigid concept as it is often portrayed.[12] Balogun supports the fact that medicine described as 'traditional' does not have to be African, and 'scientific' does not necessarily mean that it originates from the West.[13] Therefore, in this paper, I employ the terms *biomedicine* and traditional medicine, recognizing their status as contentious terms and practices.[14] Nonetheless, in every society, change is natural, and ideas are often borrowed, exchanged, resisted, and adapted, potentially leading to the emergence of a hybrid status.

The notion of hybrid societies comes out clearly in post-colonial studies. The new nations emerging from colonialism could not go back to pre-colonial life, and were not purely Westernised leading to hybridity in the health systems and practices. Tanzania, akin to numerous other (post)colonies, encountered this circumstance upon gaining independence. It was then paramount that the ex-colony located its space.[15] Locating one's space meant navigating beyond political independence to encompass other types of freedoms and dealing with the new norm that brought forth numerous dilemmas. It is in this space that I try to locate healthcare and health policy planning.

Using the concept of hybridity, I argue that health in general, and maternal health in particular, could not be solely conceived in biomedicine which the independent government of Tanzania advocated for as early as 1961. Thus, contrary to the discourse that capitalised on the use and

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[11] Anna Crozier, *Practising Colonial Medicine: The Colonial Medical Service in British East Africa* (London: Bloomsbury Publishing, 2007).

[12] Samuel Adu Gyamfi and Eugenia Anderson, "Indigenous Medicine and Traditional Healing in Africa: A Synthesis of the Literature," *Philosophy, Social and Human Disciplines*, no. 1 (2019): 69–100.

[13] Balogun Oladele Abiodun, "Medicinal Practice in Western Science and African Traditional Thought: A Comparative Analysis," *African Identities* 3, no. 2 (2005): 213.

[14] Marsland, "Modern Traditional Healer"; Walter Bruchhausen, "Medicalized Healing in East Africa: The Separation of Medicine and Religion by Politics and Science," in *Medicine - Religion - Spirituality: Global Perspectives on Traditional, Complementary, and Alternative Healing*, edited by Dorothea Lüddeckens and Monika Schrimpf (Bielefeld: transcript Verlag, 2018), 23–56.

[15] Bhabha, *Location of Culture*.

hegemony of biomedicine, the concept of hybridity delineates how different therapies in health, namely biomedicine and traditional medicine, interacted in one space. This interaction led not to a kind of assimilation or resistance but an entanglement.[16] Thus, the notion of hybridity, was how the subaltern could speak not by "locating her separateness from dominant culture but by highlighting the extent to which she moulded even those processes and cultures that subjugated her."[17] This is what Mary Louise Pratt describes as "contact zones" or "transculturation" to mean the interplay between the periphery and metropole.[18]

However, I leverage on the cultural adaptation and negotiation in the medical space fully cognisant of the challenges of this framework. Critiques have been directed towards hybridity for disregarding the hierarchical nature between the dominant and the inferior culture, as well as minimising opposition and overlooking local variations.[19] Nevertheless, in this paper, I argue that it is the government and not the people that propagated the colonial idea of a hegemonic biomedicine. The people, especially those in rural areas, viewed medical care as a means of finding help when they were sick and not as a political entity. The people did not concern themselves with which system was superior, as long as it provided a solution for their ailment or disease. This led to the concept of medical pluralism as shown by Monica Malowany.[20]

In the context of health and disease control, the interaction between indigenous knowledge and Western medicine in many African societies was inevitable. Governments, both colonial and post-colonial struggled to provide sufficient services to warrant the eradication of the popular but 'inferior' medicine. However, they failed to understand the many reasons why people sought medicine in the first place. Steven Feierman introduces his chapter on "Patterns of Control" by noting that:

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[16] Achille Mbembe, *On the Postcolony* (London: University of California Press, 2001), 14.

[17] Ania Loomba, *Colonialism/Postcolonialism* (London: Routledge, 2005), 231.

[18] Mary Louise Pratt, *Imperial Eyes: Travel Writing and Transculturation* (Routledge, 2008), 7.

[19] Bill Ashcroft, Gareth Griffiths, and Helen Tiffin, *Post-Colonial Studies: The Key Concepts* (London: Routledge, 2000), 118.

[20] Malowany, "Medical Pluralism."

> No colonial power and no independent African state has ever intervened decisively to destroy popular healing. Governments have been either unable or unwilling to provide biomedical care to their entire populations, and have therefore been forced to tolerate the survival of African healing. This fortunate outcome is also a consequence of the determination and cunning exercised by popular healers over generations. Healers have long cultivated secretiveness as a survival strategy.[21]

The survival of traditional medicine shows that the initial insistence on biomedicine in Tanzania led to failure in reaching the set health goals and plans after independence. As Ulrike Lindner has noted in the introduction of this issue, the concept of failure, as conceptualised by Detlef Müller-Mahn, Kennedy Mkutu, and Eric Kioko, "must be understood not in absolute terms, as a total collapse, but rather as a relative category in which achievements are compared to the originally declared goals."[22] The notion of failure in this paper is examined from the perspective of government planning. It highlights the fact that some policies never materialised, others experienced delays, and others were adopted but were not part of the initial plan. These detours are well captured in the interplay between the government's stance on health provision through biomedicine, voluntary agencies, and traditional health practitioners.

The initial challenge of the post-independent Tanzanian government was the failure to follow a workable plan despite the many development plans and reports that were drafted. In addition, this challenge may have been exacerbated by the fact that government plans did not involve the people in the planning process. Following the agenda of the colonial government, the initial response of the government after independence was to expand biomedicine through the building of health facilities and training of medical staff.[23] The political will was to dominate the health sector as a

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[21] Steven Feierman, "Struggles for Control: The Social Roots of Health and Healing in Modern Africa," *African Studies Review* 28, no. 2/3 (1985): 74.

[22] Detlef Müller-Mahn, Kennedy Mkutu, and Eric Kioko, "Megaprojects – Mega Failures? The Politics of Aspiration and the Transformation of Rural Kenya," *The European Journal of Development Research* 33 (2021): 1086.

[23]Edward, Frank and Ulrike Lindner. "Health Infrastructure Planning in Tanzania, 1961-1980s: The Problems of Future-making." *Zamani* 1, no. 2 (2024): 84-114; MJ Bhatt, National Health Planning in Tanzania: Report on a Mission (Geneva, World Health Organization, 1973); van Etten, *Rural Health Development*.

way towards getting legitimacy from the people. There was an attempt by the government to dominate facilities run by voluntary agencies and prohibit the use of traditional medicine as shown below. The government of Tanzania soon realised the need for cooperation and integration of different service providers in the health sector. However, the concept of biomedicine as hegemonic never waned off.

This paper, therefore, analyses the twists and turns of the government's efforts in the provision of health, particularly MCH, using the Kilombero District as an example. Kilombero District stands out as a unique case study due to its history shaped by various medical and non-medical actors, including pre-colonial Indian agricultural activities, colonial government, missionaries, and post-independence voluntary agencies.[24] These influences significantly impacted the region's medical landscape. Methodologically, the paper uses oral sources from interviews conducted in Kilombero. The interviewees included retired medical health workers, traditional health practitioners, and other categories of people who were identified as knowledgeable on the subject matter through the snowballing sampling technique. Additionally, archival data sourced from various archives in Switzerland, Tanzania, and Norway, as well as secondary sources were used. Through corroborating these sources, the paper echoes Feierman's perspective which underscores the necessity of integrating social and cultural factors into medical interventions.[25] It shows that the efforts of the government of Tanzania to recognise traditional medicine through the concept of self-reliance realised transformative change not only in the health sector, but also in the country's overall economic growth. However, within this aspiration, the disparity between intended, missed, and implemented plans becomes apparent from a historical standpoint.

A Brief Medical History of Kilombero District

Since the era of German colonial rule, the Kilombero region has been regarded as a promising area for agricultural production. Colonial surveys and feasibility studies identified Kilombero as a key site for development

[24] Jamie Monson, "Agricultural Transformation in the Inner Kilombero Valley of Tanzania 1840-1940" (PhD diss., University of California, 1991), 19.

[25] Feierman, "Struggles for Control."

projects, establishing its reputation as an important region for Tanzania's future development.[26] Regardless of whether the perceived richness of the region was real or exaggerated, Kilombero consistently attracted an influx of people. Originally home to the Ndamba, Mbunga, Ngindo, Pogoro, Hehe, and Bena peoples, Kilombero subsequently attracted settlers from across Tanzania and beyond, drawn by its diverse landscape that supported a range of economic activities, including farming, fishing, wood harvesting, trade, hunting, and employment opportunities.[27] It is also noteworthy that the administrative history of Kilombero has spanned different jurisdictions, including Mahenge and Ulanga Districts before it was established as a district in its own right.[28] The population growth in Kilombero, in turn, generated a demand for healthcare services, reflecting a long-standing recognition of the link between health, population, and productivity that dates back to colonial times, when the argument that a healthy individual was also a capable and productive worker was popularized.[29]

The provision of health services was not easy. Biomedicine, which was advocated for by the colonial government, required a complex infrastructure, namely health facilities, equipment, and personnel. Setting up these infrastructures was problematic because any colonial venture was an investment that was often interpreted in profit-accrued terms.[30] It was then obvious that the setting up of health facilities was restricted to places that were deemed economically productive. These were health centres and dispensaries that were built to offer basic services in the colonial centres.

[26] Alexander M Telford, *Report on the Development of the Rufiji and the Kilombero Valleys* (London: Crown Agents for the Colonies, 1929); Food and Agricultural Organization. The Rufiji Basin Tanganyika: Report to the Government on the Preliminary Reconnaissance Survey of the Rufiji Basin 1955-1960 Sec 2, Paper 6: Land Tenure, Population, Education and Communication. Rome: Food and Agricultural Organization, 1960; Jonathan M. Jackson, "Past Futures: Histories of Development in the Kilombero Valley, Tanzania" (PhD diss., University of Cologne, 2021).

[27] Luoneko Kaduma, "Rural to Rural Migration and Local Economies: A Case Study of Kilombero District, Tanzania, 1960–2000" (master's thesis, University of Dar es Salaam, 2019).

[28] Kilombero District Council, *Prime Minister's Office Regional Administration and Local Government Authorities. Kilombero District Council Strategic Plan, 2013/2014 to 2017/2018* (Kilombero: Kilombero District Council, 2019).

[29] Hunt, "'Le Bebe en Brousse.'"

[30] Paul Tiyambe Zeleza, *Manufacturing African Studies and Crises* (Dakar: CODESRIA, 1997), 218.

As a result, the colonial government could not fully provide health services to the people, and in the rural areas especially, health needs were provided for to some extent by the different Protestant and Catholic missions active in German East Africa.[31]

Missionaries were very active in the Kilombero region. The German Benedictine missionaries from St. Ottilien introduced medical works to Kilombero and the larger Mahenge region as early as 1888.[32] Beyond Dar es Salaam, the Benedictines established mission stations at Kwiro and Mbingu in Mahenge. In these centres, the activities of the colonial government and missionaries included the provision of medical care. The traces of German activities and infrastructure in Kwiro, Mahenge, and other regions are still visible today (see Figure 1). After the defeat of Germany in World War I, the German colonial officers and the missionaries left Tanganyika. The Catholic Church Office for Missions in Rome replaced the German Catholic missionaries with the Swiss Franciscans (Capuchins and the Baldegg Sisters). In the geopolitics of the time, missionaries from Switzerland were regarded as neutral. When the Capuchin Brothers heeded the request to take up Tanganyika, they realised the need to have sisters to accomplish their work in Tanzania. As a result, they requested the Baldegg Sisters to accompany them in their missionary work in the then Tanganyika.[33]

The first group of the Franciscans arrived in Tanganyika in 1921.[34] They later moved to different places including Mahenge. Their most notable work was medical provision and for the sisters, midwifery topped their list. The elderly women in Kilombero, fondly remember some of the Swiss nurses such as Sr. Anorlda Kury who was mentioned as the founder of medical works in Ifakara, Kilombero which culminated with the

[31] Gaitskell, "'Getting Close to the Hearts of Mothers.'" Dreier, "Health, Welfare and Development"; Michael Jennings, "Cooperation and Competition: Missions, the Colonial State and Constructing a Healthy System in Colonial Tanganyika," in *Beyond the State: The Colonial Medical Service in British Africa* ed. Anna Greenwood (Manchester: Manchester University Press, 2016), 206.

[32] Marita Haller-Dirr, "History in the Making," in *75 Years Baldegg Sisters, Capuchin Brothers in Tanzania*, edited by Marita Haller-Dirr (Lucerne: Stans, 1997), 34–61.

[33] Haller-Dirr, "History in the Making," 37.

[34] Ibid., 57.

construction of the St. Francis Hospital Ifakara.[35] The earliest structure in which Sr. Arnolda operated as a clinic, although dilapidated and abandoned, still stands and holds a wealth of memories for the people of Ifakara (see Figure 2). Sr. Arnolda is fondly remembered by the women of Ifakara as Mama Noda.[36] Markus Frei notes that she was also fondly called 'mother of Ifakara (mama wa Ifakara)'.[37] The work that was started by these missionaries continued relentlessly, even after independence. The work of Sr. Prudencia (nicknamed Kasumuni by the locals) in the pharmacy at St. Francis Hospital in Ifakara, two decades after independence, was remembered by the women of Ifakara.[38]

Figure 1: The German Footprint in MCH, Kwiro Parish in Mahenge
Source: Author, September 23, 2023.

[35] Interview with Christina Isakwisa, September 20, 2023, Uwanja Sitini; Markus Frei, "St Francis Hospital, Ifakara," in *75 Years Baldegg Sisters, Capuchin Brothers in Tanzania* ed. Marita Haller-Dirr (Lucerne: Stans, 1997), 142-144.

[36] Focus group discussion (hereafter FGD) with women, September 21, 2023, Ifakara, Lipangalala.

[37] Frei, "St Francis Hospital," 144.

[38] FGD with women, September 21, 2023, Ifakara, Lipangalala.

Figure 2: Remains of Sr Arnolda's First Clinic at Ifakara.
Source: Author, September 22, 2023.

The Baldegg Sisters ensured that the Kilombero women had access to medical maternity, including immunisation, and also gave out baby clothes.[39] They also provided food supplements, such as cooking oil and powdered milk, which were very instrumental to the nutritional needs of babies. Therefore, Kilombero had access to biomedical facilities long before government medical facilities were built. The medical work of the Franciscans in Kilombero was crowned by the opening of the St. Francis Hospital, Ifakara in 1960.[40] The research on tropical diseases in the region

[39] Interview with Christina Isakwisa, a retired nurse, at Uwanja Sitini, September 20, 2023.

[40] Rudolf Geigy, ED-REG 1 (2) 190-2-8 Rural Medical Training at Ifakara: Swiss Help to Tanzania (June 26, 1965) in Staatsarchiv Basel-Stadt, Switzerland; Klaus E. Gyr, PA 940d F2 (1) Ifakara Reiseberichte, Jahresberichte, Kursunterlagen 1960-1977 in Staatsarchiv Basel-Stadt, Switzerland; Swiss Joint Evaluation of Swiss Cooperation to Tanzania Health Projects (1977).

was further boosted by the works of Professor Geigy and his team when he started the Rural Aid Centre, Ifakara in 1960.[41]

Apart from the hospital services by the Baldegg Sisters, traditional midwifery was popular in Kilombero. According to the inhabitants of Ifakara, the services in hospitals were not holistic.[42] These women added that the Western medical practices offered at the clinic did not correspond to the reality of an African birthing process at the time. Birthing was a social affair. Women traditionally delivered in the presence of their close female relatives. The majority of traditional midwives could attend to their clients in the comfort of their homes where it was believed to take care of their anxieties in a familiar environment. Traditional midwives were also preferred because they extended the services before and after delivery, a 'luxury' that clinical medicine could not provide.[43] In addition, women chose to be attended by a traditional midwife because they were cheap, readily available, easy to access, and their services were embedded in the cultural belief system.

The usage of herbs to treat barrenness without surgery as compared to biomedicine, for instance, was a preferred non-invasive procedure by many.[44] It was seen as a more tolerable method as opposed to surgical procedures propagated by biomedicine. Moreover, the poor services, such as lack of equipment, and mistreatment by health workers that were recorded in some health facilities were reasons why some African women preferred traditional midwives.[45] Such situations were observed in other parts of the Global South, where the flexibility of the traditional midwives was noted. In Indonesia and Pakistan, for instance, the fact that the midwives could be paid in kind and instalments was a strong reason for seeking their services.[46] The same applied to Tanzania, where midwives

[41] Geigy, ED-REG 1 (2) 190-2-8 Rural Medical Training at Ifakara: Swiss Help to Tanzania in Staatsarchiv Basel-Stadt, Switzerland.

[42] FGD with women, September 21, 2023, Ifakara, Lipangalala.

[43] Interview with Zuhura Hamisi, September 21, 2023, Lipangalala.

[44] "Serikali Inakubali Waganga Wa Kienyenji Waendelee," *Uhuru*, February 17, 1962.

[45] "Huruma Kwa Waja Wazito," *Ngurumo* , June 8, 1964; "Hospitali Ya Moro Imezidisha Matusi," *Uhuru*, March, 27, 1979.

[46] Indrayani Indrayani and Romaulina Sipayung, "Who Are Midwives and Traditional Birth Attendants According to Users in the Rural Areas," *Jurnal Bina Cendikia Kebidanan* 2, no. 1 (2016): 171-179.

could be paid in kind, and within one's reach, without the pressure of having to look for money or sell property to afford the fees.[47] Secondly, the administration of traditional rituals called *kilala* as a birth ritual was perhaps the most important reason that led the majority of women in Kilombero to traditional midwives. *Kilala* was medicine for a dreaded infirmity that attacked infants immediately after birth, if proper precautions were not taken.[48] The traditional midwife administered *kilala* immediately after birth. If this was not done, it was believed that the infant would be attacked by convulsions (*degedege*).[49]

The preparation of family planning methods accorded the traditional midwives' full control and access to womanhood, childbirth, and societal values. These methods were largely supported by some men/husbands because they were not as 'dangerous' as the 'chemicals' in modern medicine which were believed to be hazardous. They were also partly in line with the African culture, and the Catholic Church. As per the culture, the majority of women did not have full personal control of their bodies, but husbands, elderly womenfolk mothers, mothers-in-law, aunts and grandmothers played a part.[50] Therefore, the traditional midwife was an important part of the MCH which the government of Tanzania failed to recognise in the early days of independence, until later, as shown below. The dominance of the Catholic Church in the Kilombero region was a result of the Swiss missionaries' influence, who were in support of the use of natural remedies and barred women from using artificial family planning methods.[51] However, what the church interpreted as natural, mainly abstinence during the woman's fertile period, was not universally accepted. There were other methods, such as those practised by traditional midwives, to address family planning issues. These methods included sealing the menstrual blood using

[47] FGD with women, September 21, 2023, Ifakara, Lipangalala.
[48] Ibid.; interview with Amina Omari, at Mang'ula B, September 30, 2023.
[49] FGD with women, September 21, 2023, Ifakara, Lipangalala; also see Veronica Kimani and Ulrike Lindner, "Change and Continuity in Midwifery," *Nordic Journal of African Studies* (*forthcoming*)
[50] FGD with women, September 25, 2023, Uwanja wa Ndege, Ifakara.
[51] Ibid.

a *kanga*[52] or in a snail shell. The act of sealing was believed to literally 'close' (*kufunga*) the womb until the same shell or *kanga* was unsealed or untied.[53]

In conclusion, this section argues that colonial, missionary, and African cultural influences shaped the construction of Kilombero's medical landscape. These influences formed the foundation upon which health activities, plans, and policies in Kilombero were aligned with broader government strategies. However, the government's health policies were predominantly oriented toward biomedicine. The subsequent attempt to incorporate traditional medicine, as discussed in the next section, reflects a shift towards a more inclusive approach, or, so it was imagined.

Postcolonial Medical Integration Initiatives in Tanzania

From 1961, the Tanzanian annual reports for the medical department showed that the numbers seeking medical attention in health facilities, particularly in MCH, were rapidly increasing.[54] The often-quoted challenge, however, was that few medical personnel and facilities, and a poor transport system, were obstacles to reaching a wider range of the population with these services. This was interpreted to mean that there was a need for increased access to health facilities and personnel The government also welcomed help from other international agencies. Organisations such as UNICEF offered cooking oil, cod liver oil, and dried skimmed milk, which were distributed to women during their scheduled visits to the clinics. They also provided Land Rovers for transportation to access the interior places of the country.[55]

The independent government of Tanzania aimed to ensure that all pregnant women were delivered in healthcare facilities.[56] This objective had two key motivations: it maintained continuity with colonial medical planning and aligned with the broader transformative agenda that pushed African governments toward modernization as a means of catching up with the developed Global North. However, numerous challenges, as previously

[52] *Kanga* is Swahili for a piece of printed fabric that is mostly worn by women.

[53] FGD with women, September 25, 2023, Uwanja wa Ndege, Ifakara.

[54] Tanganyika, *Annual Report of the Health Division 1961*, Vol. I (Dar es Salaam: Government Printer, 1961).

[55] Tanganyika, *Annual Report of the Health Division 1961*; FGD with women, September 25, 2023, Uwanja wa Ndege, Ifakara.

[56] Ibid

discussed, prevented the government from formally adopting a policy mandating facility-based childbirth, prompting a shift in strategy. This necessitated a new plan which prioritized constructing healthcare facilities to address not only midwifery needs but also broader medical sector challenges. The focus was on establishing general service health centres and dispensaries, particularly in rural areas, in line with the policy of rural healthcare prioritization. At the same time, significant hospitals continued to be built in urban centres. Additionally, the government undertook extensive training of lower-cadre medical workers, who were considered more cost-effective to train and viewed as a solution to improving rural healthcare access.[57]

Apart from medical facilities, the government, as early as 1962, embarked on increasing the number of medical workers in the maternity sector. There was a continuation of the training of village midwives, just as in the colonial period.[58] The village midwife was to assist in delivery by applying biomedical skills learnt in a six-month-long training at the nearby district hospitals.[59] After training the village midwife was to work closely to the nearby dispensary. The goal was to offer domiciliary services in the hope that people would adopt these services and not the services of the traditional midwives, who were considered 'dirty and dangerous', and in the end, reduce maternal and infant mortality.[60] However, the same predicament of who to train, young girls vs. older women, that the missionaries and the colonial government had battled during the colonial period, was recorded in the 1961 Annual Report of the Health Division.[61] The government's plan was to train young girls from school, but the problem was that the girls did not have a moral standing in the society to conduct midwifery duties.[62] The solution was to train older women, who would be acceptable to society. Challenges emerged as early as 1962, as in

[57] Van Etten, *Rural Health Development*.
[58] Tanganyika, *Annual Report of the Health Division 1962*, Vol. I (Dar es Salaam: Government Printer, 1962).
[59] Bhatt, National Health Planning in Tanzania.
[60] Ibid
[61] Letter from C. Davies to Dr Cecily Williams in WHO Archives, Geneva, 'Health H/8/6 PP/CDW/E.2/4; Tanganyika, *Annual Report of the Health Division 1961*.
[62] The concept of age was key in the practice of midwifery

some areas, such women were not available to train. Where they were trained, they were too few to actualize the government plan, which was to help carry out domiciliary services. The number was not even enough to satisfy the needs of the local dispensary and Rural Health Centres.

The government thought that the unavailability of health facilities and shortage of staff were the reason why people still consulted traditional healers. Therefore, after independence, the government called for a speedy expansion of health facilities. In 1967, the Arusha Declaration maintained the call for expansion of health facilities, this time, through the concerted efforts of the government, voluntary agencies, communities and villages.[63] While there was an increase in medical facilities, surprisingly, many women residing near St. Francis Hospital, Ifakara, opted to consult traditional midwives, despite the proximity to the facility.[64] Others, opted for a combination of traditional and hospital services, depending on which best suited their needs at the time. By 1980, it was argued that, in Tanzania, two-thirds of individuals over thirty years old were delivered with the assistance of a traditional midwife.[65] Despite the sustained efforts during both the colonial and post-colonial era to promote biomedicine, traditional midwifery practices persisted. In Kilombero, traditional medicine, specifically midwifery, persisted robustly into the post-independent era, prompting the Tanganyika African National Union (TANU) government to advocate for its integration into the biomedical arena.

Despite the huge numbers that consulted traditional midwives and healers, the government continued to expand biomedical services. In 1973, the position of the village midwife was replaced by the Maternal and Child Health Aide (MCHA). A MCHA was required to have grade seven certification and to undertake an 18-month-long training.[66] This cadre was to work together with the other medical officers, particularly the nutritionist with whom they were to educate women on what to eat during pregnancy and how to feed their children. Nutrition aides popularly known as *Bi. Afya* (Female Health Officer) *or Bwana Afya* (Male Health Officer),

[63] Julius Nyerere, *Socialism and Rural Development* (Dar es Salaam: Government Printer, 1967).

[64] FGD with women, September 21, 2023, Ifakara, Lipangalala.

[65] "Wakunga Wa Jadi Ni Muhimu." *Mzalendo*, November 15, 1981.

[66] Bhatt, National Health Planning in Tanzania, 16.

together with the MCHA, trained women on the importance of a balanced diet, especially during pregnancy. Furthermore, the government advanced the campaign for improved nutrition by condemning traditional cultures, especially those that imposed food restrictions on women.[67] While these efforts were good, they often fell short of bridging the knowledge gap. The government would hurriedly carry out health campaigns and expected a total transformation within a short period.[68] This was not enough to change the cultural orientation of people and beliefs concerning food, pregnancy, delivery, and parenting.

Later, these nutrition teachings were taken up by TANU leaders. Seminars were organised by TANU women, where demonstrations on various types of foods were given.[69] These teachings were extended to men, after the realisation that some of the food deficiencies were not caused by the lack of food, but by traditional beliefs and taboos. In some communities in Kilombero, a protein-rich diet was mainly consumed by men. The government tried to bridge the gendered gap through health education. However, challenges were inevitable. In one instance, when a nutrition topic was being taught, the women who gathered to listen were irate when an MCHA said an egg could solve the problem of an emaciated child. An old woman in the gathering said, "mw*ambieni huyo mtoto aende…tunajua shida na yai haliwezi tatua"*[70] (tell that child (the MCHA, VK) to leave, we know the problem and it can't be solved by an egg). Referring to the MCHA as a "child" portrayed the attitude they had that she was inexperienced, and the fact that motherhood was still guarded by the African gerontocratic system. Thus, for transformative dietary behaviour, men had to be included in the teachings on the topic of nutrition, especially on the question of beliefs on food.[71]

[67] "Kuleni Chakula Kizuri," *Ngurumo*, January 17, 1970; "Wagonjwa Wa Wajazito Wapewe Vyakula Maluum," *Uhuru*, November 8, 1979.

[68] See Hall Budd, *Mtu Ni Afya ('Man Is Health'): Tanzania's Health Campaign* (Washington: International Council for Adult Education, 1978).

[69]Ron Israel and Joanne Nestor eds., *Maternal and Infant Nutrition Reviews: Tanzania A Guide to Literature* (Newton, MA: Educational Development Center, Inc., 1982), 50.

[70] SJ Mamuya, *Maarifa Mapya Ya Kuelimisha Afya* (Nairobi: EALB, 1971), 39.

[71] "Kuleni Chakula Kizuri" *Ngurumo*, January 17, 1970; Richard H Hart, "Tackling the Malnutrition Problem in the Ministry of Health," *Lishe: Tanzania Food and Nutrition Journal*, 2, no. 4 (1978): 7–22; O. Jakobsen, "Economic and Geographic Factors: Influencing Child Malnutrition in Southern Highlands, Tanzania," *GeoJournal* 2, no. 4 (1978): 355–376.

However, there were instances where breaking the cultural norms and beliefs was difficult for the *Bi. Afya*. Some teachings that went against the belief system of the people led to such programmes being shunned or treated with hostility.[72] Thus, challenges persisted, highlighting the complex dynamics between biomedical interventions, traditional practices, and the socio-cultural context in postcolonial Tanzania.

From 1961 to the end of the first decade after independence, the government had not yet managed to provide health services across the entire country, with rural areas still lagging behind. As a result, it was necessary for the government to consider involving other actors in the healthcare sector. Collaboration with voluntary agencies and churches in offering medical services was taken to a higher level. In 1965, the government requested to have five hospitals run by voluntary agencies, mostly the churches, to be designated as district hospitals. These five hospitals were Mkomaido in Masasi, Kiomboi in Iramba, Sumve in Kwimba, Nyakahanga in Karagwe, and Murgwanzana in Ngara.[73] This integration aimed to supplement the government's efforts, especially where it had not been able to build such a hospital for the people. This request was accepted by the church but with conditions that they retain ownership and that the government offer subsidies to enable the hospitals to offer affordable services.

Thus, the role of voluntary agencies could not be over-emphasized. Even after independence, the Franciscans, especially the Baldegg Sisters from Switzerland, continued with their work of providing medical care, especially through the St. Francis Hospital, Ifakara. Women in Ifakara remembered with nostalgia the good old days of how maternity was provided and goods given to the mothers until when the government took over the administration of the hospital.[74] The integration of the government into a voluntary agency hospital was not easy because the government subsidy was not enough to enable the designated hospitals to offer free services. What followed was a deterioration of the very services that the

[72] Mamuya, *Maarifa Mapya Ya Kuelimisha Afya*, 39.

[73] United Republic of Tanzania, *Annual Report of the Health Division 1965*, Vol. I (Dar es Salaam: Government Printer, 1965), 42.

[74] FGD with women, September 21, 2023, Ifakara, Lipangalala.

government wanted to improve in its agenda.[75] While the locals thought the government was failing, the scenario must also be understood in the light of reduced donor funds, and the global economics at the time, when the world oil crises complicated the situation further.

The Second Five-Year Development Plan (1969-1974) in Tanzania aimed to elevate life expectancy from 35 to 50 years.[76] Renewed attention was given to MCH, which was seen as the only way to improve the health of a person from birth, if not at conception. Trained midwives were idealized, but the actual infrastructure fell short. Rapid construction of dispensaries and village posts occurred, aided by the self-help concept propagated by *Ujamaa*, but did not help solve the issues fully. The government concentrated on curative as opposed to preventive health, even after the plan was to concentrate on the latter and to improve rural health.

Transformation of Traditional Medicine and Midwifery in the 1970s

In the 1970s, the approach to health provision and maternal healthcare changed considerably. The role of traditional medicine gained impetus. Up to the mid-1970s, the government did not seriously consider the place of traditional medicine in the health system. In many instances, as early as 1962, the government had rejected registering a traditional health workers organisation.[77] The general argument was that people needed to be weaned off the traditional practices through diffusion by introducing biomedicine. Perhaps this refusal can be seen in the light of centralisation and the eradication of tribal authorities, as such associations were seen as a threat to the political unity and cohesion that was advocated for by TANU. However, there was a shift in approach in the 1970s, and even though it was not entirely comprehensive, it led to a change in how people and governments perceived the role of traditional medicine in healthcare.

On the international level, the World Health Organisation (WHO), in 1978, decided to broaden its definition of the health care system. The then Director General of WHO, Dr. Halfdan Mahler, noted that the provision of

[75] United Republic of Tanzania, *Annual Report of the Health Division 1965*, 42.

[76] United Republic of Tanzania, *Second Five-Year Plan for Economic and Social Development, 1st July 1969 to 30th June 1974*, Vol. I Dar es Salaam: The Government Printer, 1969.

[77] "Serikali Yakataa Chama Cha Waganga," *Mwafrika*, August 2, 1963.

health care for all by the end of that century could hardly be attained without harnessing the resources of traditional healers, birth attendants, and herbalists.[78] Thus, in the Alma-Ata Declaration of 1978, the WHO officially called for the use of traditional medicine in addition to biomedicine. In this declaration, traditional health workers were to be 'allies' of biomedicine.[79]

African countries embraced this call by advocating for the use of and research on traditional medicine. This call was further supported by data showing that biomedical workers were not enough, and a majority of Africans still relied on traditional medicine. For instance, in 1978, it was recorded that out of the 25 million people in Zaire (DRC), there were only 1,100 medical doctors, out of which 400 worked in the capital city. In the same year, Ghana, which was said to have had Western medicine for a century, did not have more than 25 percent medical coverage for the people.[80] In Kenya, WHO reported that the doctor to population ratio was 1:40,000 while the ratio of a traditional healer to population was 1:500.[81] The numbers portray a left-out rural populace in biomedical access and plans. By 1984, the conclusion was that 70-80 percent of health services to Africans were through traditional therapies.[82] In addition, due to the connection with African reality, traditional medicine practitioners were believed to treat diseases that were not treatable in hospitals, especially those that were solved through rituals.[83] This showed the importance of traditional medicine because it was interpreted to mean that, without traditional medical practitioners, people would have no access to health care at all. WHO followed the campaign to popularise traditional medicine with different meetings in different regions through seminars and

[78] "Herbs Have Proved Indispensable," *Sunday News*, January 8, 1978.

[79] World Health Organization*, Primary Health: Report of the International Conference on Primary Health Care, Alma-Ata, USSR, September 6-12, 1978* (Geneva: World Health Organization, 1978)

[80] Mangst Mayne, "WHO Refers to It as Traditional Medicine," *Sunday News*, September 10, 1978.

[81] "Herbs Under Threat," *Daily News*, August 13, 1988.

[82] "Madawa Ya Asilia," *Uhuru*, July 28, 1984.

[83] William Nchimbi, "Singolio: Mganga Wa Dawa Za Jadi," *Mzalendo*, May 5, 1985,

symposiums. In East Africa, such a symposium was held in Mombasa, Kenya in February 1981.[84]

Tanzania however, embraced Traditional medicine more than any other country in East Africa. The African spirit of self-reliance had been revived through the Arusha Declaration in 1967.[85] By 1969, associations of traditional healers such as *Umoja wa Waganga wa Tanzania* (UWATA), emerged.[86] This was later followed by other groups such as *Chama cha Waganga/Wakunga Tiba Asilia Tanzania* (CHAWATIATA).[87] Some of the traditional health practitioners in Tanzania were reported attending the sick day and night, even when the district hospital was just nearby. This was witnessed in many places in Tanzania such as Kilombero, and Arusha.[88] Thus, Gideon Cheyo, the Minister of Health in Tanzania, noted that to achieve 'Health for All,' the ultimate Alma-Ata goal by the year 2000, the incorporation of traditional practitioners was paramount.[89] TANU took the lead in the promotion of traditional medical practice. The party leaders were now convinced that Africa was rich in herbs, and leaders occasionally quoted the use of traditional medicine.[90]

The government of Tanzania started a research organisation at Muhimbili to research herbs.[91] There was a countrywide campaign telling the herbalists to come to the fore so they could share their knowledge with the researchers. By 1981, the Traditional Medical Research Unit at Muhimbili Medical Centre had collected 2,435 herbs, out of which 1,503 specimens had been identified botanically after the research team consulted with 500 traditional 'doctors' in Dar es Salaam, Coast, Morogoro, Tanga, and Kilimanjaro regions.[92]

[84] "Herbalists to Get Society," *Daily News*, February 10, 1981.

[85] Nyerere, *Socialism and Rural Development*; Lal Priya, *African Socialism in Postcolonial Tanzania: Between the Village and the World* (Cambridge: Cambridge University Press, 2015).

[86] "Wambulu Discard Old Traditions," *The Nationalist*, May 17, 1969.

[87] Marsland, "Modern Traditional Healer," 752.

[88] Nchimbi, "Singolio: Mganga Wa Dawa Za Jadi,"; interview with a traditional healer and midwife, October 1, 2023, Mang'ula A.

[89] Omar Bawaziri, "Warsha Wa Madaktari Wa Mikoa Yaanza," *Uhuru*, August 26, 980.

[90] "Herbs to Get Support," *Daily News*, September 21, 1983.

[91] "Moshi Arrests 21 'Herbalists'," *Daily News*, July 29, 1986.

[92] "Waganga Wa Kenyenji Watakiwa Wajitikeze Zanzibar," *Uhuru*, April 4,1984.

The unit was also working closely to have a national organisation of traditional medical workers registered.[93] However, it was clear from the onset that not every traditional health practitioner would be admitted, but only those who had fulfilled the 'laid down conditions.'[94] It was not clear which were these conditions, but recognition as a renowned herbalist, with a wide knowledge of herbs was key. There was a need to differentiate between diviners (*mpiga ramli),* witchdoctors (*Wachawi*), and herbalists *(mganga wa tiba asilia*). While this is appreciated as a significant step in the field, it overlooked the holistic traditional healing practices that encompassed a diverse range of methods beyond herbal remedies, including treatment through rituals. The cooperation and integration that the government, through the Ministry of Health popularised, was 'improving' traditional medical care to 'modernity'.

Therefore, in the 1980s, the campaign was to give traditional workers support by giving them 'instruments' to use in their work.[95] Therefore, modernising traditional medicine became a big agenda, an oxymoron which has been aptly described by Rebecca Marsland as "modern traditional medicine".[96] Marsland adds that a traditional health worker had to evolve to modernity, as that was what was deemed fit at the time. What did this mean to traditional midwifery in Kilombero?

Traditional Midwifery and the Integration to Biomedicine in Kilombero

Traditional midwifery in Kilombero was entangled with the complexities of evolving changes and enduring traditions. From 1970 onwards, the narrative was no longer trying to eradicate traditional midwifery through diffusion with 'modern ideas,' but it was now time to integrate modernity into traditional midwifery. The traditional midwives were taught 'modern' ideas through training camps organised by the government and Non-Governmental Organisations (NGOs).[97] In this training, the traditional midwives were taught about the hygiene of the mother and the child, taking

[93] "Herbalists to Get Society."
[94] "Herbalists to Get Society.".
[95] Bawaziri, "Warsha Wa Madaktari Wa Mikoa Yaanza," *Uhuru*, August 26, 1980.
[96] Marsland, "Modern Traditional Healer," 756.
[97] Interview with a retired nurse, September 20, 2023, Viwanja Sitini, Ifakara; Interview with a traditional midwife, September 21, 2023, Lipangalala, Ifakara.

care of the umbilical cord – with the emphasis on keeping it clean and free from saliva and cow dung, abstaining from the use of traditional herbs and rituals before, during and after delivery, and taking care of the baby's feeding schedule.[98] These sessions were done through discussions, role-playing, and singing to enable those who could not read and write to participate.[99] It was ironic that the use of herbs and rituals were discouraged, which were the very essence of traditional midwifery.

In Kilombero, NGOs such as Plan International conducted this training.[100] What was interesting at this level was that, contrary to the 1960s, both the government and the traditional midwives were willing to come together. Also, the international health policies led by WHO supported the incorporation of traditional medicine as already noted. Furthermore, it was argued that communities in developing countries would benefit more from traditional medicine and not the push towards the Western model of medicine.[101] In general, the new WHO approach brought about the transformation of how traditional midwifery and medicine in Africa were viewed especially at the policy level. It led to a change of attitude on the fact that traditional medicine could be useful in the health systems contrary to the attitude that was largely propagated during the colonial and early independence period. However, problems, challenges, and unfulfilled expectations continued.

At first, the hierarchical nature between traditional medicine and biomedicine, and between different cadres of health workers remained the same. Traditional medicine was secondary to biomedicine. Trained health workers were superior to traditional health workers. In addition, within the trained workers, there was a hierarchy depending on the level of training, such that doctors were at the top, while the rural health aides were at the bottom. The same was observed in the grading of health facilities. Big hospitals remained in the urban areas, while small villages were served by village health posts and dispensaries, which Oscar Gish described as ill-

[98] Interview with Zuhura a traditional midwife, September 21, 2023, Lipangalala.
[99] Interview with Christina Isakwisa, September 20, 2023, Viwanja Sitini, Ifakara.
[100] FGD with women, September 21, 2023, Ifakara, Lipangalala.
[101] Mayne, "WHO Refers to It as Traditional Medicine."

equipped and understaffed.[102] Many of these dispensaries were constructed through the efforts of the people and local and central governments. The goal was to have as many clinics as possible to increase coverage all over the country. In the case of midwifery, for instance, the government of Tanzania assumed that the consultation of traditional midwives was due to inadequate health facilities. However, in Kilombero, women near St. Francis Hospital, Ifakara, who were traditional midwives and retired nurses, agreed that the majority of women consulted traditional midwives between the 1960s and 1980s.[103]

The government was more concerned with herbs at the expense of other types of traditional therapies. This affected the intended integration of different actors in health and midwifery. It was against the expectation of the masses to eradicate rituals and herbs in health procedures, as they formed the core of the whole practice of traditional medicine. As a result, the training initiatives of the government for traditional midwives in the 1960s through 1980s confined traditional midwives to the status of 'allies,' whose major role was to encourage and educate women on the importance of health facilities. For the midwives living near health facilities, their role was that of escorting pregnant women to clinics, an issue that many did not like.[104]

In Ifakara for instance, traditional midwives residing near the St. Francis Hospital were discouraged from providing care or conducting deliveries, as it was argued that the hospital was conveniently nearby.[105] This distinction resulted in a notable disparity: when the NGOs and the government gave equipment, the traditional midwives situated further from the hospital received a delivery kit to aid in patient care, equipped with essentials, such as gloves, to ensure hygiene and those closer to the hospital were only provided with gumboots to navigate the flooding seasons caused by the overflow of River Kilombero.[106] The rationale behind this was that

[102] Oscar Gish, "The Way Forward: World Health Organisation," *Journal of World Health* 6 (1975): 8.

[103] FGD with women, September 21, 2023, Ifakara, Lipangalala; interview with Leah Mpombo, Uwanja wa Ndege; September 25, 2023; interview with Christina Isakwisa, September 20, 2023, Viwanja Sitini, Ifakara.

[104] Interview with a retired nurse), September 20, 2023, Viwanja Sitini, Ifakara.

[105] Interview a traditional midwife), September 21, 2023, Lipangalala, Ifakara.

[106] Interview with Zuhura Hamisi, September 21, 2023, Lipangalala.

those midwives near the hospital were to persuade and escort a pregnant woman to the facility, but the others could conduct delivery. The irony was that the differentiation in approach assumed that a traditional midwife would put the life of the pregnant woman in danger, yet in rural places where they had no access to a health facility, the midwives were allowed to conduct the delivery procedures.[107] Retired nurses interviewed in this study also echoed the attitude of the government that indeed, traditional midwives needed to be modernised.[108]

The integration of the traditional midwives in Kilombero into the health system as allies of the trained midwives was particularly problematic, because cultural values were detached from the process. The cultural needs of the society, such as the administration of *kilala*, were not considered 'useful' by the clinics and the government structures. As a result, women continued to seek the services of the traditional midwives. This meant that people continued to be attended to by traditional midwives and only sought medical attention in a health facility when it was necessary. This resonates with the situation in Indonesia where the integration of *paraji* (traditional midwife) into the health system also failed. Indrayani Indrayani notes that the integration was laborious, such as documentation and reports for the *paraji*, which did not have any meaning to her work, because in traditional midwifery, keeping records was not a priority.[109] Thus, there was a disconnect between the government, trainers, and the trainees.

The integration of traditional and Western medical systems was also hindered by the perception that collecting information on herbs from herbalists offered no benefits to traditional health practitioners. It was expected that the traditional workers were to share the knowledge of herbs that they used with the scientific researchers for further analysis in the lab, and in return, they were to get books published on plant knowledge. This was not attractive to the majority of the traditional healers and midwives, and some went to the extent of refusing to share their knowledge of herbs, or to only partially give out what they wanted. While this was interpreted

[107] FGD with women, September 21, 2023, Ifakara, Lipangalala.

[108] Interview with Magaret Kindasi, September 25, 2023, Kibaoni, Ifakara; interview with Christina Isakwisa, September 20, 2023, Viwanja Sitini, Ifakara.

[109] Indrayani Indrayani and Gustina Mulyawati, "Village Midwives' Experiences in Rural Areas," *Jurnal Ilmiah Permata Medika* 4, no. 1 (2015): 1–24.

as sabotage, it is also important to note that for some communities, the practice of medicine was their 'trade' which they jealously guarded.[110]

The opening up of popular herbal use in the late 1970s and 1980s was also a challenge because not everyone was recognised as a traditional health worker by the government. There was a requirement to have a license to be able to practice as a health worker. This left a gap, for not every application for licensing was granted. There were numerous cases of bans on the organisation of traditional medical workers, others were denied registration, and several cases of arrests of herbalists were reported for practising without permission from the government.[111] The absence of a license did not mean that one did not know how to practice medicine. The scenario only allowed some TANU members to harass and exercise power on the traditional health workers because practising licenses were given through TANU. Mr Jamaldin, a traditional healer seeking a license to practice circumcision was denied by the Lindi TANU branch.[112] Yet, he was only seeking to be allowed to do what he had always done. Perhaps this refusal discouraged the others from coming out publicly and continued to practice incognito. This left a loophole in the total integration of traditional medicine. This was an example of the problem of cooperation. Nevertheless, in the rural areas, the traditional midwives and healers continued to practice because of the demand. Importantly, there was no explicit policy prohibiting the utilization of traditional healers and midwives, so the practice continued. In addition, the people were not weaned off their cultural practices so rituals such as *kilala* were a must which was only available at the service of a traditional midwife.

Lastly, the challenge of integration was a political question. There was no clear path as to how this integration was to be done, it was left to campaigns such as *Mtu ni Afya* (Man is Health).[113] These types of campaigns were short-lived and were used to sensitise people on particular health issues. The short period of campaigns was arguably cheaper perhaps than

[110] Samuel S. Antwi-Baffour et al., "The Place of Traditional Medicine in the African Society," *American Journal of Health Research* 2, no. 2 (2014): 49.

[111] "Moshi Arrests 21 'Herbalists'"; "Serikali Yakataa Chama Cha Waganga"; "Herbalists to Get Society."

[112] TNA HET/120/15: Tawi La TANU

[113] Budd, *Mtu Ni Afya ('Man Is Health')*.

building facilities or permanently planning a budgetary allocation on health education. In most cases, the government had to rely on help from NGOs and support from friendly nations, as in the case of the Kilombero traditional midwives training. The government also left the bulk of the work to medical professionals who, because of their training in biomedicine, had biases towards traditional medicine. It was also not clear as to who was to coordinate what, and therefore the same old narrative of the dominance of Western medicine was repeated. It is questionable as to whether governmental officials, even as they advocated for the use of traditional midwives and healers could use their services because they had access and the resources to access big facilities in the city.[114] Unless one had a condition that necessitated the 'local expertise' beyond the hospital. Thus, the duality of traditional medicine and biomedicine continued. However, in most cases, the binary situation often evolved to a hybrid utilisation of both traditional medicine and modern aspects of medicine, such as vaccination as seen in the case of Kilombero.

Conclusion

After independence, the government of Tanzania encountered numerous challenges as a provider and a planner of medical services. Infrastructural failure and lack of personnel were major concerns. Despite encountering numerous challenges, it is undeniable that the Tanzanian government invested significantly in the promotion of medicalized health services, particularly MCH. This concerted effort raises the question: where did traditional midwifery and voluntary agencies fit into this evolving landscape? While the government wanted to provide health to all its citizens, it was not fully feasible due to the many competing needs, not only in the medical field but in all sectors. This led to the integration of other actors in the health sector through negotiation and cooperation. The pivotal role played by traditional midwives, which endured since time immemorial, was recognised, and the government sought to train them, aiming to modernise their practice.

However, to modernize midwifery through health worker training and by discouraging home deliveries, the government ignored the cultural

[114] Mayne, "WHO Refers to It as Traditional Medicine."

needs of its people and continued with the colonial modernisation strategies which sought to popularise biomedicine. The popular campaigns of promotion of traditional medicine were largely a WHO agenda which was interpreted as understanding the knowledge of traditional herbal medicine. The government of Tanzania used a lot of resources and time to get the herbs from the renowned herbalists in the villages. This reduced traditional medicine to a herbal venture. It failed to understand traditional medicine in its broad and holistic nature. The role of rituals in medicine was often ignored. The search for herbs dominated the process and not the overall promotion of traditional medicine. Despite governmental investments, traditional medicine persisted in a secondary role. The state recognized the value of traditional herbs as complements to pharmaceuticals, yet condemned other therapeutic practices rooted in African culture.

In midwifery, essential rituals for the safety of both mother and baby were denounced without educating the population on the potential risks. Similarly, the voluntary agencies did not fully cooperate with the government and this cooperation had its shortcomings. However, post-independence Tanzania, although following colonial footsteps, made efforts to integrate traditional medicine into biomedical practices. It is observed that many ex-colonies often followed external influences, resulting in suboptimal implementation of health plans and policies. This was largely due to the failure to localize these initiatives and adapt them to the local context, particularly by involving local health workers, patients, and the broader Tanzanian population in planning and implementation. The neglect of traditional medical practices and the imposition of biomedical models without proper integration further complicated healthcare efforts. Had a more inclusive approach been taken – one that acknowledged the coexistence and potential synergy between traditional medicine and biomedicine – Tanzania and other countries in the Global South might have been better positioned to achieve their post-independence health goals, particularly in MCH.

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Focus group discussion with women, September 25, 2023, Uwanja wa Ndege, Ifakara.
Interview with Margaret Kindasi, September 25, 2023, Kibaoni, Ifakara.
Interview with Amina Omari, Mang'ula B, September 30, 2023.
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