Healing, Evangelism, and Modern Healthcare:
German Protestant Missionary Medicine in Tanzania's Southern Highlands, 1891–1940

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Declaration

I hereby declare that this dissertation is my own original work and that it has been written independently. It has not been submitted, in whole or in part, to any other university or institution for the award of a degree or any other academic qualification. All sources and materials used have been properly acknowledged. Where the work of others has been used, whether directly or indirectly, this has been clearly indicated and cited in accordance with academic standards.

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Conflict of Interest and Funding

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Note on Language and Translation

This dissertation is written in English, but it is based on sources produced in different languages and historical contexts. During my research in Tanzania, most of the archival materials I consulted were written in Swahili and German, and all interviews were conducted exclusively in Kiswahili. In addition, my archival research in Germany involved materials that were mainly in German. In cases where it was important to preserve the original meaning or usage, I have retained certain Swahili and German terms, as well as direct quotations, in italics. Unless otherwise stated, all translations are my own and represent my understanding of the original texts. The dissertation also includes some historical terms that are now outdated or considered offensive. Such terms are reproduced with caution, usually in italics or quotation marks, and are explained in the text where necessary.

Operational Definition of Terms

All-round therapy	refers to the missionary approach to healing that combined physical treatment with moral and spiritual reform.
Catechism	formal missionary instruction preparing converts for baptism and Christian moral life.
Christian moral economy	I use the term to refer to a system of values linking health, discipline, and moral behavior to Christian identity.
Colonial medical infrastructure	the network of mission hospitals, dispensaries, clinics, and personnel established under colonial rule to deliver healthcare in the Southern Highlands.
Deacon	refers to a church-appointed assistant who supported missionary work by supervising moral discipline and religious instruction.
Medical evangelism	the deliberate use of medical treatment as a means of promoting Christian conversion and reinforcing missionary authority and moral teachings.
Medical mission	indicates the use of medical care by Christian missionaries as an integral part of evangelization, combining healing with religious instruction, moral discipline, and social reform.
Medical pluralism	this refers to the integration of biomedical treatment with traditional African healing.

Abbreviations and Acronyms

BMS	Berlin Mission Society
BMW	Berliner Missionswerk
CMS	Church Missionary Society
DOA	*Deutsch-Ostafrika* (German East Africa)
ELCT	Evangelical Lutheran Church in Tanzania
GEACO	German East African Company
GKR	Gemeinde Kirchenrat (Congregational Church Council)
GIS	Geographic Information System
HGF	Holy Ghost Fathers
IMPA	International Mission Photography Archive
KLSA	Kidugala Lutheran Seminary Archives
LMS	London Missionary Society
RAMC	Rungwe Archive and Museum Center
TNA	The Tanzania National Archives
UMC	United Missionary Church
UMCA	Universities' Mission to Central Africa

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ABSTRACT

This dissertation examines the development of German Protestant medical missions in the Southern Highlands of Tanzania between 1891 and 1940, with particular attention to the Moravian Church and the Berlin Lutheran missions in the Mbeya and Njombe regions. It analyzes the transformation of missionary practice from an initial emphasis on evangelization toward the strategic deployment of Western biomedicine as a central instrument for extending religious authority, consolidating institutional presence, and expanding social influence. The study argues that missionary medicine cannot be understood either as a purely humanitarian enterprise or as a simple extension of colonial domination. Rather, it constituted a contested and unstable field in which religious ideals, colonial imperatives, and African social and therapeutic systems intersected, overlapped, and frequently conflicted. In the early period, Protestant missionaries prioritized preaching and religious instruction; however, conversion outcomes remained limited. Faced with the persistence of indigenous healing systems and ongoing resistance to religious transformation, missionaries increasingly incorporated Western biomedicine to legitimize their presence and strengthen their authority. Medical work thus became closely integrated with evangelization, leading to the establishment of hospitals, dispensaries, and clinics at mission stations such as Kidugala, Ilembula, Rungwe, Itete, and Matema. These institutions not only provided medical treatment but also promoted new regimes of bodily discipline, hygiene, and domestic organization, while seeking to marginalize indigenous therapeutic practices through regulatory frameworks such as the *Platzordnung.*

Nevertheless, African communities did not passively receive missionary medicine. Families, elders, chiefs, and healers actively evaluated biomedical interventions in relation to local moral worlds, spiritual beliefs, and social obligations. While certain treatments were selectively appropriated, indigenous healing systems remained central to everyday life. This produced plural and hybrid therapeutic landscapes that remained beyond the control of missionary and colonial authorities, thereby limiting efforts to enforce biomedical and Christian exclusivity. Drawing on archival records, missionary writings, ethnographic materials, and oral interviews, this study reinterprets colonial medical history by foregrounding African agency and negotiation. It demonstrates that medical missions in the Southern Highlands were shaped as much by African actors and local social dynamics as by missionary objectives and colonial structures.

Dedication

This dissertation is dedicated to Philemon Kaduma, Zena Kaduma, Kang'wa Kazi, Kourtney Kaduma, Bravin Kaduma, and Khloe Kaduma.

CHAPTER ONE
INTRODUCTION

1.1 Background of the Study

The late nineteenth century marked a pivotal turning point in African history, as the continent became increasingly subjected to European imperialism and expansion. Powerful European nations, including Britain, France, Germany, Belgium, Portugal, and Spain, competed aggressively for territory, leading to the arbitrary partition of Africa and the establishment of colonial rule.[1] These imperial powers were driven by the desire to expand their global influence and access valuable resources. They often justified their actions by claiming it was their moral duty to "civilize" and "develop" African societies.[2] One of the most significant developments during this period was the involvement of Carl Peters, a German adventurer with strong imperial ambitions. Through manipulation and deception, Peters obtained so-called treaties from African chiefs that granted him sovereign rights over vast areas of land. These territories would later form the basis of German East Africa.[3] Following the Berlin Conference of 1884-1885, which formalized the 'Scramble for Africa,' the German government, under Chancellor Otto von Bismarck, took decisive action. In February 1885, Bismarck authorized the Imperial Letter of Protection (*Schutzbrief*), placing the territories claimed by Peters, based on highly questionable treaties, under the formal protection of the German Emperor. This move effectively marked the beginning of Germany's colonial involvement in East Africa.[4]

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[1] For a good narrative on the partition of Africa continent by imperial powers see, Henk Wesseling, *Divide and Rule: The Partition of Africa, 1880-1914* (Westport, CT: Praeger Publishers, 1996). See also, Rudyard Kipling, *The White Man's Burden* (1899); and Thomas Pakenham, *The Scramble for Africa* (London: Random House, 1991).

[2] See for instance, Rudyard Kipling, *The White Man's Burden* (1899).

[3] The political history of East Africa, and how it came under German control, is complex and cannot be fully explained here. For a fuller account of East Africa's political history in the nineteenth century, see Reginald Coupland, *The Exploitation of East Africa: The Slave Trade and the Scramble* (Evanston: Northwestern University Press, 1967). Chapters 17-20 deal specifically with the German period. For a relevant primary source account, see Carl Peters, *Wie Deutsch-Ostafrika enstand* (Leipzig: R. Voigtländer's Verlag, 1912).

[4] It has been argued that Carl Peters achieved his objective by pressuring the German government, threatening to sell the treaties to King Leopold II of Belgium unless a *Schutzbrief* was granted. For this reference see, John Flint, in Roland Oliver and Gervase Mathew (eds.), *History of East Africa*, vol. 1 (London: Oxford University Press, 1963), 369. See Detlef Bald, Peter Heller, Volkhard Hundsdörfer, and Joachim Paschen, *Die Liebe zum Imperium: Deutschlands dunkle Vergangenheit in Afrika* (Bremen, 1978), 59-60. See also, Ernst Gerhard Jacob, ed., *Deutsche Kolonialpolitik in*

Administration under the German East Africa Company (GEACO) proved inefficient and poorly organized. As a result, in 1891, the German government assumed direct control of the territory, formally incorporating it into the German Empire. German East Africa, which included present-day mainland Tanzania, Rwanda, and Burundi, was officially declared a German protectorate.[5] German authorities, including Bismarck and his subordinates, now firmly regarded the region as Germany's sphere of influence in East Africa.

For German Protestant missionaries, however, German East Africa represented more than a geopolitical possession of the empire. It was understood as an expansive mission field, offering opportunities for evangelization among diverse African communities. This period of intensified colonial expansion coincided with what church historian Kenneth Latourette described as "the Great Century" of Christian missions, during which European missionary societies expanded their activities across Africa.[6] As imperial competition reshaped the continent, missionary ambition expanded alongside colonial control.

German Protestant missions developed gradually as colonial authority became more secure. The first Lutheran missionaries arrived in Dar es Salaam in 1887 under the Evangelical Mission Society for German East Africa (Berlin III). The missionaries work expanded after the Anglo-German Agreement of 1 July 1890, which brought the Southern Highlands under German control and opened the region to the Berlin Mission Society (Berlin I) and the Moravian Mission Institution of the Unity of the Brethren (Herrnhut Mission). In the same year, the Evangelical Lutheran Mission Society of Leipzig began work in the northern part of the colony.[7] Together, these

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Dokumenten: Gedanken und Gestalten aus den letzten fünfzig Jahren (Leipzig: Dieterich, 1938), 97-98.

[5] Throughout this study, the word German East Africa denotes the Southern Highlands under German colonial rule, whereas Tanganyika (or mainland Tanzania) refers the same region under British colonial administration.

[6] This term is used here in reference to the title of Latourette's book on Christian missions in the nineteenth and early twentieth century's. See Kenneth Scott Latourette, *A History of the Expansion of Christianity, vol. 5, The Great Century in the Americas, Australasia, and Africa A.D. 1800 - A.D. 1914* (New York: Harper, 1943).

[7] In this study, the term 'Berliner Lutherans' refers to the Berlin Mission Society (Berlin I), while 'Moravian mission' indicates the Herrnhut Mission, the site from which the Moravian missionary movement originated. This terminology follows usage found in contemporary missionary sources. For

societies established churches, mission stations, schools, and health centers, and began systematic efforts to spread Christianity among African communities.

It was within this broader missionary project that medical work emerged as one of the most significant and effective tools of evangelization. Among all missionary activities, medical missions proved particularly influential, largely because they developed at a time when many African societies were facing widespread animal and human diseases. Moreover, increased interaction with Europeans and rapid changes in lifestyle made Africans more vulnerable to new illnesses, many of which could not be effectively treated through existing traditional healing practices.[8]

In addition, David Hardiman argued that African engagement with mission medicine reflected concerns about both moral and physical contamination. Missionaries believed that "any Godly person who understood the rudimentary principles of hygiene and sanitation was in a position to bring health to the 'native' by cleansing their bodies with soap and their minds with the Gospel."[9] However, the introduction of the so called 'civilization package' by the missionaries was not without contestations. This was because Africans possessed deeply rooted cultural beliefs and lifestyles that had shaped their societies for centuries. Indeed, African communities had well-developed systems of health and healing grounded in indigenous beliefs and practices. As a result, missionary medicine achieved only limited success in displacing traditional healing methods, which remained widely trusted and actively practiced within African communities.

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more information on the history of German Protestant missionaries in Tanzania, see Roland Oliver, *The Missionary Factor in East Africa* (London: Oxford University Press, 1952); Marcia Wright, *German Missions in Tanganyika* 1891-1941: *Lutherans and Moravians in the Southern Highlands* (Oxford: Clarendon Press, 1971), S. von Sicard, "The Berlin Mission Society in the Southern Highlands" in *African Theological Journal* (Arusha: Makumira Publications, 1991); and Joseph W. Parsalaw, *A History of the Lutheran Church, Diocese in Arusha Region, from 1904 to 1958* (Usa River: Makumira Publications, 1999).

[8] Steven Feierman, "Struggles for Control: The Social Roots of Health and Healing in Modern Africa," *African Studies Review* 28, no. 2/3 (1985); Helen Tilley, "History of Medicine: Medicine, Empire and Ethics in Colonial Africa," *AMA Journal of Ethics* 18, no. 7 (2016); Gregory Maddox, James Giblin, and Isaria Kimambo, eds., in *Custodians of the Land: Ecology & Culture in the History of Tanzania* (Dar es Salaam: Mkuki na Nyota, 1996).

[9] David Hardiman, *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa* (Amsterdam: Rodopi, 2006), 11.

Consequently, rapid changes in mission medicine were closely connected to European colonization and the scientific developments of the nineteenth century. This period also coincided with the evolution of germ theory, which began to associate the causation of disease with microorganisms known as pathogens.[10] Moreover, the era witnessed the rise of pharmaceutical treatments and vaccination campaigns, which came to predominate in many parts of the world.[11] These developments revolutionized mission medicine, making it more professional and giving it a distinct place within evangelical mission work.[12] It was also during this period that a theology of healing gained prominence within missionary settings, and mission dispensaries and clinics began to extend into the interior regions of Africa.[13]

These developments in missionary medicine did not occur in isolation but unfolded within a broader colonial medical landscape shaped by the priorities of the German colonial state. Various scholars have asserted that since the inception of German colonial rule in mainland Tanzania, the indigenous population was subjected to the Western medical culture by missionaries and the colonial state. While medical provision was a significant instrument of colonial control across European empires, its implementation in German East Africa was uneven and highly selective. By analyzing colonial archival records, many historians of missionary and medicine have agreed that in the colonial context, state-sponsored medical services were rudimentary and largely confined to coastal areas and key centers of administration

[10] For literature on the relationship between mission medicine, European colonization, and the development of germ theory in the nineteenth century, see Roy Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity* (London: HarperCollins, 1997); Anne Hardy, *The Epidemic Streets: Infectious Disease and the Rise of Preventive Medicine, 1856-1900* (Oxford: Clarendon Press, 1993); David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India* (Berkeley: University of California Press, 1993); and Michael Worboys, "Germ Theories of Disease and British Veterinary Medicine, 1860-1890," *Medical History* 35, no. 3 (1991), 308-327.

[11] For a detail information about this, see Helen Tilley, *Africa as a Living Laboratory, Empire, Development, and the Problem of Scientific Knowledge, 1870-1950* (Chicago, 2011); Tilley, "History of Medicine: Medicine, Empire and Ethics in Colonial Africa"; MM Lock and VK Nguyen, *An Anthropology of Biomedicine* (UK: Wiley-Blackwell, 2010).

[12] Jean Comaroff and John Comaroff, *Of Revelation and Revolution: The Dialectics of Modernity on a Southern African Frontier* (Chicago & London: Univeristy of Chicago Press, 1997), 329.

[13] Michael Jennings, "Healing of Bodies, Salvation of Souls: Missionary Medicine in Colonial Tanganyika, 1870s-1939," *Journal of Religion in Africa*, no. 38 (2008): 27–56, 30.

and production.[14] Therefore, the responsibility for medical care in the interior regions fell primarily to missionary societies, whose work focused heavily on individual, curative medicine, particularly among marginalized communities, women, children, and former slaves.

The objectives of colonial medical services differed sharply from the humanitarian rhetoric often associated with mission medicine. State medical policy was principally designed to protect and restore the health of Europeans, soldiers, and African laborers, especially in relation to tropical diseases, in order to sustain colonial governance and economic productivity. African labor was regarded as a crucial asset for determining the success or failure of colonial enterprises; maintaining workers' health was therefore essential to maximizing profit for colonial investors.[15]

A German historian of medicine, Wolfgang Eckart provided a detailed study that reinforced this interpretation, demonstrating that colonial health services were never intended to improve African health comprehensively. Instead, they concentrated on Europeans and strategic production zones, largely excluding rural populations where the majority of Africans lived.[16] Even large-scale campaigns against epidemic diseases such as sleeping sickness, cholera, and smallpox were primarily undertaken to facilitate effective control, exploitation, and governance of African territories rather than to address indigenous welfare.[17] In this context, missionary medicine emerged not only as a supplement to state medical neglect but also as a contested arena where evangelization, healing, and colonial power intersected.

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[14] Hardiman, *Healing Bodies, Saving Souls,* 5. See also Carl Paul, *Das Evangelium in Deutsch-Ostafrika: eine Zeitgeschichte Studie* (Leipzig: Wallmann, 1892), 27; and Jennings, "Healing of Bodies, Salvation of Souls: Missionary Medicine in Colonial Tanganyika, 1870s-1939," 35–40.

[15] For the account of the way colonial medical services given priority for the African soldiers see, Michelle R. Moyd, *Violent Intermediaries: African Soldiers, Conquest, and Everyday Colonialism in German East Africa* (Athens, OH: Ohio University Press, 2014), 104-105; Ann Beck,. "Medicine and Society in Tanganyika, 1890-1930; A Historical Inquiry." *Transactions of the American Philosophical Society* 67, no. 3 (1977): 1–59; 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): 208–31, 210; Andrew Cunningham and Bridie Andrews, *Western Medicine as Contested Knowledge* (Manchester: Manchester University Press, 1997), 1; and Paul Jim, "Medicine and Imperialism in Morocco," *Middle East Research and Information Project, Inc,* 1977, 3–12, 3.

[16] Wolfgang U Eckart, *Medizin Und Kolonialimperialismus: Deutschland 1884-1945* (Brill: Schöningh, 1997), 461.

[17] Eckart, *Medizin Und Kolonialimperialismus,* 301–8; See also Lindner, "The Transfer of European Social Policy Concepts to Tropical Africa," 211.

Apparently, it was not until the very end of the German colonial period that the colonial government became actively involved in providing health care for the indigenous population. To some extent, the outbreak of the Maji Maji War altered the administration and implementation of German health policy. In 1906, one year before the end of the Maji Maji war, Rechenberg, the then governor of German East Africa, realized that African grievances had long been ignored. As a result, he tried to adopt a more conciliatory approach toward the African population, believing that reduced brutality would help stabilize the colony and ensure smoother colonial administration. Changes in the structural, political, and ideological frameworks of colonial governance compelled the governor to reform the colony's economic and social systems.[18]

According to Juhani Koponen, the development imperative began to emerge before the First World War as a rhetorical framework within colonial thinking, even though colonial practice in German East Africa prior to 1914 remained dominated by settler interests and extractive priorities. In this context, the expansion of infrastructure networks and the growing demand for labor limited the prospects for meaningful investment in public health services. Moreover, communities that actively resisted German colonial rule, particularly those involved in the Maji Maji resistance, such as populations in southern Tanzania, were largely excluded from colonial development schemes.[19] Consequently, the provision of medical care in these areas fell primarily to missionaries who had been active in the region even before the outbreak of the resistance.

[18] Juhani Koponen, *Development for Exploitation: German Colonial Policies in Mainland Tanzania, 1884-1914* (Finland: Raamattutalo, 1994), 461.

[19] The war deeply unsettled the German colonial authorities. Districts that participated in the conflict, such as Lindi, Songea, Kilwa, and parts of Morogoro, were subjected to increased exploitation. Tax records show that the tax burden in these areas was as heavy as, or heavier than, in other regions, while export values from southern ports consistently exceeded imports. Although the Germans planned a railway from Kilwa to Lake Nyasa, the project was abandoned and never revived by the British. This neglect continued after independence, as the Dar es Salaam to Mtwara all-weather road was completed only after decades of delay. For further discussion, see Iliffe, *A Modern History of Tanganyika,* 130; Juhani Koponen, 'Maji Maji in the Making of the South,'*Tanzania Zamani:* A Journal of history research and writing, vol. 7, no. 1, (2010), 17 and 28. See also S. Mesaki and J. Mwankusye, "The Saga of the Lindi–Kibiti Road: Political Ramifications," in *The Making of a Periphery: Economic Development and Cultural Encounters in Southern Tanzania*, ed. Pekka Seppälä and Bertha Koda (Uppsala: Nordiska Afrikainstitutet, 1998), 58–74.

Christian missions introduced biomedicine to the peripheral regions of mainland Tanzania, particularly in areas beyond the effective reach of the colonial state due to limited infrastructure, personnel shortages, and restrictive policies toward indigenous health services. Within these local contexts, missionaries were nonetheless successful in transforming and establishing networks of medical services that penetrated rural society. As a result, 'where there was a mission hospital, there was an option for local people to choose Western biomedicine as a form of healing,' and these services continued to operate across vast territories.[20] However, missionary medicine was largely characterized by small-scale operations, fragmented mission posts, and rudimentary health facilities that suffered from limited resources and a shortage of trained medical expertise.

Most colonial medical histories produced on Africa over the past six decades have grounded their analyses in political economy, institutional approaches, discourse analysis, and social histories of health and healing.[21] Scholarly attention has largely focused on the evolution of Western medicine, the establishment of medical institutions, the ways missionaries supported the broader objectives of the colonial state, and the policies that shaped colonial health services.[22] Much of this literature concentrates on Western medicine in African colonies during the post-First World War period, particularly from the 1920s onward. However, these works have largely neglected the nexus between mission medical work and German colonial health policy in local African settings, African responses to this interaction, including the critical roles played by African evangelists and ordained pastors, and the long-term legacies of mission medicine in mainland Tanzania between 1891 and 1940, particularly in shaping concepts of hygiene, discipline, and medical knowledge.

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[20] Jennings, "Healing of Bodies, Salvation of Souls," 38.

[21] For this discussion see, David Clyde, *History of the Medical Services in Tanganyika* (Dar es Salaam: Government Press, 1962); Beck, "Medicine and Society in Tanganyika 1890-1930: A Historical Inquiry"; Feierman, "Struggles for Control: The Social Roots of Health and Healing in Modern Africa"; David Arnold, *Imperial Medicine and Indigenous Societies* (Manchester: Manchester University Press, 1988) For the understanding of colonial medical ideas, discourse and how African cultural behaviors affect colonial health, see Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Stanford University Press, 1991), 283–95.

[22] Charles Good, "Pioneer Medical Missions in Colonial Africa," *Social Science and Medicine* 32, no. 1 (1991): 1–10; Clyde, *History of the Medical Services in Tanganyika*; Beck, "Medicine and Society in Tanganyika 1890-1930: A Historical Inquiry"; Ranger, "Godly Medicine: The Ambiguities of Medical Mission in Southeast Tanzania."

This study argues that evangelical missionaries deliberately reoriented their priorities away from an exclusive emphasis on evangelistic zeal toward the systematic provision of medical care. I develop this argument in the next chapter by examining the specific initiatives and motivations that led to this shift. In particular, I show how the medical programs of the Moravian Church and the Berlin Lutheran missionaries were directed primarily toward African communities in interior regions, where access to colonial medical services was limited.

Scholars such as Ann Beck, Charles Smythies, and Terence Ranger have acknowledged the role and contribution of missionaries in introducing the principles of Western medicine as a viable alternative to Africa's pluralistic medical traditions.[23] This concern remained central to missionary efforts, as evangelical work and medical care became increasingly interconnected from the late nineteenth century onward. It is this sustained effort and perseverance, embodied in the missionaries' struggle for both body and soul, their expansion of medical care to rural populations, and their provision of holistic care, that has inspired this historical study.

Therefore, this study intends to contribute to the rich historiography of missionary enterprise in Africa by examining the interplay between missionary medical work and the ways it shaped healing practices, discipline, and the production of knowledge at the local level, an area that has received relatively limited scholarly attention. By foregrounding local agency, the study highlights how African communities actively engaged with, adapted, negotiated, and at times resisted missionary medical

[23] Beck, "Medicine and Society in Tanganyika 1890-1930: A Historical Inquiry," 32; Charles Smythies, *Central Africa* (London: Society for Promoting Christian Knowledge, 1893), 51–52. Smythies served as the Anglican Bishop of Central Africa from 1889 to 1894, working mainly in what is today Malawi, Zambia, and parts of Tanzania. He was associated with the Universities' Mission to Central Africa (UMCA). For further details, see Gertrude Ward, *The Life of Charles Alan Smythies: Bishop of the Universities' Mission to Central Africa* (London: Society for Promoting Christian Knowledge, 1896), esp. chap. 3, "First Visit to Nyasa," 48ff. See also, Terence Ranger, "Godly Medicine: The Ambiguities of Medical Mission in Southeast Tanzania," *Social Science and Medicine*, 1981, 256–82; Jennings, "Healing of Bodies, Salvation of Souls: Missionary Medicine in Colonial Tanganyika, 1870s-1939," 27.

interventions, challenging interpretations that portray medical missions as a one-directional process. Through a focus on micro-historical exchanges, this study addresses a gap that has not yet been explored by historians of medical missions in the modern history of mainland Tanzania.[24] In doing so, it widens knowledge in the historiography of Christianity and medical care by examining the work of German Protestant missionaries between 1891 and 1940.

This study focuses on the Moravian Church and the Berliner Lutheran mission, among the earliest German missionary societies active in what is today Southern Highlands of Tanzania, whose contributions to medical work are widely acknowledged. It examines the evolution of German Protestant missionary medicine in the Southern Highlands of Tanzania from the 1890s to 1940, tracing the shift from evangelical zeal to organized medical care within the context of colonial rule. It also analyzes missionary medicine as both a religious and colonial project, while foregrounding African agency by exploring how local communities resisted, negotiated, and appropriated missionary medical practices through indigenous healing systems, kinship relations, collective memory, and neighborhood based cultures of care. This study further interrogates missionary medicine as a contested arena of knowledge production, in which biomedical ideas, Christian moral discipline, and indigenous therapeutic practices interacted to co-produce new understandings of healing, authority, and social order in the colonial Southern Highlands.

1.2 State of the Art

This dissertation is situated at the crossroads of several historiographical and methodological approaches within African history. Rather than working within a

[24] Some historical studies on missionary medical work focused more on the involvement of Christian missionaries in treating the marginalized diseases such as leprosy. See a well coverage study of Eckart, *Medizin Und Kolonialimperialismus: Deutschland 1884-1945*, 319–40; Kathleen Vongsathorn, "First and Foremost the Evangelist? Mission and Government Priorities for the Treatment of Leprosy in Uganda, 1927–48," *Journal of Eastern African Studies* 6, no. 3 (2012): 544–60 For a more recent study see; Lorne Larson, "Disease, Science and Religiosity: A Case Study of Leprosy in German East Africa," *Tanzania Zamani* XIII, no. 1 (2021). Others paid an attention on the general history of missionary, for instance, see Wright, *German Mission in Tanganyika*; Oliver, *The Missionary Factor in East Africa.* Unfortunately, neither of these mission works in Tanzania considered to look at the nexus between mission medical work and colonial health policy and how Africans response in a local level. .

single unified theoretical framework, it draws flexibly on three main bodies of scholarship: colonial medical history; critical mission studies, particularly literature that examines missionary medicine, moral discipline, and power from postcolonial perspectives; and debates on medical pluralism and hybridity. These approaches are used in combination, while the study remains focused on detailed historical reconstruction at the local level. This methodology emphasizes careful use of historical evidence, close attention to context, and interpretive flexibility. It recognizes that medical practices and encounters in colonial Africa were shaped by multiple forms of knowledge and authority, which cannot be fully explained through any single analytical lens. By combining these perspectives, the dissertation allows local actors, practices, and experiences to guide the analysis, while still engaging with broader historiographical debates.

Historical scholarship on colonial medicine in Africa expanded significantly after 1960s, as political decolonization across the Global South created new intellectual and political conditions that encouraged scholars to reexamine colonial institutions, including health and medical systems established under empire. Early post-independence studies sought to reconstruct the development of colonial health services, paying particular attention to hospitals, dispensaries, public health campaigns, and mission medical work in Africa, which played a central role in the delivery of biomedical care. Much of this scholarship, produced in the 1960s and early 1970s, approached colonial medicine from a largely secular, administrative perspective and treated it as one of colonialism's more constructive legacies.

These works focused on the colonial state as the primary actor in organizing medical services, regulating disease control, and allocating of health resources. In this line of thought, scholars such as David Clyde and Michael Gelfand adopted a largely affirmative view of Western biomedicine. They contended that colonial medical interventions contributed to measurable improvements in African health, particularly through large-scale campaigns targeting endemic and epidemic diseases. By focusing on how well these programs worked and on their scientific methods, these scholars

presented Western medicine as a positive and modern system. They argued that it helped reduce illness and deaths among African populations.[25]

While continuing to focus largely on the colonial state as the primary organizer of medical services, some scholars began to challenge earlier celebratory narratives. From the 1970s, historians such as Ann Beck adopted a more critical approach to colonial medicine. Beck argued that until the 1920s, Western medicine could not have produced a general improvement in the well-being of most Africans because its reach was extremely limited. Medical services were concentrated mainly in towns and key sites of production, rather than in rural areas where the majority of Africans lived.[26] She emphasized that colonial medicine primarily functioned to protect European health, maintain African laborers in a productive condition, and prevent diseases from spreading into large-scale epidemics that might threaten colonial order.

Drawing on the political economy perspective, researchers such as Meredith Turshen, Randall Packard, Helge Kjekshus, Steven Feierman, and John Janzen studied health and disease in colonial East Africa at both national and local levels. They showed that patterns of illness were closely linked to colonial conquest, land loss, and the integration of African societies into imperial economies. Labor migration, cash-crop farming, taxation, and forced movement of people disrupted local livelihoods, weakened nutrition, and increased exposure to disease. As a result, sickness and death rose among African populations. Within this framework, colonial medical interventions were interpreted as instruments of governance rather than expressions of humanitarian concern. Public health measures such as vaccination campaigns, disease surveillance, and control programs targeting smallpox and sleeping sickness aimed to maintain a productive labor force and ensure political stability. Colonial medicine thus functioned to support economic extraction and

[25] David Clyde, *History of the Medical Services in Tanganyika* (Dar es Salaam: Government Press, 1962); Michael Gelfand, *Lakeside Pioneers: Socio-Medical Study of Nyasaland, 1875-1920* (Oxford, Basil Blackwell, 1964), see also Michael Gelfand, *Tropical Victory: An Account of the Influence of Medicine on the History of Southern Rhodesia 1890-1923* (Cape Town: Junta and Co., 1954).

[26] Ann Beck, *A History of the British Medical Administration of East Africa* (Cambridge: Harvard University Press, 1970); Ann Beck, "Medicine and Society in Tanganyika 1890-1930: A Historical Inquiry" in *Transactions of the American Philosophical Society* Vol. 67 No.3 (1977); Ann Beck, *Medicine, Tradition, and Development in Kenya and Tanzania, 1920-1970* (Waltham, Crossroad Press, 1981). See also Ahmed Bayoumi, *The History of Sudan Health Service* (Nairobi, Kenya Literature Bureau, 1979).

administrative control, reinforcing the broader objectives of imperial rule while reshaping African health landscapes.[27]

This dissertation builds on this critical scholarship; however, it moves the analysis in a different direction. Rather than centering the colonial state and its planning apparatus as the primary locus of medical power, it shifts attention to missionary institutions and to everyday medical encounters at the local level. By focusing on mission hospitals, dispensaries, and routine clinical interactions, the study foregrounds the micro-politics of care and examines how medical authority was produced, contested, and negotiated in daily practice. Missionaries emerged as agents of colonial medicine and also as actors who worked at the intersection of religious, medical, and colonial politics. Their work both aligned with and diverged from state priorities, shaping how biomedical knowledge was translated, adapted, and sometimes resisted in the local contexts. In tracing these interactions, the dissertation challenges histories that focus mainly on the colonial state and demonstrates how missionary medicine functioned as a crucial site where colonial power, religious ambition, and African therapeutic practices intersected, producing outcomes that were neither fully determined by imperial policy nor entirely derived from local traditions.

From the late 1980s onward, historians began to broaden the scope of inquiry and turn more explicitly to the study of medical missions. This shift coincided with the emergence of critical mission history, which challenged earlier portrayals of missions as monolithic agents of Westernisation or simple instruments of colonial domination. Scholars instead began to analyse missions as socially embedded and internally contested institutions, shaped by local conditions, practical constraints, and sustained interaction with African societies.

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[27] Meredeth Turshen, *The Political Ecology of Disease in Tanzania* (New Brunswick: Rutgers University Press, 1984); Randall Packard, *White Plague, Black Labor: Tuberculosis and the Political Economy of Health and Disease in South Africa* (Berkeley: University of California Press, 1989); Helge Kjekshus, *Ecology Control and Economic Development in East African History: The Case of Tanganyika, 1850–1950* (London: Heinemann, 1977); Steven Feierman, "Struggles for Control: The Social Roots of Health and Healing in Modern Africa," *African Studies Review* 28, no. 2/3 (1985): 73–147; John M. Janzen, *The Quest for Therapy in Lower Zaire* (Berkeley: University of California Press, 1978).

Within this scholarship, medical missions have been recognised as central institutions in colonial healthcare systems, particularly in rural areas where state medical services were limited or absent.[28] Missionary hospitals, dispensaries, and training schools played a major role in the expansion of biomedical care, the education of African medical workers, and the dissemination of Christian ideas about health and healing. This interpretive turn aligns with critical approaches associated with Jean and John Comaroff, which conceptualise Christianity and missionary practice not as unidirectional impositions but as historically contingent and contested processes.[29] From this perspective, missionary medicine emerges as a field of interaction in which African moral worlds, therapeutic traditions, and social structures continually reshaped missionary intentions and practices. Healing encounters thus became sites of negotiation rather than simple instruments of colonial power.

In the 1990s, scholars increasingly analyzed medical missions as cultural processes shaped by specific ideologies, moral frameworks, and assumptions about African health, illness, and society. This cultural turn in the historiography shifted attention away from purely institutional or economic explanations and toward the meanings embedded in medical practice. Medical missions came to be understood as sites where ideas about the body, morality, civilization, and religious conversion intersected with everyday experiences of sickness and healing. Megan Vaughan's *Curing Their Ills* marked an important shift in this scholarship. Vaughan argued that Western biomedicine operated as a cultural tool used by missionaries and colonial agents to define African bodies, diseases, and social life. She emphasized that missionary medicine was a central component of early colonial health services.[30]

Similarly, Walima Kalusa described missionary medicine as a site of cultural negotiation between European missionaries and African patients, highlighting how

[28] Hardiman, *Healing Bodies, Saving Souls*; see also Steven Feierman, "Africa in History: The End of Universal Narratives," *Africa Today* 38, no. 1 (1991): 5–32;
[29] Comaroff and Comaroff, *Of Revelation and Revolution*; see also Walima T. Kalusa and Megan Vaughan, *Death, Belief and Politics in Central African History* (London: Palgrave Macmillan, 2013); Nancy Rose Hunt, *A Colonial Lexicon: Of Birth Ritual, Medicalization, and Mobility in the Congo* (Durham, NC: Duke University Press, 1999).
[30] Vaughan, *Curing Their Ills*.

Africans engaged with, adapted, and sometimes resisted missionary medical practices.[31] Scholars such as John Janzen and David Hardiman further showed that medical encounters were structured by differing explanatory models of illness. Missionaries and African patients often held contrasting views about disease causation and appropriate treatment, leading to misunderstanding, selective acceptance, and reinterpretation of biomedical therapies.[32] Together, these studies framed missionary medicine as a dynamic arena shaped by cross-cultural exchange and contested meanings rather than a straightforward extension of colonial authority.

Furthermore, scholars of colonial medicine have increasingly drawn attention to the role of medical pluralism in shaping medical practices during the colonial period. Historians have demonstrated that concerns about health, reproduction, and population were shaped by interactions between African communities and colonial authorities. In colonial Kenya, for example, Lynn Thomas has argued that changing approaches to reproduction and maternal health from the 1920s onwards emerged from the convergence of local priorities and imperial objectives. Her work shows that colonial medicine took shape within shared yet contested spaces, in which African actors actively participated in defining health problems and shaping medical responses.[33]

Similar patterns are evident in studies of medicine in South Africa. Karen Flint has argued that the development of colonial medicine there emerged through ongoing exchanges of ideas, technologies, and practices among Africans, Europeans, and Indians. By advancing this argument, Flint destabilized categories such as 'African medicine' or 'indigenous perspectives,' which scholars have often treated as synonymous with cultural authenticity. She emphasized that what is commonly

[31] Walima Kalusa, "Missionaries, African Patients, and Negotiating Missionary Medicine at Kalene Hospital, Zambia, 1906–1935," *Journal of Southern African Studies* 40, no. 2 (2014): 283–94, 285.
[32] See the discussion on the central role of the "therapy management group," which symbolizes the contested nature of medicine and therapeutic practices, in the study of John Janzen, *The Quest for Therapy: Medical Pluralism in Lower Zaire: Comparative Studies of Health Systems and Medical Care* (California: University of California Press, 1978), 26; See also Hardiman, *Healing Bodies, Saving Souls,* 36.
[33] Lynn M. Thomas, *The Politics of the Womb: Women, Reproduction, and the State in Kenya* (Berkeley: University of California Press, 2003), 19; see also Julie Livingston, *Debility and the Moral Imagination in Botswana* (Bloomington and Indianapolis: Indiana University Press, 2005).

understood as African medical knowledge was, in fact, an evolving assemblage of multiple cultural influences, shaped by Africans' continuous interactions with Europeans, Indians, Chinese, and Arabs.[34] From this perspective, medicine in South Africa was neither exclusively African nor Western, but rather a plural medical landscape that integrated diverse epistemologies and practices.

This perspective has informed my own analysis of medical missionaries in this dissertation. Medical pluralism provides a useful analytical lens for examining colonial contexts in which multiple healing traditions operated simultaneously. In the Southern Highlands, missionary bio-medicine entered societies where healing was already embedded in complex moral, spiritual, and social frameworks. Indigenous therapeutic systems addressed illness not only as a physical condition but as a relational and communal event involving kin, elders, ritual specialists, and spiritual forces.[35] Missionary medicine did not displace these systems; instead, it became one option among several within a broader therapeutic landscape.

Other studies have shown that missionaries prioritized diseases that visibly altered the body and social identity, such as leprosy, blindness, and severe disability.[36] These conditions attracted missionary attention because they symbolized suffering, marginalization, and the need for compassion, while also offering opportunities for sustained institutional care. Missionaries also devoted considerable effort to maternal health, childcare, hygiene education, and public health initiatives.[37]

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[34] Karen Flint, Healing Traditions: African Medicine, Cultural Exchange, and Competition in South Africa, 1820-1948 (Athens, Ohio University Press, 2008). See also the recent unpublished PhD thesis by Veronica Kimani, *"*Creating Health Futures: Maternal Health Policy, Planning, and the Making of Postcolonial Tanzania, 1961–1980*"* (PhD Dissertation., University of Cologne, 2025).

[35] See Steven Feierman, "Struggles for Control: The Social Roots of Health and Healing in Modern Africa," *African Studies Review* 28, no. 2/3 (1985): 120.

[36] Angetile Musomba documents that in the early history of the Moravian Church in Rungwe, evangelization was closely intertwined with social and medical care, including the treatment of leprosy patients, midwifery services, child welfare initiatives, and general healthcare. For further discussion, see Musomba, *Historia Fupi ya Kanisa la Moravian Kusini Tanzania, 1891–1976*. For maternal health, see Oswald Masebo, *"*Society, State, and Infant Welfare: Negotiating Medical Interventions in Colonial Tanzania, 1920–1950*"* (PhD Dissertation., University of Minnesota, 2010); and Veronica Kimani, "Creating Health Futures: Maternal Health Policy, Planning, and the Making of Postcolonial Tanzania, 1961–1980" (PhD Dissertation., University of Cologne, 2025). See also archival material in The National Archives (TNA), CO 18/7, John Stuart Wells, District Officer, Rungwe District, to DMSS, 23 May 1922, ref. 18/3/2.

[37] Jennings, "Healing of Bodies, Salvation of Souls," 27–56.

These medical practices were closely tied to European ideologies that justified colonialism. From the late nineteenth century, European powers promoted Eurocentric ideas that portrayed African societies as backward and in need of civilization. Racial theories that emphasized white superiority were often embedded in colonial medical practices. The provision of missionary medicine thus became one way through which European actors sought to control and transform African bodies and societies. This study is interested in uncovering how mission medicine participated in what can be described as the colonization of African bodies.[38]

Furthermore, literature on missionary histories shows that in the initial stages some mission societies opposed the idea of medical missionaries preferring to believe that Christian faith and prayer were sufficient to remove all the obstacles including ensuring the health of the majority of Africans who resided in rural areas.[39] However, it became imperative for the missionaries to establish medical care for the Africans as "treatment [of the sick] was seen to put people in a receptive frame of mind to the message of the Gospel" and that was instrumental for the missionaries to reach the goal of spiritual salvation.[40]The opening of mission dispensaries and hospitals at different times and places in Africa acted as a "magnet" that brought up indigenous patients from near and distant to the mission medical centres and that expressed many fundamentals of the medical missionary endeavor in colonial Africa.[41]

The literature on the social history of medicine in Africa explains that colonial state medicine largely neglected the health needs of rural Africans. In contrast, medical missionaries were deeply involved in providing health care to these populations. In order to do so, missionaries had to compete directly with indigenous systems of traditional healing on their own ground. Missionary medicine was not limited to treating physical illness; rather, missionaries viewed their work holistically. They

[38] For a detailed discussion, see chapter five of this dissertation.
[39] Good, "Pioneer Medical Missions in Colonial Africa," 1 and see also; Vaughan, *Curing Their Ills: Colonial Power and African Illness*, 25.
[40] Hardiman, *Healing Bodies, Saving Soul*, 25 See also, ; Good, "Pioneer Medical Missions in Colonial Africa," 1.
[41] Vaughan, *Curing Their Ills*, 55; Musomba, *Historia Fupi ya Kanisa La Moravian Kusini Tanzania 1891-1976*; Clyde, *History of the Medical Services in Tanganyika*; Oliver, *The Missionary Factor in East Africa.*

understood medical care as part of a broader mission to heal both the body and the social order by combining health services with Christian faith. Curing the sick was connected with social reform and the saving of souls. The indigenous population as a result saw mission doctors as being of a completely different species to official colonial doctors.[42] Kalusa argued that the medical missionaries in Africa came to appreciate that they could not successfully treat local patients in isolation from their existing culture. No missionaries were unaware of the importance of assimilating pre-existing knowledge of healing into African medical practice to popularize their medicine.[43] As a result, the missionary and local medical came to co-exist, enabling African patients to move easily between these systems as they sought effective treatments, while missionaries adapted their practices to make them culturally meaningful.

1.2.1 Medical Missions, Colonial Authority, and African Agency

The relationship between Christian missionary enterprise and colonial rule in Africa has long been characterized by ambiguity, cooperation, and conflict. Situated within the framework of critical mission studies, this section examines missionary activity not as a purely religious or humanitarian undertaking, but as a historically contingent enterprise embedded within colonial structures of power. Scholars working in this tradition emphasize that missionaries operated within colonial societies while occupying shifting and often contradictory positions shaped by evangelical objectives, political realities, and African responses. Rather than portraying missions as either benevolent agents of progress or straightforward instruments of colonial domination, critical mission studies foregrounds the contested relationships between missionaries, colonial authorities, and African communities. Within this analytical framework, medical missions emerge as a key arena through which colonial authority was articulated, negotiated, and enacted in everyday life.

Scholarly debates on the relationship between missionaries and colonial capitalism expanded significantly in the period following African political independence.

[42] Vaughan, *Curing Their Ills: Colonial Power and African Illness*, 295.
[43] Kalusa, "Missionaries, African Patients, and Negotiating Missionary Medicine at Kalene Hospital, Zambia, 1906–1935," 284.

Historians seeking to reassess the colonial encounter began to question earlier celebratory narratives of missionary activity and to examine more critically the place of Christian missions within colonial structures. Despite extensive scholarship, however, no consensus has emerged. Instead, historians have advanced competing interpretations that reflect different understandings of power, agency, and collaboration in colonial Africa.

Early interpretations tended to emphasize missionaries as morally driven actors whose primary objective was evangelization rather than political domination. These scholars portrayed missionaries as courageous individuals who entered unfamiliar environments marked by disease, ecological challenges, and strong indigenous belief systems. According to this view, missionaries' evangelical priorities often placed them at odds with colonial authorities, whose interests lay primarily in commerce, taxation, and political control.[44] In some cases, missionaries criticized colonial abuses and advocated for African communities, which contributed to tensions with colonial administrations.

However, describing missionaries simply as victims of colonial capitalism obscures an important dimension of their historical role. Many missionaries actively welcomed or even requested the establishment of colonial rule in areas where they operated. They believed that colonial order, military protection, and administrative stability would enable them to evangelize more effectively. In regions such as German South West Africa and German East Africa, missionaries petitioned colonial governments for protection, land rights, and legal authority.[45] Mission societies that aligned themselves with colonial objectives often received state support, while those that openly challenged colonial policies faced restrictions. As Don Rempel Boschman has shown in the case of the London Missionary Society in southern Africa, missionary-state relations depended less on moral principles alone and more

[44] Obed Kealotswe et al., eds., "African Christianity in Colonial Times," in *Anthology of African Christianity* (UK: Regnum Books International, 2016), 43.
[45] See Gröschel, *Zehn Jahre christlicher Kulturarbeit in Deutsch-Ostafrika*, 163-168; Jeremy Best, *Heavenly Fatherland: German Missionary Culture and Globalization in the Age of Empire* (Toronto: University of Toronto Press, 2021), 27, 32; Arne Perras, *Carl Peters and German Imperialism, 1856-1918: A Political Biography* (New York: Clarendon Press, 2004), 82.

on the extent to which missionaries were perceived as useful to colonial governance.[46]

Other scholars have drawn attention to the deeply ambivalent and often contradictory character of relationships between missionaries and colonial authorities. Rather than operating as a unified front, these two groups were frequently driven by distinct priorities and worldviews. As Robert Strayer has argued, missionaries and colonial officials often pursued goals that diverged sharply and, in some cases, directly clashed with one another. Missionaries tended to focus on moral reform, religious conversion, and the reshaping of local societies according to Christian ideals, while colonial administrators were primarily concerned with political stability, economic extraction, and effective governance. These tensions were particularly visible at the local level, where missionaries provided services, such as education and medical care, which the colonial state was either unwilling or unable to supply. In the field of health, missionary medicine often filled gaps left by weak colonial health systems in rural areas.[47]

As Hardiman observed, despite the prominent place of medical missionaries in the 'Western imagination' as straightforward agents of imperial expansion, their actual relationship to imperial power was far more complex.[48] Many missionaries did not simply endorse colonial authority or act as its willing instruments. Instead, they often approached imperial rule with caution, moral unease, and even open ambivalence.[49]

Such depictions were criticized by the nationalist school of thought, that in the reassessment of the place of missionary work in European colonialism they hold the view that missionaries were the connivers if not active agents that assisted the imposition and maintenance of colonial rule in Africa. They strongly refute the view

[46] See Don Rempel Boschman, *The Conflict Between New Religious Movements and the State in the Bechuanaland Protectorate Prior to 1949* (Gaborone: University of Botswana, 1994).
[47] Robert Strayer, "Mission History in Africa: New Perspectives on an Encounter," *African Studies Review* 19, no. 1 (n.d.): 9.
[48] Hardiman, *Healing Bodies, Saving Souls*, 5; see also, Helmut Walser Smith, *German Nationalism and Religious Conflict: Culture, Ideology, and Politics, 1870–1914* (Princeton, NJ: Princeton University Press, 1995).
[49] See Oliver, *The Missionary Factor in East Africa.*

that Christian missionaries were generous and "well intentioned philanthropists."[50] Arguing on the same line, Walter Rodney, for instance, considered the nineteenth-century missionaries 'as much part of the colonizing forces as were explorers, traders, and soldiers'. Regardless of their intentions, missionaries were in fact 'agents of colonialism in the practical sense, whether or not they saw themselves in that light.'[51]

This argument has been further developed by Jean and John Comaroff in their study of Protestant missions in South Africa. They contend that missionaries were among the most influential cultural agents of empire. Through education, religion, and medicine, missionaries sought to reconstruct African societies according to European moral and cultural ideals. In doing so, they helped produce disciplined, governable colonial subjects, even when they criticized specific colonial practices. For Comaroff's, missionaries were:

> Not only … Nonconformist evangelists the vanguard of the … [colonial rule] presence in th[e] part of South Africa [and in other African colonies]; they were also the most active cultural agents of empire, being driven by the explicit aim of reconstructing the 'native' world in the name of God and European civilization.[52]

From that argument, Christian missionary activities had a direct link with the colonial structure in Africa and this means that all of their activities including the ministry of healing which was part of their mission in Africa linked with the colonial policies. According to Thomas Beidelman, Christianity in Europe was a core part of Western culture and could not be separated from other aspects of Western power. He explains that military strength, the ability to manufacture medicines and textiles, and widespread literacy were all seen as parts of one cultural system. When missionaries came to Africa, they carried this entire "package" with them.[53] As a result, Christian teaching and healing practices were presented alongside Western knowledge and

[50] Comaroff and Comaroff, *Of Revelation and Revolution: The Dialectics of Modernity on a Southern African Frontier*, 7.
[51] Walter Rodney, *How European Underdeveloped Africa* (Washington: Howard University Press, 1981), 252.
[52] Comaroff and Comaroff, *Of Revelation and Revolution*, 7.
[53] Thomas Beidelman, "Social Theory and the Study of Christian Missions in Africa," *Journal of the International African Institute*, 1974, 244.

technology, reinforcing the idea that Western culture was superior and meant to lead African societies.

Studies of education and medicine further highlight the intermediary role of missionaries. Ado Tiberondwa, writing on missionary teachers as agents of colonialism in Uganda, argues that missionary involvement in and support for the colonial government was 'two-fold'."[54] On the one hand, missionaries actively facilitated the spread of colonial rule by acting as recruitment agencies and by training Africans for administrative positions. On the other hand, they functioned as cultural brokers in "both relatively benign and more explicitly coercive" ways, encouraging compliance with both the church and the colonial state as a core Christian moral value.[55]

In the same lens, the study of medical missions in Belgian Congo by Nancy Rose Hunt has suggested that missions were entwined with the colonial government and commercial interests, and turned a blind eye toward the exploitation of the people of Congo. She also adds that the view of medical mission as anomaly within colonial medicine, as a benign, influential, sentimental form has been often used to underscore the coercive aspect of colonial medicine being commercial or secular based. Therefore, for her, the dichotomy does not fit here as the "colonial evangelism was not soft, and the colonial state was not [always] strong".[56] Thus, the relationship between the medical mission and the colonial state was often very complex and problematic. The detailed coverage of missionary endeavours in South Africa presented by the Comaroffs suggests that:

> Recent writings at the juncture of history and anthropology have begun to show how important were the divisions within colonising populations. … The Christian missions were from the start caught up in these complexities. Not only did the various denominations have diverse and frequently contradictory designs on Africa, design that sometimes turned out to have unpredictable consequences; their activities also brought them into ambivalent relations with other Europeans on the colonial stage. Some found common cause, and

[54] Ado Tiberondwa, *Missionary Teachers as Agents of Colonialism: A Study of Their Activities in Uganda* (Kampala: Fountain Publishers, 1998), chapter, 3–4.
[55] Tiberondwa, *Missionary Teachers as Agents of Colonialism.*
[56] Nancy Rose Hunt, *A Colonial Lexicon: Of Birth Ritual, Medicalization and Mobility in the Congo* ((Durham: Duke University Press, 1999), 161.

> cooperated openly, with administrators and settlers. Others ended up locked in battle with secular forces for what they took to be the destiny of the continent.[57]

Nevertheless, missionaries were sometimes strongly criticized by the colonial and chauvinistic groups in Germany and in the colonies for spoiling Africans. Not imparting them with working skills while bringing light to the understanding that all human beings are equal before God something they feared would weaken European influence and power toward colonial subjects. Also, there was a strong debate that insisted that the mission medical services should never override the real aim of their mission in Africa.[58] However, missionaries were bound to their mission first and foremost but at some point their mission interests coincided with those of the colonial authority, hence, that shaped their relations with the colonial state. And to defend themselves from the attacks they had to associate with the colonial government and sought confidence, support and trust while maintaining their religious freedom and integrity.[59]

Moreover, Barbara Turshen, in her work on Tanzania, explains that medical missions were an integral component of the Benedictine mission in Songea District, southwest Tanzania. These missions provided medical care that focused on maternal health and infant welfare. However, such involvement also served to regulate and sustain the reproduction of the African labour force required by both colonial entrepreneurs and the colonial state for the functioning of the colonial economy.[60]

Similarly, writing from a Tanzania historical perspective, Arnold Temu elucidates that missionaries largely operated as handmaidens of the colonial government.[61] From this viewpoint, missionary activities in Tanzania were crucial in facilitating the smooth operation of the colonial system. Their significant contribution to the

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[57] Comaroff and Comaroff, *Of Revelation and Revolution,* 10–11.
[58] David Hardiman, "The Mission Hospital, 1800-1960," in *From Western Medicine to Global Medicine: The Hospital beyond the West*, ed. Margaret Jones and Helen Sweet (New Delhi: Orient Blackswan, 2009), 200.
[59] Hardiman, 383.
[60] Turshen, "The Impact of Colonialism on Health and Health Services in Tanzania," 29–30.
[61] Arnold Temu, *British Protestant Missions* (London: Longman, 1971), 132.

establishment and maintenance of colonial rule in many African territories, particularly in Tanganyika, therefore cannot be overlooked.

This collaboration was especially evident in the realm of public health. In implementing preventive measures in African colonies, colonial states were acutely aware of the advantages of cooperating with missionaries during vaccination campaigns in rural areas. Because missionaries possessed extensive knowledge of local communities, colonial efforts to control disease became more efficient and less time-consuming. During such initiatives, the colonial state frequently supplied missions with funds, drugs, and medical equipment, while missionaries carried out the practical work on the ground.[62] Medical missions thus became an integral component of colonial governance, extending state reach into areas where administrative presence was otherwise limited.

As Marcia Wright suggests, however, the close relationship between missionaries and colonial officials often created confusion among local communities. Because missionaries worked alongside colonial administrators and benefited from colonial protection, Africans sometimes perceived them as representatives of the colonial state rather than as purely religious agents.[63] Missionary activities such as education, medical services, and moral instruction appeared to support colonial authority and discipline. As a result, local people frequently failed to distinguish between missionary work and colonial governance, viewing both as parts of the same system of foreign control and influence.

Despite this general alignment, relations between missionaries and colonial authorities were not always harmonious. At certain moments, missionaries came into conflict with colonial officials and maintained uneasy relationships with local chiefs, particularly during periods of crisis such as the Maji Maji War. Nevertheless, their overall position remained closely aligned with colonial power. During the resistance, missionaries were publicly praised by the German colonial government and even by

[62] Jennings, "Healing of Bodies, Salvation of Souls: Missionary Medicine in Colonial Tanganyika, 1870s-1939," 46.
[63] Wright, *German Mission in Tanganyika*, 139.

the German emperor for the role they played in promoting order, stability, and loyalty to the colonial state.[64] Such official recognition further reinforced African perceptions that missionaries were deeply embedded within colonial authority, despite occasional tensions and disagreements.

Building on this interpretation, Michael Jennings explains that the role of missionaries as agents of European culture and conquest was particularly visible in the medical sphere. For Jennings, the establishment of rural clinics enabled missionaries to engage directly with African cultural practices and social life. Mission medicine transmitted not only biomedical knowledge but also missionary ideas about sanitation, rooted in assumptions about the unsanitary nature of African life. Concepts such as proper behaviour, industriousness, obedience, and the encouragement of routine and discipline to ensure cleanliness and health were embedded within a broader medico-moral discourse.[65] Western ideas of the body, illness, and healing were thus wrapped within the ministry of medicine, explicitly challenging African healing practices that were grounded in indigenous traditions, social structures, and cultural belief

Yet the association of missionaries with colonial authority did not eliminate African agency; rather, it shaped the conditions under which Africans engaged with and negotiated missionary influence. While some communities viewed missionaries as extensions of colonial power, African actors continued to reinterpret missionary teachings and medical practices in ways that reflected local priorities and social realities. Engagement with mission medicine did not necessarily entail acceptance of missionary moral discipline or Christian worldviews. Instead, Africans selectively appropriated elements of Western medicine while maintaining existing social, spiritual, and therapeutic frameworks. These everyday acts of adaptation and reinterpretation reveal that missionary medicine functioned as a site of negotiation rather than one of unilateral domination.

[64] Gröschel, *Zehn Jahre Christlicher Kulturarbeit in Deutsch-Ostafrika*, 4:224; Giblin and Monson, *Maji Maji*, 253.
[65] Jennings, *Healing of Bodies, Salvation of Souls,* 33.

Taken together, the scholarship reviewed in this section demonstrates that missionary enterprise in Africa operated within a shifting spectrum of colonial power relations rather than occupying a single or coherent position. Medical missions played a significant role in extending colonial authority by promoting Western medical knowledge, Christian moral values, and new forms of social discipline. At the same time, their effectiveness depended heavily on African participation, interpretation, and cooperation. Missionary medicine did not simply impose Western biomedical models or Christian norms from above; instead, it was enacted through everyday encounters in which African actors actively engaged with, adapted, and at times constrained missionary interventions. This study therefore argues that medical missions in the Southern Highlands of Tanzania between 1891 and 1940 constituted a contested arena in which colonial authority and African agency were mutually constituted. Examining missionary medicine through the lens of critical mission studies reveals how colonial power was not only exercised but continually produced and reshaped through local interactions between missionaries, colonial officials, and African communities.

1.2.2 Mission Medicine as a Contested Site of Social and Cultural Exchange

Studies of missionary medicine offer a valuable lens for examining how Christian missionaries pursued evangelization in African societies. Medical work served as a strategic entry point, as healing practices attracted local populations and created opportunities to introduce Christian teachings. In many African colonies, Western medicine and Christian evangelism thus developed together, reinforcing one another within everyday missionary practice.[66] Hospitals, dispensaries, and clinics were not merely sites of treatment but also spaces where religious instruction and moral discipline were embedded in the provision of care.

Moreover, missionaries widely believed that the promotion of African welfare was inseparable from the Christianization of African souls. The more missionaries invested in the physical and social well-being of the African communities among

[66] See Latourette, *A History of the Expansion of Christianity*; Martin Ballard, White Men's God: The Extraordinary Story of Missionaries in Africa (Oxford: Greenwood World Publishing, 2008); see also Fiedler, C*hristianity and African Culture: Conservative German Protestant Missionaries in Tanzania, 1900-1940.*

whom they lived, the closer their relationships with local populations became. This proximity, in turn, provided missions with greater access and legitimacy to promote and expand the 'religious agenda of missionary institutions.' [67] Strengthening missionary authority, however, often required undermining African traditions, cultural practices, and belief systems, including indigenous understandings of illness and popular healing.

Scholars have emphasized that the development of Western missionary medicine was not a straightforward process of imposition. Rather, it involved ongoing negotiations with Africans as historical actors, as well as with colonial states that regulated and administered colonial territories. These interactions were frequently complex and contested, shaped by local resistance, selective acceptance, and the practical limitations of colonial governance. As a result, missionary medicine emerged through compromise and adaptation, rather than as a simple extension of either religious or colonial power.

The spread of Christianity and the winning of converts were central to the long-term relationships that missionaries established with African local chiefs, colonial authorities, and the local people among whom they lived.[68] The provision of curative and preventive medical care by both the colonial state and Christian missions enabled direct intervention in African concerns related to health, mortality rates, and maternal welfare. This access to Africans' internal affairs created opportunities for missionaries and colonial administrators to introduce Western cultural ideologies and practices, which in turn helped legitimize colonial rule, particularly among rural African communities.

However, missionary engagement with African societies was often marked by a form of self-delusion. Many missionaries believed they possessed a God-given and superior understanding of African cultures and social systems, despite their limited knowledge of local realities. This sense of certainty shaped missionary strategies and

[67] Oliver, *The Missionary Factor in East Africa,* 211; Leslie Doyal and Imogen Pennell, *The Political Economy of Health* (London: Pluto Press, 1979), 251.
[68] For the relationship between the missionaries and the local chiefs see, Merensky, *Deutsche Arbeit am Njaßa,* 172; Kerr-Cross, "Crater-Lakes North of Lake Nyasa," p.119; Meyer, WaKonde, 217-218.

expectations, especially regarding conversion. Medical care, for example, was frequently viewed not only as a humanitarian service but also as a means of attracting converts.[69] Missionaries assumed that access to Western medicine would encourage Africans to abandon their traditional customs and belief systems and fully embrace Christianity along with Western cultural values.

Conversion, in the missionary imagination, required more than religious acceptance; it demanded a complete transformation of social and cultural identity. As a result, missionaries often expected converts to withdraw from their villages and establish separate Christian communities, believing that physical separation from traditional environments was essential for sustaining a Christian way of life. In practice, this expectation proved unrealistic. Over time, missionaries were forced to recognize that African converts were unwilling to sever ties with their families, communities, and cultural foundations. Rather than conforming to missionary ideals, African Christians adapted Christianity to fit within existing social structures, compelling missionaries to modify their evangelical approaches.

Angetile Musomba argues that Protestant missionaries in the Southern Highlands eventually realized that their expectations did not materialize and were forced to accept that local people did not wish to live fully according to Christian ideals.[70] As a result, missionaries had to continue their evangelical mission while accommodating the ways Africans responded to Christianity. This became particularly evident in the continued reliance of African Christians on indigenous healing practices. Despite conversion, many Africans privately sought explanations for misfortune, such as illness, barrenness, accidents, snakebites, and death, through traditional healers.[71]

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[69] For more extended discussion, see Gröschel, *Zehn Jahre Christlicher Kulturarbeit, 128-29 and 169;* James Giblin and Blandina Kaduma, *A History of the Excluded: Making Family a Refuge from State in Twentieth-Century Tanzania* (Athens: Ohio University Press, 2006), 275; Terence Ranger, "The African Churches of Tanzania, Historical Association of Tanzania," This Reference Is from EAF PAM BR1443T35., no. 5 (n.d.): 5; See also Haussleiter Halle, "Die Bedeutung der medizinischen Mission in den deutschen Kolonien," in *Verhandlungen des Deutschen Kolonial-Kongresses*, 1910 (Berlin, 1910), 748.

[70] *Periodical Account,* (1897), No. 029, 12 and Musomba, *Historia Fupi Ya Kanisa La Moravian Kusini Tanzania*, 23.

[71] Erich Schultze, *Der Njaßabund: Bilder Aus Der Weiblichen Liebestätigkeit Der Berliner Mission in Deutsch-Ost-Afrika*, No. 43, (Berlin: Buchhandlung der Berliner Evangelischen Missionsgesellschaft, 1912), 86.

These practices remained deeply embedded in African worldviews and social life, and in many cases indigenous healers were more trusted and respected than European doctors, especially when imported Western medicine failed to cure certain local diseases. This persistence demonstrates that conversion did not result in the complete rejection of African belief systems but rather a selective and negotiated engagement with Christianity.

Through ongoing negotiations between African medical systems and colonial and mission medical services, it becomes clear that both converts and non-converts, men and women alike, were not passive recipients of Western medical ideas and practices. Africans were important historical agents whose negotiations formed an integral component in the progress and development of medical missions. Richard Waller and Kathy Homewood explain that African responses to mission medical interventions were shaped by the existence of long-established traditions and cultures of healing. As a result, Africans assessed Western medicine by resisting, adapting, and selectively incorporating its interventions, while infusing them with meanings that aligned with their own understanding of medicine and healing. This process, in one way or another, altered the mission medical landscape.[72]

Drawing on archival documents on missionary medicine in colonial Zambia, Walima Kalusa explains that encounters between medical missions and Africans were often fields of conflict and resistance. However, missionaries overlooked the fact that mission hospitals were not always sites of contestation but also spaces where African patients interacted with mission doctors through social and cultural exchange and negotiation. Kalusa further argues that there were no "sick Africans [who were]

[72] Richard Waller and Kathy Homewood, "Elders and Experts: Contesting Veterinary Knowledge in a pastoral community," in Andrew Cunningham and Bridie Andrews eds., *Western Medicine as Contested Knowledge* (Manchester, Manchester University Press, 1997): 69-93. See also, Amy Kaler, "The White Man in the Bedroom: Contraception and Resistance on Commercial Farms in Colonial Rhodesia," in Poonam Bala ed., *Medicine as a Contested Site: Some Revelations in Imperial Contexts* (Lanham, Boulder, and New York, Rowman and Littlefield Publishers, 2009): 79-98; Jean Allman and Victoria Tashjian, *I Will Not Eat Stone: A Women's History of Colonial Asante* (Portsmouth, NH., Heinemann, 2000), Chapter 5; Thomas, *The Politics of the Womb*, 19 and Julie Livingston, *Debility and the Moral Imagination in Botswana* (Bloomington and Indianapolis, Indiana University Press, 2005).

completely without social and cultural bargaining power."[73] Therefore, medical missionaries and African men and women were required to support one another both medically and culturally.

Contributing to the historiography of missionary activity and maternal healthcare in the twentieth-century Upper Congo, Nancy Rose Hunt, drawing on ethnographic observations and oral accounts, argues that the development of mission biomedical work involved continuous negotiation and transactions with Africans. In mission childbirth practices, the penetration and acceptance of mission medicine were facilitated by African medical workers, such as midwives, nurses, and medical attendants, who acted as intermediaries and shaped the mediating contacts between African communities and missionaries.[74]

Similarly, writing on medical interventions in Southwest Tanzania during British colonial rule, Oswald Masebo demonstrates that local people actively shaped medical missions rather than passively accepting them. He shows that Africans drew on a wide range of past ideas, practices, and experiences related to health and healing, rooted in long-standing indigenous medical knowledge. These pre-existing understandings informed how local communities interpreted, assessed, and engaged with mission medicine. As a result, mission medical practices were redefined through African agency, as people selectively adopted, adapted, or resisted biomedical interventions in ways that aligned with their social, cultural, and spiritual frameworks. This process transformed not only Africans' relationships with mission medicine but also reshaped broader social relations and patterns of action within local communities.[75]

This study therefore makes a new contribution to the historiography of African medical missions by shifting attention from missionary intentions to African intellectual and practical agency in medical encounters. Focusing on the Southern

[73] Kalusa, "Missionaries, African Patients, and Negotiating Missionary Medicine at Kalene Hospital, Zambia, 1906–1935."
[74] Hunt, *A Colonial Lexicon*; Shula Marks, *Divided Sisterhood: Race, Class, and Gender in the South African Nursing Profession* (New York: St. Martins Press, 1994).
[75] Masebo, "Society, State and Infant Welfare," 2; See also Fr Severino Zucchelli, *Medical Development in Tanganyika* (Tabora: T.M.P Printing Department, 1963).

Highlands of Tanzania under German colonial rule, it demonstrates that African engagements with mission medicine were not acts of passive acceptance or outright rejection, but dynamic processes of negotiation grounded in long-standing indigenous understandings of health, healing, and the interaction between social, environmental, and spiritual worlds. By foregrounding oral recollections alongside archival and ethnographic sources, the study reveals how local medical knowledge actively shaped, contested, and reconfigured missionary medical practices. In doing so, it moves beyond existing mission medical histories to show how Christian medical missions in Tanzania were co-produced through African epistemologies, thereby offering a more nuanced understanding of medical missions in Africa as sites of encounter, negotiation, and mutual transformation rather than unilateral colonial imposition.

1.3 Methodology and Sources

This study adopted a qualitative approach to data collection and analysis, drawing on a combination of oral recollections, written archival sources, and extant ethnographic accounts to examine the interactions between missionaries, colonial authorities, and African communities, as well as African responses to mission medical services in the Southern Highlands of Tanzania between 1891 and 1940. Although these sources were produced by different social actors and at different historical moments, they were treated as complementary forms of evidence, since none could adequately illuminate the historical processes under investigation on its own. Reading these materials against one another made it possible to interrogate their respective perspectives and subjectivities while situating them within a shared colonial context shaped by negotiation, adaptation, and unequal power relations.

Oral histories were collected through semi-structured interviews. Initial participants were identified through local community networks, and additional interviewees were recruited through snowball sampling. Interviews were conducted in Langenburg (present-day Kyela and Rungwe districts of Mbeya Region) and at former Berlin Missionary Society mission stations in Kidugala, Yakobi, Ilembula, Milo, and Bulongwa, in Njombe Region. Interviews were conducted in Kiswahili and local languages, including Kinyakyusa, Kibena, and Kipangwa, which were widely spoken

among indigenous communities in southwestern Tanzania. Kiswahili was used with informants who were fluent in the language, while local languages were employed when interviewing elderly men and women who were not conversant in Kiswahili. Since the researcher was not familiar with all the local languages, this work was made possible through the assistance of two research assistants who were fluent in these languages. Their role was essential in facilitating effective communication between the researcher and participants, as well as ensuring accurate translation and interpretation of respondents' narratives.[76]

Given the temporal distance between the period under study and the time of data collection, most respondents were elderly individuals whose knowledge of missionary activities, mission medical services, and African responses to Western medicine was derived from memories transmitted by parents and grandparents. While many respondents' own lived experiences related primarily to the late 1940s and 1950s, their recollections consistently reflected practices, institutional arrangements, and moral frameworks associated with the period of German Protestant missionary presence in the region from 1891 to 1940. These intergenerational memories bridged the temporal gap between the German colonial era and later decades, allowing the study to reconstruct earlier experiences of mission medicine as they were remembered, interpreted, and reworked over time.

Rather than treating this time gap as a methodological limitation, the study approached it as analytically productive. Oral narratives made it possible to trace the long-term legacy of German mission medicine, demonstrating how medical practices, ideas of healing, and engagements with mission institutions continued to shape African experiences well beyond the end of formal German colonial rule. Acknowledging that individual interviews could contain divergent information, exaggerations, or distortions, the study evaluated oral testimonies through careful

[76] While conducting interviews in the Njombe region at the well-known Berliner Lutheran missionary station, I was privileged to be accompanied by a local guide, Mzee Leonard Mkolwe. In Kyela, I benefited greatly from the support of Neema Mwaisanja. Additionally, my collaboration with my father Philemon Kaduma, who introduced me to the current Bishop of the Evangelical Lutheran Church in Tanzania (ELCT), Rev. Geoffrey Mwakihaba, and his assistant, Rev. Dr. Meshack Njinga, helped me to identify and locate retired pastors who have served the church since the 1960s.

comparison with contemporary written accounts and ethnographic sources. This triangulation strengthened the credibility of the evidence while also foregrounding the subjective meanings attached to past events.

Although oral sources were limited in scope, they proved indispensable for recovering the voices of ordinary African men and women who were largely excluded from mission archives and official historical records. The study drew on oral narratives that continued to circulate in the Southern Highlands to reveal African responses to mission medical work and the ways encounters with missionaries were remembered and narrated across generations. The researcher's social position, as someone born and raised in the region, facilitated access to local communities and enhanced sensitivity to cultural meanings, thereby aiding the reconstruction of the legacy of mission medical interventions. Finally, the study contributed to a relatively under explored field, as local studies that employ oral sources to articulate mission medical work and its long-term legacy in colonial Tanzania remain scarce.

Archival research for this study was conducted in both Tanzania and Germany, allowing for a multi-sited examination of missionary history and its local and transnational dimensions. In Tanzania, several key repositories were consulted. These included the Rungwe Archive and Museum Center, which holds locally curated historical materials for the Moravian Church and the Kidugala Lutheran Seminar Archive, an important repository for ecclesiastical and educational records related to Lutheran training institutions. Additional research was carried out at the Tanzania National Archives in Dar es Salaam, the country's principal depository of government and colonial-era historical records.

Beyond state and institutional archives, the study also examined records preserved by the Lutheran Church in the Mbeya Region. These church-held materials proved especially valuable for accessing perspectives often absent from official archives, including locally produced correspondence, parish reports, and mission station records. Collectively, these sources yielded rich and complementary information on mission organization, religious practice, educational programs, and health-related

initiatives, offering detailed insights into how missionary activities were structured and experienced at the local level in Southern Highlands Tanzania.

In Germany, archival research was conducted at the Bundesarchiv in Berlin and the Evangelisches Landeskirchliches Archiv. These repositories were examined to gather detailed evidence on missionary activities, health care provision, and the interactions between missionary societies and colonial authorities in German East Africa. Collectively, these sources enabled the situating of missionary engagement within wider colonial, political, and administrative frameworks.

The study also drew extensively on ethnographic accounts, particularly those produced by missionaries and early European observers, which remain among the most detailed written records of indigenous societies during the early colonial period. These sources were used to reconstruct social practices, belief systems, and everyday life in Unyakyusa, as well as to assess how such practices were interpreted and reshaped through missionary perspectives. One particularly significant source was *Wa-Konde: Maisha, Mila na Desturi za Wanyakyusa*, written by Theodor Meyer. Covering the period from the 1890s to the early 1910s, Meyer's work provides detailed ethnographic descriptions of indigenous social organization, religious practices, and customary norms, offering valuable insight into local life prior to, and during, the early years of sustained missionary and colonial intervention.[77]

Another key ethnographic text was *The Spirit-Ridden Konde* (1925), authored by the British missionary Duncan R. Mackenzie, who resided in Unyakyusa for approximately two decades. Drawing on long-term residence and close engagement with local communities, Mackenzie's work offers important perspectives on the history and social significance of witchcraft beliefs, spirit possession, and ritual practices.[78] At the same time, it sheds light on the evolving influence of missionary activity and Christian discourse among indigenous populations in the Southern

[77] Theodor Meyer, *Wa-Konde: Maisha, Mila Na Desturi Za Wanyakyusa* (Mbeya: Metheco Publications, 1993) Translated from German into Kiswahili by Judith Siegrist. .
[78] Duncan R. Mackenzie, *The Spirit Ridden Konde: A Record of the Interesting but Steadily Vanishing Customs & Ideas Gathered During the Twenty-Four Years' Residence among These Shy Inhabitants of the Lake Nyasa Region, From Witch-Doctors, Diviners, Hunters, Fishers & and Every Native Source* (Philadelphia: J.B. Lippincott Company, 1925).

Highlands, revealing the complex interplay between local belief systems and missionary interventions.

Among these sources was the work of Dr. Alexander Merensky, *Deutsche Arbeit am Njassa* (*German Work on Nyasa*), published in 1894, in which Merensky documented his experiences introducing the Moravian Church to Unyakyusa beginning in 1891. Also significant was Wilhelm Neuberg's *Lutengamaso in Milo oder 'Was Gottes Gnade aus einem Heiden machen kann*' (*"Lutengamaso in Milo, or "What God's Grace Can Do among the Heathen"*), published in 1920. The work of Traugott Bachmann and Paul O. Hennig, *Ambilishiye: Lebensbild eines eingeborenen Evangelisten aus Deutsch-Ostafrika* (*"Ambilishiye: Life story of a native (indigenous) evangelist from German East Africa"*), published in 1921, further provides valuable insight into the role of African evangelists and pastors in the medical history of the region.[79]

Further relevant accounts by David Kerr-Cross, James Elton, Joseph Thomson, and Henry Cotterill were also consulted. These authors, writing as missionaries, explorers, and colonial observers, produced detailed narratives that documented missionary enterprises, exploratory travel, and the consolidation of colonial influence in the Southern Highlands.[80] Collectively, their writings provide rich descriptive material on local religious beliefs, social customs, and cultural traditions, as well as indigenous understandings of disease, medicine, and healing practices. At the same time, these sources offer important insights into the processes of colonial penetration and the varied African responses to missionary and colonial interventions, ranging from accommodation and adaptation to resistance. Portions of this material were critically examined and integrated into the analysis presented in Chapters Two and Three of the study.

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[79] Traugott Bachmann and Paul O. Hennig, *Ambilishiye: Lebensbild eines eingeborenen Evangelisten aus Deutsch-Ostafrika.* (Herrnhut: Verl. D. Missionsbuschh., 1921).

[80] A sample of this documentation includes David. Kerr-Cross, "Geographical Notes on the Country between Lakes Nyassa, Rukwa and Tanganyika," *The Scottish Geographical Magazine Vol. VI* (1890):281-293; James F. Elton, *Travels and Researches among the Lakes and Mountains of Eastern and Central Africa* (London, 1879), pp. 318-335; Joseph Thompson, *To the Central African Lakes and Back*, Vol.1 (London, Frank Cass and Company, 1881), pp.281-282 and Henry B. Cotterill, "On the Nyassa and Journey from the North End to Zanzibar," *Proceeding of the Royal Geographical Society* (1878) X11, pp. 233 -251

The research also relied extensively on periodical records produced by the Moravian missions, which were widely circulated, remain accessible to scholars, and have been frequently utilized in historical research. These mission periodicals provide detailed and continuous accounts of the activities, priorities, and experiences of Moravian missionaries operating in East and Central Africa between 1891 and 1940. They are particularly valuable for tracing the development of missionary institutions, including medical work, evangelization strategies, and interactions with local communities over time. In addition, the East Africana Section of the University of Dar es Salaam Main Library was consulted to identify relevant secondary literature on the history of missions, medicine, and colonialism in the region. This collection proved especially useful for locating scholarly works, theses, and rare publications that contextualize missionary activity within broader social, political, and medical histories of German-era East Africa.

Finally, newly published studies on the history of missionary activity and medical services in Tanzania during the German colonial period were systematically monitored and selectively incorporated where relevant. Particular attention was given to works that reassess the role of Christian missions within colonial structures, interrogate the intersections between evangelization and biomedical practice, and foreground African agency in encounters with missionary medicine. Engaging with this recent scholarship allowed the study to situate its findings within ongoing historiographical debates and to move beyond earlier narratives that treated missionary medicine primarily as a benevolent or auxiliary enterprise of empire. In doing so, the study reflects current scholarly interpretations of the complex and often contested relationship between Christianity, colonial rule, and the provision of medical care in German-era Tanzania.

1.4 Remarks on Periodisation and Scope

The intellectual contribution of this study is that it departs from traditional scholarship that has often treated medical work as distinct from missionary enterprise. While acknowledging that medical missions had already received scholarly attention and were therefore not an entirely new field of inquiry, this study

approached the subject through a distinctly local historical lens. It examined how missionary medicine was experienced, negotiated, and remembered within a specific community, thereby centering local actors and social worlds that had remained marginal in broader or institutionally focused narratives.

In particular, the study foregrounded the roles of local healers, family networks, African evangelists, and ordained African pastors, who acted as crucial intermediaries and knowledge brokers between missionary medicine and local therapeutic cultures. These actors mediated medical knowledge, translated religious and biomedical ideas, and shaped everyday encounters with missionary health institutions through kinship relations, spiritual authority, and long-standing healing practices. By tracing these interactions, the study revealed how missionary medicine was embedded within local social relations rather than imposed upon a passive population.

The study further documented how German missionaries and colonial authorities collaborated, overlapped, or diverged in practice, while demonstrating that their influence was continually refracted through local intermediaries. By situating medical missions within family relations, healing economies, and religious networks, the study highlighted the enduring local legacies of missionary medicine in shaping health practices, religious authority, and social memory. In doing so, it sought to reinvigorate the social histories of religious medicine by firmly anchoring them in local histories and lived experience.

The Southern Highlands of Tanzania provide an appropriate setting for this study because the region became a focal point of missionary activity after the German East Africa colonial frontiers was settled following the Anglo-German Treaty in July 1, 1890 which made the region under the German influence. Protestant Christian missionaries, particularly the Moravian and the Berlin Lutherans, believed they were divinely called to evangelize Africa, and East Africa in particular. As a result, they had already established a strong presence in the Southern Highlands before and during the early years of colonial rule. Their primary aim was to spread Christianity; winning souls was understood as part of the Great Commission and a central

obligation for Protestant missionaries of the period. Consequently, missionary efforts focused on preaching the Christian faith and converting those considered non-believers. Evangelization in foreign lands was pursued primarily through the establishment of mission stations and churches, which served as centers for religious instruction and social engagement. In addition to preaching the gospel, missionaries viewed the treatment of the sick and the provision of welfare services as effective tools for attracting converts and legitimizing their presence.

From 1891 onward, German Protestant missionaries affiliated with the Moravian Church and the Berlin Mission Society established a network of mission stations and medical institutions across the Southern Highlands of Tanzania, guided by the stated aim of 'redeeming human life through the power of gospel.'[81]This religious vision was closely tied to the material and institutional presence of missions, which took concrete form in churches, schools, dispensaries, and hospitals. These institutions were strategically located in what are today Rungwe, Kyela, Njombe, Ludewa, and Wanging'ombe Districts, areas inhabited by diverse communities with long-established spiritual and therapeutic traditions. Among the most significant foundations were Rungwe mission in Tukuyu, Itete and Matema in Unyakyusa; Kidugala and Ilembula in Wanging'ombe and Mbozi mission in Unyiha.[82] Far from being purely religious outposts, these mission stations functioned as key nodes of colonial engagement, where evangelization, medical care, education, and social regulation intersected. Through hospitals and clinics, missionaries sought not only to treat disease but also to demonstrate the moral and spiritual superiority they associated with Christianity and Western biomedicine.

This research focuses on the historical transformation of German Protestant missionary activity in the Southern Highlands of Tanzania from the late nineteenth century to 1940, with particular attention to how these missionaries integrated medical care into their evangelizing projects. Drawing on archival sources,

[81] Joseph H. Oldham and Betty D. Gibson, *The Remaking of Man in Africa* (London, 1931), 18.
[82] Mdegella Owdenburg, Samwel Kilimhana, and Obadiah Kasumba, *Karne Ya Kwanza Ya Injili, 1891-191: Kanisa La Kiinjili La Kilutheri Tanzania Ukanda Wa Kusini* (Dar es Salaam: Dar es Salaam University Press, 1991); Musomba, *Historia Fupi Ya Kanisa La Moravian Kusini Tanzania 1891-1976.*

ethnographic accounts, and oral histories, the study situates missionary medicine within broader colonial projects of cultural regulation, moral discipline, and knowledge production. It shows how medical care was used to advance Christian ideals, reorganize everyday life, and challenge indigenous therapeutic authority, while also revealing the limits of missionary power. At the same time, the research foregrounds African agency by analyzing how local communities, healers, families, and kinship networks negotiated, adapted, resisted, or selectively appropriated missionary medicine alongside enduring indigenous therapeutic practices. By situating medical missions within everyday social relations, memory, and community life, the study argues that colonial healthcare in the Southern Highlands emerged through dynamic and contested encounters rather than simple imposition, resulting in hybrid medical landscapes shaped by both missionary ambitions and African perspectives.

1.5 Outline of the Dissertation

This dissertation is organized into six chapters that together examine the transformation of Protestant missionary activity from evangelical zeal to medical care in the Southern Highlands of Tanzania between the 1890s and 1940. The dissertation argues that the development of missionary medicine was not a linear imposition of Western biomedicine but a negotiated process shaped by interactions among missionaries, African communities, traditional healers, colonial authorities, and local intermediaries. Through these negotiations, medical missions became sites where healing, discipline, knowledge, and cultural authority were continuously contested and reconfigured.

The current chapter introduces the central arguments of the dissertation, situates the study within existing historiography on Christian missions and colonial medicine in Africa, and outlines the methodological framework. It highlights the limitations of earlier scholarship that emphasized evangelization and education while giving limited attention to medical missions as historical agents in their own right. The chapter also explains the dissertation's evidentiary base, which combines missionary archives, colonial records, ethnographic writings, and oral recollections. Drawing on

oral history methodology, the chapter emphasizes the importance of memory, generational transmission, and African perspectives in reconstructing the everyday realities of missionary medical encounters.

The second chapter examines the early phase of Protestant missionary activity in the Southern Highlands, focusing on the Mbeya and Njombe regions during the late nineteenth and early twentieth centuries. It explores how Moravian and Berliner Lutheran missionaries initially prioritized evangelization and spiritual healing, and how their limited success prompted a gradual shift toward medical work. The chapter argues that missionary engagement with medicine emerged as a pragmatic strategy aimed at attracting converts, alleviating suffering, and legitimizing missionary presence. It also highlights African responses to early missionary medicine, showing how local communities evaluated its effectiveness alongside existing healing practices.

Chapter three analyzes missionary medicine as a form of cultural intervention within the colonial context. It begins by analyzing the foundational principles of medical missionaries, particularly the role of the *Platzordnung* in structuring mission life and determining the success or failure of mission medicine. The chapter then explores the dynamic interactions between missionaries and indigenous medical practices, with particular attention to maternal healthcare as a key site of negotiation and contestation. Finally, it investigates the cultural encounters between Western biomedicine and African therapeutic systems within mission hospitals, examining how medical care became a means of disciplining African bodies, households, and moral conduct. While missionaries understood medical practice as inseparable from broader projects of cultural transformation, the chapter demonstrates that indigenous resistance, adaptation, and selective acceptance constrained missionary authority. Rather than the displacement of African healing systems, these encounters produced a dynamic coexistence of medical systems.

Chapter four turns to kinship, neighborhood relations, and communal care as central frameworks through which African societies interpreted and responded to missionary medicine. It examines how families, elders, neighbors, and traditional healers

mediated decisions about illness and treatment, often combining biomedical therapies with indigenous healing practices. The chapter argues that healing remained a collective and social process, shaped by shared responsibility and moral obligation. By foregrounding oral testimonies and collective memory, the chapter shows how African communities appropriated missionary medicine in ways that reinforced local social networks and produced hybrid therapeutic systems beyond missionary and colonial control.

Chapter five examines the consolidation of missionary medicine between 1891 and 1940, focusing on hospitals, dispensaries, and mission schools as interconnected institutions of healing, discipline, and knowledge production. Drawing on case studies from Rungwe, Kidugala, Ilembula, and Matema, the chapter analyzes how missionaries integrated medical care with education and moral regulation to produce disciplined Christian subjects. It also highlights the role of African evangelists and pastors as intermediaries who translated, adapted, and contested biomedical knowledge. The chapter argues that authority over healing became a key site of epistemic struggle, revealing how medical modernity in the Southern Highlands emerged through collaboration, contestation, and negotiation rather than unilateral imposition. Chapter six provides the overall summary and conclusion of the dissertation. It synthesizes the central arguments developed across the preceding chapters and reflects on their significance for understanding the history of Protestant missions, colonial medicine, and African healing practices in the Southern Highlands of Tanzania.

CHAPTER TWO

FROM MISSIONARY ZEAL TO MEDICAL CARE: THE EVOLUTION OF PROTESTANT MISSIONS IN SOUTHERN HIGHLANDS TANZANIA, c. 1890s TO 1940

2.0 Introduction

This chapter examines the development of Protestant medical missions in the Southern Highlands of Tanzania, with particular emphasis on the Mbeya and Njombe regions, from the late nineteenth century to 1940. Scholarly interest in missionary activity in German East Africa has been evident since the 1960s, with early studies emphasizing evangelization, education, and cultural encounters between African societies and European missionaries.[83] Within this body of scholarship, attention has been given to the expansion of Lutheran and Moravian missions and their relationship with colonial authority. This chapter builds on that historiography by directing attention to the medical dimension of Protestant missionary work and its contribution to the formation of healthcare practices in the region.

Two historical processes are examined in this chapter. The first concerns the transformation of Protestant missionary priorities, as spiritual evangelization came to be complemented by medical care. Missionaries increasingly regarded the treatment of bodily illness as an essential component of their religious calling and as a means through which Christian teachings could be disseminated. Western biomedicine was incorporated into missionary strategies in response to widespread disease, physical suffering, and the practical demands of missionary expansion. The second process concerns African engagement with missionary medicine. Local communities encountered biomedical practices alongside established indigenous healing systems

[83] For extensive work on the missionary education system, see Johanna Eggert, "The School Policy of the German Protestant Missions in Tanzania before the First World War," in *Missionary Ideologies in the Imperialist Era: 1880–1920,* ed. Torben Christensen and William Hutchison (Struer: Christensens Bogtrykkeri, 1982); John White, "The Historical Background of National Education in Tanzania," in *Language in Tanzania*, ed. Edgar C. Polomé and C. P. Hill (Oxford: Oxford University Press, 1980); see also Wilhelm Lattmann, *Die Schulen in unseren Kolonien* (Berlin: Wilhelm Süssrott, 1906).

and evaluated their effectiveness within existing social, spiritual, and therapeutic frameworks.

The central argument advanced in this chapter is that German Protestant missionaries played a significant role in shaping early healthcare development in the Southern Highlands through the integration of evangelization and medical practice. Although missionary activities were disrupted during the First World War, medical and evangelical work was resumed during the 1920s and continued into the late 1930s. During this period, medical missions became firmly established as important sites of treatment and care. At the same time, missionary medicine functioned as a form of colonial intervention, as biomedical knowledge and practice were introduced within structures shaped by European authority and Christian moral discipline.

This chapter is included in the dissertation for three main reasons. First, it highlights the origins of biomedical healthcare in the Southern Highlands prior to the expansion of colonial state medical services, demonstrating that medical missions were among the earliest and most influential providers of formal healthcare in the region. Second, the chapter establishes a foundation for subsequent chapters that explore African engagement with colonial and missionary health institutions during the interwar period. Understanding these early missionary encounters is essential for explaining later African negotiations with colonial medicine. Third, the chapter foregrounds African agency by showing how local populations evaluated, adapted, and sometimes contested missionary biomedicine in relation to indigenous therapeutic systems.

The chapter is organized into three sections. The first section discusses the beginnings of Protestant evangelical work in Mbeya and Njombe, situating missionary activities within the broader context of German colonial rule. The second section examines the shift toward medical work, focusing on inter-missionary competition, the expansion of medical services, and the institutionalization of healthcare provision. The final section analyzes interactions between missionary biomedicine and local healing practices, emphasizing the processes through which medical authority was negotiated in the Southern Highlands.

2.1 Planting the Seeds of Faith: Evangelical Work in the Southern Highlands of Tanzania

Before the formal onset of colonialism in the late nineteenth century, Africa, including East Africa, had already witnessed interactions with European scientists, traders, geographers, and explorers. These early European visitors were motivated by a range of factors, including trade, exploration, and scientific curiosity. Although some individuals also engaged in Christian missionary activities, the spread of Christianity was not their primary objective during this period. The European presence in Africa began to assume a more organized missionary character during the Christian revival that took place in Europe between the seventeenth and mid-eighteenth centuries. This revival sparked renewed interest in evangelization, leading to the formation of organized mission groups with the explicit goal of spreading the gospel overseas. As a result, an increasing number of Christian missionaries ventured to Africa during this time. Following the formal colonization of Africa, various mission groups embarked on journeys to the continent from 1885, driven by a profound sense of Christian responsibility towards saving African societies. The Christian missions' advance into tropical regions and coastal areas of East Africa was motivated by several factors, including the desire to end slavery, humanitarian reasons, and a strong Christian zeal to save the souls of heathen, and propagate the teachings of Christianity among African communities.[84]

However, the extensive 'expeditions' of earlier explorers and missionaries paved the way for the subsequent mission parties to view East Africa as a promising location for evangelization, owing to its favorable climate and relatively settled population. One noteworthy individual among these pioneers was Johannes Rebmann, a German missionary who, together with his colleague Ludwig Krapf, believed that for Christianity to take root in Africa, Christian Europeans had to venture into East Africa and establish mission stations first, before it could truly spread in other

[84] Christopher Steed and Sundkler Bengt, *A History of the Church in Africa* (Cambridge: Cambridge University Press, 2004), 515.

regions of Africa.[85] Rebmann considered East Africa as the most suitable location for missionary work on the continent, because there was so much work that had already been done to learn local languages.[86] His belief in the importance of establishing Christian's presence in East Africa was not just a matter of religious conviction, but stemmed from his understanding of the local cultures and traditions. He understood that by learning the local languages and customs, missionaries could better communicate with the people they were seeking to serve and eventually spread Christianity.[87]

Another prominent individual was David Livingstone, a renowned Scottish medical doctor, explorer and a missionary. Livingstone's expeditions to the interior of East and South Africa are widely acknowledged for their significant contributions to the exploration of Africa.[88] In one of his notable statements, Livingstone remarked that "no part of Africa I have seen so teems with people as the shores of Lake Nyasa. … [And] there is more work than can be reached by one body of Christians."[89] Such a comment was instrumental in motivating the missionaries to establish evangelical missions in Lake Nyasa which is lies in the Southwest of Tanzania.

Inspired by the accounts of earlier generations of explorers, missionaries, and traders who ventured into the interior of East Africa, mission societies in Europe became interested in propagating Christianity among the people of Africa. Mission societies in Europe sought out idealistic young men who were eager to settle and establish mission posts within diverse communities of East Africa.[90] The missionaries made their way to the coast of East Africa by sea and established several mission posts for evangelization activities. Initially, their activities were mostly confined to the coast, but later on, they expanded further inland: Zanzibar and Bagamoyo were crucial

[85] S. Gideon Were and Derek Wilson, *East Africa through a Thousand Years: A History of the Years A.D 1000 to the Present Day* (London: Evans Brothers Ltd, 1972), 124.
[86] Matthew Unangst, "Building the Colonial Border Imaginary: German Colonialism, Race, and Space in East Africa" (PhD Diss., the Temple University Graduate Board, 2015), 99.
[87] The comprehensive information about Rebmann's life and work is widely elaborated in the work of Steven Paas, *Johannes Rebmann: A Servant of God in Africa Before the Rise of Western Colonialism*, Revised, Enlarged edition (Wipf and Stock, 2018).
[88] For detail coverage of this see, Oliver, *The Missionary Factor in East Africa*, 2.
[89] Periodic Account for Moravian Mission, *Moravian Church and Mission Agency* 1, no. 5 (1891): 215.
[90] Chadwick Mackenzie, *Grave* (London, 1959), 9–26.

points of departure in the history of Christianity in mainland Tanzania before the mission groups moved inland.[91]

Moreover, between 1863 and 1888, several European countries, most notably Britain and France, established a strong missionary presence along the East African coast. During this period, at least seven missionary missions were firmly founded and actively operating in the region. These included the Church Missionary Society (CMS), the Universities Mission to Central Africa (UMCA), the Society of Holy Ghost Fathers (HGF), Scotland Missions, and the United Missionary Church (UMC), among others. These were among the earliest mission churches that operated before German colonial rule took hold.[92]

The turning point in the history of Christianity in mainland Tanzania can be traced back to the late 19th century, which coincides with German colonial rule. This colonization began in 1885, with the formation of the German East Africa Company (GEACO), which was granted a charter by the German government to establish a colonial presence in East Africa. In 1891, the German government took over the administration of the colony from the GEACO and made it a protectorate, and renaming it German East Africa, or *Deutsch-Ostafrika* (DOA), which included present-day countries such as Rwanda, Burundi, mainland Tanzania and a small section of Mozambique.[93]

At the beginning of German colonization, the territories of Kyela and Rungwe Districts were subject to a territorial dispute between the British and Germany colonial powers. The Livingstonia of the Free Church of Scotland had already been established in Northern Malawi, previously referred to as Nyasaland. The Scottish mission campaigned to extend their influence from northern Malawi to the northern end of Lake Nyasa, Rukwa and Lake Tanganyika, which was under negotiation. In

[91] Steed and Bengt, *A History of the Church in Africa*, 510–11.
[92] Steed and Bengt, 517; Oliver, *The Missionary Factor in East Africa*, 11; Bartle Frere, *Eastern Africa as a Field for Missionary Labour: Four Letters to His Grace the Archbishop of Canterbury with a Map* (London: J. Murray, 1874), 22.
[93] For a fuller and more nuanced understanding of East Africa's political history in the nineteenth century, see Reginald Coupland, *The Exploitation of East Africa: The Slave Trade and the Scramble* (Evanston: Northwestern University Press, 1967). Chapts. 17-20 deal specifically with the German period. See also Carl Peters, *Wie Deutsch-Ostafrika enstand* (Leipzig: R. Voigtländer's Verlag, 1912).

August 1888, the Scottish mission established a mission station at a place called Kararamuka in Ukukwe, the former name of the Nyakyusa region or Kyela District.[94] However, the Scottish did not win the negotiation, and the areas around the northern end of Lake Nyasa, including Kyela and Rungwe Districts, went into German possession under the terms made in July 1, 1890, at the Anglo-German Treaty.[95] Therefore, from then on, German Protestant missionaries came to understand that a substantial part of the new German territory was yet to receive Christian evangelization.

On November 4th 1890, the Moravians of Herrnhut and the Lutherans of the older Berlin Mission (Berlin I) met in the city of Halle, Germany to discuss about their interest in establishing new mission stations in East Africa. They were assured that DOA frontiers had been settled and were aware that no other German missions wished to venture into the new German sphere of influence. During their discussion, the Moravians and Berlin Mission Society identified Kyela and Rungwe Districts (previously known as Ukukwe and Bundali regions) as prime areas for their mission work.[96] They provisionally agreed that their mission work in the area should be separated at thirty–fourth degree of longitude from the north of Lake Nyasa, serving as the boundary. They also agreed to build their first mission station near each other to facilitate mutual assistance.[97]

Before embarking on their new mission, the Moravians and Berliner Lutherans had to collaborate closely with the Scottish missionaries of Livingstonia, who were well established in Malawi, which is close to Kyela and Rungwe Districts. This partnership proved to be beneficial in many ways. The Scottish missionaries had

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[94] David Kerr-Cross, "Notes on the Country Lying between Lakes Nyassa and Tanganyika," *Proceedings of the Royal Geographical Society and Monthly Record of Geography*, 13, no. 2 (1891): 86–99 See also, Free Church of Scotland, "The Livingstonia Mission: Third Quinquennial Narrative" (Glasgow, 1891), 6, 20 and 24.

[95] Wright, *German Mission in Tanganyika, 1891-1941*, 40.

[96] Oliver, *The Missionary Factor in East Africa*, 115 See also; Wright, *German Mission in Tanganyika, 1891-1941*, 8.

[97] Carl Paul, *Das Evangelium in Deutsch-Ostafrika : Eine Zeitgeschichtliche Studie* (Leipzig: Wallmann, 1892), 27; Eric Schultze, *Der Njaßabund*, 67; See also, Bishop Taylor Hamilton, *Twenty Years of Pioneer Missions in Nyasaland: A History of Moravian Missions in German East Africa* (Bethlehem, Pennsylvania: Society for Propagating the Gospel, 1912), 9; Oliver, *The Missionary Factor in East Africa*, 116; Periodic Account for Moravian Mission, 219.

extensive knowledge about the local culture, customs, and beliefs of the people of Southern Highlands, which enabled the Moravians and Berliner Lutherans to make a promising start in their new mission. Apart from collaborating closely with the Livingstonia missionaries of the Free Church of Scotland, Moravians and Berliner Lutherans also had to establish a cooperative relationship with the African Lakes Company.[98] This was a British trading company that operated in Central and East Africa during the late nineteenth and early twentieth century. The company acted as an agents, responsible for supplying and transporting goods and equipment from the Indian coast, through Mozambique, and then along the great Zambezi River and Shire River, into Lake Nyasa.

Moreover, German Protestant mission dispatched men to Glasgow, Scotland to learn about their intended mission field. Earlier in 1891, the Livingstonia Committee wrote to Dr. Robert Laws, who was a leader of Scotland's Livingstonia mission in northern Malawi, that the German societies were likely to work well near their mission. In addition, the Scottish missionaries were ready to offer their assistance by providing African interpreters and co-workers to help the Moravians and Berliner Lutherans in establishing their mission stations.[99] This positive response from the Livingstonia Mission, together with the cooperation of the African Lakes Company, paved the way for the Moravians and the Berliner Lutherans to establish mission stations in the Southern Highlands of Tanzania. It is important to note that this collaboration not only signaled the Scottish missionaries' acceptance of the legitimacy of German territorial claims in the region, but also facilitated the expansion of missionary activity. Through such cooperation, these religious groups were able to entrench themselves in the Southern Highlands, a process that played a significant role in shaping the region's emerging political landscape.

Another missionary who played a great role was Alexander Merensky, a missionary and a doctor who had spent two decades in South African Transvaal. Merensky played a significant role in inspiring the Moravians and Berliner Lutherans to commence mission work in the Southern Highlands. In 1884, Merensky visited the

[98] Wright, *German Mission in Tanganyika,* 43.
[99] Wright, *German Mission in Tanganyika,* 40.

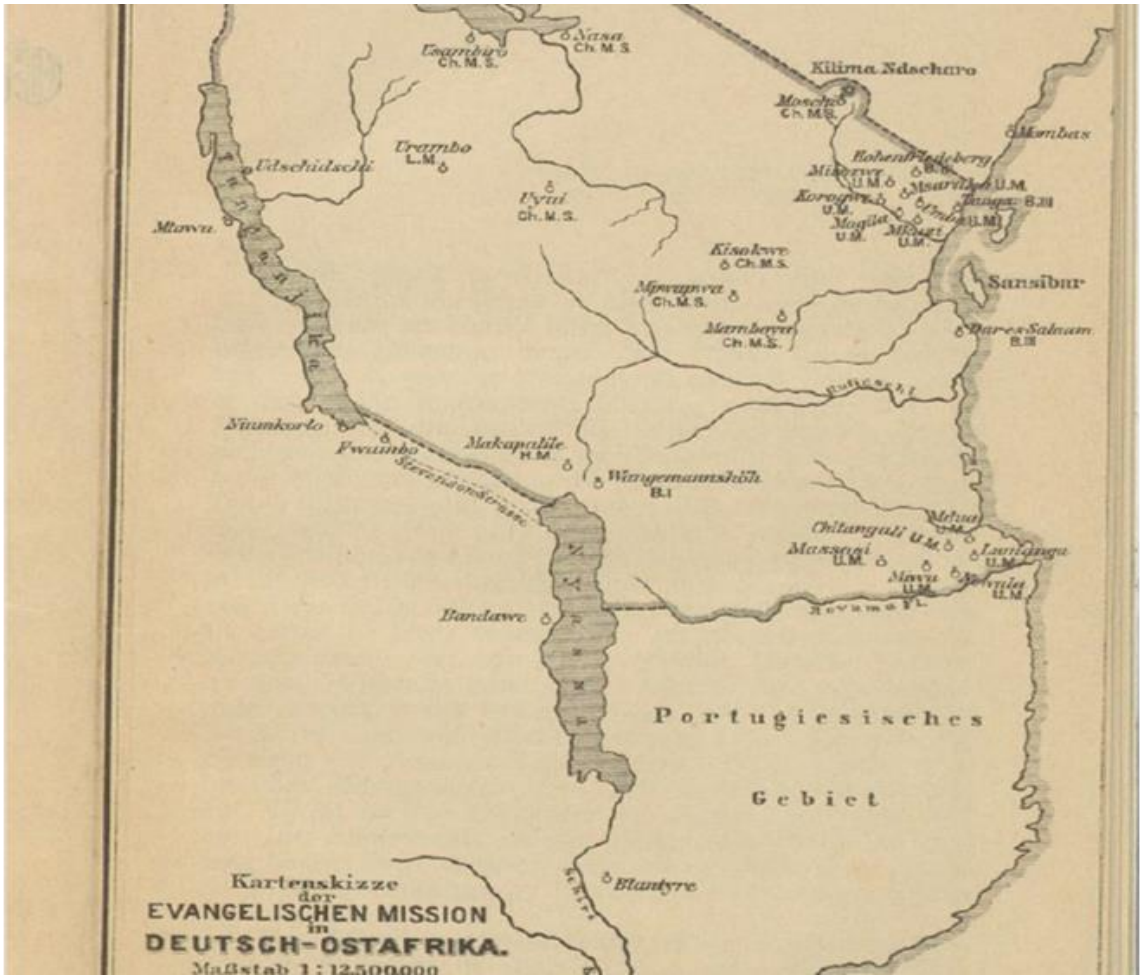
northern end of Lake Nyasa, where he identified the area's potential for German missionary activity, a region that he described as healthy and untouched by the influence of Islam[100] and Europeans, making it a promising site for the Moravians and Berlin Lutherans mission work.[101]

While missionaries in the Southern Highlands cooperated with many missionaries, they were reluctant to associate themselves with the East African Missionary Society (Berlin III), later known as Bethel, which had a mission station on the coast of Tanzania and posed an obstacle towards their mission objectives.[102] Nonetheless, Southern Highlands Tanzania remained an unexplored region and was characterized by a unique environment, with cold uplands, fertile soil for agriculture, and undulating terrain with plenty water sources.[103] Besides, the nature of local people who were hospitable, and the region's relative peace also attracted the missionaries.[104] Another factor was the presence of the Shire River, which flows out of Lake Nyasa and joins the Zambezi River in Mozambique which made the southwest border accessible. Moreover, presence of high population density that had suffered greatly from the impact of slave raiding made it a strategic location for the missions' activities.[105]

In September of 1891, Theodor Meyer led a group of Moravian missionaries to the foot of Rungwe Mountain, and established a permanent mission station.[106] This station served as the center of their mission activities in the region. One month later, on 2 October 1891, the Berlin Mission under the leadership of Alexander Merensky

[100] Before 1914, German missionaries were worried about the spread of Islam and had a concern that the colonial government 'inadvertently aiding its spread.' For this see, Per Hassing, "German Missionaries and the Maji Maji Rising," *African Historical Studies*, 1970, 382.
[101] Alexander Merensky, *Der Nyassa-See Als Gebiet Für Deutsche Missionstätigkeit* (Berlin, 1890), 26.
[102] Hamilton, *Twenty Years of Pioneer Missions in Nyasaland*, 8.
[103] Cross, "Geographical Notes on the Country between Lakes Nyassa, Rukwa, and Tanganyika," 285.
[104] Hamilton, *Twenty Years of Pioneer Missions in Nyasaland*; Cross, "Geographical Notes on the Country between Lakes Nyassa, Rukwa, and Tanganyika," 285.
[105] For instance, in November 1893, Rungwe mission provided shelter to freed slaves, particularly women and children. For this see, Hamilton, *Twenty Years of Pioneer Missions in Nyasaland*, 76.
[106] The first missionaries were Theodore Meyer (superintendent), Theophil Richard, George Martin and Johannes Häfner. For this see, Hamilton, J. Taylor and Hamilton, Kenneth G., *History of the Moravian Church*, (Bethlehem, Pa: Interprovincial Board of Christian Education Moravian Church in America (1967), 597.

established their mission station at Wangemannshöh, named after its longtime mission director, of which the locals referred to as Ipangamasi due to difficulty in pronouncing the German name (see Figure 1).[107] In 1899, the missionary station had to be relocated inland and underwent a name change due to tension with the locals and the unfortunate loss of some missionaries. The new name chosen for the station was Neu-Wangemannshöh, which eventually changed into a present-day Itete.



[107] Interview with a retired Moravian Pastor, Mzee William Mwakikato, Iwambi-Mbeya, 29th February, 2023, and also Bibi Zena Mwambyale, Kalobe-Mbeya, 22nd February, 2023. See also Mdegella Owdenburg, Samwel Kilimhana, and Obadiah Kasumba, *Karne Ya Kwanza Ya Injili, 1891-191: Kanisa La Kiinjili La Kilutheri Tanzania Ukanda Wa Kusini* (Dar es Salaam: Dar es Salaam University Press, 1991), 16, see also Julius Richter, *Geschichte Der Berliner Missionsgesellschaft 1824-1924* (Berlin, 1924), 640–41.

Figure 1: Spatial Distribution of Christian Mission Stations in German East Africa, c. 1891

Source: Carl Paul, *Das Evangelium in Deutsch-stafrika: eine zeitgeschichtliche Studie* (Leipzig: Wallmann, 1892), iii.

As time went on, the Berliner Lutherans expanded their activities in various areas of Mbeya, Njombe, and Iringa regions. They extended into Unyakyusa, Ukinga, Ubena, Uhehe, Uwanji, Upangwa, and Umasagati. In Unyakyusa, they established mission stations in Manow in 1892, Mwakaleli in 1893, Ikombe in 1893, Itete in 1899, and Matema in 1909. Expanding to Ukinga, stations were opened in Bulongwa in 1895 and Tandala in 1897. Moving on to Ubena and Uhehe, stations were founded in Kidugala in 1898, Mufindi in 1898, Emmaberg in 1898, Lupembe in 1899, Muhanga in 1899 [which later relocated to Pommern in 1912], Yakobi in 1899, and Ilembula in 1900. Additionally, they established stations in Magoye in 1900 within the Uwanji area, followed by Milo station in 1902 in Upangwa. Furthermore, Brant station was set up in 1908 in the Usangu area, while Lwamate and Kingori stations were established in 1913 within Wambunga and Wasagati, respectively.[108] Therefore, by the end of 1908, Berliner Lutherans had 18 stations, 31 missionaries and two nurses.[109]

Similarly, the Moravian Church expanded its presence in various places in Mbeya and Tabora regions. They started missions in Rungwe in 1891, Rutengano in 1894, Ipyana in 1894, Utengule in 1895, Mbozi in 1899, Isoko in 1899, Ileje in 1906, Mwaya in 1907, and Kyimbila in 1908. In 1896, the London Mission Society decided to transfer their mission stations in Urambo and Unyamwezi to the Moravian Church. This transfer opened up new opportunities for the Moravians missionaries to expand their missionary work to the northern and northwestern parts of the Southern Highlands, including the Mbozi District and Tabora region.[110] As a result, they

[108] Carl Mirbt, *Mission Und Kolonialpolitik in Den Deutschen Schutzgebieten* (Tübingen : Mohr, 1910), 32. See also Owdenburg, Kilimhana, and Kasumba, *Karne Ya Kwanza Ya Injili,* 19.
[109] Mirbt, *Mission Und Kolonialpolitik in Den Deutschen Schutzgebieten*.
[110] In 1898, the Edmund Dahls, the Konrad Meiers and the Rudolf Sterns started the mission in the Unyamwezi Hamilton, *Twenty Years of Pioneer Missions in Nyasaland*, 609; John Iliffe, *A Modern History of Tanganyika* (Cambridge: Cambridge University Press, 1979), 217.

established stations in Kilimani-Urambo in 1898, Kitunda in 1901, Sikonge in 1902, Ipole in 1903, Kipembabwe in 1904 and Usoke in 1907. By the end of 1908, the Moravian missions had a total of 15 stations and 31 missionaries.[111] Moreover, both the Moravians and the Berliner Lutherans were able to establish new churches, schools, and healthcare facilities to serve the need of local communities in these expanded areas.

In sharp contrast with other missionary groups, the Moravians and Berliner Lutherans deliberately chose to establish their mission stations far away from the colonial administrative centers.[112]They were not interested in gaining access to the colonial network or military protection, as their work was solely focused on religious and non-secular reasons.[113] Apart from some missionaries being critical of exploitative practices of the colonial powers they also emphasized on religious mission and distanced themselves from political and economic agendas, that means missionaries aimed to maintain their independence and credibility among the local population.

Initially, they openly opposed supporting the German colonial movement and therefore found the northern end of Lake Nyasa to be an ideal location for their missions, as the area was not yet under direct control of the colonial authority. Until the end of 1891, there was limited information about the southwestern parts of DOA, as reports from the German missions of Moravians and Berliners were not received in time in Dar es Salaam Headquarters.[114] However, it was not until in 1893, when as part of the Nyasa-Tanganyika expedition led by Herrmann von Wissmann, a prominent figure and the Reich Commissioner for German East Africa laid a foot on the Southwest of Tanzania. The military moved to Langeburg (which was later

[111] Mirbt, *Mission Und Kolonialpolitik*, 33.
[112] Max Montgomery, "Colonial Legacy of Gender Inequality: Christian Missionaries in German East Africa, Politics and Society," *Politics and Society*, 2017, 240 See also; Owdenburg, Kilimhana, and Kasumba, *Karne Ya Kwanza Ya Injili, 1891-191: Kanisa La Kiinjili La Kilutheri Tanzania Ukanda Wa Kusini*.
[113] Majida Hamilton, *In Kolonialen Umfeld: Deutsche Protestanische Missiongesellschaften in Deutsch-Ostafrika* (Universitatsverlag Gottingen, 2009), 85.
[114] TNA, IX A 6, Von Soden to Caprivi, May 12, 1891.

renamed Kyela District) and this allowed a direct contact between the missionaries and the colonial government.[115]

From the early days of colonialism in Africa, missionaries believed that introducing Christianity to African societies would be a means of civilizing the so called "pagan" population. They assumed that presenting the Bible to African societies they would easily persuade Africans to abandon their traditional religions and embrace Christianity as the only alternative for saving their souls.[116] However, this assumption proved to be unrealistic and reflected a lack of understanding of the complex social, cultural, and political factors that were at play in African societies.[117] Therefore, we can argue that since the introduction of Christianity in African communities, the local people were not naive and willing to adopt new ideas solely because they were presented by Europeans. Rather Christianity was only embraced and accepted by the majority of Africans when it became useful to them.

The above explained general phenomenon in Africa also existed in the Southern Highlands. Converting the local population in the Southern Highlands of Tanzania was not an easy task for the missionaries. They then opted to fight tropical diseases which decimated the number of missionaries, making it challenging to maintain sufficient personnel in the mission stations.[118] The obstacle posed a significant challenge to the missionaries' ability to reach out to a larger number of local communities in the area.

Despite the notion that Africans did not have a religion, the Moravians and Berliner Lutherans found themselves in what John Mbiti called 'notoriously religious'[119] areas where the local people had a strong belief in their traditional religion. The people of Mbeya and Njombe regions believed in their religion of Kyala, Mbasi and Lwembe. These religions had many devotees among the Nyakyusa and Kinga

[115] Rainer Tetzlaff, *Koloniale Entwicklung Und Ausbeutung. Wirtschaftsund Sozialgeschichte Deutsch-Ostafrikas 1885-1914* (Berlin: Schriften zur Wirtschafts- und Sozialgeschichte, 1970), 286.
[116] Robert Slayer, "Mission History in Africa: New Perspective on an Encounter," *African Studies Review* 19, no. 01 (1976): 2.
[117] Felix Ekechi K., "Colonialism and Christianity in West Africa: The Igbo Case, 1900–1915," *The Journal of African History* 12, no. 1 (1971): 104.
[118] Hassing, "German Missionaries and the Maji Maji Rising," 385.
[119] John S. Mbiti, *African Religions and Philosophy* (Nairobi: East African Educational Publishers Ltd, 1969), 104.

communities and were widespread and popular.[120] To the local people, especially among the Nyakyusa, these traditional religion represented their way of worshipping God in their own language. However, the missionaries interpreted any African belief as a cult. It is clear that the interaction between African and Christian beliefs was complex since the African people largely believed in the supernatural dimension of life and the cosmos.[121] Later, the missionaries identified a religious belief system that included ancestral worship and various cults as Satanic and with no value. This led to the conflict between missionaries and local religious leaders.[122]

In different parts of Africa, a range of complex and diverse factors shaped Africans' decisions to accept Christianity before the turn of the twentieth century. One significant reason was social exclusion: individuals who had been marginalized because of social or physical disabilities, misfortune, or their status as former slaves often viewed Christianity as a pathway to acceptance and communal support. Others were drawn to Christianity by the material and social rewards they believed conversion could bring. Some Africans embraced the faith after recognizing the practical advantages of living near mission stations, where converts often received preferential treatment, including access to education, medical care, and other forms of assistance.[123] As a result, many Africans regarded Christianity less as a purely spiritual commitment and more as a source of protection and a means of aligning themselves with groups that held power and influence, often with only limited understanding of Christian doctrine.

Nonetheless, local chiefs embraced Christianity as a way of gaining influence and power over their fellow Africans.[124] Therefore, it can be argued that, local people in the Southern Highlands of Tanzania like in other places in Africa did not accept Christianity because they believed it was superior to their religion. Instead, the decision to embrace Christianity was influenced by various external factors that

[120] Merensky, *Deutsche Arbeit am Njaßa*, 8–9; Steed and Bengt, *A History of the Church in Africa*, 536.
[121] Merensky, *Deutsche Arbeit am Njaßa*; Steed and Bengt, *A History of the Church in Africa*, 536.
[122] Simon Robert Charsley, *The Princes of Nyakyusa* (Nairobi: East African Publishing House, 1969), 8–9.
[123] Wright, *German Mission in Tanganyika*, 51 and 64.
[124] Charsley, *The Princes of Nyakyusa*, x.

stemmed from social, economic, and political situations that acted as mediating circumstances, which led the locals embrace Christianity.

Therefore, the challenges faced by European evangelists in the Southern Highlands of Tanzania made them recognize the importance of presenting Christianity in a way that resonated with Africans and was relevant to their daily lives. It then became clear to the missionaries that it was not just a matter of presenting the Bible and expecting Africans to abandon their beliefs and traditions overnight and embrace Christianity. Rather, they had to explore other methods of evangelism that would draw locals to the mission stations. And from there, they realized the potential of Western medicine as a tool for evangelism. They believed that providing healthcare to Africans who resided in rural areas would not only alleviate their suffering but would reduce resistance, helped to bring trust and more sympathy among Africans and also create an opportunity to spread the Gospel and win converts.

However, such an approach was not universally accepted by all mission societies. Different groups of missionaries had different opinions on how to approach their work. Some missionaries believed that their main goal of spreading their religious message was more important than providing medical treatment to the local population. They thought that their primary duty was to preach the gospel and convert as many Africans as possible because they believed it was the most effective way to bring about spiritual transformation. And they believed that Christian faith and prayer were sufficient to remove all the obstacles, including ensuring the health of the local population.[125] Furthermore, these missionaries argued that putting resources, time, and effort into medical activities could take away their attention of spreading the religious message. They were concerned that getting involved in medical practices might weaken the focus on religious instructions and hinder the overall mission's objective.[126]

Moreover, it is important to note that not all missionaries held the same view. Some understood that medical care was important. This group saw it as a way to show compassion and the love of God more practically. They believed that by taking care

[125] Good, "Pioneer Medical Missions in Colonial Africa," 1; Vaughan, *Curing Their Ills*, 35.
[126] Comaroff, *Of Revelation and Revolution*, Vol. 2, 323-326.

of people's physical health, they could build stronger relationships, gain trust, and have more opportunities to share their religious message. They also believed that treating the sick was an essential part of their mission, following the teaching of Christ about love, compassion, and taking care of others.

They also placed great importance on the duty of caring for the sick, drawing direct inspiration from biblical teachings that underscored the moral and spiritual significance of compassion. Within the text, several scriptural passages were cited to reinforce the idea that caring for those who suffer is not merely an act of kindness, but a fundamental religious obligation. These verses framed care for the vulnerable as an expression of faith in action rather than a secondary or optional practice. One particularly compelling example appears in Matthew 25:35, 36, and 40, where the act of tending to the hungry, the sick, and the marginalized is presented as equivalent to serving God Himself. In this passage, assistance offered to those in distress is portrayed as a direct reflection of one's devotion and moral integrity. By emphasizing that service to the suffering is service to God, the text elevates caregiving to a sacred responsibility, reinforcing its central place within religious life. As a result, caring for the sick was understood not only as a social duty, but as a deeply spiritual practice rooted in biblical authority and ethical commitment.[127]

From this standpoint, missionaries believed that it was imperative to provide medical care to Africans, as 'treatment [of the sick] put people in a receptive frame of mind to the message of the Gospel'. [128] Such an approach was instrumental for the missionaries in achieving the goal of spiritual salvation.[129] Addressing the physical needs of the local population allowed missionaries to better connect with local communities and help to spread the message of Christianity. As a result, missionaries established medical dispensaries and hospitals at various places and at different times across Africa and Tanzania was not an exception. These medical facilities became a

[127] See also Chammah Kaunda and Isabel Apawo Phiri., "Health and Healing in African Christianity" in Isabel Apawo Phiri ed., *Anthology of African Christianity.* (Switzerland: Regnum Books Internationa, 2016), 1149.
[128] Hardiman, *Healing Bodies, Saving Souls*, 25; Good, "Pioneer Medical Missions in Colonial Africa," 1.
[129] Hardiman, *Healing Bodies, Saving Souls.*

"magnet" for local patients, who came from near and far seeking treatment.[130] The provision of medical care was often accompanied by evangelism, and missionaries saw this as a way of fulfilling their dual mission of addressing the physical and spiritual needs of the local population.

2.2 Contesting Souls and the Expansion of Mission Medical Work in Southern Highlands of Tanzania, 1891-1940

Transforming local social and cultural settings into Christian communities, winning converts, and interacting with Africans proved to be a daunting task for the German mission enterprise in Tanzania. From the outset, a competitive evangelization dynamic existed between Catholic and Protestant mission societies, despite their shared goals of expanding European influence and saving African souls. The two groups had different approaches towards local social and cultural life, shaped by their mission foundations' histories, theological viewpoints, cultural disparities, and African responses. While both Catholic and Protestant missionaries aimed to create Christian communities. The former preferred a Eurocentric approach, emphasizing European values and traditions that resembled those in Europe while downplaying or even suppressing local cultural practices and traditions incompatible with Catholic doctrine.[131]

In contrast, Protestant missionaries were generally more hesitant to interfere with the lifestyle and traditions of the local population. This is partly because many of them believed in the principles of contextualization, which involved understanding the cultural context of the people they were evangelizing and adapting the message of the gospel to fit their worldview and cultural values.[132] By incorporating local languages, customs, symbols, African music, and rhythms into their church services, Protestant missionaries made Christianity relevant and meaningful to the local people

[130] Vaughan, *Curing Their Ills*, 55; See also Musomba, *Historia Fupi Ya Kanisa La Moravian Kusini Tanzania*; David Clyde, *History of the Medical Services in Tanganyika* (Dar es Salaam: Government Press, 1962); see also Oliver, *The Missionary Factor in East Africa*, 210–11.

[131] Adrian Hasting, *The Church in Africa, 1450-1950* (Oxford: Oxford University Press, 1994); see also Paas, *Johannes Rebmann: A Servant of God in Africa Before the Rise of Western Colonialism*, 51.

[132] Indeed, the use of local languages played a crucial role in the spread and development of Christianity in Africa. For a comprehensive exploration of the use of local languages by missionaries in Africa see, Lamin Sanneh, "Translating the Message: The Missionary Impact on Culture," *American Society of Missiology Series*, no. 42 (2015): 20, 28 & 37.

in order to get deeply into their soul and culture for more control and domination. However, this approach allowed for greater cultural flexibility and sensitivity towards the local population, and attracted more converts to Christianity.

The tension and competition between Catholics and Protestants in German colonial Tanzania can be traced back to the late 19th and early 20th century, when Germany established control over the region. At the time, both Catholics and Protestants were actively engaged in missionary work, aiming to convert Africans to their respective religions. Conflicts between the Catholic and Protestant missionaries were primarily driven by theological differences. Disagreements and conflicts sometimes arose from their desire to convert people to their respective faith and seek to gain influence in the region.[133] Additionally, tension was fueled by various other reasons, such as who was the first to enter the area, become acquainted with local authorities, and claim entitlement to the land.[134] Political and economic reasons also contributed to the tension, with Catholics accusing German colonial authorities of favoring Protestant missionaries. This perception of bias and unfair treatment led to further tension between Catholic and Protestant missionaries.[135]

During the period from the 1890s to 1910, there were tensions in the Southern Highlands of Tanzania. For example, in Neu-Langenburg (now Rungwe district), there were conflicts between Catholic White Fathers and Protestant Moravian missionaries regarding their respective territories and the conversion of the local populations. Similarly, in Iringa-Mahenge, Berliner Lutherans and Benedictines had disagreements over mission territories and the evangelization of the locals. In Lindi, conflicts emerged between the Universities Mission and the Benedictines regarding the control of mission stations and the conversion of locals. In Pare, located in the northeastern Tanzania, there was competition for control of over mission territories and converts between the Black Fathers, Leipzig Mission and Adventists.[136] These

[133] Paul Gifford, *African Christianity: Its Public Role* (Indiana University Press, 1998), 156–72.
[134] Adam Jones et al., "4 Mission Spaces in German East Africa: Spatial Imaginations, Implementations, and Incongruities against the Backdrop of an Emerging Colonial Spatial Order," in *Transnational Religious Spaces Religious Organizations and Interactions in Africa, East Asia, and Beyond* (Berlin, Boston: De Gruyter Oldenbourg, 2020), 51.
[135] Jones et al., "4 Mission Spaces in German East Africa."
[136] Jones et al.

examples of tensions and misunderstandings shows the evangelization was not an easy task.

In addition to causing tension between the mission parties, these disputes also frustrated the colonial state which had to balance the interests of the imperial government with those of the mission parties. They had to maintain order in the colonies while also respecting the rights of the mission parties to practice their religion. The involvement of the mission societies' headquarters in Europe added another layer to this complex situation. The societies had invested significant resources in establishing and maintaining missions in Africa, and they were keen to see their efforts succeed. Therefore, they put pressure on the imperial government in Berlin to ensure that the mission parties were allowed to operate freely in the colonies.[137]

The General Act of the Berlin Conference, which was signed in 1885 and governed European colonization and trade in Africa, included Article 6 of Chapter I, which ensured freedom of religion across the continent. This article mandated that every European nation "shall, without distinction of creed or nation, protect and favor all religions … that aim at instructing the natives and bringing the blessings of civilization to them."[138] The mission societies used this act to justify their right to spread Christianity in the colonies, argued that their actions were an exercise of religious freedom, and cited the act as their justification.

Another worrisome source of tension was the spread of Islam in the region.[139] Missionaries observed that Islam was expanding rapidly, at a pace they believed exceeded that of Christianity. Their anxiety intensified in 1904 when they discovered that Nyamwezi porters engaged in long-distance trade were actively observing the fast of Ramadhan, a development that signaled the growing influence of Islamic practice within local communities. The fear of losing religious ground to Islam soon became a recurring topic in missionary discourse and featured prominently at

[137] Owdenburg, Kilimhana, and Kasumba, *Karne Ya Kwanza Ya Injili, 1891-191,* 51.
[138] For further information on this, refer to Authur Berriedale Keith, *The Belgian Congo and the Berlin Act* (Oxford: Clarendon Press, 1919), 304.
[139] See Herrmann, Memorandum, 19th July 1912 TNA G9/48/9.

missionary conferences. This concern reached an international stage at the World Missionary Conference in Edinburgh in 1910, where the expansion of Islam was treated as a central challenge to Christian mission work. At the conference, missionaries argued that "every missionary problem of the day should be given [priority] in the race against Islam,"[140] reflecting the extent to which competition with Islam shaped missionary strategies and priorities during this period.

Moreover, missionaries noticed that the spread of Islam posed a significant threat not only to their evangelism, but also to the German colonial government.[141] The missionaries frequently alerted the government to this danger, and were particularly worried that the government's actions might actually be aiding the spread of Islam because Muslims occupied nearly every subordinate post. They also noticed that educated yet polygamous Muslims were at every government station.[142] Later in the Colonial Congress in Berlin in 1910, missionaries agreed that supporting Muslims in German East Africa would be perceived as opposition to the European expansion into Africa.

Hence, their attempt to counter the perceived threat of Islam in German East Africa, German missions began to be involved into colonial politics. Nonetheless, in the regions where the Islamic religion had a strong influence, such as North Africa and the coastal areas of East Africa, missionaries often used Western medicine as a means of entry and influence. Thus, many of the missionaries recruited to work in these areas were either trained physicians or received medical training before being sent into the field while others treated without any medical knowledge.[143]

Karl Axenfeld, who became a leader of the executive office and seminary in Berlin and an inspector for German East Africa in 1905, closely monitored the Catholic and Protestant competition for spheres of influence, as well as problems related to Islam, education, healthcare, and church development. He warned that "whatever has not been taken under Christian care in this period [since 1891s] will surely fall to

[140] Beck, 205.
[141] See Schultze, *Soll Deutsch-Ostafrika Christlich Oder Mohammedanisch Werden?*
[142] Beck, "Medicine and Society in Tanganyika 1890-1930," 205.
[143] Paul Jim, "Medicine and Imperialism in Morocco," *Middle East Research and Information Project*, 1977, 3–4.

Islam."[144] Heinrich Schnee, who governed German East Africa from 1912 to 1918, served as the last governor of German East Africa, encouraged principles of religious freedom while actively discouraging disturbances caused by mission disputes. Schnee viewed the mission conflict as detrimental to Christianity, as it provided an advantage to Islam and misrepresented Christian faith.[145] By 1912, the number of Muslims in mainland Tanzania had reached between 300,000 and 500,000.[146]

Various approaches were considered to address the disagreement regarding the sphere of influence. One such approach was taken by Alexander Meresky, the leader of the Berlin Mission Society, who sought assistance from Dr. Von Jacobi to contact the Foreign Office and the Colonial Council (*Kolonialrat*) to resolve the disputes in the Southern Highlands of Tanzania.[147] The German commander of Iringa, Von Prince, proposed a solution whereby Berliner Lutherans would be allocated the north half of the region with the Wahehe and Wasangu, and the Catholics would be given the south half of the district with the Wabena and Wazungwa.[148] This proposal was ultimately accepted, and the agreed demarcated borders were reflected in the extensive German colonial Atlas.[149]

In 1910, the German colonial administration implemented a strategy to settle the conflict about the demarcation of mission territories by precisely defining the zones where Protestants and Catholics missionaries were allowed to carry out their work. To accomplish this, the two mission groups signed a treaty which was supervised by the government. This agreement established the particular areas in which each mission was permitted to operate, and both sides pledged to adhere to these boundaries for another ten years.[150]

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[144] Verhandlungen des Deutschen Kolonial-Kogress (Berlin, 1910), 633 & 635.
[145] TNA IX A 3a. For boundary conflicts in the region see also, See BMW 1/6069, A report of C. Schumann to Kaiser M. S in Lupembe, (August 14, 1906)
[146] Heinrich Schnee, Deutch-Ostafrika im Welkriege (Leipzig, 1919), 135.
[147] TNA IX A6, Berlin Committee to von Jacobi 18 October.
[148] Wright, *German Mission in Tanganyika, 1891-1941*, 71 Quoting from Von Prince to Bunk, 5 September 1898 (Berlin IX1 8b).
[149] Paul Sprigade and Max Moisel, *"Deutsch-Ostafrika [Map]" in Der Grosse Deutsche Kolonialatlas 1920* (Braunschweig: Arch Verlag, 2002).
[150] Periodic Account for Moravian Mission, 1911, 232; Musomba, *Historia Fupi Ya Kanisa La Moravian Kusini Tanzania*, 38.

The preference of the colonial administration and advisors to address these conflicts internally stemmed from their aim to retain control and authority over the African population. As the overall authority overseeing the operation of colonial social and economic enterprises, the colonial state sought to prevent any confrontation or disputes that could weaken the authority of European colonizers in the eyes of the local population. The colonial government was reluctant to engage African leaders as mediators in disputes concerning the demarcation of mission territories. This was because they feared that the involvement of Africans would diminish the European superiority and undermine their power and control over the population.[151]

To prevent conflicts, Catholic and Protestant missions agreed on operating only one mission in a specific area. However, disagreements on how to divide the mission field often led to disputes and occasional confrontations.[152] Nonetheless, Catholic missionaries did not encounter any issues with other Catholic societies regarding their sphere of influence, and similarly, Protestants had amicably resolved their differences.[153] In the Southern Highlands of Tanzania, the Berliner missionaries and the Moravians agreed to work together and that helped to spread the gospel rapidly and expand European influence in the area.[154]

[151] Hamilton, *Twenty Years of Pioneer Missions in Nyasaland: A History of Moravian Missions in German East Africa*, 111–13; Oliver, *The Missionary Factor in East Africa*, 79.
[152] Berriedale Keith, *The Belgian Congo and the Berlin Act*.
[153] Owdenburg, Kilimhana, and Kasumba, *Karne Ya Kwanza Ya Injili, 1891-191: Kanisa La Kiinjili La Kilutheri Tanzania Ukanda Wa Kusini*.
[154] Periodic Account for Moravian Mission, 219; See also Hamilton, *Twenty Years of Pioneer Missions in Nyasaland: A History of Moravian Missions in German East Africa*, 9; Oliver, *The Missionary Factor in East Africa*, 116.

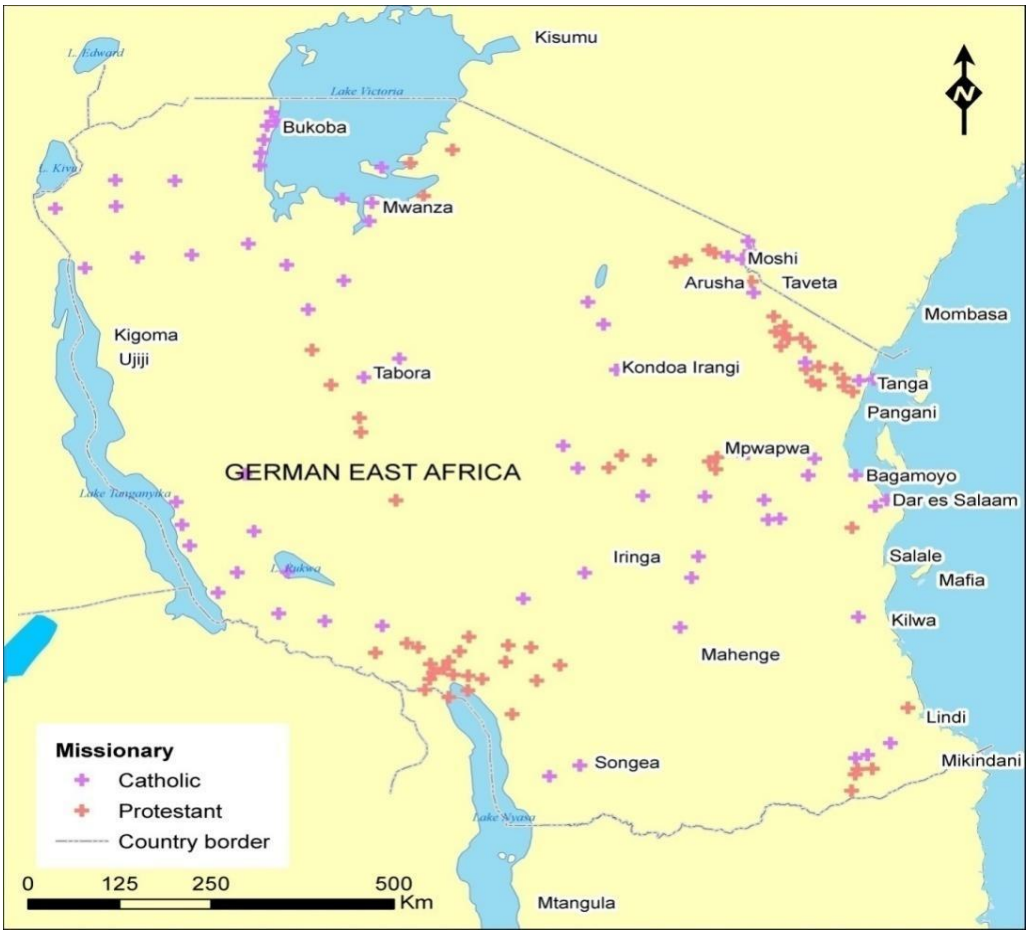

Figure 2: A Map Displaying the Location of All Protestant (Red) and Catholic (Purple) Missions in German East Africa in 1914

Source: Redesign by the GIS Laboratory Scientist at the Institute of Resource Assessment, University of Dar es Salaam, June 2023. The original map is found in, Roome William, *Ethnographic Survey of Africa: Showing the Tribes and Languages Also the Station of Missionary Societies"* [Map] (London: Edward Stanford Ltd, 1925), 5.

It is worth noting that the mission contests over the area of influence were not new to the history of the church in Europe. In the earlier days of mission expansion in Europe, the White Fathers in Rome, Moravians in Saxony, Benedictines in Bavaria, the Berlin Mission in Prussia, the imperial government in Berlin, and a Catholic advisor in Cologne experienced conflicts over territorial demarcations for their

influence.[155] Therefore, the mission conflicts in the Southern Highlands of Tanzania during the German colonial period were part of a long history of competition for influence and resources in the mission field.

Before the Germans took control of territory from the German East African Company in 1891, Carl Peter was critical of the missionary work that focused on evangelizing the Africans and instead believed that they should prioritize educating them to work in German plantations. He aimed was to align the missionary efforts with the larger colonialism movement.[156] However, in 1890, during the height of the colonial era, Herrmann von Wissmann who was a colonial administrator urged the Protestant missionaries operating in the region to view themselves as invaluable cultural agents whose primary aim was not merely to Christianize the new subjects but to offer essential services such as education and medical aid.[157] This marked a significant shift in the German colonial altitude of the time, which began to recognize the critical role of cultural influence in maintaining control over colonial territory. Therefore, in this context, Western biomedicine was used by missionaries in Africa as a cultural tool to construct African health and illness and intervene in African social life during the entire period of colonialism. Hence, Von Wissmann's statement underscores the importance of cultural diplomacy in colonial rule and highlights the evolving nature of colonialism during this period.

Both Catholic and Protestant missionaries recognized the need to expand medical services as a means of addressing the critical health needs of the local population and in reaching the goal of spiritual salvation, securing mission territory, and consolidating their influence.[158]The effectiveness of this strategy led the missionaries to acknowledge to their metropolitan leaders that providing medical care to the locals was beneficial, as it 'opens many doors that would otherwise remain closed.'[159] In this way, medicine became both a tool of care and a mechanism of cultural and

[155] Jones et al., "4 Mission Spaces in German East Africa," 81.
[156] Oliver, *The Missionary Factor in East Africa*, 96.
[157] Oliver, *The Missionary Factor in East Africa*.
[158] Hardiman, *Healing Bodies, Saving Souls*, 25; See also Good, "Pioneer Medical Missions in Colonial Africa," 1; Terence Ranger, "Godly Medicine," 261.
[159] Jim, "Medicine and Imperialism in Morocco," 4, quoted from Jean-Louis Miege, "Les missions protestantes au Maroc, 1875-1905," Hesperis, Vol. 42 (1955), 176.

spiritual penetration, reinforcing the intertwined nature of health, power, and religious ambition within the missionary enterprise.

Missionary medicine in Africa was not limited to the treatment of physical ailments alone.[160] In addition to the provision of medical care, missionaries provided hope and encouragement to the sick. Also, medical missionaries provided what was known as an 'all-round therapy' that aimed to treat both the body and the soul. The mission intention was to civilize the so-called 'primitive people,' and bring them closer to Christian modernity.[161] However, Christian missions were also interested in treating diseases that involved a physical transformation of one's body and social identity, such as leprosy and blindness. Missionary also paid attention to maternal health and childcare as well as public health and hygiene.[162]

The German colonial state acknowledged the need for the provision of education and medical care in their African colonies. German colonial reports emphasized on the importance of promoting medicine and public health for the progress of DOA. However, by 1910, the DOA had a population of 10 million people; only 43 doctors were available to cater the medical needs of the entire colony. Moreover, out of these 43 doctors, 36 were government employees burdened with both administrative tasks and medical duties.[163] Thus, the colonial government actively encouraged Christian missionaries to provide medical services to the local population to fill the gap left by colonial medicine.

Therefore, the German colonial government showed a preference for missionaries who provided practical benefits to the locals. By offering medical care, these missionaries were able to legitimize their presence and establish a foothold in the region, winning the trust and support of the local population, which in turn facilitated their conversion efforts and allowed the expansion of mission work.[164] Successful mission work was not measured in terms of the number of converts, but also in the degree to which missionaries were able to expand their mission. Those who were

[160] Hardiman, *Healing Bodies, Saving Souls*, 19–50.
[161] Hardiman, *Healing Bodies, Saving Souls.*
[162] Jennings, "Healing of Bodies, Salvation of Souls."
[163] Beck, "Medicine and Society in Tanganyika 1890-1930," 6.
[164] Wright, *German Mission in Tanganyika, 1891-1941*, 108.

able to establish medical facilities and treat the locals were seen as more successful missionaries than those who did not. Furthermore, successful medical work helped to attract additional resources for the mission and funding from public and private sponsors in Germany.[165] As a result, the mission was able to further expand its influence and impact on the local population.

During the period when Tanzania was under foreign colonial control, Christian missionaries faced mixed reactions from local communities. Initially, some communities viewed them with suspicion and hostility, as they were perceived as foreign agents trying to impose their beliefs. However, when local people came to understand the benefits of western medicine, the missionaries' image changed, and they became more accepted and embraced, especially by those seeking solution to social and moral issues.[166] Although only a few were interested in the Christian message, many were attracted by opportunities around mission stations such as employment, a refuge from local rulers, and access to western medicine.[167] Despite the small number of missionaries in Tanzania, their medical work provided a platform for evangelism, leading to the spread of Christianity in the country.[168]

Despite the colonial state's reluctance to have a close relationship with the missions in DOA, they recognized and relied on the valuable contributions of the missionaries. The missionaries' intimate knowledge of the local customs and language, as well as their ability to operate independently in a challenging environment, made them an asset in the provision of medical care to the African population. However, the government's preference for maintaining the separation between mission and colonial medical services meant that they were not willing to fund medical missions.[169] Nevertheless, during times of epidemics, the government sought the help of mission medical personnel to prevent the spread of diseases. The colonial state

[165] Montgomery, "Colonial Legacy of Gender Inequality: Christian Missionaries in German East Africa, Politics and Society," 235; Oliver, *The Missionary Factor in East Africa*, 95.
[166] Terence Ranger, "The African Churches of Tanzania, Historical Association of Tanzania," 5.
[167] Paul Gröschel, *Zehn Jahre Christlicher Kulturarbeit in Deutsch-Ostafrika,* 128–29 and 169; See also Giblin and Kaduma, *A History of the Excluded*, 275.
[168] Ranger, "The African Churches of Tanzania, Historical Association of Tanzania," 3 See also, The discussion of significance of medical mission in the German colonies by Haussleiter Halle in des Deutschen Kolonial-Kogress, 1910 (Berlin, 1910), 748.
[169] Beck, "Medicine and Society in Tanganyika 1890-1930: A Historical Inquiry," 30.

launched vaccination campaigns, surveillance and confinement measures since the diseases posed a threat to their interests and agenda in Africa.[170]

Moreover, the influence of the mission on the local population became more significant when missionaries began collaborating with the colonial government during the vaccination campaigns against epidemic diseases. The partnership with the colonial medical services provided the ideal opportunity for the expansion of medical evangelism among the locals.[171] The Moravians and Berliner Lutherans in the Southern Highlands enjoyed a distinct advantage during vaccination campaigns as they had already established relationships with the local communities through their religious and medical work. As a result, the missionaries were able to influence these existing relationships to gain the trust of the locals and persuade them about the importance of vaccination.

During the smallpox outbreak of 1899, Western medicine proved to be a valuable tool when the colonial government asked missionaries help with vaccination campaigns. From the account of a Berliner Lutheran missionary named Paul Groeschel, revealed that within one year of his arrival in Kidugala, the missionaries were able to vaccinate 2,000 local Africans, allowing them to establish direct contact with thousands of individuals who were open to new therapies.[172] In Ilembula in the Njombe region, during the time of the missionary Priebusch, a significant number of people, around 1,200, were vaccinated against smallpox.[173] The Berliner missionaries who were active in the area also placed great emphasis on promoting preventive medicine and hygiene practices to the local population.[174] This successful effort not only controlled the spread of smallpox but also served as an opportunity for the missionaries to spread Christianity to the local population.

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[170] Steven Feierman and John Janzen, *The Social Basis of Health and Healing in Africa* (Berkeley: University of California Press, 1992), 1.
[171] Walter Bruchhausen, "Practising Hygiene and Fighting the Natives' Diseases: Public and Child Health in German East Africa and Tanganyika Territory, 1900-1960," *Dynamis: Acta Hispanica Ad Medicinae Scientiarumque Historiam Illustrandam*, 23 (n.d.): 3; See also Wright, *German Mission in Tanganyika, 1891-1941*, 72; Ann Crozier, *Practising Colonial Medicine: The Colonial Medical Service in British East Africa* (United Kingdom: Bloomsbury Academic, 2020), 61.
[172] Gröschel, *Zehn Jahre Christlicher Kulturarbeit in Deutsch-Ostafrika*, 25 and 41.
[173] BMW 1/6023: Station Lwamate Bericht 1. Lupembe Tangebucher 1914-1935, Bd. 2 (1914), 2.
[174]Steed and Bengt, *A History of the Church in Africa*.

The successes of vaccination campaigns helped missionaries gain prestige and acceptance from the local people in the Njombe region. This recognition also caught the attention of colonial officers, who believed that providing medical assistance was an effective way to gain the trust of Africans.[175] This led to encouragement from the German military officer named Tom von Prince for the establishment of a mission station near Lupembe and Ngosingosi chiefs. The colonial government aimed to utilize the mission's newfound trust to increase its influence in the region. However, it is important to note that all of these eroded the traditional beliefs and practices of the locals, which were often seen as incompatible with Christianity and the European way of life.

2.3 Navigating the Interface: Western Medicine and Local Healing in Complex Healthcare Interventions

Before the introduction of Christianity, Islam, and the advent of colonialism, African communities had their own unique religious beliefs and practices. These religions were based on the customs, spiritual beliefs, and social structures of various local groups and were widely embraced and practiced across different regions and communities. The traditional African belief systems were characterized by a strong connection with nature and the spiritual powers believed to exist in it. They often involved the worship of ancestral spirits, gods, and natural things like rivers, mountains, and animals. These beliefs helped them to make sense of the world and think about things like how it was created, what was right and wrong, and how humans were connected to gods. These religious beliefs changed and developed over time, as different African communities had their own cultures and histories. They played an important role in bringing the community together and making people feel like they were valued and integral parts of the community.[176] These religions had ceremonies and special events that were done to ask for good things like blessings, protection, and wealth, and to help people get better when they were sick. The ceremonies often involved participants, giving gifts, praying, and dancing, all to

[175] Beck, "Medicine and Society in Tanganyika 1890-1930." 10.
[176] Laurenti Magesa, *African Religion: The Moral Traditions of Abundant Life* (Maryknoll, New York: Orbis Books, 1997), 65.

connect with spiritual forces and foster a sense of unity among everyone and make a connection to God or the gods, and to the entire community.[177]

In different African communities, people's ideas about health, healing, and diseases were influenced by their religious beliefs. Africans believed that taking care of one's health and getting better from illnesses was not an individual's duty, but a responsibility shared by the whole community.[178] It is important to understand that they did not see health as a separate condition but as something connected to the overall balance of the universe. Therefore, to attain and preserve good health, they believed it was crucial to restore and cultivate positive relationship within the community and the wider world.[179]

And it was believed that a person cannot attain good health by themselves. This belief is based on the understanding that humans are not separate from their environment, both visible and invisible, but are closely linked to it. Health was viewed as a result of maintaining balance and harmony across different aspects of life, including the body, emotions, relationships, and spirituality. When these aspects were in harmony, individuals experienced a sense of being healthy.[180] If someone got sick, it was seen as an indication of a bigger problem that went beyond individuality. It was believed that the disharmony or imbalance that affected one person was a sign of a certain issue in the community or even the whole universe. In this way, sickness or illness was seen as a disruption in the spiritual or social balance, either within a person or in the world around them.[181]

However, before colonial times, it was common for Africans to associate uncertainties, suspicions, and unexplained mysterious occurrences with sorcery and

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[177] Magesa, *African Religion*.
[178] Romero-Daza, "Traditional Medicine in Africa," 2002, 173–76.
[179] Samuel Adu-Gyamfi and Eeugenia Anderson, eds., "Indigenous Medicine and Traditional Healing in Africa: A Systematic Synthesis of the Literature," *Philosophy, Social and Human Disciplines* (2019), 73.
[180] Ali Arazeem Abdullahi, "Trends and Challenges of Traditional Medicine in Africa," African Journal of Traditional, Comlementary and Alternative Medicines, 8, no. 5 (2011): 115.
[181] Magesa, *African Religion*, 65; see also Obed Kealotswe et al., eds., "African Christianity in Colonial Times," in *Anthology of African Christianity* (UK: Regnum Books International, 2016), 1149; Chammah Kaunda, "Towards an African Theological Education for Gender Justice and Peace: An African Theological Reflection on the Concept of Just-Peace" 18, no. 1 (2012): 137–53.

witchcraft.[182] Therefore, the occurrence of suspicious and strange illnesses that defied explanation followed the failure of simple local remedies led people to believe that witchcraft or magic was the only possible explanation. As a result, the afflicted person would seek the help of a sorcerer who possessed magical abilities to identify and remove the source of their misfortune.[183] In cases where persistent sickness occurred and neither a natural cause nor supernatural forces were suspected, a diviner would be summoned to determine which ancestral spirits had been offended and become angry enough to cause the disease.[184]

Upon arrived in Africa, missionaries discovered that the local people's healing practices and belief systems were deeply rooted in their culture and held great importance. This posed a significant challenge to the missionaries' endeavors. A similar scenario occurred when Protestant missionaries from Berliner Lutherans and Moravians ventured into the Southern Highlands of Tanzania in 1891. They discovered that the local inhabitants of the Unyakyusa and Undali regions had a strong faith in traditional beliefs, which was deeply intertwined with their belief. This frustrated the missionaries in the area.

Furthermore, as Protestant missionaries engaged with the community they came to learn about the special rituals practised by the locals, such as Mbambe, Kyala and Mbasi. These rituals held deep cultural and spiritual meaning for the people they encountered. The leader of the Berlin mission, Alexander Merensky, strongly criticized these rituals, labeling them as 'superstitious practices.'[185] This caused the relationship between the Wanyakyusa and the missionaries to deteriorate. Merensky openly expressed his determination to eliminate witchcraft by any means necessary and assumed the role of the ultimate authority in the entire region. He followed the statement made by his German fellow missionary, Henry Drumond, which suggested

[182] Schultze, *Der Njaßabund,* 42–43.
[183] Elizabeth Harrop, 'Tied That Binds: African Witchcraft and Contemporary Slavery,' (2012), 2; Ranger, "The African Churches of Tanzania, Historical Association of Tanzania," 335–65.
[184] Donald Fraser, *Winning a Primitive People: Sixteen Years' Work among the Warlike Tribe of the Ngoni and the Senga and Tumbuka Peoples of Central Africa* (London: Seeley Service & Co. Limited, 1922), 146.
[185] Merensky, *Deutsche Arbeit Am Njassa, 225.*

that "… when a white man settles among native people, he quickly becomes their king, lawyer, and judge".[186]

Merensky's attitude generated immense hostility between him, the chiefs, and the local population, eventually leading to his departure from Kipangamasi and his return to Germany in the mid-1892.[187] Alexander Merensky's behavior and his tendency to rule with absolute power without involving the local people made all the missionaries appear biased and arrogant. This situation also made it difficult for the Berlin missionaries' services to be accepted by the Wanyakyusa, especially in the Kipangamasi mission station which later was relocated to Itete in 1899.[188]

Pioneer medical missions were cautious about being accused of witchcraft. It is documented that not only mission doctors who faced the risk of being charged with witchcraft, but all missionaries, especially during the early stages of missions in Africa, were vulnerable to certain accusations. As a result, when treating local patients, they selectively focused on treating conditions that were considered curable. However, there was a specific incident in 1893 when rinderpest, a highly contagious viral disease, spread through eastern Africa and reached Kyela District. The local religious leaders from the Nyakyusa community attributed the outbreak to the presence of missionaries. In certain cases, however, when treatment at the hospital failed, medical missionaries were even accused of practising witchcraft.[189]

As in many other areas of mainland Tanzania, missionary work encountered significant resistance and hesitation from local communities from the outset. These communities were often cautious of foreign religious interventions that threatened established social structures, belief systems, and cultural practices. Missionaries, however, were not solely concerned with religious conversion; they also sought to promote Western moral frameworks and social values, which they frequently presented as superior to indigenous ways of life. In doing so, traditional African cultures were increasingly portrayed as backward, deficient, or incompatible with Christianity. A telling example of this attitude is found in the writings of Taylor

[186] Merensky, *Deutsche Arbeit Am Njassa, 225.*
[187] Owdenburg, Kilimhana, and Kasumba, *Karne Ya Kwanza Ya Injili, 1891-191*, 18.
[188] Owdenburg, Kilimhana, and Kasumba, 18.
[189] Iliffe, *A Modern History of Tanganyika*, 204.

Hamilton, who asserted that Africans did not possess a "real" culture and could only develop one after abandoning beliefs in witchcraft and so-called superstitions.[190] Such statements were not merely rhetorical but formed part of a broader ideological effort to delegitimize indigenous knowledge systems and erode the cultural pride embedded in African customs and traditions. By undermining these cultural foundations, missionaries sought to weaken local resistance and facilitate both religious conversion and cultural realignment along European lines.

Nonetheless, since the beginning of mission work in the Southern Highlands of Tanzania, the delivery of healthcare across the vast regions has faced significant challenges due to a limited number of health personnel. However, with the turn of the twentieth century, the expansion of colonial economic ventures, the development of transportation systems, and an increase in labour mobility within the colony led to a rise in infectious diseases. This situation prompted missionaries to realize the need for wider provision of medical services to the local population residing in marginalized rural areas, under served by the colonial health services. Unfortunately, the presence of a small number of European medical staff, including government doctors, mission doctors, and their spouses proved inadequate in meeting the growing demand for Western medicine.

However, it was common for missionaries operating in Africa to be called upon to treat the sick, regardless of whether they possessed formal medical training. The scarcity of biomedical practitioners and facilities meant that missionaries were often perceived by local communities as the only available source of medical assistance. This was evident in the experience of Paul Gröschel, a missionary affiliated with the Berliner Lutherans. Upon his arrival in the Njombe region at Kidugala in June 1898, Gröschel began treating patients and effectively working as a doctor alongside fellow missionaries, despite lacking formal medical training and having limited knowledge of local languages.[191] His experience underscores both the acute demand for medical

[190] See Hamilton, *Twenty Years of Pioneer Missions in Nyasaland*.
[191] Gröschel, *Zehn Jahre Christlicher Kulturarbeit in Deutsch-Ostafrika*, 4–46; See also James Giblin, "Taking Oral Sources Beyond the Documentary Record of Maji Maji: The Example of the "War of Korosani" at Yakobi, Njombe" in James Giblin and Jamie Monson, eds., *Maji Maji: Lifting the Fog of War* (Leiden ; Boston: Brill, 2010), 270.

care in the region and the ways in which missionary medicine often emerged from necessity rather than professional expertise. While such practices reflected the urgency of local health crises, they also reveal the blurred boundaries between humanitarian assistance, religious duty, and colonial presence within the missionary enterprise.

Consequently, it became imperative to train local individuals in the healthcare field to enable the practical expansion of medical services. Initially, a small group of African healthcare assistant emerged, primarily composed of former patients who had experienced healing through the medical intervention of the mission. The majority of these individuals chose to stay near the mission compounds and embraced Christian teachings, and offered their assistance in palliative care which included treating boils, dressing wounds, and pulling teeth (see Figure 3 and 4). Over time, they acquired essential medical skills leading to the expansion and enhancement of their role in healthcare provision.[192]

Figure 3: Local Dentistry at work in Milow village, Njombe District

Source: Archiv des Berliner Missionswerk (BMW) 2/530 – Milow – Africa

[192] Vaughan, *Curing Their Ills*, 61.

As time went on, the majority of African medical assistants were recruited from individuals who had received education at mission schools. These recruits predominately male, were commonly referred to as '*dawa'* (medicine).[193] The main reason for the predominant presence of African males in the healthcare field during this period was the limited access to education for women. This lack of education opportunities hindered women from acquiring the necessary qualifications to participate in healthcare work.

This strategic approach played a critical role not only in providing healing for the sick but also in expanding access to healthcare in remote areas where healthcare providers were scarce. The involvement of converted locals in medical care was considered an integral part of the ministry's commitment to caring for the ill. Additionally, missionaries held much hope that these medical assistants would contribute to eradicating superstitions that hindered the acceptance of Western medicine among the local population.

Furthermore, as these assistants were able to communicate with patients in their own language and explain unfamiliar medical procedures, medical work in rural Africa began to fall under mission control. However, this also led to an increased influence of medical missions over traditional African healing practices. Gradually, new medical knowledge and the practice of Western medicine penetrated into the daily lives of the locals, shaping their understanding of medical practices within their cultural context. This marked a significant step towards the dissemination of Western medicine and the overall impact of mission medical work in the region. In fact, Western medicine gained popularity among the locals, and the role of African medical assistants cannot be marginalized. They played an essential part in bridging the gap between Western medicine and local communities, contributing to the success and acceptance of medical missions in African communities.[194]

Figure 3 shows a local convert holding a bottle of lysine disinfectant, with a gauze bandage in his hand. This symbolizes the widespread influence of Western medical

[193] Vaughan, *Curing Their Ills.*
[194] David Arnold, *Imperial Medicine and Indigenous Societies* (Manchester: Manchester University Press, 1988), 2.

practices in the region. However, this approach not only played a significant role in the conversion of individuals but also fostered a deep sense of ownership and responsibility among local converts, who actively participated in the ministry of healthcare and contributed meaningfully to the well-being of their own communities.[195] Such a transfer was instrumental in the expansion of mission medical work in the Southern Highlands of Tanzania.

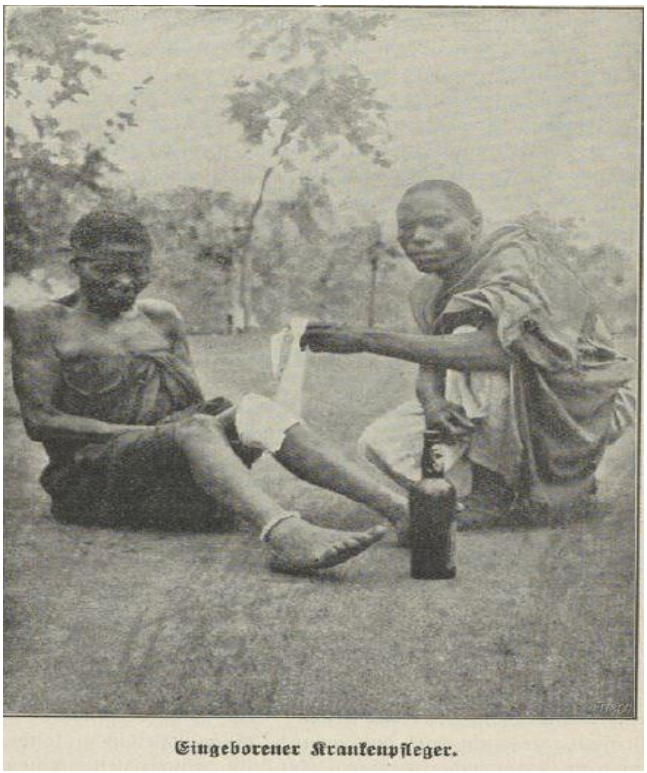

Figure 4: A Picture of African Medical Assistant in Rungwe (1911)

Source: Schultze, *Der Njaßabund : Bilder Aus Der Weiblichen Liebestätigkeit Der Berliner Mission in Deutsch-Ost-Afrika / von Erich Schultze, Pastor in Triebusch*, 88

The transfer of medical skills by missionaries in the Southern Highlands of Tanzania played a significant role in sharing medical knowledge in different mission stations.

[195] Schultze, *Der Njaßabund : Bilder Aus Der Weiblichen Liebestätigkeit Der Berliner Mission in Deutsch-Ost-Afrika / von Erich Schultze, Pastor in Triebusch*, 87.

In one way or another, this transfer of knowledge had a major impact on the region's healthcare system. The locals recognized the value of this knowledge and incorporated it into their traditional healing practices, blending Western medicine with their own methods. However, the acceptance and application of Western medicine were often met with resistance, and locals would turn to it only when their traditional medicine failed, and vice versa.[196]

For instance, in early March 1892, Chief Mwakatungila, one among of local ruler of Unyakyusa, fell ill and sought treatment at the mission station. The locals witnessed an improvement in his health after receiving care from the mission's healthcare facilities. However, upon returning home, his condition deteriorated, leading him to seek medical care again at the mission station, this time in a grave state. Surprisingly, he recovered, and therefore some converted locals saw this as a victory of the mission's medical system over traditional practices.[197]

Moreover, the interaction between mission medicine and traditional healing practice during the German colonial period presented challenges for both local patients and medical mission personnel. These misunderstandings were seen particularly in terms of the interpretation and translation of medical concepts and cultural differences. For example, Chief Merere of Wasangu insisted on being treated with specific types of medication, such as big pills, while rejecting smaller ones. Similarly, some patients requested white pills but refused red ones.[198] It is worth noting that these preferences were indeed rooted in cultural beliefs and traditional healing practices that assigned specific meanings to certain medical features.

However, it is important to note that starting from the turn of twentieth century; medical missionaries increasingly opposed the practices of traditional healers. They not only discouraged local converts from seeking treatment from traditional healers but also stigmatized local medicine and associated any element of African spirituality to evil or harm.[199] Nonetheless, it is crucial to recognize that even prior to colonial

[196] Musomba, *Historia Fupi Ya Kanisa La Moravian Kusini Tanzania 1891-1976*, 76.
[197] Charsley, *The Princes of Nyakyusa*, 12.
[198] Periodic Account for Moravian Mission, *Moravian Church and Mission Agency* Vol 1, no. 12 (1892): 624–26.
[199] Iliffe, *A Modern History of Tanganyika*, 549.

period; Africans have a long deep connection with traditional medicine. They attributed the etiology of diseases to the evil spirits and supernatural powers. As the result, it remains unsurprising that majority of African Christians even to date continue privately to seek explanations for their misfortunes such as barrenness, accidents, sickness, and deaths, and other unexplained phenomena, by consulting African traditional healers.

Although the primary focus of missionary medicine was centered on curative practices, it is important to note that its scope and application extended beyond curative measures. In the Southern Highlands of Tanzania, medical missions not only trained African medical personnel but also placed significant emphasis on health and sanitary education.[200] These missions held the belief that illness that affected Africans was manifestations of both moral and physical contamination. Thus, they regarded African practices related to hygiene, sanitation, and cleanliness as inadequate or unsophisticated. They also believed that individuals with good character and a comprehensive understanding of hygiene and sanitation principles had the potential to promote community health and prevent diseases. Therefore, the medical mission advocated for education and aimed to uplift Africans to conform to Western standards of hygiene. They believed that achieving that this involved not only physically cleansing their bodies with soap but also spiritually purifying their minds through the teachings of the Gospel.[201]

Missionaries also sought to instill in the local population the values of the Christian nuclear family, hygiene, and general cleanliness in their mission to combat diseases arising from unclean environments and self-inflicted ailments such as venereal disease and alcohol-related conditions. By encouraging the adoption of hygiene principles, missionaries aimed to empower the local population to take responsibility for their health. They recognized that certain diseases were linked to unsanitary

[200] Jennings, "Healing of Bodies, Salvation of Souls."
[201] Hardiman, *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa*, 11.

conditions and personal behavior, and sought to address these issues through education and the promotion of Christian values.[202]

The medical missionaries in the Southern Highlands of Tanzania were aware that many of the diseases that afflicted the African population were a direct result of unsanitary conditions and poor hygiene practices. The medical missions operating in this region were well aware that certain infectious diseases, such as cholera and typhoid fever, were prevalent due to inadequate sanitation and hygiene practices. To address this issue, from the turn of twentieth century both the Moravians and Berlin Lutherans focused on educating the converted Africans about the importance of drinking clean water and practising personal hygiene habits, including proper hand washing.[203]

Furthermore, the missionaries observed that the local marketplaces, such as those in Unyakyusa, played a significant role in the spread of disease, which they attributed largely to what they perceived as unhygienic food handling practices. According to missionary accounts, food vendors commonly sold agricultural produce directly on the ground or displayed it on banana leaves without any form of protection from dust, insects, or human contact (see Figure 5). From the missionaries' perspective, these practices created environments conducive to contamination and the transmission of infectious diseases, particularly in crowded market settings where food, people, and animals frequently interacted.

To address this issue, the Berlin mission advocated for hygienic food handling practices and sought to reshape market environments to align with European sanitary ideals. As part of these efforts, the mission constructed a purpose-built market hall equipped with large windows to improve ventilation and tables designed to elevate food off the ground (see Figure 6). Local vendors were encouraged, sometimes instructed, to use these facilities and to adopt cleanliness measures such as keeping food surfaces clean and organized.

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[202] Schultze, *Der Njaßabund : Bilder Aus Der Weiblichen Liebestätigkeit Der Berliner Mission in Deutsch-Ost-Afrika / von Erich Schultze, Pastor in Triebusch*, 39.
[203] Schultze, 39.

This market hall functioned not only as an infrastructural intervention but also as a pedagogical space through which missionaries sought to model and enforce their understanding of hygiene. Moreover, it served as a visible and practical demonstration of the missionaries' belief in the relationship between environmental conditions, personal hygiene practices, and disease prevention. In this way, the market hall embodied broader missionary objectives that extended beyond healthcare, reflecting their efforts to transform everyday social and economic practices according to biomedical and moral frameworks rooted in European conceptions of cleanliness and public health.

Figure 5: Locals Market in Neu-langenburg (Tukuyu)
Source: O. W Neumeister, *Eingeborenenmarkt in Neulangenburg (Tukuyu) Ostafrika; Erdnüsse AufBananenblättern. / RKB / 1302* (Tanganyika; Tanzania; Neu-Langenburg, n.d).

It is important to understand that every community possesses its own systems of knowledge, cultural norms, and practices for maintaining hygiene and promoting health, developed over generations in response to local environmental, social, and

spiritual conditions. African communities were not devoid of concepts of cleanliness or disease prevention; rather, they practiced forms of hygiene and healing that were embedded within indigenous belief systems, social structures, and everyday routines.

Missionaries, however, often framed health and hygiene through a distinctly European and Christian lens. In promoting Christian moral values, the nuclear family model, and standardized hygiene practices, missionaries presented these ideals as universally superior and inherently linked to notions of progress, morality, and civilization. Such ideas were not just religious or medical interventions but also functioned as tools of social regulation and cultural transformation. By associating cleanliness and health with Christian conversion, missionaries were able to legitimize their authority and facilitate the spread of Christianity within African societies.

This approach had profound consequences. By positioning missionary knowledge as superior, indigenous practices were frequently dismissed as backward, unscientific, or harmful, despite their effectiveness and cultural significance. As a result, African communities were often discouraged, or even prevented, from relying on their own systems of knowledge and decision-making. This process weakened local autonomy and undermined confidence in traditional health practices, while reinforcing unequal power relations between missionaries and African populations.

Furthermore, when the missions promoted hygiene practices, it led to the gradual erosion of traditional religious beliefs in many regions. Among communities such as the Wasangu and Wabena peoples in the Southern Highlands of Tanzania, who followed traditional religion systems for a quite a long time, began to doubt the effectiveness of their customs when they saw the practical benefits of the medical missions. As a result, the popularity of traditional religious started to decline as more locals sought help and safety from the missions.[204] This change in trust had a profound impact on the social and cultural aspects of the local community.

[204] Wright, *German Mission in Tanganyika*, 102.

Figure 6: Missionary Built the Hygienic Market for Locals in Neu-Langenburg (Tukuyu)

Source: O. W Neumeister, *Wir Bauten Den Eingeborenen Markthallen: Hygiene! Neu-Langenburg (Tukuyu) Dt. Ostafrika / RKB / 1301* (Deutsch-Ostafrika; Tanganyika; Tanzania, n.d.).

2.4 Conclusion

This chapter has traced the complex and transformative trajectory of Protestant missionary activity in the Southern Highlands of Tanzania during the late nineteenth and early twentieth centuries. Drawing on archival records, missionary accounts, ethnographic materials, and secondary literature, it has demonstrated that missionary engagement in the region cannot be understood solely through the lens of evangelism. Rather, it reveals a gradual yet significant shift in which the provision of medical care became inseparable from religious work and central to the consolidation of missionary presence. The establishment of missions unfolded within a landscape already shaped by long-standing and deeply rooted traditions of healing, cosmology,

and therapeutic practice. These traditions did not simply disappear with the arrival of missionaries; instead, they formed the basis upon which missionaries were compelled to negotiate their authority, legitimacy, and relevance.

As this chapter has shown, missionaries were not passive agents imposing a fixed biomedical or religious agenda. They actively engaged with local expectations surrounding illness, healing, and spiritual causation, often adapting their medical practices to accommodate beliefs in spirits, witchcraft, and ancestral intervention. Gaining patients and converts required navigating existing hierarchies of healers and responding to popular preferences for particular forms of treatment. These negotiations reveal that African communities were not merely recipients of missionary medicine, but participants who shaped how, when, and why Western medical practices were adopted or resisted.

At the same time, the increasing demand for Western medicine created new pressures and opportunities. Missionaries responded by establishing medical facilities, offering regular treatment, and training African medical assistants, thereby embedding biomedical care within everyday community life. These interventions addressed urgent health needs but also strengthened missionary authority and expanded institutional control. Medical work thus became both a humanitarian response and a strategic tool through which missions secured influence, visibility, and permanence in the region. Taken together, this chapter emphasizes that missionary medicine emerged through processes of negotiation, adaptation, and contestation between missionaries and local communities. While medical care enabled missions to gain trust and expand their reach, it also contributed to the marginalization of indigenous healing systems, which were increasingly framed as incompatible with Christian and European ideals. In highlighting these dynamics, the chapter underscores the intertwined nature of religion, medicine, and power in the colonial encounter.

CHAPTER THREE
NAVIGATING COLONIAL ENCOUNTERS: INDIGENOUS RESISTANCE, IDENTITY, AND AGENCY IN MISSIONARY MEDICAL WORK IN SOUTHERN HIGHLANDS COLONIAL TANZANIA, 1891-1940

3.1 Introduction

In 1891, when the German government assumed authority over German East Africa and transformed it into a protectorate, two German Protestant missionary groups, the Moravians and Berliner Lutherans, entered into the South-west colonial Tanzania. Their presence in the region was defined by the establishment of a unique connection between missionary enthusiasm and provision of medical care, which became a hallmark of their influence in shaping the historical trajectory of healthcare. In integrating of Western medicine to Africans, missionaries viewed the improvement of African health as a project which required sweeping changes in African life and culture. In making sure Africans moved away from their cultural traditions and way of thinking, missionaries established twenty (20) regulations referred to as '*Platzordnung'* which served as tools for governing the lives in the mission stations where Western medicine was introduced. These regulations granted missionaries a degree of control over Africans by restricting the practice of traditional healing and the expression of cultural beliefs among locals in the stations.

The combination of regulations, church discipline, and the introduction of Western medicine played a significant role in cultural intervention, leading to various reactions from indigenous communities in the region. While scholars have acknowledged the contribution of missionaries to the development of biomedicine, the establishment of medical institutions, and the formulation of policies that shaped health services in the colonies. In my work I explore the ways in which missionaries understood that transforming African cultures was essential if they were to provide medical care. This paper argues that medical missions made an effort to adapt pre-existing African mindsets to fit with the principles of Western biomedicine in the field of healthcare. Despite this, the interaction between mission medicine and traditional African therapies did not lead to replacement of one healing system for another. Instead, the field of healing in the colonial African societies came to

incorporate various practices and practitioners leading to the occurrence of dynamic coexistence of different approaches within the area of health and healing.

The chapter is organized into three sections. The first examines the ideological foundations of medical missionary work, with particular attention to the *Platzordnung* as a framework that shaped the possibilities and limits of mission medicine. The second explores interactions between missionaries and indigenous therapeutic practices, focusing especially on maternal health and reproduction as contested domains of care. The third analyzes encounters within mission hospitals themselves, tracing how African communities negotiated, resisted, and reinterpreted Western medicine in practice. Together, these sections illuminate how missionary medicine became a key site of negotiation over authority, identity, and cultural meaning in southern Highlands colonial Tanzania.

3.2 Foundation of Medical Missionary: The Influence of *Platzordnung*

The provision of medical services by missionaries, particularly during the initial phases of their work, proved valuable in establishing ties with African communities. In the early 1890s, Alexander Merensky, a missionary, assumed the role of superintendent leader of the Berliner Lutherans in the region. He quickly gained a reputation as a skilled healer among the Nyakyusa people in Kondeland within the Southern Highlands. Erich Schultze recalled that "Merensky served not only as a missionary, but also as a doctor in Kondeland and soon became very popular. He himself tells us that before long, his tent was surrounded by a number of huts inhabited by patients who sought his art or awaited healing. He had to pull teeth, treat wounds, set broken bones, and administer medicines for internal diseases." [205] Merensky medical skills became a cornerstone of Berlin Lutherans initial mission efforts, which were fundamental in the early healthcare initiatives.

As an experienced missionary who had previously served with the Berlin mission society in South Africa before relocating to the Southern Highlands, Merensky hoped that providing medical care would be a way to gain the trust of the indigenous population. In his account, he documented that "… in this way we won the friendship

[205] Schultze, *Der Njaßabund*, 41.

of many people here, and such a labor of love obliged them to be grateful."[206] That perspective is closely reflected in the views of Erich Schultze, a missionary pastor in the region, who argued that the medical care provided by the Berlin Lutherans "bears good fruit for the spread and rooting of the Gospel in Njasaland" and that "throughout the whole country a mission station is regarded as a place where help can be found by those who need it."[207] From these accounts we can argue that the introduction of mission medical care played a crucial role in building trust among the locals and fostering their acceptance of Christianity. Esme Cleall's study observed that the use of mission medics was a strategy to "ingratiate people to Christianity who were otherwise suspicious of it" and "provide an 'object lesson' of Christian benevolence that would be welcomed and appreciated."[208]

In addressing both the spiritual and physical aspects of African communities, missionaries came to realize that, apart from preaching the gospel amidst the backdrop of African cultural beliefs and lifestyle, it became clear that the success of missionary work demanded that all missionaries in the field possess specialized skills. From then on, the idea of a missionary became known as "the man in whom the preacher, the doctor, and the colporteur are rolled up in one."[209] Therefore, missionaries who were sent to the field were required to have diverse skills aimed at effectively serving the communities to which they were assigned.

When the mission's medicine proved to be a good thing that bringing the local population closer to the mission during times of epidemics and assisting those seeking access to medical care, education and other forms of support, missionaries came to believe that, for a fuller embrace of Christianity and Western medical knowledge, Africans were required to move away from their cultural traditions and ways of thinking. To achieve this, missionaries had to guide Africans through the process of conversion, aiming to reshape their identities by leading them away from

[206] Merensky, *Deutsche Arbeit Am Njassa*, 198; Schultze, *Der Njaßabund*.
[207] Schultze, *Der Njaßabund,* 90-91. Nyasaland constituted a segment of the Southern Highlands region present day Kyela and Rungwe Districts.
[208] Esme Cleall, *Missionary Discourses of Difference: Negotiating Otherness in the British Empire, 1840-1900* (New York: Palgrave Macmillan, 2012), 94.
[209] *Periodical Accounts of the Moravian Missions,* vol. 1, no. 8 (1891).

their cultural traditions. Missionaries viewed that improving African health was a project that required sweeping changes in African life and culture.

In early 1897, Carl Nauhaus, a missionary who was born and raised in South Africa, then later, moved to the Southern Highlands as part of Berliner Lutherans efforts to evangelize the locals. At first, he introduced twenty (20) regulations known in German as *Platzordnung,* at Ikombe station in Langenburg, present-day Kyela District. These rules were aimed to guide the locals living in the stations. The decision to impose these rules at first to Ikombe station stemmed from the unique situation at the station, which was 'situated on a piece of land over which no chief claimed jurisdiction.'[210] However, to enforce these rules, missionaries at Langenburg needed clearance from the district authorities and they were required to report any revisions or conflicts in the stations to the colonial government.[211] Due to the overall authority that overseeing the operation of colonial social and economic enterprises, the colonial government wanted to stay informed about any rules or laws introduced by the missionaries to the local population. This approach allowed the government to prevent any confrontation or disputes that could weaken the authority of European colonizers in the eyes of the local population.

Surprisingly, these regulations also extended to other stations, such as the Bena-Hehe Synod in the Njombe region, where they were implemented without obtaining clearance from the district authorities. Marcia Wright emphasized that there was "no such clearance with the district authorities preceded the inauguration of these [rules] in the [Njombe region], however, and there it became a bone of contention."[212]This unilateral imposition not only strained relations between mission authorities and local administrators but also exposed the ambiguities of jurisdiction that characterized colonial governance at the local level. District officials, who were formally responsible for civil administration, viewed the regulations as an encroachment on their authority, while mission leaders justified their actions by appealing to moral reform and ecclesiastical autonomy. As a result, the regulations

[210] TNA, IXA6, Nauhaus to Langenburg station, 12 January 1897, von Elpons to Ikombe Mission, 23 September 1897.
[211] TNA, IXA6, Nauhaus to Langenburg station.
[212] Wright, *German Mission in Tanganyika*, 80.

became a focal point of wider disputes over power, legitimacy, and the boundaries between religious and secular control, illustrating how seemingly localized missionary initiatives could provoke broader administrative and political tensions within the colonial system.

In all stations and among those converted Africans who lived nearby, it was required to follow the twenty rules. Few men and women among the converted Africans were chosen to report any member who behaved contrary to the twenty mission regulations to the missionary. Apart from banning the drinking of local beer, traditional dances, initiation ceremonies for young people, divination, and superstitious customs, the 8th principle from the *Platzordnung* explicitly stated that the practice of traditional healing and cultural beliefs within the station's boundary was prohibited for Africans. In addressing African hygiene, the regulations established cleanliness codes and special rules to uphold overall moral standards.[213]

Missionaries maintained the view that without bound to the *Platzordnung* the mission system would collapse.[214] Therefore, locals at the stations were encouraged to maintain order and embrace European model of life as a better way of living. In one way or another, it is fair to interpret that these regulations granted missionaries a degree of control over Africans healing systems in the stations, posing a threat to the authority of local healers, elders and chiefs who traditionally held significant power and influence over the community health and healing systems.

3.3 Missionaries and Traditional Practices in Maternal Health Care

At the beginning of twentieth century, mission authorities recognized the need to appoint a trained nurse to oversee the care of missionaries' wives within the station. Among the most notable was Sister Elise Franke, a professionally trained midwife with expertise in childcare. Having arrived in German East Africa from Cameroon in 1901, she assumed medical responsibility within the Berliner Lutheran mission, thereby contributing to the gradual institutionalization of structured, gendered medical care in the region.

[213] Wright, *German Mission in Tanganyika*, 18; see also Falres I. Ilomo. *Christianity: A Secondary Religion Experience among the People of Livingstone Mountian* (Soni, Tanzania: Vuga Press, 2011), 218.
[214] TNA, IXA 3a, Berlin Mission to Gov., May 1909.

Her engagement in colonial healthcare can be traced back to 1896, when she joined the German Women's Association for Nursing in the Colonies, an organization founded in the context of expanding German imperial ambitions to supply trained female medical personnel to overseas missions and colonial settlements.[215] This association played a crucial role in mobilizing middle-class German women into imperial service, particularly as nurses and midwives, thereby embedding gendered forms of care within the broader structures of colonial governance and missionary activity.

In response to a call for trained midwives and nursing personnel in the early twentieth century, driven by high mortality rates, limited medical infrastructure, and the needs for both missionary families and African communities, she was posted in 1901 to the mission station of Mwakaleli in Nyasaland.[216] Her placement in Mwakaleli clearly demonstrates the close relationship between missionary medicine and colonial expansion, where healthcare, while presented as a humanitarian service, also functioned as a practical means of consolidating missionary presence and extending influence in the Southern Highlands of Tanzania.

Between 1901 and 1905, Sister Franke devoted her time and energy to caring for sick, concentrating her efforts particularly on the fifteen Lutheran mission stations scattered across southwest Tanzania. Working under demanding and often precarious conditions, she succeeded in providing essential medical assistance to the African population, many of whom had little to no access to formal healthcare.[217] Her early work focused primarily on general nursing and the treatment of common illnesses, injuries, and infections. Over time, however, she recognized the urgent needs of women and families and broadened her responsibilities to include midwifery, offering care during pregnancy and childbirth.

Despite being the sole nurse for the entire Berliner mission in the region, Sister Franke faced immense logistical and physical challenges. Reaching patients

[215] Schultze, *Der Njaßabund,* 17.
[216] I retain the term 'Nyasaland' as used in the mission records to refer to the present-day Kyela and Rungwe Districts.
[217] Schultze, *Der Njaßabund.*

frequently required long and exhausting journeys on foot or by rudimentary transport, often across difficult terrain and in harsh weather conditions (see Figure 7). Despite these obstacles, she remained steadfast in her commitment, responding to calls for help from distant mission stations and surrounding communities alike.[218]

Figure 7: A picture of Sister Elise Franke leaves Mwakaleli for Medical Duty in 1904

Source: Erich Schultze, *Der Njaßabund : Bilder Aus Der Weiblichen Liebestätigkeit Der Berliner Mission in Deutsch-Ost-Afrika* (Berlin: Buchhandlung der Berliner Evangelischen Missionsgesellschaft, 1912), 65.

In recognition of her dedication and service, the Berliner Mission Committee formally appointed Sister Franke in February 1904 as the first Nyasa Covenant Sister.[219] This appointment marked a significant milestone in the development of women's medical and missionary work in the region. At the time, however, broader ideas of collective organization or structured women's movements, such as the later

[218] Schultze, *Der Njaßabund*, 17.
[219] Schultze, *Der Njaßabund.*

Nyasa Women's League, had not yet emerged. Sister Franke's work thus unfolded in relative isolation, shaped more by personal vocation and necessity than by institutional frameworks, yet it laid important groundwork for future cooperative efforts among women in mission and healthcare service.

In the early months of 1905, Karl Axenfeld assumed leadership of the executive office and seminary in Berlin, while also serving as an inspector for the Berlin Mission Society operating in German East Africa. In this dual capacity, Axenfeld played a key role in overseeing both theological training and the practical administration of missionary work abroad. That same year, he undertook an inspection tour to the Southern Highlands of Tanzania, a region that had become an important center of Lutheran missionary activity. During his visit, Axenfeld closely observed the daily operations of the mission stations and engaged directly with missionaries working on the ground. These encounters revealed significant challenges, particularly in the area of healthcare. Lutheran missionaries repeatedly expressed serious concern, both to Axenfeld personally and to mission headquarters in Berlin, about their inadequate medical training.[220] This deficiency was especially acute in matters of maternal and reproductive health, where complications during pregnancy and childbirth were common and often life-threatening. Lacking the professional expertise to respond effectively, missionaries found themselves unable to meet the urgent health needs of local communities.

Missionary wives in the region they actively advocated for the deployment of female nurses in South-west Tanzania. They recognized the potential benefits of having individual capable of providing both medical care and help with the household tasks for sick missionary women. In contrast, missionary men were troubled by the harsh reality that they felt not prepared to handle serious illness, especially during childbirth or when their children were serious ill.[221] Despite the existence of colonial government doctors, accessing their services was difficult for missionaries in the

[220] German Colonial Congress, *Proceedings of the German Colonial Congress 1910 in Berlin, October 6–8*, with 8 maps and 4 plates as supplements and 5 illustrations (Berlin: Dietrich Reimer Publishing House, 1910), 633 and 635.
[221] Schultze, *Der Njaßabund.*

region. These doctors were located far away from the mission centres, and that required several days of travel to reach the nearest medical professional. In some instance, even if a messenger was dispatched, they might return with the news that the doctor was in a completely different corner of the colony.[222] This further intensified the sense of urgency among missionaries for additional medical personnel, either in the form of doctors or nurses, to be stationed in the region.

In the late nineteenth century, missionaries faced a significant dilemma as they sought professional medical support for maternal care. This challenge became turning point in the history of mission healthcare in the region. Faced with the obstacle of limited access to trained doctors, missionaries explored alternative solutions. Recognizing the practical knowledge possessed by African midwives in maternity related matters, they turned to traditional healing practices and sought the expertise of the African midwives.[223]

In both archival documents and reports of missionaries, African traditional medicine is consistently portrayed as a practice associated with witchcraft and considered more dangerous. As the result, mission reports tend to overlook the extent to which traditional healers were searched for support by Christian missions. The reason for that can be attributed to the prevailed cultural perspective that influenced missionary activities during the colonial period in Africa. Missionaries, shaped by their cultural biases, actively promoted the concept of European superiority. Hence, they viewed Western medicine as more advanced and superior, while underestimated the value of African healers and indigenous beliefs within the framework of European biomedicine.

Paul Gröschel, a Lutheran missionary from Berlin stationed at Bena-Hehe Synod[224] in Yakobi, provides insights into how missionaries began to appreciate the knowledge of traditional practices, especially in maternal health, when faced with a serious illness affecting a missionary's wife. Gröschel describes an episode that

[222] Schultze, *Der Njaßabund*, 8.
[223] Gröschel, *Zehn Jahre Christlicher Kulturarbeit in Deutsch-Ostafrika*, 28.
[224] The term Bena-Hehe Synod is employed in mission files to refer to stations located in today's Njombe and Iringa regions.

unfolded upon his return from a Christmas journey to Bulongwa and Ikombe stations in January 1899. While passing through Manow station, he received a warm welcomed from Brother Källner. To his surprise, Gröschel discovered that Brother Källner's wife, who had recently given birth, was in a critical condition. According to Gröschel, later that evening, an experienced African midwife was called to attend a sick missionary wife. Interestingly, it turned out that this was not the first time the same local midwife had successfully attended to the health needs of a missionary spouse.[225] According to this account, the locals started to assess the efficacy of mission medicine, a factor that played a crucial role in determining the success or failure of the medical mission in the future.

The leaders of the Berlin Mission Society at the party headquarters in Berlin increasingly acknowledged that effective missionary work in Southern Highlands, Tanzania required systematic healthcare support. Reports from the field made clear that missionaries were struggling to respond to widespread illness, high maternal mortality, and the growing expectations of local communities for medical assistance. Recognizing that these challenges could no longer be addressed through informal or improvised means, mission leaders concluded that trained medical personnel were essential to sustaining and expanding their work.[226]

In response, the Berlin Mission Society established the Nyasa Women's League in 1905. This organization was specifically created to recruit, train, and dispatch female medical workers to mission stations. Through the Nyasa Women's League, women were prepared to serve as nurses and midwives, roles that were considered particularly appropriate and effective in addressing women's and children's health needs in German East Africa.[227] Their deployment also reflected broader gender norms within missionary medicine, where female caregivers were seen as better suited to provide intimate care, especially in maternity and childbirth.

[225] Paul Gröschel, *Zehn Jahre Christlicher Kulturarbeit in Deutsch-Ostafrika*.
[226] Mirbt, *Mission und Kolonialpolitik*, 68 and 177.
[227] Mirbt, *Mission und Kolonialpolitik*.

By 1908, the impact of this initiative was clearly visible. At least ten trained mission sisters were active in the region, working not only as nurses but also as teachers within mission stations.[228] Their presence significantly expanded the scope of missionary activity, integrating healthcare with education and evangelization. In this way, the establishment of the Nyasa Women's League marked a crucial step in the professionalization of mission medicine and underscored the central role of women in the development of missionary healthcare in south-western German East Africa.

Figure 8: A Picture of Njaßabund Sister Care for a Black Infant in 1906

Source: Christian Schumann, *25 Jahre Berliner Mission in Deutsch-Ostafrika, 1891-1916: Ein Rückblick* (Berlin. Ev. Missionsgesellsch, 1916), 48.

The establishment of this association marked a crucial turning point in the mission medical history in the region. As considerable friction arose between missionaries, local healers, and community following the these nurses who came with European

[228] Mirbt, *Mission und Kolonialpolitik*.

model of life and started to confront with the traditional practices and beliefs that related to maternal health, clothing, hygiene, and food. Missionaries viewed the spread of diseases among Africans were the result of a combination of intrinsic factors that ranged from superstition, poor hygiene, ignorance, and the lifestyle practices, all of which according to them were intensified by cultural factors.[229]

The mission nurses viewed that the reason for high mortality rate among African children was influenced by various factors, such as limited knowledge of obstetrics, the danger of unhygienic way of life, and the practice of superstitious customs.[230] For instance, the medical mission in Unyakyusa[231] observed that community traditions involved providing infants with items like herbs, as well as solid foods such as porridge, avocados, and bananas shortly after birth. This practice was deeply rooted in African world view, which emphasized a community understating of the health and illness of an infant. According to this world view, it was believed that once the life spirit of the newborn had experienced the good taste of the natural foods like banana, rice, or corn flour, the infant would be reluctant to depart from the earthly realm. Contrary, if a child passed away without ever enjoyed these items, they would not be considered fulfilled even in the realm of spirits. Therefore, these foods were traditionally offered as part of cultural practices for newborns, emphasizing local beliefs in the supernatural realm for the well being and growth of both individual children and the community as whole.[232]

Medical mission persuaded local women to abandon these practices they perceived as superstitious customs, which were considered dangerous and unsafe for the wellbeing of African children. This triggered the clash with the local healers and communities who held the expectation that linking an infant with the spirits of gods was a means of safeguarding and ensuring the future health, protection, and prosperity of the child. Missionary medics aimed to dismantle this mindset and belief system that was common among Africans. Their approach involved providing public

[229] Schultze, *Der Njaßabund*, 86.
[230] Jennings, "Healing of Bodies, Salvation of Souls."
[231] The term Unyakyusa is used in numerous mission sources to describe Langenburg, now known as Kyela and Rungwe Districts, where the Nyakyusa Bantu community resides.
[232] Schultze, *Der Njaßabund*.

health education and utilizing Western medicine as an important tool to break the chains of what they perceived as ignorance among Africans regarding maternal health and childcare. Though missionaries viewed Africans ideas of maternal health as primitive, however, Africans as active actors in shaping history, they actively engaged in the study of their children health from birth and they used that accumulated knowledge to critically assess missionary medical ideas and practices.

Nevertheless, in promoting maternal education within the missionary stations, women were their primary focus. However, mission nurses clashed with dominant cultural norms that were wide accepted in many African societies. Historically, in most of African culture women are considered as property of men, that kind of notion is reinforced by customs such as the bride price.[233] Therefore, this cultural perspective were regarded as an obstacle for mission nurses South-west colonial Tanzania, as it was thought to undermine women's agency, particularly in matters related to their children health. To bring about visible changes in terms of child nutrition, missionaries felt that it could be difficult to empower women, given their subordinate position in household and the prevailing belief in men as the authoritative heads of families. [234] However, medical missionary considered themselves as guardians of a more enlightened approach towards African health. Therefore, their efforts to reshape local customs and aligned them with their own standard of health and well being were intended to have an impact in African communities in the future.

However, communities, guided by chiefs, elders, and local healers, ensured that the medical influence of missionaries remained confined to narrow areas of social life. They wanted the missionaries to caring for those who were already sick, rather than trying to make a broad changes in society which were intended to prevent the occurrence of illness. Therefore, the missionary's spheres of influence were more limited within the mission stations. And inside the stations they had degree of control over the converted Africans and those living nearby, such as former slaves,

[233] Simon Robert Charsley, *The Princes of Nyakyusa* (Nairobi: East African Publishing House, 1969), 73 and 78.
[234] Schultze, *Der Njaßabund.*

abandoned wives, individuals who wanted to liberate themselves from customary social obligations and also those who sought access to medical care, education, and other forms of support.[235]

Missionaries understood these limitations on their influence, as articulated by Marcia Wright. She noted that 'the Moravians missionaries at Rungwe preached the gospel [and practiced Western medicine with a] … rigidly anti tribal terms, and that, even after many years of missionary work, a number of them doubted if an African could remain a faithful Christian [and adopted Western medical knowledge] in their village without having first stayed for an extended period on the mission station.' [236] Similarly, Klaus Fielder, explain that, 'the fact that the missionaries initially preached mainly to people dependent on them delayed their coming to terms with the host culture, and allowed them to present conversion as a radical break with [communities of South-west Tanzania].'[237]

As the acceptance of missionary's teachings was not a uniform phenomenon, rather it occurred for formal or pragmatic reasons, such as gaining access to services provided by the missionaries. This frustrated the missionaries who started to question if their teachings had a meaning for the converted Africans. For that case, missionaries became keen on ensuring that Christian Africans remained committed to the faith, even beyond the confines of the mission stations. However, in Southern Highlands of Tanzania, similar to other parts of Africa, the local people maintained a strong trust in traditional healers and their methods. The fact that healthcare for African communities was intertwined with spirituality and cultural norms, created a resilient connection to traditional healing practices. Despite the growing influence of Christianity, traditional healing practices still remained dormant to many Africans. In that context, we can argue that Africans were able to preserve their cultural identity and traditional practices by meeting the expectations imposed upon them by missionaries.

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[235] Wright, *German Mission in Tanganyika*, 86; see also Iliffe, *A Modern History of Tanganyika*, 228.
[236] Wright, *German Missions in Tanganyika*, 43; see also, Musomba, *Historia Fupi Ya Kanisa La Moravian Kusini Tanzania*, 33.
[237] Fielder, *Christianity and African Culture*, 50.

3.4 Cultural Negotiations at Mission Hospitals

In the colonial Southern Highlands, as in other communities in Africa, the course of treatment was not solely determined by the afflicted individual. Instead, kinship relations and the culture of neighborhoods shaped the healing systems. Therefore, the decision making process related to the healthcare and the therapeutic choices was not an isolated event but rather it was integrated into a broader networks based on social and family relations. In traditional healing, family members which also includes close relatives were an important figure in offering support and actively engaged in the decision making process. Local healers navigated through the kinship relations to address individual treatment, thus, the establishment of mission hospitals came into conflict with the socio-cultural bond of the African societies. According to Steven Feierman, the introduction of colonial medical services 'transformed healing in Africa from a communal enterprise to one with a greater focus on individualistic therapeutics.'[238]

In the mission reports, it became evident that Africans were deeply connected to their traditional healing systems when interacting with the mission medics. They made efforts to understand the Western medicine within the framework of their cultural lives. From the beginning, when sick Africans approached the mission hospital, many, except for the converted Africans and those seeking benefits by living with missionaries, such as former slaves, resisted being treated inside the mission hospital. Instead, they preferred a mission doctor to administer treatment in the small huts that were always seen surrounding the mission hospital. Missionaries observed this pattern since they started to provide medical care to the locals. Carl Paul, in his account on missionaries in German East Africa, highlights that in the earlier years of mission medical work in Langenburg, around 1890s, there were approximately 60 small huts near Wangemannshöh with 200 patients and their relatives.[239]

The trend of African patients refusing to receive medical treatment inside the mission hospital escalated at Kidugala in Njombe region in February 1911 when Berliner

[238] Steven Feierman, "Struggles for Control: The Social Roots of Health and Healing in Modern Africa," *African Studies Review* 28, no. 2/3 (1985): 120.
[239] Paul, *Die Mission in unsern (unseren) Kolonien*, 257.

Lutherans built a hospital that was designed for African and European patients. The available data indicates that the hospital had two rooms for African men and women and two special rooms exclusively for white patients.[240] The hospital structure reflected a racist element that prevailed in the colonial altitude towards Africans. Moreover, the Nyasa League provided essential household equipment, including beds, while the mission's Medical Association supplied the necessary medical tools. The hospital contained a pharmacy equipped with a microscope and work table, an operating room connected to the polyclinic room, and a patient room primarily intended for surgeries.[241]

To navigate the complexities of Western medical intervention, many local patients deliberately avoided treatment in mission hospitals. Their reluctance stemmed largely from the unfamiliar healing environment these institutions represented, characterized by architectural forms, medical equipment, and clinical routines that were foreign and unsettling to African patients. Hospitals embodied Western notions of disease and treatment that contrasted sharply with indigenous healing practices, making them spaces of anxiety rather than comfort. Moreover, the prospect of being isolated from family members and relatives during treatment further discouraged local communities from seeking hospital care.[242]

As the number of sick individuals seeking mission medical assistance increased, local communities responded by constructing their own small huts around the mission hospital in Kidugala. These huts allowed patients to remain within a familiar cultural and social environment while still accessing certain forms of missionary medical aid. Recognizing this growing demand and the limitations of conventional hospital models, missionaries adapted their approach by constructing a 'native hospital' designed specifically for African patients (see Figure 9).

This hospital featured large communal sick rooms and was built using locally familiar materials such as wood and clay, with shed roofs that closely resembled indigenous huts. Its design reflected a deliberate attempt to bridge Western medical

[240] Schultze, *Der Njaßabund*, 108 and 109.
[241] Schultze, *Der Njaßabund.*
[242] Schultze, *Der Njaßabund*, 112 and 113.

practices with African healing traditions. In doing so, missionaries were compelled to reconsider and restructure their medical services, aligning them more closely with local understandings of illness, care, and recovery. The native hospital thus illustrates how African agency and healing practices significantly shaped the form and function of missionary medical institutions, challenging the rigid application of Western biomedical models in colonial contexts.

Figure 9: A Native Hospital located at Kidugala in 1911

Source: Erich Schultze, *Der Njaßabund : Bilder Aus Der Weiblichen Liebestätigkeit Der Berliner Mission in Deutsch-Ost-Afrika* (Berlin: Buchhandlung der Berliner Evangelischen Missionsgesellschaft, 1912), 113.

Missionaries believed that good health required African patients to attend a mission hospital for scientific diagnosis while also exposed to fresh air that were thought to help the healing process. However, the community's expectations contradicted to the idea promoted by missionaries. They insisted that sick individuals should be given privacy during the healing process, emphasizing the importance of staying indoors, a practice rooted in cultural beliefs. Furthermore, locals contested the idea of staying at

the hospital and being separated from their communities during illness, as it clashed with traditional practices that valued communal support and privacy in the healing process. The quest for privacy, grounded in traditional therapies, played a crucial role in shaping how Africans sought to balance colonial healthcare with their indigenous practices.

The mission medical approach to disease and treatment differed significantly from the traditional perspective of disease management and control. When sick individuals sought treatment at mission hospitals, conflict often arose between the missionaries, the patients or their accompanying relatives, especially regarding the handling of wounds. In explaining the history of Moravians medical services in Rungwe District, Bishop Taylor Hamilton noted a key aspect of the conflict, whereby local people seemed to interpret mission medicine through the lens of their understanding of healing in the traditional realm.[243] The missionaries, in their efforts to train Africans as medical assistants, introduced a curriculum that included palliative care. This training involved instructing Africans in the treatment of boils, dressing wounds, and pulling teeth. Nevertheless, this approach created tension within the local communities.

The local population perceived the medical work, particularly tasks involving personal care and treatment, as the exclusive domain of trusted local healers. Therefore, when missionaries began to involve African medical assistant, they initially met with 'a point-blank refusal.'[244] Such reaction was influenced by the notion that it was entirely against the indigenous custom for anyone who is not closely related to the patient and is not a local healer to have anything to do with handling matters related to the sick person's bandages and similar medical needs. Furthermore, to understand and accept missionary medical practices in the colonial Southern Highlands, communities had to enter into negotiations to align them with their longstanding traditional therapies.

[243] Hamilton, *Twenty Years of Pioneer Missions in Nyasaland*, 102.
[244] Hamilton, *Twenty Years of Pioneer Missions in Nyasaland.*

When Kidugala station transformed into a medical center for the Berliner Lutherans in South-west Tanzania, mission doctors conducted various surgeries. An incident occurred during one such surgery when physicians removed a bone splinter from a young man's skull. Many missionaries' medical practitioners' had the feeling that by showcasing Western medical procedures was first and foremost a golden opportunity to show their high level of skill and proficiency. However, this perspective sharply contrasted with the reaction of African patients and communities, who remained unsurprised by these procedures.[245] Africans' reaction stemmed from the fact that the extraction of unknown objects from a patient's body had long been a common practice within traditional healing systems. Such procedures were often understood as the removal of harmful substances, spiritual afflictions, or sources of illness, making the act seem familiar rather than shocking, even when performed in a medical or foreign context.

Missionaries believed that by giving injections and surgeries they would easily draw African communities into accepting Western therapeutic systems. But to their surprise and dismay, they realized that they could not alter the fundamental religious and psychological foundation of African health beliefs. Instead, 'Africans incorporated biomedicine as an add-on to their own practices and came up with an eclectic, pluralistic new system.'[246] As the result, the encounter between European mission medicine and African traditional medicine did not lead to replacement of one healing system for another. Rather, healing practices within African societies came to incorporate diverse practices and practitioners. And that emerged as a 'defining feature of the medico-religious frontiers in colonial and postcolonial Africa.'[247]

Local communities used linguistic distinctions that were observed in their terminologies to understand the nature and purpose of the mission medical care. Mission sources inform us that communities deliberately used the term *bwana mganga*, for missionary and colonial health practitioners, which means a doctor and also the term, were used to identify traditional healers. Except that for healers they

[245] Schultze, *Der Njaßabund*, 107.
[246] See, Charles M. Good, *The Steamer Parish: The Rise and Fall of Missionary Medicine on an African Frontier*. (Chicago: University of Chicago Press, 2004), 287.
[247] Good, *The Steamer Parish.*

term *bwana* was omitted, when referring them they were simply referred as *mganga*. However, it is interesting that in Swahili language, the term *bwana* carries a certain level of respect that holds a cultural significance. This paper argues that by not employing this term for healers, communities may have been reflecting an existing social hierarchy within the community, one that might not have been explicitly imposed but was communicated and well understood through language. Therefore, by applying the term *bwana* for missionary healthcare providers, the communities might have unintentionally reinforced an idea of hierarchy that placed missionary in a position of higher authority. Nevertheless, by such distinction local communities may have aimed to preserve their cultural identity and avoid direct assimilation with Western practices.

3.5 Conclusion

This chapter sheds light on the complex encounter between mission-based medical interventions and long-established systems of traditional healing in Southern Highlands from 1891 to 1940. Drawing on a careful analysis of written archival records, ethnographic accounts, and relevant secondary literature, the study argues that the institutional structure of healthcare in the region during the German colonial period in Tanzania was profoundly shaped by the introduction and gradual expansion of mission healthcare services. Mission stations became important sites where biomedical ideas, Christian moral frameworks, and emerging colonial administrative priorities intersected, influencing how healthcare was organized and delivered.

Yet this transformation was far from straightforward. Missionaries did not enter a medical vacuum; instead, they encountered an old, deeply rooted, and socially embedded tradition of healing that had long served local communities. Indigenous healers possessed specialized knowledge of herbs, spiritual therapies, and social rituals that addressed illness not merely as a biological condition but as a phenomenon tied to morality, ancestry, and communal relationships. Faced with this reality, missionaries were compelled to reflect critically on their own medical practices and strategies. They had to negotiate how, and whether, to adapt mission medicine in ways that could resonate with populations whose trust and therapeutic expectations were firmly anchored in traditional healing systems. Moreover, despite

the often-sharp contrasts between mission medicine and indigenous therapies, their interaction did not result in the complete displacement of one system by the other. Instead of a linear process of replacement, the colonial medical landscape evolved into a pluralistic field. Mission clinics, traditional healers, midwives, and spiritual specialists coexisted, competed, and sometimes complemented one another. Patients moved pragmatically between different therapeutic options depending on accessibility, perceived effectiveness, social meaning, and personal belief.

CHAPTER FOUR

KINSHIP, MEMORY, AND MISSIONARY MEDICINE: HEALING AND THE CULTURE OF NEIGHBORHOOD IN COLONIAL SOUTHERN HIGHLANDS OF TANZANIA, 1891-1940

4.0 Introduction

The colonial Southern Highlands of Tanzania, particularly the regions of Mbeya and Njombe have long been home to diverse communities, including the *Wabena*, *Wahehe*, *Wasangu*, *Wanyakyusa*, and *Wandali*, each community with its own distinct cultural traditions and social systems. For generations, these communities relied on networks of kinship and shared local knowledge to address both physical illness and spiritual problems. Healing practices were primarily guided by traditional healers, elders, chiefs, family ties, and neighbors, whose authority as custodians of health and well-being played a central role in maintaining individual health and social cohesion. These indigenous systems of care shaped local conceptions of illness, healing, and communal life.

However, the arrival of German Protestant missionary groups in the late nineteenth century marked a significant turning point in the region's history, particularly in the sphere of medical care. Missionaries introduced new medical practices, instruments, and therapeutic routines that gradually undermined the long-established healing practices that had sustained local communities for generations. Over time, missionary medicine reshaped the therapeutic landscapes of the Southern Highlands, eroded indigenous medical authority, and introduced new understandings of disease, health, and healing.

For nearly five decades, from their arrival in 1891 until their forced removal by British colonial authorities in 1940, missionaries of the Moravian Church and the Berliner Lutherans established an extensive and increasingly influential network of medical missions throughout the Southern Highlands of Tanzania. Operating within shifting political and social landscapes, these missionaries founded hospitals, dispensaries, and small rural clinics that were strategically located to serve both

emerging mission stations and surrounding African communities.[248] While these institutions addressed pressing health concerns, such as epidemic diseases, injuries, and maternal care, they also functioned as key sites of sustained interaction between missionaries and local populations. At different times and in different spaces, medical missions served multiple, overlapping purposes. On the one hand, they provided biomedical treatments that were often perceived as effective and unfamiliar, attracting patients who might otherwise have had little direct contact with missionary activity. On the other hand, these facilities were deliberately embedded within evangelistic strategies: medical care was frequently accompanied by religious instruction, prayer, and moral teaching. Healing the body thus became inseparable from attempts to transform belief systems, social practices, and understandings of illness and causality. In this sense, medical missions became integral components of the larger colonial project, offering healing while simultaneously advancing cultural and religious transformation.

Yet the encounter between missionary medicine and indigenous healing traditions was far from one-sided. African communities responded in diverse and complex ways: they resisted certain practices that conflicted with established beliefs, blended new therapies with their own healing traditions, and incorporated selected elements of missionary medicine into existing cultural and social frameworks. In different places, families carried their sick relatives to mission stations for diagnosis or medicine, but they continued to rely on herbalists, diviners, and kin-based care at home. Elders, chiefs, ritual specialists, and neighbors, who had long shaped the care of the sick, managed to evaluate Western bio-medicine through the lens of experience, spiritual reasoning, and a sense of communal responsibility. They embraced new therapeutic knowledge that appeared effective or compatible with local understandings of illness and rejected those which seemed foreign and incompatible with existing traditional healing systems. This led to the creation of

[248] See Christian Schumann, *25 Jahre Berliner Mission in Deutsch-Ostafrika, 1891-1916: Ein Rückblick* (Berlin Missionsgesellsch, 1916); Gröschel, *Zehn Jahre Christlicher Kulturarbeit in Deutsch-Ostafrika;* see also Musomba, *Historia Fupi Ya Kanisa la Moravian.*

hybrid therapeutic systems that remained beyond the full control of medical missionaries and colonial officials.[249]

This chapter examines the complex relationship between kinship networks, neighborhood relations, and missionary medicine in the colonial Southern Highlands of Tanzania. It demonstrates how African communities navigated, negotiated, and at times actively contested the medical changes introduced by German Protestant missions. At the same time, it shows how local actors selectively appropriated aspects of missionary health interventions, integrating them into existing social and therapeutic practices when they seemed useful or culturally acceptable.

At the center of this discussion is the argument that family relationships and local social networks fundamentally shaped how communities received and interpreted new medical ideas. These networks influenced the extent to which missionary medical therapies were embraced, adapted, or resisted. Within these societies, illness was rarely understood as a private or individual condition. Instead, it was a shared experience that mobilized households, extended kin, and neighbors in a coordinated effort to provide care, advice, and emotional support. Thus, healing was as much a social process as it was a medical one.

While this chapter draws on written archival records and ethnographic accounts, it emphasizes that a comprehensive understanding of colonial healing practices must also include the voices of those who experienced them. Informed by Jan Vansina's pioneering contributions on oral historical methodology, this study insists on the legitimacy and richness of oral testimony in the reconstruction of the social dynamics of missionary medical encounters. As Vansina informs us, oral traditions reflect more than just the distant past; they are vibrant, living archives, shaped by generational memory, cultural interpretation, and collective experience.[250]

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[249] See Veronica Kimani, "Creating Health Futures: Maternal Health Policy, Planning, and the Making of Postcolonial Tanzania, 1961–1980" (Unpublished PhD Dissertation., University of Cologne, 2025), 157-158; see also Good, "Pioneer Medical Missions in Colonial Africa."

[250] For a detailed discussion of the methodology, significance, and interpretive frameworks of oral traditions in historical research, see Jan Vansina, *Oral Tradition as History* (Madison: University of Wisconsin Press, 1985). Vansina argued that, when critically analyzed, oral narratives can function as legitimate historical sources, particularly in African contexts where written records are limited.

In addition to Vansina, this chapter engages a wider body of scholarship that has established oral history as a rigorous and respected field of historical inquiry. Donald Ritchie's work on interviewing techniques, memory, ethics, and the interpretive challenges of oral testimony is particularly significant for this discussion. Several scholars remind us that oral narratives are shaped by context, power relations, and the passage of time, yet these very qualities make them essential for recovering everyday experiences and community perspectives.[251] Thus, through these voices, the chapter examines how local communities in the Southern Highlands navigated questions of health, healing, authority, and social belonging within a rapidly changing social landscape.

In regions, where written records are scarce or shaped by the priorities of missionaries and colonial authorities, oral histories provide an essential means of accessing African perspectives on the past. These narratives provide insights that were often excluded, silenced, or distorted in missionary diaries, administrative reports, and official correspondence. Oral accounts give depth to social experiences that rarely appeared in colonial archives, such as how families navigated illness, how healers understood their roles, and how local communities evaluated the expectations and limits of medical missions. Through that, one can reconstruct social and cultural worlds that written records alone cannot adequately capture, especially in contexts where local voices were systematically marginalized.

Besides that, the use of oral histories to reconstruct events from the late nineteenth and early twentieth century's demands careful reflection on the temporal distance between the period under study, from 1891 to 1940, and the contemporary moment of research. It is clear that most of the individuals we interviewed did not directly witness the missionary encounters of that era; instead, much of the material collected represents memories that have travelled across generations. These are stories

[251] For an understanding of oral sources as legitimate historical evidence, see Donald A. Ritchie, ed., *The Oxford Handbook of Oral History* (Oxford: Oxford University Press, 2012). For other comprehensive guides to oral history, see Paul Thompson, *The Voice of the Past: Oral History* (Oxford: Oxford University Press, 1978); and Valerie Yow, *Recording Oral History: A Guide for the Humanities and Social Sciences* (Lanham, MD: Rowman & Littlefield, 1994).

transmitted through family conversations, pastoral teachings, traditional practices, and the communal memory, and each story was shaped by context, emphasis, and the interpretive choices of those who preserved it. Therefore, this chapter argues that rather than viewing this temporal gap as a methodological weakness, it should be understood as central to the historical analysis itself. The distance between past events and their contemporary narration reveals how communities have chosen to remember colonial encounters and how such inherited memories continue to shape present-day identities, moral authority, and social knowledge in the Southern Highlands.

In societies where oral tradition forms the foundation of historical knowledge, the transmission of memory becomes a significant process in its own right. The informants we encountered, particularly elderly males and women, retired pastors, and local healers, shared narratives that revealed not only what happened in the past but also why certain events, practices, or figures have remained central to communal remembrance. Their accounts often conveyed moral lessons, expressed social concerns, and reflected on questions of authority, all connected to memories of healing, episodes of tension, and moments of cooperation with missionary medicine. In this context, therefore, the temporal distance between the period under study and the moment of narration becomes an analytical advantage rather than a constraint. This time gap also shows how local communities have selected, reinterpreted, and, at times, forgotten particular events as part of the ongoing process through which collective memory is formed, negotiated, and transmitted across generations.

This chapter is organized into four interconnected sections, each addressing key themes that shed light on the complex relationships between healing practices, family structures, neighborhood relations, and the expanding influence of medical missions in the colonial Southern Highlands of Tanzania between 1891 and 1940. The first section examines how nuclear and extended families functioned as the primary sources of care and decision-making during illness. These families often combined long-established healing knowledge with discernment, choosing to accept or reject the new medical therapies introduced by medical missionaries. The second section

turns to the culture of neighborhood, conceptualized as both a moral and therapeutic space. In these settings, healing extended beyond the household, nurtured through trust, mutual assistance, and a shared sense of responsibility that bound neighbors together. The third section stresses the historical encounters and tensions between indigenous healing systems and missionary medicine, focusing in particular on the establishment of Kidugala hospital in 1911. This section highlights how these interactions reshaped local therapeutic landscapes and produced new forms of negotiation, conflict, and adaptation. The fourth section examines the establishment of communal kitchens and the broader politics of care within missionary hospitals. It explores how these kitchens emerged as negotiated spaces where ideas about health, discipline, domestic labor, and communal responsibility intersected.

4.1 Healing through Kinship: Family, Medicine, and Care in Colonial Southern Highlands

For decades, the concept of kinship has been a subject of interest among scholars from different academic disciplines such as history, sociology, and anthropology. Researchers have long examined how kinship shaped the social, political, and economic foundations of African societies. In the early twentieth century, classical anthropologists like Alfred Radcliffe-Brown and Bronislaw Malinowski established the dominant analytical framework for studying kinship, grounding it within a functionalist perspective. They interpreted kinship as a system primarily rooted in biological descent, designed to ensure the cohesion, order, and stability of society.[252] According to this view, kinship functioned as an orderly and predictable mechanism for organizing social life and mediating relationships within communities.

Alfred Radcliffe-Brown, a prominent figure in structural functionalist anthropology, emphasized the formal and systematic nature of kinship in African societies. He viewed kinship as the backbone of African social organization, providing structured guidelines for crucial societal functions, including inheritance, marriage, succession,

[252] Alfred Radcliffe-Brown, *The Andaman Islanders: A Study in Social Anthropology*. (Cambridge: Cambridge University Press, 1922); see also, Bronislaw Malinowski, *Argonauts of the Western Pacific*: *Account of Native Enterprise and Adventure in the Archipelagoes of Melanesian New Guinea.* (London: Routledge & Kegan Paul Ltd, 1922).

political authority, and ritual duties.[253] His work provided an early analytical vocabulary for understanding African social organization, one that subsequent historians and anthropologists would revisit, critique, and significantly transform as the field evolved.[254]

In both pre-colonial and colonial African societies, kinship operated not only as a network of emotional or family ties but also as a highly structured social system that shaped the foundations of communal life.[255] Recognizing the importance of kinship relations in African history, James Giblin has noted that any attempt to interpret African societies without considering the role of kinship would result in a distorted or incomplete understanding of historical realities. Kinship, he contends, constituted a core framework through which individuals and communities navigated social life, especially under the shifting pressures of colonial rule.[256]

Kinship provided an organizing structure through which roles, relationships, and responsibilities were clearly defined and maintained. In many African societies and in the Southern Highlands in particular, the position of a father, uncle, or sister was shaped less by individual identity and more by specific obligations embedded in kinship norms.[257] These responsibilities included caring for children, supporting the sick, and participating in important communal gatherings, such as bride-wealth negotiations, funerals, settling of disputes, and rituals for honoring ancestors.[258]

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[253] Alfred Radcliffe-Brown and Daryll Forde, eds., *African Systems of Kinship and Marriage* (London: Oxford University Press, 1951), 5-6.

[254] For more discussion on the studies of kinship in African societies, see, Meyer Fortes, *The Web of Kinship Among the Tallensi* (London: Oxford University Press, 1949); and also Edward Evans-Pritchard, *Kinship and Marriage Among the Nuer* (Oxford: Clarendon Press, 1951).

[255] James Giblin argues that kinship should not be seen as a fixed set of familial ties; rather, it operated as a dynamic social space in which people made decisions, shaped their identities, and addressed health-related challenges. The reference is from, James Giblin, "Kinship in African History" in *A Companion to African History*, ed. William H. Worger et al. (Los Angeles: University of California Press, 2018), 163.

[256] Giblin, "Kinship in African History." 175.

[257] Simon Robert Charsley, *The Princes of Nyakyusa* (Nairobi: East African Publishing House, 1969), 54 and 72. See also Monica Wilson, "Nyakyusa Kinship," in *African Systems of Kinship and Marriage*, ed. Alfred Radcliffe-Brown and Daryll Forde (London: Oxford University Press, 1951), 125.

[258] See Peter Rigby, *Cattle and Kinship among the Gogo: A Study of Rural Social Structure in East Africa* (Ithaca, NY: Cornell University Press, 1969), 15-17; and John Iliffe, *A Modern History of Tanganyika.* (Cambridge: Cambridge University Press, 1979), 22 and 29.

Furthermore, in the Southern Highlands of Tanzania, kinship systems were central to the cultural organization of daily life, shaping family structure, the distribution of authority, and the regulation of social relations. These systems governed key social practices, including marriage arrangements, inheritance rights, and patterns of family leadership. Among many communities in the region, kinship norms prohibited marriage between close relatives, particularly within the same clan, in order to prevent incest and preserve clear clan boundaries.[259] Inheritance practices varied across the region, reflecting the coexistence of different kinship systems. For instance, the Nyakyusa generally adhered to a patrilineal system in which property was transmitted from father to son, reinforcing male authority and ensuring continuity within the male lineage. In contrast, other communities practiced matrilineal inheritance, where descent and property rights were traced through the mother's line, granting women and maternal relatives a more prominent role in lineage continuity and social organization.[260]

Kinship played a great role in organizing social duties during major life events such as weddings, funerals, childbirth, and illness. In the cultures of the Nyakyusa, Hehe, and Bena, for instance, funerals were deeply communal.[261] Extended family members played essential roles, taking responsibility for mourning rituals, food preparation, and offering emotional and material support to the grieving family. Hence, this stands as a symbol of kinship relations in carrying out collective responsibilities during such significant events.

Moreover, kinship in the Southern Highlands, as in other parts of colonial Africa, was not just about family; it was the cornerstone of identity, behavior, and belonging, shaped the very way people lived and interacted with one another. Even strangers meeting for the first time could trace connections through shared clan names or

[259] Monica Wilson, *Rituals of Kinship among the Nyakyusa*. (London: Oxford University Press, 1957), 201 and 250.
[260] Wilson, *Rituals of Kinship among the Nyakyusa.*
[261] Based on my interactions with informants, kinship and ancestral ties remained central to the organization of funeral practices in the communities of the Southern Highlands of Tanzania. This reference is from a focus group discussion I conducted with Leonard Mkolwe, Mashaka Kidekule, Anastazia Msaganzi, and Nashimwene Luhende in Ilembula, Njombe, on 16th May 2024. See also Wilson, *Nyakyusa Kinship*, 129.

ancestral regions, helping them understand how to speak, relate, and what duties they owed each other.[262]

In the village settings, raising of children extended far beyond the biological household; it was embedded in a wider network of kin and neighborhood relations. A child might refer to many women as *'mother'* or *'aunt'*, not because of direct genealogical ties, but because caregiving responsibilities were widely shared among female relatives and other senior women in the community.[263] Therefore, these terms reflected both affection and the functional roles these women played in feeding, disciplining, guiding, and protecting children on a daily basis. Similarly, men in the community were addressed as *'father'* or *'uncle'*, representing a broader moral obligation toward the younger generation.[264]

These expansive kinship terms carried meanings that went far beyond their linguistic expression; they reflected a dense social landscape in which people lived in close proximity, often in settlements whose boundaries were fluid, overlapping, and socially intertwined. As Monica Wilson and Godfrey Wilson observed during their fieldwork among the Nyakyusa of Kyela District between 1934 and 1938, these communities revealed rich moral systems, cosmologies, and social structures. What appeared to be a single clustered settlement could, in fact, comprise several closely connected units, which they termed as 'age-village,' each associated with particular generational groups and leadership structures.[265] In such a kind of environment,

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[262] Monica Wilson, *Rituals of Kinship among the Nyakyusa*, 7; Michael G. McKenny, "The Social Structure of the Nyakyusa: A Re-Evaluation," *Journal of the International African Institute* 43, no. 2 (1973), 100. See also Mbiti, *African Religions and Philosophy*, 104-107.

[263] Monica Wilson, *For Men and Elders: Change in the Relations of Generations of Men and Women among the Nyakyusa-Ngonde People 1875-1971.* (New York, African Publishing Company, 1977), 85-99. This ethnographic study was published nearly four decades after her fieldwork, in which she adopted a historical approach to examine how Nyakyusa society transformed over a century of interaction with external forces.

[264] Monica Wilson, "Nyakyusa Kinship," in *African Systems of Kinship and Marriage*, ed. A. R. Radcliffe-Brown and Daryll Forde (London: Oxford University Press, 1951), 45; see also, Mbiti, *African Religions and Philosophy*, 104.

[265] Godfrey Wilson. "An Introduction to Nyakyusa Society." *Bantu Studies* 10 (1936): 253-291; 256; Monica Wilson, *Good Company: A Study of Nyakyusa Age-Villages* (Prospect Heights: Waveland Press, 1951), 121-127. See also, Simon R. Charsley, *The Princes of Nyakyusa*, East African Studies No. 32 (Nairobi: Makerere Institute of Social Research and East African Publishing House, 1969), 83.

kinship ties crossed multiple household clusters, enabling a child to have dozens of 'mothers' or 'aunts' distributed across intersecting social networks.[266]

Furthermore, children were traditionally taught their genealogies, which served as historical records and as source of identity, spiritual responsibility, and continuity.[267] Such knowledge enabled individuals to position themselves within broader communal structures and reinforced their connections to both people and places. John Mbiti noted that genealogies functioned as sacred links to the past and served as moral frameworks guiding present behavior.[268] In addition, Mbiti described how the '*totemic web'*, which connects people to animals, plants, and sacred objects, further deepened these relationships, embedding individuals within a wider spiritual and natural cosmos that strengthened their sense of identity as well as their obligations to the community and the world around them.[269]

This wide circle of caregivers built strong emotional and practical bonds that shaped local systems of health and healing long before the arrival of Berliner Lutheran and Moravian medical missionaries. The communal ethic of care meant that knowledge, support, and responsibility for children and the sick were shared across the community, generating a form of social unity that was based not on fixed boundaries or permanent settlements, but on people, relationships, and generational ties. Yet the fact that the local communities were organized around kinship-based structure of care-giving and healing went largely unrecorded by both missionaries and the colonial administration. This kind of omission reflected the broader epistemic limits of colonial observation. Missionaries, trained within the medical and social categories of European Christian thought, tended to interpret African societies through frameworks that privileged individual bodies, nuclear family structures, and

[266] See Theodor Meyer, *Wa-Konde: Maisha, Mila na Desturi za Wanyakyusa* (Mbeya: Motheco Publications, 1993). Translated from German into Kiswahili by Judith Siegrist. Meyer was a Moravian missionary who lived in the region for twenty four years, from 1890 until the outbreak of the First World War, when German missionaries were expelled. His writings offer detailed observations on the lives of local communities from the 1890s to the early 1910s.
[267] Mackenzie, *The Spirit Ridden Konde,* 47.
[268] Mbiti, *African Religions and Philosophy*,105-106.
[269] Mbiti, *African Religions and Philosophy*,104.

institutional forms of care.[270] While the colonial administrators were primary concerned with mapping political and military authority, identifying chiefs, and extending German control, their reports focused heavily on taxation, labor, and governance.[271] As a result, little space was devoted to documenting the everyday social relationships that underpinned health, healing, and communal welfare.

The arrival of German Protestant missionaries introduced a mission medical model centered on individualized clinical care, which in turn led to the establishment of mission hospitals and dispensaries across the region. However, this approach differed significantly from the communal, spiritual, and culturally rooted healing practices that had long been central to healthcare in the Southern Highlands. Moreover, missionaries believed that healing should occur within controlled institutional settings, which they viewed as more effective and morally uplifting than the indigenous healing practices.[272] As a result, they established a network of mission hospitals, dispensaries, and health outposts strategically spread throughout the region. Missionaries also believed that good health required African patients to seek treatment at mission hospitals for scientific diagnosis and to benefit from fresh air, which they believed aided the healing process. However, this notion clashed with the community's expectations. Local traditions emphasized that sick individuals should be given privacy during the healing process, with a strong cultural belief in the importance of staying indoors, in contrast to the missionaries' approach.

Among the most significant medical initiatives established by German Protestant missions in the colonial Southern Highlands of Tanzania were four major hospitals built by the Berliner Lutherans: at Ilembula and Kidugala in the Ubena region (now Wanging'ombe District), and at Matema and Isumba in Unyakyusa (present-day Kyela District). The spatial distribution of these institutions, all located within the present-day Njombe and Mbeya regions, is shown in Figure 10. The Isumba facility

[270] TNA 450/178/33, Moravian Mission (Moravian Church), 1927-1932.
[271] TNA 11414 Vol. 11: Native Authorities: Southern Highlands Province. See also, New Langenburg District Annual Report, 1918/1919; and TNA John Wells, New Langenburg District Annual Report, 1918/19.
[272] Gesellschaft zur Förderung der evangelischen Missionen unter den Heiden, *Berlin Missionsberichte*, hereafter BMB (Berlin: Verlag des Missionshauses, 1911), 93. Retrieved from, https://redstorage.gemeinsam.ekbo.de/d/7e53f6a4bdfa46d896da/

was later relocated to Kabembe and renamed Itete hospital. Meanwhile, the Moravians established two key hospitals in Rungwe and Mbozi.[273] These institutions quickly became vital health centers, attracting patients not only from nearby villages but also from more distant areas seeking treatment.[274]

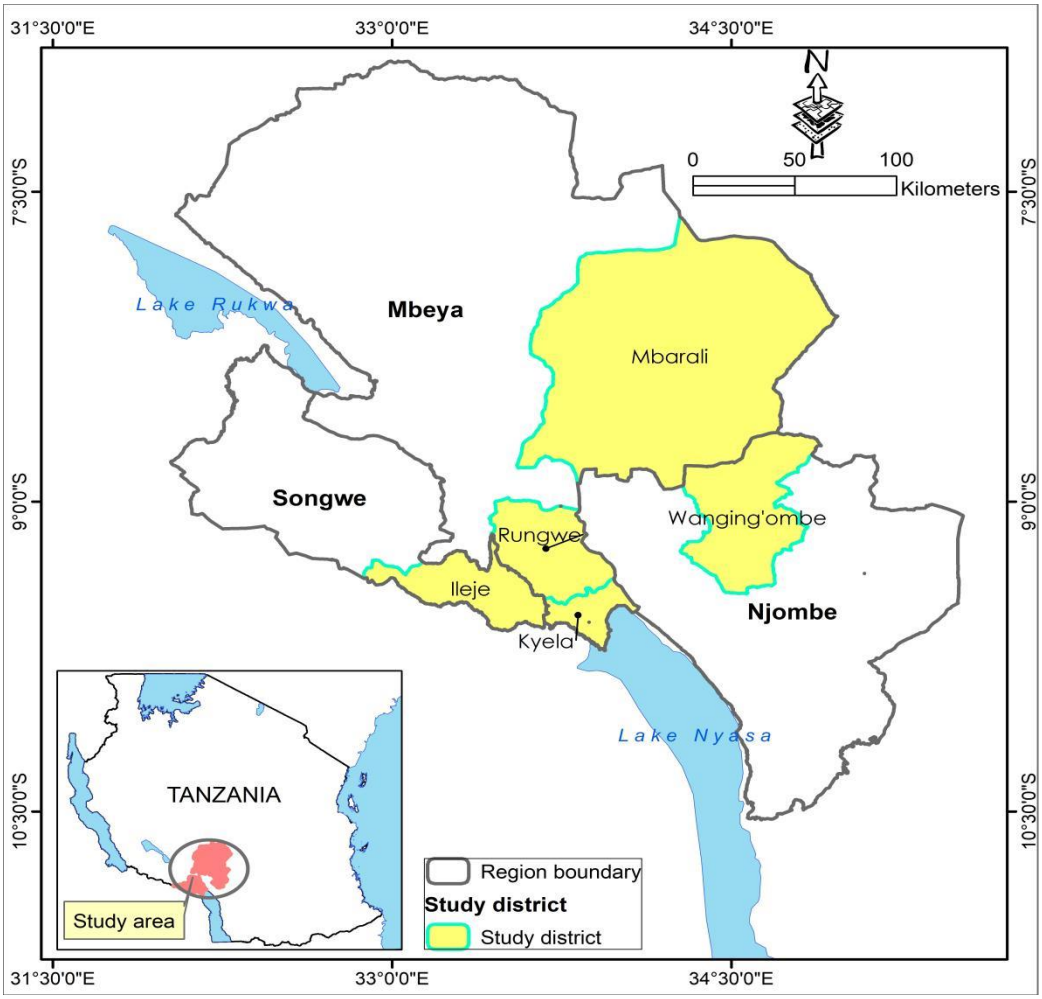

Figure 10: Locations of Major Lutheran and Moravian Mission Hospitals in the Southern Highlands of Tanzania

Source: GIS Laboratory Scientist at the Institute of Resource Assessment, University of Dar es Salaam, June 2026.

[273] Mwaihabi, Mwaijega, and Mwampeta, *Miaka 100 ya Injili 1891-1991*, 16.
[274] Vaughan, *Curing Their Ills*, 55; Musomba, *Historia Fupi ya Kanisa La Moravian Kusini Tanzania*; Clyde, *History of the Medical Services in Tanganyika*; see also, Oliver, *The Missionary Factor in East Africa*, 210-211.

However, these mission hospitals were more than centers for medical care. The provision of healthcare was deeply connected with religious instruction, as missionaries seized the therapeutic setting as a means to preach the Gospel and promote their vision of mass conversion. In this way, the medical programs served a dual purpose: they demonstrated Western biomedical knowledge while furthering the missionaries' central goal of mass Christianization. It is therefore fair to say that this approach had significant implications for the Christian communities that emerged in the region, blending religious and medical practices in a way that reshaped local belief systems and transformed approaches to healthcare.

Missionary hospitals, far from established spaces for the treatment of illness, also played a significant role in transforming society. Beyond providing medical care, these missions introduced new concepts of hygiene, parenting, and health management.[275] Hygiene practices for the sick, in particular, became a focal point that shaped local understandings of cleanliness and well-being.[276] However, these changes were not unilaterally accepted, and this resistance emerged as a 'defining feature of the medico-religious frontiers in colonial and postcolonial Africa'.[277]

Despite the dominance of missionary narratives, Africans were not passive recipients of these foreign health ideas. Instead, they were active agents in shaping their healthcare experiences. Many engaged critically with the new medical knowledge, often blending it with indigenous practices to create hybrid approaches to health. Therefore, this dynamic interaction between indigenous knowledge and missionary medicine shows how African communities, as active participants in history, negotiated, adapted, and sometimes resisted the imposition of foreign medical frameworks. Through this process, they critically assessed and transformed missionary medical practices, ensuring that they aligned with local realities and cultural values.

[275] Charsley, *The Princes of Nyakyusa*, 73 and 78
[276] Schultze, *Der Njaßabund*, 86-87.
[277] Good, "Pioneer Medical Missions in Colonial Africa," 1.

During my fieldwork in Itete, Tukuyu District, I interviewed Bibi Tumpe Mwasandende, who shared memories that shed light on the complex relationship between kinship structures, indigenous healing practices, and missionary medicine in colonial Tanzania. Speaking about her childhood during the late British colonial period, she explained that children were raised to honour elders and ancestors, maintain harmony within the family, and avoid behaviour associated with witchcraft, values believed to be essential for preventing illness. She further said that when sickness occurred, particularly conditions such as mental illness, local healers often attributed the root causes to broken kinship ties or disturbances within the lineage.[278] Although Tumpe's memories refer to the late British colonial period, they are analytically valuable in this chapter because they help us to understand nearly fifty years of German Protestant missionary activity in the region, from 1891 to 1940. In this way, her descriptions are important precisely because many of the social and therapeutic principles she described, especially the emphasis on lineage cohesion and ancestral mediation, were long-standing features of healing in the Southern Highlands of Tanzania. These continuities and changes allow us to draw on her accounts to reconstruct how communities interpreted illness and mobilized kinship throughout the era of German Protestant missions.

In Tumpe's account, healing required more than the biomedical treatments introduced by medical missions. While missionary medicine provided new remedies, she insisted that recovery ultimately depended on the continued observance of ancestral traditions, the mending of fractured kinship ties, and the restoration of social harmony through offerings, reconciliations, or the intervention of respected healers. She emphasized that without addressing these deeper relational issues, biomedical treatment alone was considered incomplete, and in some cases, ineffective. For her, and for many others in the Southern Highlands, therapeutic success rested on the combined use of missionary medicine and indigeneous healing

[278] Tumpe Mwasandende, interview by the author. Itete-Kyela, 03rd July, 2024.

traditions, each addressing different dimensions of illness: the physical, the spiritual, and the social.[279]

This blended approach shows how local communities in the region relied on kinship relations as the foundation of health and healing. Within these social networks, families, extended relatives, and neighbors offered emotional support, shared responsibilities, and coordinated collective responses to illness. Kinship shaped decisions about where to seek treatment, whether from a respected elder, a local healer, or from a mission hospital, and determined who assumed the primary role in attending the sick. It also shaped how different healing processes were arranged, including the preparation of medicines, and the supervision of the patient throughout the healing process. In this way, we can argue that responses to sickness were structured through long-established social relationships and a sense of communal obligation rather than individual action.

In my conversation with Itika Moga from Ipinda, Kyela, she made it clear that the account she shared was a retold experience, a memory passed down through her mother and older relatives who lived during the late colonial period. According to Moga, her elders often described how, in the 1950s, a decade after the German Protestant missionaries had been expelled, local families continued to navigate between mission medicine and ancestral healing practices. Women would take seriously ill infants to the mission hospitals for treatment when necessary, yet this never stopped them from administering *unkota*, or traditional medicine, within the household.[280] As she recalled their words: "Our medicine made the child strong and protected them from those who are envious or who might use harmful spiritual forces. The hospital was good, but *unkota* was ours; it connected us to our ancestors."[281]

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[279] Tumpe Mwasandende, Mongi Mwakikota, Sekela Anyigulile, interview by the author. Itete-Kyela, 03rd July, 2024.

[280] In the Nyakyusa language, the word *unkota* refers to local medicine, which is translated as *dawa* in Swahili. Interestingly, *dawa* also carries the same linguistic meaning when used in the context of Western medicine.

[281] Itika Moga, interview by the author. Ipinda-Kyela, 30 June, 2024. This belief persisted into the postcolonial period in Tanzania. In Kilombero District, Catholic missionaries established St. Francis

Although these memories refer to the 1950s, they remain analytically valuable for explaining the wider period between 1891 and 1940, the era in which German Protestant missionaries introduced biomedical practices in the Southern Highlands of Tanzania. Moga's retold account reveals the types of therapeutic decisions and cultural reasoning that likely developed during the German missionary's era and continued long after. Her recollections help us to clarify how local communities consistently blended biomedical treatment with ancestral healing practices, demonstrating the enduring strength of indigenous medical systems and their influence on how people engaged with missionary medicine throughout the colonial period.

These oral recollections closely correspond with evidence preserved in mission archives, especially in annual medical reports and the diaries of missionaries and African pastors. Mission records repeatedly presented that, despite persistent efforts to persuade Africans to abandon indigenous healing systems and embrace Western bio-medicine and Christianity, local communities continued to rely on their established cultural understandings of illness and well-being. Such observations date back to the early period of missionary activity in the region. For instance, on 23 March 1895, the Moravian missionary Shaw explained that while local residents seemed to enjoy participating in church services, he later recorded: "I am sorry to say there is no sign of even one trying or wanting to live a new life in Christ Jesus." Despite engaging both publicly and privately with community members, he found that many responded, "Yes, what you say is good and true, but our customs and ways are good enough for us."[282]

A similar account comes from another Moravian missionary, Kretchmer, stationed at Rungwe in 1897. After careful observation of surrounding communities, he wrote

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hospital in Ifakara, where female nurses were trained to work with traditional midwives and promote Western biomedical practices during and after childbirth. Despite these interventions, local communities continued to observe childbirth rituals involving herbal medicine and the invocation of ancestors, believed to protect both mothers and infants. The Kilombero case illustrates the coexistence of biomedical and indigenous healing practices, a pattern also evident in southern Tanzania more broadly, where modern medicine did not replace established ritual traditions. For a more detailed discussion, see Kimani, "Creating Health Futures," 110-112.

[282] Periodic Account, Vol. 3, No. 29, (1897), 218.

that, “I have not met a single sick person who, through their illness, became in the least more receptive to the Gospel. The influence of the witch-doctors and soothsayers may have a good deal to do with this.”[283] His diary further reveals that attendance at mission activities did not necessarily lead to religious conversion or the abandonment of local beliefs.[284]Together, these accounts demonstrate that the people of the Southern Highlands engaged with mission medical services selectively, using them when convenient, while remaining firmly rooted in their own healing traditions and cultural practices. Historically, this highlights both the resilience and continuity of local healing systems throughout the colonial period, even under sustained missionary pressure.

Another episode is recorded in the diary of Pastor Israel Mwipopo, dated October 5, 1939, just one year before the eviction of German Protestant missionaries from the Southern Highlands. This account vividly illustrates the tensions and negotiations surrounding medical care during the final years of German missionary presence. Mwipopo recounts a visit to Mambegu, a mission outpost under Ilembula station, where he discovered that the local teacher, a converted African Christian, had abandoned his post following a tragic incident. His wife had fallen ill and been admitted to the mission hospital at Ilembula, under the care of Sister Helene, one of the German deaconesses serving in the Berliner Mission’s medical department.[285] Mwipopo recalled that Sister Helene had assured the community that the woman was recovering, although she remained physically weak and required close care. Dissatisfied with what he considered the slow progress of missionary treatment, her husband secretly took her out of the hospital during the night. He took her to a local “pagan” healer, an intervention that, according to Mwipopo, resulted in her death due to ‘unsuitable treatment.’[286] This event highlights the conflicted position of Teacher Lupelelo, a baptized Christian and mission school teacher, who, when confronted with doubts about the efficacy of biomedical care, turned to indigenous therapeutic

[283] Periodic Accounts, Vol 3, No. 32, 391.
[284] Periodic Account, Vol 3, No. 32, (1897), 392.
[285] Berliner Missionwerk (hereafter BMW), 1/5607, Evangelisches Landeskirchliches Archiv, Berlin, Pastor Israel Mwipopo diary, third quarter, 1 July to 30 September 1939, translated by Martin Priebusch at Kidugala Station. (5 October 1939), n.p.
[286] BMW, 1/5607, Pastor Israel Mwipopo diary (1939).

practices. Lupelelo actions revealed the complex negotiations between missionary medicine and local healing traditions in colonial Southern Highlands Tanzania.

Moreover, this event exposed the complex landscape of medical pluralism in the colonial Southern Highlands of Tanzania. As it reveals that African converts, even those entrusted with the moral and pedagogical responsibilities of the mission, did not simply abandon traditional systems of healing upon conversion. Instead, they navigated between two distinct epistemologies of health: the missionary medicine rooted in European biomedical rationality and the longstanding indigenous healing systems, which emphasized relational, spiritual, and communal dimensions of illness.

Even in contemporary world, many individuals continue to rely on a harmonious blend of traditional therapies alongside Western medicine, acknowledging the unique contributions of both in addressing specific health concerns. When asked about the efficacy of local healing practices, individuals often emphasize their enduring relevance.[287] This reveals a strong belief in the continued importance of indigenous methods, something that shows the adaptability and ongoing significance of these knowledge systems in meeting the health needs of local communities. Moreover, these traditional healing practices, far from being obsolete, remain valuable and relevant in addressing the health needs of local communities, even in the face of modern advancements in healthcare.

In the colonial Southern Highlands of Tanzania, kinship ties played a crucial role in maintaining social harmony and personal well-being. Family members were expected to be actively involved in key family occasions, particularly during times of illness or death. These responsibilities were mainly entrusted to close relatives, such as siblings, parents, aunts, and uncles, who had strong obligations toward each other.[288] This included not only providing emotional support but also offering practical assistance to vulnerable family members during times of hardship.

[287] Bibi Bishola Seleleka, interview by the author, Lufilyo-Tukuyu, 04th July, 2024, and Haruni Efaya, Kidugala-Njombe, 8th June, 2024.
[288] See Mbiti, *African Religions and Philosophy,*104.

During periods of illness, the primary responsibility for care rested with the family, who were expected to ensure that the sick person received the attention and support necessary for recovery. Family care involved a wide range of practical and emotional tasks. These included preparing traditional medicines, such as boiling medicinal herbs, grinding roots, and mixing plant-based remedies, administering special diets believed to restore strength and balance, and maintaining cleanliness of both the patient and the household environment. In addition, caregivers assisted the patient with everyday activities they were no longer able to perform independently, such as eating, bathing, and moving around. Beyond physical care, family members also provided emotional reassurance and spiritual support, reinforcing communal bonds and shared beliefs about healing and well-being.

Beyond physical care, families also followed cultural and ritual protocols, such as practices aimed at protecting the patient's spiritual well-being, which were considered integral to the healing process. Failure to uphold these familial duties could lead to serious social consequences, including exclusion or tension within the family, further destabilizing relationships and trust. In this way, healing was deeply intertwined with social cohesion, trust, and the maintenance of communal norms, highlighting how family obligations and kinship were central to health, healing, and societal stability.

The significance of kinship also influenced how local communities engaged with mission medicine. Despite the introduction of mission medical practices by the Moravian and Berliner Lutheran missionaries, kinship structures were not displaced. Rather, these new therapies were assimilated into existing care systems that allowed for local control over healing practices. Family members remained integral to patient care, even with the presence of mission medical services.

In an interview with a retired Pastor Gordon Mwakapeje, recalled that during the 1970s, when he was an adult, it was common for families to accompany their sick relatives to mission clinics. In such cases, a close family member, often the wife of a sick husband would remain outside the mission compound, responsible for providing

food, attending to daily needs, and ensuring the continuity of care.[289] Historically, this practice reflects patterns established throughout the period of German medical missionary activity in the region. Moreover, for nearly fifty years, mission medical facilities were scarce and often located far from the majority of local communities, making family involvement in patient care an essential social duty. Even decades after the end of formal German missionary administration, these logistical and social arrangements persisted, shaping local expectations of family assistance and reinforcing a model in which relatives remained central to the provision of health care. Thus, the practices observed in the 1970s embody both pragmatic adaptations and the enduring imprint of colonial era medical institutions on postcolonial social and health frameworks.

Without doubt, the persistent presence of indigenous healing traditions, whether expressed through herbal remedies, spirit possession rituals, or communal healing practices, were sustained and transmitted through kinship networks, family narratives, and ritual customs. These networks of care, deeply embedded in the cultural fabric of local communities, became essential sites of both resistance and adaptation. Kinship, with intergenerational connections, provided a framework for the transfer of memory and knowledge, ensuring that, even as missionary medical practices gained a foothold, traditional healing systems were adapted rather than entirely replaced. Rituals and ancestral healing practices, passed down within extended families and local communities, were reinterpreted to incorporate new medical ideas while preserving core values and healing wisdom that had sustained these communities for centuries.

Thus, rather than eradicating indigenous healing knowledge, missionary medicine together with colonial medical interventions, motivated the reinvention and resilience of these traditions. While medical missionary practices introduced new methods, they could not replace African healing systems. Instead, missionary medicine engaged with existing frameworks, influencing them in profound ways. This

[289] Interviews with retired Lutheran Pastor, Gordon Mwakapeje, Itezi-Uyole, 14 July 2024, and Andawike Mwasomola, Itete, Kyela, 3 July 2024.

interaction allowed for the continuation of traditional healing practices, albeit in modified forms. For example, African healers began integrating new therapeutic techniques into their own methods, combined them with traditional healing and spiritual care. Thus, this blending of old and new ensured the survival, adaptation, and continued relevance of indigenous healing traditions.

4.2 The Spirit of *Ujirani Mwema*: Neighborhood, and Communal Healing Systems

In addition to kinship networks, this chapter examines the concept of 'neighborhood' in the colonial Southern Highlands of Tanzania.[290] In this region, as in much of colonial Africa, the idea of neighborhood extended well beyond physical closeness or shared boundaries. To be a neighbor meant belonging to a moral and social community defined by mutual obligation, trust, and cooperation. Neighbors were expected to provide assistance during times of illness, childbirth, hunger, or other hardships, often stepping in where family support was limited. Through these everyday practices of care and reciprocity, neighborhood relations became a crucial social institution that sustained collective identity, social cohesion, and community well-being.

These neighborhoods were shaped by longstanding customs, shared histories, and sometimes overlapping kinship connections. People depended on one another for everyday needs, such as food, labor, and care during illness, but also for broader communal responsibilities, including rituals practices, mediating disputes, and the transmission of knowledge and traditions.[291] Thus, neighborhood system created social bonds that were as significant as those formed within families. These bonds offered a familiar, locally grounded framework for cooperation, care, and mutual responsibility, even as colonial interventions, missionary agendas, and expanding

[290] *Ujirani Mwema* is a Swahili term that literally means "good neighborhood." In this study, it refers to a shared cultural ethic of mutual support, cooperation, and collective responsibility among community members. Historically, especially in rural Tanzanian communities, *Ujirani Mwema* shaped everyday social life by encouraging neighbors to care for one another, share resources, and offer help during times of need such as illness, childbirth, or hardship.

[291] Wilson, *Rituals of Kinship among the Nyakyusa*, 222-228; see also Godfrey Wilson, "An Introduction to Nyakyusa Society", 253-291.

economic pressures increasingly disrupted established social structures and reshaped everyday life.[292]

In the Southern Highlands of Tanzania, particularly in the regions of Mbeya and Njombe, caring for the sick was traditionally understood not as an individual or purely familial responsibility, but as a collective obligation rooted in community life. This responsibility was shared among extended family members, neighbors, and other members of the local community, reflecting strong norms of solidarity and mutual assistance. Acts of care included visiting the sick, providing food and labor, assisting with treatment and household tasks, and offering emotional and spiritual support. During the colonial period, when access to formal medical services was limited, these communal caregiving practices were essential for survival and recovery.[293] As such, communal care was not only a moral expectation but a central organizing principle of social life in the region.

During the extensive interviews conducted with retired pastors, most of whom were born during the late British colonial period in the 1940s and early 1950s, and are now well over seventy years old, their recollections provided more than personal memories. They offered historically meaningful reflections shaped by decades of accumulated knowledge, including what they had learned from fellow brethren within the Synod and from oral histories embedded in their communities. Although these accounts recall experiences from the later years of British colonial rule, their accounts carried significant value in this chapter. Their narratives help reconstruct the social worlds of the past, revealing how individuals understood, interpreted, and responded to the changing realities of colonial life.[294]

Across districts such as Mbeya, Kyela, Rungwe, and Busokelo in the Mbeya Region, as well as Njombe, Wanging'ombe, Makete, and Ludewa in the Njombe Region,

[292] John Taylor Hamilton, *Twenty Years of Pioneer Missions in Nyasaland: A History of Moravian Missions in German East Africa.* (Bethlehem, PA: Society for Propagating the Gospel, 1912), 30-39.
[293] Interview with retired Lutheran Pastor Mmenye Mwasampeta, Iwambi-Mbeya, 7 July 2024.
[294] In the early post-independence period, the pastoral ministry remained overwhelmingly male dominated. The limited presence of women in pastoral leadership helps explain why no female pastor appears in the oral accounts for this period. This absence should not be read as a lack of contribution by women, but rather as a reflection of the gendered structures within church institutions at the time.

local residents consistently emphasized a central principle: the sick were not left unattended.[295] From minor ailments to severe illnesses, neighbors, relatives, and wider community members mobilized through practices of mutual aid. In these rural settings, healing was understood as a collective responsibility, grounded in a moral ethic that framed illness as a shared social burden rather than an individual misfortune.Yet this ethic of collective care was neither universal nor all-encompassing. Every community also contained excluded members, individuals who, for social, moral, or historical reasons, lived at its margins. For such people, including former slaves or those otherwise cast outside communal networks, missionary compounds often held particular appeal. These spaces offered alternative forms of belonging and care, precisely because they lay beyond the obligations and exclusions that structured village life.

Pastor Gordon Mwakapeje, a retired minister of the Konde Synod and a member of the Nyakyusa community in Kyela District, is now in his mid-eighties, a generation whose memories bridge the final decades of British colonial rule and the early years of independence. His recollections, shaped not only by his own childhood but also by the shared memories of fellow pastors within the Synod.[296] Altogether, these intertwined narratives offer valuable insight into how communities understood care, illness, and social responsibility across generations.

He emphasized that during the late British colonial period; formal health services in the rural Southern Highlands were extremely limited and often situated at considerable distances from the people they were meant to serve. Similarly, the uneven and underfunded nature of colonial medical infrastructure meant that the state played only a marginal role in everyday health provision for Africans in these areas. In this context, missionary medical stations, particularly those established by the Moravian and Lutheran missions, remained the only consistent points of access to Western biomedical care. Therefore, the structural absence of reliable state health

[295] An interview with a focus group of local respondents asserts that this cultural practice continues to this day. If someone falls ill, it is the responsibility of relatives and familial relations to provide care. This reference is based on focus group discussion I had with Leonard Mkolwe, Mashaka Mwaisabila, Anastazia Msaganzi, and Nashimwene Luhende of Ilembula-Njombe, interviewed on 16th May, 2024.
[296] Interviews with retired Lutheran Pastor, Mzee Gordon Mwakapeje, Itezi-Uyole, 14 July 2024.

services, combined with the limited reach of mission hospitals themselves, created persistent gaps in healthcare provision.

Nevertheless, these gaps did not create a complete absence of care. Rather, as most of the historical evidence suggests that local healing traditions, kinship based support systems, and neighborhood networks functioned as resilient and adaptive institutions.[297] They compensated for the limited reach of state and mission medicine while simultaneously expressing broader moral expectations of mutual aid, reciprocity, and social responsibility. In this regard, the community based responses Mwakapeje described were far more than temporary replacements for formal medical care. They were deeply rooted historical systems of support and healing that long predated colonial intervention and continued to shape everyday life well into the postcolonial era.

Reflecting on this historical context, Pastor Mwakapeje emphasized that the spirit *Ujirani Mwema*, was particularly strong within rural communities. He described it as a deeply rooted social value that had long shaped the ways in which the Nyakyusa lived and related to one another. Moreover, he explained that when an individual fell ill, the immediate family assumed the primary responsibility for care, yet they were left to manage alone. Therefore, the entire village mobilized, neighbors, relatives, and even distant kin contributed in whatever ways they could.[298] Children, too, were socialized from an early age to participate in communal care. They were taught how to fetch water, collect firewood, or assist in the kitchen, tasks that were viewed as lessons in supporting others.[299] Therefore, caring for the sick extended far beyond the treatment of symptoms. It involved providing comfort, maintaining a continuous presence around the patient, and sharing both the emotional and practical burdens that illness imposed.

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[297] The reference is from, Wilson, "Nyakyusa Kinship," in *African Systems of Kinship and Marriage*, ed. Alfred Radcliffe-Brown and Daryll Forde (London: Oxford University Press, 1951); see also James Giblin, "Kinship in African History" in *A Companion to African History*, ed. William H. Worger et al. (Los Angeles: University of California Press, 2018),

[298] Gordon Mwakapeje.

[299] Interview with a retired Moravian Pastor William Mwakikato, Iwambi-Mbeya, 29 February 2023, and also Zena Mwambyale, Kalobe-Mbeya, 22 February 2023.

This communal engagement stemmed from a collective understanding that individual welfare was closely connected to the health of the whole community. As a result, the idea of the 'neighborhood' acted as an important therapeutic safety net, reinforced family obligations and ensured that no one faced illness alone. In this context, the line between family and neighbors often faded, created a strong network of support that helped both physical and emotional healing.[300] Thus, we can argue that neighborhood was not just a place, but also a social and moral system that kept family and community ties alive.

This strong sense of mutual care existed long before and alongside the arrival of German Protestant missionaries in 1891. Local communities maintained complex networks of support, in which neighbors, extended kin, and even more distant relations were expected to participate actively in caring for the sick and vulnerable. This tradition of collective responsibility did not vanish with the introduction of missionary activity; rather, it persisted and adapted alongside the institutional structures imposed by the missionaries.[301]

The Berliner Lutherans established several synods to coordinate both church and medical activities. Among these were the Bena-Hehe Synod, serving the Bena and Hehe communities in what is today the Njombe region, and the Konde Synod, which focused on the Nyakyusa-speaking areas of present-day Mbeya region.[302] Missionary accounts indicated that local communities relied heavily on communal care. As missionary Carl Paul observed, even in cases of serious illness, patients were rarely left alone; neighbors and relatives gathered around them, providing continuous support.[303] This suggests that such communal care was not simply a traditional practice but a vital social mechanism that often operated alongside, or even beyond the reach of, the missionary medical system.

[300] Feierman, "Struggles for control: the social roots of health and healing in modern Africa," 78-79.
[301] Schultze, *Der Njaßabund*, 113.
[302] Owdenburg, Kilimhana, and Kasumba, *Karne ya Kwanza ya Injili*, 43; Mwaihabi, Mwaijega, and Mwampeta, *Miaka 100 ya Injili 1891-1991*, 52; see also Julius Richter, *Geschichte Der Berliner Missionsgesellschaft 1824-1924* (Berlin, 1924), 640-41.
[303] Paul, Die *Mission in unsern (unseren) Kolonien*, 257.

Moreover, these observations suggest that German missionaries recognized the resilience and persistence of indigenous social practices, even as they introduced Western medical models. Rather than completely replacing these networks, missionary medicine often operated alongside them, sometimes complementing local care but frequently asserting a different hierarchy of authority, particularly regarding diagnosis and treatment. Altogether, these accounts demonstrate that communal care was not simply a customary practice but a critical social strategy for survival. It persisted under both German and later British colonial rule, despite colonial efforts to centralize and control health services.

The vision for mass Christianization and provision of medical care in these synods faced significant challenges. One the problem missionaries encountered was presence of cultural systems that emphasized collective responsibility and communal care, and indigenous healing practices among the local population. These traditional community structures were deeply intertwined with the local understanding of health, well-being, and spirituality, where care was a shared responsibility and local healers, elders, and chiefs played a central role. As a result, the introduction of Western medicine and Christianity often clashed with these indigenous practices, leading to tensions and gradual adjustments in both religious beliefs and healthcare approaches.

Nevertheless, in light of the arguments made regarding the importance of kinship ties and neighborhood associations, this chapter emphasizes that kinship and neighborhood networks served as crucial therapeutic systems throughout the period of German Protestant missionary presence in the Southern Highlands of Tanzania, from 1891 to 1940. Thus, to overlook these concepts in historical interpretations of African communities is, indeed, to neglect a foundational structure that has long shaped governance, social experiences, and approaches to health and healing practices across generations.

Therefore, kinship and neighborhood ties form a vital web of relationships that, in one way or another, are foundational to understanding the essence of African identity, as well as the paths to healing and resilience. In support of this argument, James Giblin emphasizes that:

> If you are thinking of African people in the past without thinking about kinship, you are missing a vital source of their identity and focus of their energies. You miss the social space where African women and men have most often made a difference in their world; you miss their intimate concerns and dilemmas; you miss a volatile matrix of love, desire, hatred, and jealousy. [Most importantly, you miss how kinship served as a path for healing and resilience] … If, like me, you are a historian who tries to imagine themselves back into the minds and bodies of African people in the past, you cannot skip over kinship [and the culture of neighborhood].[304]

Neighborhood therefore, served as fundamental social and economic structures and as crucial lenses through which processes of health and healing in African societies could be understood. It also formed the backbone of communal relationships, social obligations, and collective responsibilities, which in turn influence how health, illness, and healing are conceptualized and addressed. It is no doubt; therefore, to fully comprehend the complexities of diseases, medical missions, and indigenous African healing practices, it is imperative to consider the role of kinship and the culture of neighborhood.

This network of familial and social ties profoundly shaped historical discourses surrounding health and healing in the study area, influencing not only methods of care and treatment but also the cultural values underpinning them. These ties functioned as essential channels for therapeutic engagement, shaping how healing was understood, practiced, and legitimized within the community.

In these societies, the concept of good health was the absence of disease and a sign of balance between individuals, their communities, and the spiritual world. That means a person's health was linked to their relationships with others, their adherence to cultural traditions, and their respect for ancestral customs.[305] Therefore, illness was interpreted as the disruption of this balance. Besides that, the cause of sickness was not always attributed to biological factors alone but also to social fractures, unresolved conflicts, witchcraft, or violations of sacred customs.[306] Thus, healing

[304] Giblin, 'Kinship in African History', 163.
[305] Mahamadu T. Iddrisu, "Healing and Medicine in Traditional African Societies, A Reflection of the Worldview", *UDS International Journal of Development* Volume 3 No. 2, (2017), 54.
[306] Many informants, when asked about the causes of diseases, said that even today, if someone develops madness, they first attribute it to witchcraft. Later, they wait for the healerto reveal the real

involved not only medicinal treatment but also efforts to restore harmony within both the individual and the community.

This concept of health and healing as a collective responsibility was not confined to the Southern Highlands of Tanzania; similar patterns were observed across Africa. Both John Janzen's and Gordon Chavunduka'semphasize in their work that therapeutic decisions often extended beyond the individual, involving family and community members in determining both the type and course of treatment. Janzen shows that in rural Zaire, now the Democratic Republic of Congo, even when patients and their families lacked detailed knowledge of clinical realities, family members and neighbors exercised authority in choosing therapies, including when consulting local healers (*nganga*).[307]Chavunduka presents a parallel case among the Shona of Zimbabwe, where relatives played central roles in selecting treatment, often mediating between hospital care and traditional healing practices.[308]

Although both studies emphasize the centrality of family and community, their analyses diverge in focus. Janzen emphasizes the authority of the family as a social institution that could override individual preferences or the healer's guidance, highlighting the collective negotiation of therapy in rural villages.[309] Chavunduka, meanwhile, focuses more on the interplay between traditional and modern medical systems, noting that socioeconomic factors such as income and education did not significantly alter patients' reliance on relatives for treatment decisions.[310] Together, these works demonstrate that in diverse African contexts, healing was a negotiated social process, where the authority of kin and neighbors often determined outcomes more than the professional expertise of healers or doctors. Such practices revealed the resilience of indigenous social systems and the limits of external medical authority in shaping local therapeutic norms.

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cause, but still, the patient's relatives continue to navigate medical pluralism in search of treatment. See also, John S. Pobee, *"Health, Healing and Religion: An African View,"International Review of Mission* (2009), 59.

[307] Janzen, *The Quest for Therapy in Lower Zaire*, 134.

[308] Chavunduka, *Traditional Healers and the Shona Patient*, 45.

[309] Janzen, *The Quest for Therapy in Lower Zaire*.

[310] Chavunduka, *Traditional Healers and the Shona Patient*.

Prior to the arrival of German Protestant missionaries in the Southern Highlands, traditional healers occupied a central and widely respected position within local healthcare systems. Ethnological studies and historical accounts suggest that these healers were understood not merely as providers of medicinal remedies, but as key mediators between the physical, social, and spiritual realms of life. Their therapeutic practices addressed illness as a multidimensional experience, linking bodily symptoms to social relations, moral conduct, ancestral influences, and spiritual imbalance.[311] As such, healing often involved a combination of herbal treatments, ritual interventions, and communal consultation, reinforcing the healer's authority as both a medical and moral figure within the community.

Steven Feierman's study of the Shambaa in northeastern Tanzania explained how healers were frequently traveled across the region to practice their specialized medical skills. According to Feierman, these journeys provided healers valuable opportunities not only to learn new techniques but also to demonstrate their abilities in comparison with practitioners from other areas. Such movements enabled them to exchange knowledge, adapt practices, and introduce innovations into their own healing methods.[312]

Moreover, oral recollections from the region indicate that such extensive movements were not confined to healers, as Feierman indicated in his study. Like the healers, ordinary individuals also traveled extensively, establishing regional networks that enabled them to identify and consult skilled practitioners far from their locality.[313] In this context, health and healing within the traditional realm were relational and mobile practices, shaped as much by social knowledge, kinship, and community connections as by the therapeutic interventions themselves.

Lucas Mwalyambi, a respected elder from the Safwa community, explained the profound disruptions caused by missionary medicine in an interview. He recalled,

[311] Hamilton, *Twenty Years of Pioneer Missions in Nyasalan;* see also Wilson, "An Introduction to Nyakyusa Society."
[312] Steven Feierman, *Peasant Intellectuals: History and Anthropology in Tanzania* (Madison: Wisconsin University Press, 1990), 102-103.
[313] Tumpe Mwasandende; Itika Moga, Ipinda-Kyela, 30 June, 2024, and Leonard Mkolwe, Ilembula-Njombe, 16th May, 2024.

"Before the missionaries came, we had our own ways of caring for the sick. The missionaries brought different treatments and discouraged our practices, causing conflict as many felt they disrespected community traditions."[314] For Mwalyambi, healing was not about treating physical symptoms it was about aligning the body, spirit, and community in a way that Western medicine, in his view, could never fully achieve.

Nevertheless, local communities did not passively submit to the imposition of missionary medical practices. Instead, they actively engaged with, resisted, and negotiated the terms of these new medical interventions. Archival evidence from missionary medical reports and oral testimonies reveals these instances in which African individuals and communities contested the authority of missionary medics.[315]This resistance was not simply about rejecting unfamiliar treatments; it reflected a broader contestation of the cultural, spiritual, and social disruptions brought about by colonial and missionary influence.

4.3 Between Hut and Hospital: Negotiating Medical Authority at Kidugala, Njombe, 1911

In the colonial Southern Highlands of Tanzania, the encounter between missionary medicine and traditional healing practices created a contested and dynamic space of negotiation. Kinship and neighborhood networks, which formed the foundation of local therapeutic systems, shaped the community's understanding of Western biomedicine and also offered practical frameworks for engaging with and responding to it. Although the Berliner Lutheran and Moravian medical missionaries initially secured entry into local communities through the provision of medical care, they were soon met with new expectations. No longer confined to treating physical ailments, they were drawn into the deeper social and cultural life of these closely

[314] Lucas Mwalyambi, interview by the author. Kalobe-Mbeya, 9th March, 2024. A few months after our interview, Mzee Mwalyambi who was in his mid-eighties, sadly passed away. His family shared that he never believed in modern medicine and, even during his final illness, he consistently relied on traditional medicine from a local healer.
[315] *Berlin Missionsberichte* (BMB), 1911, 94.

connected communities, where healing also meant understanding local values, relationships, and ways of life.

This complex interplay between medical mission and indigenous healing practices became particularly pronounced in the Njombe region after the establishment of the Kidugala hospital in February 1911. Although initially the hospital was planned as a small polyclinic intended to serve both European and African patients, Kidugala quickly became the main center for the Berlin Mission Society's medical enterprise in the Southern Highlands.

From the outset, however, the hospital exposed the weaknesses in the missionaries' expectations. Shaped by European notions of scientific medicine and Christian moral reform, the missionaries believed that the introduction of modern healthcare in the region would swiftly persuade local communities to abandon their traditional healing practices and embrace Christianity on a large scale. This expectation, however, soon proved to be overly optimistic and largely detached from the complex social and cultural realities on the ground.[316]

Rather than becoming an easy and accepted center for biomedical treatment, Kidugala hospital turned into a site of tension, where two very different understandings of illness and healing came into contact. A fundamental point of tension laid in the divergent social logics that underpinned each system. Missionary medicine, grounded in Western scientific principles, emphasized the treatment of the individual and approached disease as a physical condition to be diagnosed and managed within a clinical setting. In contrast, African healing practices were deeply embedded in communal life. Health was not seen as something belonging only to the individual, but as something connected to family ties, spiritual balance, and social harmony.

[316] At the turn of the twentieth century, missionaries increasingly recognized that beyond the boundaries of their stations, the indigenous belief systems they labeled as "pagan" remained remarkably resilient and largely untouched. See Carl Paul, *Die Mission in unseren Kolonien*, 278; see also, BMW 1/6008, Martin Priebusch annual report at Ilembula Station, vol. 4. (1905-1939), 413.

For the Berliner Lutheran missionaries who established the hospital, the concept of institutionalized care was taken for granted. According to mission medical reports, the medical mission strongly believed that proper healing could only take place within the walls of a mission hospital, where African patients would receive scientific diagnoses and treatment in accordance with European standards of hygiene, discipline, and order.[317] Elements such as fresh air, rest, and a clean environment were parts of the healing process, and these were believed to be best provided in the hospital setting. Once admitted, patients were expected to remain under the strict supervision of trained medical staff, follow prescribed treatments, and accept the authority of missionary doctors and nurses.

However, for the local communities, the understanding of illness and healing was very different. Healing was not viewed as an individual concern to be handled in isolation; instead, it was regarded as a collective process involving the wider family and community. Decisions regarding the choice of treatment were not often made by the patient alone.[318] Rather, such matters were commonly discussed with elders and extended family members, whose guidance drew upon shared cultural beliefs and longstanding local traditions.

Evidence from the early days of Kidugala hospital highlights the profound influence of local cultural beliefs on the community's response to missionary healthcare. Dr. Rudolf Öhme and Sister Alice Bastian, two of the first medical missionaries to oversee the hospital, shared an account that sheds light on these beliefs. In one particular incident, they described how the local community's reaction revealed the unfamiliarity and, at times, confusion surrounding the concept of hospital treatment, especially in contrast to traditional healing methods. Their story offers valuable insight into the early operations of the hospital and the cultural misunderstandings that accompanied the introduction of missionary medicine. In their account, they recounted a particularly challenging encounter with a family who resisted receiving care at the mission:

[317] Schultze, *Der Njassabund*, 86-87.
[318] See D. Merensky, *Berlin Missionsberichte* (BMB), October 1905, 418.

> In the first few days, a family brought us a man gravely ill with fever, a condition that demanded immediate and focused care. We immediately told them he would stay overnight at the hospital, where we would administer medicine and provide food to help his recovery. The response was immediate and emphatic: 'no'. Both the patient and his relatives refused to leave him in our care.[319]

For the missionaries, the refusal of hospital care by local populations was difficult to comprehend. Shaped by European medical thought, medical missionaries regarded hospitals as act of kindness and embodiments of modern science, institutions that should obviously improve people's health. However, for the indigenous communities, the very idea of isolating a sick person within an unfamiliar institution, separated from the close care of family and community was profoundly strange and culturally unacceptable.

In these societies, healing was far more than a clinical process; it was a deeply social and spiritual practice embedded in daily life.[320] The presence of kin, neighbors, and spiritual intermediaries, most notably traditional healers played a vital role in both understanding sickness and aiding recovery. As a result, the home and surrounding environment rather than the hospital were regarded as the most suitable and trusted spaces for addressing health concerns. The home functioned as more than a shelter; it was a spiritually resonant and protective space where illness was interpreted through culturally grounded meanings. Transferring care from this environment to a mission hospital often distant from the community and operated by foreign medical personnel was not simply a logistical shift. For many, it marked a deep cultural dislocation that altered the meaning of illness and left the patient feeling exposed and disconnected.

Furthermore, the reluctance of local communities to embrace missionary medicine did not stem from ignorance, as many missionaries assumed, but reflected a deliberate adherence to longstanding and deeply embedded cultural logics of healing and care. In this context, relatives of those in need of missionary care took matters into their own hands. Missionary records indicate that in 1911, local communities

[319] Schultze, *Der Njassabund*, 112.
[320] Steven Feierman and John M. Janzen, eds. *The Social Basis of Health and Healing in Africa*. (University of California Press, 1992).

were regularly visiting the Kidugala hospital.[321] They built small, temporary huts near the facility, created informal settlements that allowed them to remain close to their loved ones during treatment. Within these spaces, families prepared food, offered prayers, and continued their traditional healing practices alongside the medical care provided by the missionary. This approach reflected the centrality of kinship and community in African healing traditions, where family involvement was a key to the well-being of the patient. Altogether, by blending traditional and missionary medical practices, families ensured that their loved ones were cared for in a way that honored both their cultural values and the medical interventions introduced by the medical missions.

However, the presence of these structures which were simple and rudimentary, frustrated medical missionaries and colonial health officials, who viewed them as unsanitary and a significant obstacle to the exclusive application of biomedicine in the region. The huts, that were associated with traditional healing practices, were seen as symbolic of what missionaries deemed to be 'superstitious' and 'primitive' customs.[322]

Influenced by European medical orthodoxy, which prioritized the exclusive use of biomedicine, missionaries were determined to eliminate what they perceived as non-scientific and backward approaches to health care. They viewed the local communities' reliance on traditional forms of healing, including herbal medicine and spiritual rituals, as inferior and, in some cases, dangerous. Missionaries and colonial officials believed that their hospitals should serve as the central authority on health and healing, reinforcing a model of care that adhered strictly to Western medical principles.

Sister Alice, a missionary working in the region, was particularly vocal about her frustration with African patients' reluctance to stay in the hospital. She noted that

[321] BMB, 1911, 94.
[322] Berliner Missionwerk, hereafter BMW, 1/6069, Brandt, *Ostafrika (Sanguland and Hehe), 1906–1939* (Berlin: Berliner Missionsgesellschaft, 1908), n.p.

many patients preferred to return to their homes or seek out traditional healers rather than remain in the hospital for treatment. She remarked that;

> In the first few weeks, we struggled to get people to stay in the hospital. When the black man is sick, he prefers to remain in his hut, lie beside a large fire, wrap himself completely in his straw mat, and even pull it over his head. The thought of moving into a strange house and sleeping there was unimaginable.[323]

For the missionaries, this resistance was not an inconvenience or a matter of logistical frustration but it was challenge to the very foundation of mission medical authority. It showed that their attempts to impose Western ideas of health, discipline, and obedience were doomed to fail. Missionaries tried to enforce these ideas not just through medicine, but as part of their broader goal to change local customs and values. On the other hand, for the local communities, this resistance was more than just rejecting medical care. It was a strong refusal to abandon long held beliefs and cultural practices that were central to their understanding of health and healing.

As the number of individuals seeking medical assistance from the missionaries continued to grow, the local population persisted in building their own huts around the mission hospital in Kidugala. Confronted with increasing resistance and the escalating demand for care, the missionaries found themselves at a critical juncture. They faced two choices: to uphold the Western model of hospitalization, which they had introduced, or to adapt to the social realities and cultural practices of the local community.

The available historical evidence suggests that the medical missionaries in the Southern Highlands region eventually opted for a strategy that extended beyond the confines of traditional hospital settings. Rather than confining medical care to the hospital walls, they decided to build a 'native hospital,' a structure designed with large wards to accommodate the sick (see Figure 8). The building was crafted using local materials such as wood and clay, with shed roofs meant to resemble the traditional huts of the local people.[324] Medical missionaries began to make regular

[323] Schultze, *Der Njassabund*, 111-112; see also a report from D. Merensky in BMB, 1905, 512.
[324] See BMB, 1911, 94.

rounds through the native hospital, administered medicine directly to the sick in the presence of their families.[325] In one way or another, this architectural choice was meant to symbolize an effort to bridge the cultural divide between Western medical practices and local customs.

Thus, despite their initial intentions, medical missions were forced to abandon their strictly hospital based approach, as it proved ineffective. Instead, they had to adjust their biomedical knowledge to align with the social and cultural practices of the communities they sought to serve. Medical missionaries came to recognize that, without integrating these local healing traditions into their practices, their medical efforts would continue to face resistance, as local population's trust and understanding of healthcare were deeply intertwined with their own cultural systems of healing. In this way, cultural adaptation was a pragmatic response to local resistance and an acknowledgment that the African understanding of health, rooted in kinship and communal ties, played a critical role in shaping the healing process in the region. The integration of local healing traditions into missionary practices allowed both systems to coexist; creating a hybrid approach to healthcare that reflected the social and cultural realities of the region.

Furthermore, while missionary medicine introduced new treatments, technologies, and diagnostic frameworks, it was never able to fully replace indigenous healing systems. African therapeutic traditions were deeply embedded in social life, spirituality, and understandings of the body and illness, giving them a resilience that biomedical interventions alone could not displace. Rather than abandoning their own practices, African communities exercised agency by engaging in selective adaptation. Certain biomedical techniques, such as the use of quinine, vaccination, or surgical procedures, were adopted when they proved effective or useful, particularly in treating acute conditions. At the same time, these practices were often reinterpreted through local epistemologies and incorporated alongside existing healing rituals, herbal knowledge, and spiritual interventions. This process of integration allowed indigenous healing systems to persist while also evolving, resulting in plural medical

[325] Schultze, *Der Njaßabund.*

landscapes where missionary medicine functioned as a supplement rather than a substitute. Such dynamics highlight that colonial medical encounters were not simply characterized by imposition and replacement, but by negotiation, hybridity, and the enduring authority of local knowledge systems.

By 1912, medical missionaries stationed at Kidugala hospital faced an acute shortage of medical personnel, a longstanding challenge that had hindered the expansion of mission healthcare in the Southern Highlands. At the time, the hospital was staffed by two physicians, Dr. Rudolf Öhme and Dr. Grimm, the latter, however, passed away in 1913 at the age of 67. Additionally, there were two nurses, Sister Alice Bastian and Anna Böhlau, as well as Sister Helene Höchel, who also served as a seminary teacher in the region.[326] The question of limited medical personnel in mission clinics became increasingly pronounced as the demand for healthcare services grew. Similarly, this trend was also observed in other mission stations administered by both the Moravian Church and the Berliner Lutheran missionaries.

During this period, and even earlier, missionary medical correspondence was replete with appeals to the Berlin Mission headquarters for additional medical personnel to cope with the expanding scope and demand of mission medicine in the region. These reports consistently emphasized the strain placed on existing staff as patient numbers increased and medical facilities took on broader responsibilities, ranging from routine outpatient care to emergency treatment and public health interventions.[327] For Dr. Öhme, such appeals were not unprecedented. Prior to this moment, he had repeatedly drawn attention to the chronic understaffed that hindered both the effectiveness and sustainability of missionary healthcare initiatives. By the time he assumed his role as director of Kidugala Hospital, these concerns had become more urgent. In response, Öhme convened a series of meetings with the leadership of the Berlin Mission Society, using these forums to articulate the practical challenges facing the hospital and to advocate for the recruitment and deployment of additional trained healthcare practitioners. These discussions underscored the growing

[326] Schumann, *25 Jahre Berliner Mission in Deutsch-Ostafrika*, 47. See also BMB, 1911, 91.
[327] The training of African medical assistants and their role in mission healthcare is examined in detail in Chapter two of this dissertation.

institutionalization of mission medicine and revealed the tension between the ambitious medical and evangelical goals of the mission and the limited human resources available to support them.

The Berlin I leaders acknowledged the urgency of the matter raised by Dr. Öhme, and they deemed the deployment of a nurse necessary. In his requests, Dr. Öhme emphasized the immediate need for a missionary sister to assist with both medical and domestic responsibilities at the hospital. He specifically sought a trained nurse who could not only provide clinical care but also oversee the hospital's kitchen, ensuring that both patients and staff received proper nutrition, an essential aspect of holistic medical care.[328] In response, the Medical Mission Society forwarded this request to the Nyasa Women's League, an organization founded in 1905 to recruit and dispatch mission nurses and midwives to German East Africa.[329] By May 1912, with the joint endorsement of the Berlin Mission Society and the Association of Medical Missions, Sister Marie Manthey, a formally trained medical professional, was assigned to Kidugala. She became the fourth Nyasa League sister stationed at the hospital.[330]

In addition to requesting more medical personnel, Dr. Dehme also advocated for improvements in infrastructure to facilitate the smooth operation of mission medical services at Kidugala hospital. One of his key proposals was the construction of a residence for mission nurses, directly connected to the hospital via a shared veranda an architectural design intended to foster a communal and supportive living environment for the hospital's medical staff. Furthermore, he secured approval from the Berlin Mission Society for the construction of essential utility buildings, including an isolation ward specifically designated for patients suffering from contagious diseases and mental illness.[331]

The developments at Kidugala hospital illustrate that the expansion of medical mission services in the Southern Highlands was a complex and contested process.

[328] See also, BMB, 1911, 92.
[329] Mirbt, *Mission und Kolonialpolitik.* 168 and 177.
[330] Mirbt, *Mission und Kolonialpolitik.*
[331] BMB, 1911.

Missionary records, oral histories, and ethnographic studies indicate that the dissemination of medical knowledge and the growth of hospital institutions were shaped by multiple practical challenges. These included shortages of trained personnel, limited infrastructure, and the financial and logistical constraints inherent in running a colonial mission. The success of missionary medicine, therefore, depended on the missionaries' technical skills as well as their ability to engage with local communities and navigate social and cultural expectations. This dynamic underscores the tension between ambition and limitation in the practice of mission medicine. While missionaries sought to implement Western healthcare models, their efforts were constantly mediated by local customs, community demands, and material realities. The experience of Kidugala hospital demonstrates that the outcomes of mission medicine varied widely and were never assured. They relied on ongoing negotiation, compromise, and adaptation to the social and cultural context of the local population. In this sense, the hospital was more than a site of medical treatment; it embodied the intricate intersections of power, knowledge, and everyday life in colonial Southern Highlands Tanzania, revealing both the potential and the operational limits of mission medicine.

4.4 Communal Kitchens and the Politics of Care in Mission Hospitals

For generations before the arrival of mission medicine, healing in the Southern Highlands of Tanzania was understood as a shared social burden, one that mobilized families, neighbors, elders, and ritual specialists within a wider moral economy of care. African therapeutic systems were therefore shaped by questions of control, specifically, how authority over treatment was distributed among different actors.[332] Similarly, the authority over healing never rested with a single figure. Instead, it circulated through a network of relatives and specialists whose roles were mutually dependent. Families prepared food, fetched water, stayed awake through the night, and collectively decided when to call a herbalist, diviner, or respected elder.[333] In explaining this, Steven Feierman observed that control over healing in African contexts extended into a wider sphere of practical responsibility. It involved deciding

[332] Feierman, "Struggles for Control," 75. See also, Vaughan. *Curing Their Ills, 35-40;*see also Hunt. *A Colonial Lexicon,* 45-51.
[333] Pastor Gordon Mwakapeje, Andawike Mwasomola, and Pastor Anyitike Mwakanjuki.

when a person was too ill to work, assigning caregiving duties, and determining which relatives would provide food, labor, or payment, functions that reflected the deeply social nature of African therapeutic systems.[334]

It is important to note that women stood at the center of this coordinated system of care, and their role must not be marginalized in any historical scholarship on African healing systems. In the Southern Highlands, as elsewhere in Africa, women occupied a central position in the healing landscape, a role rooted in long standing domestic and social structures. Their responsibilities extended far beyond ordinary household work. During illness, women served as the primary attendants, remaining close to the patient through long nights of fever or seizures.[335] This centrality reflected a broader moral economy of care in which women were expected to sustain the continuity of life, health, and social stability. Thus, their presence created a sense of reassurance for the patient and provided structure and cohesion to the wider caregiving network.

Historically, women's authority in matters of health came from what they had learned through everyday practice, from knowledge passed down through generations, and from their respected roles within the family and community. Megan Vaughan noted that in many parts of Eastern and Central Africa, healing was shaped by gendered responsibilities, and women often stood at the center of these practices.[336] In the Southern Highlands, women accumulated practical knowledge not through formal training but by being constant present: watching over the sick, noticing changes in symptoms, sensing when an illness was becoming serious, and deciding when to call herbalists or ritual specialists.[337] Thus, we can argue that during the colonial period, women held a form of authority that was subtle yet deeply influential, grounded in long-standing experience, lived memory, and the trust invested in them through kinship ties.

[334] Feierman, "Struggles for Control."
[335] Wilson, *Rituals of Kinship among the Nyakyusa*, 223; see also Wilson, "An Introduction to Nyakyusa Society", 253-291.
[336] Vaughan, *Curing Their Ills*, 42.
[337] Wilson, *For Men and Elders*, 5.

These traditions did not disappear with the establishment of mission medical centers. Families continued to accompany their sick relatives into the mission compounds, constructing temporary shelters, cooking over open fires, and recreating the familiar rhythms of care that resembled those of their homesteads.[338] The persistence of home-based care giving practices, however, presented significant challenges for missionaries, who placed increasing emphasis on hygiene, discipline, and spatial order within hospital compounds. Deeply influenced by European ideals of cleanliness as a marker of civilization, missionaries viewed the presence of patients' family members, who camped around hospital wards and prepared food in uncontrolled outdoor spaces, as a serious threat to the sanitary environment they sought to impose.[339] For them, healing encompassed more than the treatment of physical illness; it also involved reshaping African practices and attitudes toward personal hygiene, domestic discipline, and public order.

In response, missionaries introduced communal kitchens: controlled cooking spaces positioned at a regulated distance from the hospital buildings but still strategically close enough for the missionaries to watch and supervise. These structures served several purposes. On one level, they recognized an undeniable reality: African families remained essential to feeding, comforting, and emotionally supporting the sick, and mission hospitals depended on this labor to function. On another level, the kitchens became tools of social reform. By directing where and how Africans cooked, missionaries sought to reshape domestic routines according to European sanitary ideals, promoting new habits of cleanliness, order, and obedience that fit their broader vision of Christian modernity.

From the early twentieth century, communal kitchens were established at the major health centers of Kidugala, Matema, Ilembula, Rungwe, and Itete. Located within the hospital compounds but set apart from the wards, these kitchens offered a regulated

[338] Schultze, *Der Njaßabund,* 112-113.
[339] Schultze, *Der Njaßabund ,*39. See also, Michael Jennings, "Healing of Bodies, Salvation of Souls: Missionary Medicine in Colonial Tanganyika, 1870s-1939," *Journal of Religion in Africa*, no. 38 (2008), 11.

space where patients' families could prepare food under mission imposed rules.[340] The communal kitchens were intended to accommodate African caregiving traditions while at the same time creating a controlled environment that reflected missionary sanitary standards.

Figure 11: Communal kitchen at Kidugala in Waging'ombe District, Njombe region[341]

Source: Photograph by Luoneko Kaduma, 14 June, 2025.

Medical missionaries insisted on cleanliness and proper hygiene, which showed how the power relationship between African family members and mission authorities was negotiated. Missionaries frequently conducted inspections of these kitchens and ensured that African families followed European standards of cleanliness. In doing

[340] O. W. Neumeister, *Eingeborenenmarkt in Neulangenburg (Tukuyu) Ostafrika; Erdnüsse Auf Bananenblättern*, RKB 1302, (Tanganyika; Tanzania; Neu-Langenburg, n.d). See also Schultze, *Der Njaßabund* ,39.

[341] This building was originally established by the Berliner Lutheran Mission at Kidugala. Although its walls and roof have been altered several times over the decades, the concrete floor remains the original one laid by the medical missionaries during the early phase of construction. This information is drawn from my interview with Dr. Zedekia Njogela, a senior medical officer in charge at Kidugala hospital, and from focus group discussion with four Bena women, namely, Elida Mlowoka, Rehema Mponzi, Twilumba Lwena and Nolina Haule, conducted at Kidugala hospital, Wanging'ombe District, 14th June, 2025.

so, they reinforced the power dynamics of the mission medical system.[342] However, through these kitchens, missionaries sought to regulate and redefine domestic and communal spaces within the hospital setting. They imposed a sanitized model of care while attempting to reconcile African care giving traditions with their own ideas of health and hygiene.

Figure 12: Communal Kitchen at Matema Lutheran Hospital, in Kyela District, Mbeya region[343]

Source: Photography by Luoneko Kaduma, 07 June, 2025

In this way, women acted as cultural intermediaries. They adapted missionary medical settings to African expectations of care, insisted on feeding patients with familiar foods, and interpreted symptoms for mission nurses. Through these practices, women quietly retained a measure of authority over therapeutic decisions,

[342] BMW 1/5965, *Ikombe-Matema,* Tagebücher, Bd. 3, No. 43, Georgenkirchstr. 70 (Berlin: Berliner Missiongesellschaft, 1939), 8.

[343] The communal kitchen at Matema Lutheran hospital retains its original brick pillars and concrete floor, constructed by German missionaries, although the roof has been replaced several times. This information comes from an interview with Meshack Njinga, currently Assistant Bishop of the Evangelical Lutheran Church in Tanzania, Konde Diocese, Tukuyu-Rungwe, on 9 October 2024. As well as from conversations with Elida Mwalukolo, Rehema Mwakasitu, Bupe Mwaisanja, and Anitha Kanyoka, who were cooking for their sick relatives during my visit to Matema on 7 June 2025. All the women depicted in the photograph kindly gave their consent for me to use this image.

even in settings where missionaries attempted to regulate domestic routines. Far from passive figures, they remained essential agents whose labor and knowledge shaped the lived reality of illness in the colonial Southern Highlands.

Nevertheless, the establishment of communal kitchens around mission hospitals was not an automatic outgrowth of missionary ideas about hygiene, discipline, or the moral reform of African domestic life. Their creation was driven above all by the material realities of mission finance. Throughout the early twentieth century, both the Moravian and Berliner Lutheran missions in the Southern Highlands operated under persistent financial constraints, and these pressures shaped the daily operations of their medical work.[344]

In explaining this, the Moravian financial statement of 1913 clearly highlighted how unstable the mission's position was. In this report, it revealed that even in the early years of the twentieth century, the mission was already burdened with a substantial deficit. Consequently, the mission board had to acknowledge that continuing work in the Southern Highlands was "balanced on the edge of impossibility."[345] While financial pressures had existed from the beginning, by late 1912 the missionaries recognized that they had accumulated a significant deficit. Contributions received in 1913 helped to reduce some of the burden, but the year nonetheless closed with a significant deficit. By 31 December 1913, the total liability had reached £4,173. Additional donations amounting to £1,179 were received by July 1914, but a balance of £2,994 remained outstanding.[346]

Missionaries attributed these financial problems to rising expenses that included training missionaries in Europe, educating their children abroad, covering unexpected medical costs for sick missionaries, and paying missionaries who were

[344] For a general overview of the financial history of Moravian mission fields, including the management of resources, the funding of mission stations and the economic strategies employed to sustain missionary activities. See Hamilton, *A History of the Missions of the Moravian Church*, 220-224.
[345] Periodic Accounts of Moravian Church, "Financial Statement of 1914" Vol 9, No 99, (London: Moravian Church and Mission Agency, 1914), 154-157.
[346] Periodic Account, 154.

on leave in Germany, all of which demanded additional funds.[347] At the same time, there was pressure stemming from the decline of regular funding sources, such as the Morton Legacy, which was one of their major annual funds and dropped by £2,000 compared to 1912.[348] Even the '*Kaiserspende',* a German word meaning 'emperor's gift' of £10,000 offered little relief, as all the funds were designated for new building projects such as the construction of Rungwe Secondary School rather than for daily operational needs.[349]

Furthermore, these financial pressures highlighted how mission work depended heavily on external funding from European congregations and private donors whose support was neither stable nor guaranteed. Consequently, the sustainability of medical, educational, and pastoral initiatives in the colonial Southern Highlands depended not only on African participation and local conditions but was also profoundly shaped by the financial priorities and constraints of the missionary societies in Germany. Therefore, the decision regarding budgets, fundraising, and the allocation of personnel were made at mission headquarters in Berlin for the Berliner Lutherans and Herrnhut for the Moravian Church. These decisions, in one way or another, shaped the kinds of projects that could be undertaken in the mission fields, determined which hospitals received supplies, and influenced how far missionary work could be extended. Hence, the daily operations of mission stations in colonial Southern Highlands of Tanzania were inseparable from the economic climate and strategic priorities of the German mission societies that financed and directed their activities.

4.5 Conclusion

The entanglement of kinship, memory, and missionary medicine profoundly shaped the healing cultures that defined neighborhood life in the colonial Southern Highlands of Tanzania between 1891 and 1940. Over nearly five decades, German Protestant missionary groups, most notably the Moravians and Berliner Lutherans, introduced new medical ideas, technologies, and institutional practices that altered

[347] Periodic Account, 155.
[348] Periodic Accounts, "General Statement of Mission Fund, 1913", No. 99 (1914), 161-162.
[349] Periodic Accounts, "General Statement of Mission Fund."

local landscapes of care. As this chapter has shown, their presence reshaped certain aspects of healing, especially through mission hospitals, dispensaries, and the moral expectations embedded in missionary medical work.At the same time, this influence was neither uniform nor uncontested. Missionary efforts did not erase the longstanding connections between healing, kinship structures, and neighborhood forms of mutual support. Instead, local understandings of illness, recovery, and wellbeing continued to rest on deeply rooted social relationships and shared memories of how communities had cared for one another long before missionaries arrived. These kinship networks and neighborhood bonds formed an enduring framework through which people evaluated new medical ideas and decided what to adopt, ignore, or reinterpret.

In addition, African actors did not simply absorb missionary interventions. Community members engaged with missionary medicine selectively, drawing on it when it aligned with existing knowledge systems while adapting, reinterpreting, or resisting aspects that conflicted with their moral, spiritual, or social expectations. Through these everyday decisions, they maintained healing practices that reflected their own priorities and cultural logics. Taken together, these dynamics illustrate that the medical landscape of the Southern Highlands emerged not from missionary authority alone but from an ongoing interplay between local memory, community resilience, and the evolving ambitions of missionary medicine. Oral recollections have been especially important in revealing these layered experiences. Through the memories of elders, retired pastors, and local healers, it becomes evident that healing was never limited to the physical body; it was simultaneously a reaffirmation of kinship ties, emotional support, and a deep sense of communal belonging. These narratives highlight the moral and affective dimensions of healing, elements often absent from written missionary records. They further show that the neighborhood functioned as a vital space for cultural continuity, where memory and experience were passed down through generations, sustaining a distinctive healing culture despite the pressures exerted by colonial rule and missionary authority.

CHAPTER FIVE

HEALING, DISCIPLINE, AND KNOWLEDGE: GERMAN PROTESTANT MISSIONARIES AND MODERN HEALTHCARE IN SOUTHERN HIGHLANDS, TANZANIA, 1891-1940

5.0 Introduction

Following the formal establishment of German colonial rule under the Anglo-German Agreement of 1 July 1890, the Southern Highlands of Tanzania became a strategically important frontier within the expanding German East African colony. German Protestant missionaries soon perceived an urgent need to evangelize the local population, as a substantial part of the newly acquired territory had not yet been exposed to Christian teaching. During the early phase of evangelization, both the Moravian Church and the Berliner Lutherans came to realize that preaching alone was insufficient to achieve mass conversion, particularly in communities with deeply rooted spiritual and healing traditions. Drawing on experiences from other parts of Africa and guided by broader European missionary strategy, they concluded that the provision of biomedical care could serve as a more practical and persuasive means of attracting converts and transforming African society. Within this framework, healing the body became closely linked to healing the soul.

Consequently, missionaries established dispensaries and hospitals at different times and in various locations across the region, institutions that simultaneously served as centers of medical care, education, and religious evangelism. Overtime, however, missionaries came to realize that their influence remained largely confined to a narrow segment of the population.[350] This group consisted of former slaves who had been displaced by social and economic upheavals, marginalized individuals on the peripheries of local communities, and others who sought refuge, land, employment, or medical assistance within the protective confines of the mission stations.[351] Although these individuals engaged with the missions out of necessity or

[350] Although missionary activity initially reached only a narrow segment of the population, later developments show a gradual expansion of influence. Over time, Christianity gained adherents among influential members of African communities, including chiefs, local elites, and the emerging educated classes. The engagement of these groups was particularly significant, as it helped to facilitate the broader social penetration of missionary institutions and Christian ideas.

[351] Wright, *German Mission in Tanganyika,* 51 and 64.

opportunity, their integration into the broader Christian moral and social framework was often limited and uneven. Beyond the boundaries of mission compounds, the authority of indigenous religions and the persistence of what missionaries labeled "pagan" customs remained largely intact.[352] In this context, missions operated less as engines of comprehensive societal transformation and more as isolated spheres of influence, shaping the lives of specific groups while leaving wider local structures of belief and authority largely undisturbed.

At the turn of the twentieth century, these missionary groups regarded it as imperative to the success of their enterprise to forge a disciplined and orderly Christian community. They envisioned the emergence of a new kind of African Christian who not only accepted the gospel but also embodied the cultural, moral, and intellectual ideals of Christian modernity. This vision demanded a comprehensive transformation, one that touched every dimension of local life. To the missionaries, such a transformation required the simultaneous reform of both body and mind.[353] The body was to be reshaped through the adoption of European standards of hygiene, dress, work discipline, and health practices. Cleanliness, proper clothing, punctuality, and regular labor were treated as outward signs of spiritual progress and moral reliability. The mind, meanwhile, was to be molded through the internalization of Christian teachings, moral values, and new modes of thought that aligned with European notions of order, rationality, and faith.

Mission schools, catechism classes, and mission clinics functioned as central sites for this dual process of formation. In these spaces, religious lessons were closely connected to practical instruction and moral guidance. School children were taught to pray, read, and memorize scripture, but they were also taught to maintain bodily hygiene, infant care, and nutrition.[354] Mission clinics reinforced these lessons by promoting missionary ideas about illness, cleanliness, and proper conduct, while presenting Western medicine as both a practical and spiritual solution. Through these

[352] Paul, *Die Mission in unsern (unseren) Kolonien*, 278.
[353] Hardiman, *Healing Bodies, Saving Souls,* 25, and Good, "Pioneer Medical Missions in Colonial Africa," 1.
[354] TNA 450/108/22 Letter from Scott to Briggs, 2nd June 1936 reference 108/22/101. See also Schultze, *Der Njaßabund*, 86.

institutions, missionaries sought to produce a generation of converts who were not only devoted Christians but also disciplined members of society, people whose behavior, appearance, and everyday habits reflected the missionaries' vision of Christian modernity.[355] This was not merely an abstract goal: in mission reports, missionaries frequently highlighted the transformation of pupils, catechumens, and baptized Christians as proof that their work was bearing visible fruit.[356]

Drawing on archival materials, missionary correspondence, reports by African evangelists and pastors, ethnographic accounts, and oral recollections, this chapter examines how German Protestant missionaries, particularly those of the Moravian Church and Berliner Lutherans, actively reshaped the landscape of healing, moral discipline, and modes of knowledge production in Tanzania's Southern Highlands between 1891 and 1940.

The discussion focuses on four principal mission stations in the Southern Highlands of Tanzania: Rungwe, the headquarters of the Moravian mission; Kidugala and Ilembula, Berliner Lutheran stations in the Njombe region; and Matema in the Mbeya region. Missionary reports frequently identified these stations as among the most successful in the region.[357] By 1910, Kidugala's hospital had developed into the primary hub of mission medical services, supporting an extensive array of educational, medical, and social initiatives.[358] Rungwe, as the Moravian mission headquarters, preserves its historical materials at the Rungwe Archive and Museum Center (R.A.M.C), while the Kidugala Lutheran Seminary Archive (K.L.S.A), maintained by the Evangelical Lutheran Church in Tanzania, Southern Diocese,

[355] See Vaughan, *Curing Their Ills*, 55; Musomba, *Historia Fupi Ya Kanisa La Moravian Kusini Tanzania*; Clyde, *History of the Medical Services in Tanganyika*; Oliver, *The Missionary Factor in East Africa*, 210-11.

[356] Schultze, *Der Njaßabund*, 90-91.

[357] Reports of the Berliner Mission are held in the Berliner Missionswerk (hereafter BMW), Evangelisches Landeskirchliches Archiv in Berlin. See, for example, BMW 1/6008, Martin Priebusch, annual reports from Ilembula Station; BMW 1/5603 (Kidugala); and BMW 1/6003, reports covering the period 1898–1914. See also BMW 1/3036 (1930), *Brief von Schwester Gertrud Döhring* (Berliner Frauenmissionsbund) concerning medical work in Kidugala and Tandala. Additional Ilembula materials include BMW 1/6008 (1905–1939), *Ilembula (Mischband)*, vol. 4; BMW 1/6007 (1936–1947), *Tagebücher Ilembula*, vol. 3; and BMW 1/6005 (1900–1927), *Missionsstation Ilembula*, vol. 1.

[358] Paul, *Die Mission in unsern (unseren) Kolonien*, 257. See also Schultze, *Der Njaßabund,*, 113 and Gröschel, *Zehn Jahre Christliche Kulturarbeit in Deutsch-Ostafrika*, 39-41.

holds substantial records from the mission era. These collections demonstrate that, despite the passage of time, primary sources from the colonial and early mission era remain accessible for scholarly research. Focusing on these stations allows for a detailed, evidence-based study of missionary activity, reducing reliance on scattered or fragmentary sources. Through the establishment of hospitals, dispensaries, schools, and catechetical centers, missionaries forged an interconnected institutional network intended to advance a broader project of social, spiritual, and moral transformation in the Southern Highlands.

This chapter contends that German Protestant missionaries in colonial Southern Highlands of Tanzania acted as transformative agents who deliberately integrated healing, discipline, and knowledge with their broader evangelizing mission. Healing was employed as a strategic avenue for conversion, providing a visible demonstration of Christian benevolence and divine power. Discipline functioned as a moral and social framework that regulated behavior, parenting practices, household organization, hygiene, and communal order within mission compounds. Through this framework, missionaries sought to reshape how individuals prayed or believed and also how they lived, worked, interacted, and raised their families. Knowledge, especially medical knowledge, became a contested and symbolically significant arena in the encounter between missionaries and local communities. Medical missionaries introduced biomedical concepts of disease such as germs, hygiene, and diagnosis, which often did not match local explanations such as spiritual causes or social imbalance. Thus, medical knowledge during missionary encounters was full of cultural meaning, power struggles, and negotiations.

The chapter further examines how these processes were negotiated within local contexts. African evangelists, pastors, traditional healers, and community elders did not passively accept missionary authority; they interpreted, adapted, and at times openly challenged the medical knowledge and disciplinary practices introduced by German Protestant missions. By following these encounters closely, the chapter illustrates that the reconfiguration of health, morality, and medical knowledge in the Southern Highlands cannot be understood as a simple projection of European norms

onto African communities. Rather, it was a negotiated and often tension-filled process that generated new social hierarchies, redefined expertise, and gave rise to hybrid medical and spiritual practices shaped through continuous interaction between missionary agendas and African agency.

The question of who possessed the authority to heal exposed deeper tensions over epistemic sovereignty and spiritual legitimacy in the Southern Highlands. Local chiefs, healers, ritual specialists, and community elders claimed expertise in diagnosing and treating physical ailments and also in interpreting their social, moral, and spiritual dimensions. Missionary medics, in contrast, claimed that scientific knowledge, guided by Christian moral principles, provided a superior framework for understanding both body and soul.[359] These competing claims were not abstract debates; they played out in everyday contexts, within villages, homes, and healing spaces, where patients navigated between European trained doctors and local healing practices. In this way, missionary medical knowledge was not simply imposed but actively negotiated, highlighting how African agency and missionary authority were mutually implicated in shaping health, healing, and moral order under colonial rule.

This chapter is structured around three interrelated themes. The first section situates the historical context of medical missionaries, examining how they linked bodily cleanliness, clothing, and domestic hygiene to broader conceptions of health, morality, and spiritual well-being. Missionaries framed physical purity as a matter of personal health, and also as a visible marker of moral and social discipline. In this context, clothing emerged as a crucial site of intervention: the act of sewing, mending, and wearing proper garments was interpreted as both a hygienic practice and a demonstration of adherence to missionary ideals. Through these intertwined practices, missionaries sought to shape bodies, households, and communities, promoting an ethic of cleanliness that encompassed personal appearance, domestic order, and spiritual conduct.

[359] See Hardiman, *Healing Bodies and Saving Souls*, 5. See also, Gröschel, *Zehn Jahre christlicher Kulturarbeit*, 132.

The second section focuses on the idea of the Christian village and how missionaries used housing as a tool for moral and spiritual change. Missionaries believed that poor housing conditions, such as dirt, bad air, and smoke inside homes, showed moral disorder and weak spiritual discipline. They saw these conditions as problems that needed to be corrected. To address this, missionaries promoted Christian villages with orderly layouts and clean, well-ventilated houses. They believed that living in such homes would encourage discipline, cleanliness, and Christian behavior.

The third section emphasizes the pivotal role of African evangelists and pastors as intermediaries, translators, and knowledge brokers operating at the intersection of missionary medicine and African therapeutic traditions. These actors did far more than implement missionary directives; they actively shaped the circulation of medical knowledge by interpreting, modifying, and at times contesting European biomedical concepts.

5.1 Clothing as Hygiene: Sewing, Health, and Missionary Discipline

As German Protestant missionaries expanded their activities across the globe, they frequently asserted that their primary objective was to create "Christians and not Germans."[360] This claim significantly shaped missionary interactions with local communities. By positioning themselves as benevolent spiritual reformers rather than agents of colonial domination, missionaries cultivated a self-image that justified a "paternalistic" mode of engagement.[361] African converts were treated as subjects to be instructed, disciplined, and reshaped according to Protestant moral norms. Indigenous religious practices, healing systems, and social institutions were commonly dismissed as superstition or backwardness, even as missionaries professed respect for local cultures.[362] In practice, this respect translated into selective

[360] From this perspective, German Protestant missionaries framed their work as fundamentally spiritual, stressing that their aim was the conversion of individuals to Christianity rather than the imposition of German nationality, culture, or political authority. They presented themselves as bearers of a religious calling, distancing their mission from overt nationalist or colonial ambitions. For further discussion, see Jeremy Best, *Heavenly Fatherland: German Missionary Culture and Globalization in the Age of Empire* (Toronto: University of Toronto Press, 2021), 41.

[361] See Ulrich van der Heyden, "Christian missionary societies in the German colonies, 1884/85-1914/15," in *German Colonialism: Race, the Holocaust, and Postwar Germany*, ed. Volker Langbehn and Mohammad Salama (New York: Columbia University Press, 2011), 217.

[362] Gröschel, *Zehn Jahre christlicher Kulturarbeit in Deutsch-Ostafrika*, 169.

adaptation rather than cultural preservation: elements of African life were tolerated only insofar as they did not conflict with Protestant moral and social frameworks. Local customs were thus accepted conditionally, when they could be reconciled with missionary expectations, rather than valued on their own terms.[363]

This objective also profoundly shaped how missionaries perceived and evaluated African societies. Upon their arrival in the Southern Highlands in the late nineteenth century, Berliner Lutheran and Moravian missionaries noted that large segments of the population had not embraced Christianity.[364] Within missionary discourse, this absence of Christian practice was interpreted as evidence of moral and cultural deficiency. African social norms, religious practices, and worldviews were consequently labeled as "heathen" or "inferior," reflecting the moralized and hierarchical lens through which missionaries understood the societies they sought to transform.[365]

In the context of widespread European perceptions of Africa as inherently "sickly" and culturally inferior, German missionary writings unsurprisingly expressed a particularly dismissive view of local medical knowledge and practices. In his ecclesiastical work in 1910, Carl Theodor Mirbt, a German Lutheran historian, characterized the African medical condition as: "medicine is at a shockingly low level of development. Ignorance of the structure of the human body and the nature of diseases, inability to operate, and total neglect of sanitation coincide with the use of barbaric remedies."[366] In Mirbt's account, the African medical landscape was

[363] Comaroff and Comaroff, *Of Revelation and Revolution*, vol. 1, esp. chaps. 5 and 8; Terence Ranger, "Christianity and Indigenous Peoples: A Personal Overview," *Journal of Religious History* 27, no. 3 (2003): 256, 263.

[364] Paul, *Das Evangelium in Deutsch-Ostafrika*, 27. See also Hamilton, *In Kolonialen Umfeld*, 85.

[365] Alexander Merensky, *Deutschlands Pflicht gegenüber den Heiden und dem Heidentum in seinen Kolonien, Beiträge zur Missionskunde*, (Berlin: Buchhandlung der Berliner evangelischen Missionsgesellschaft, 1905), 15. See also, Håkansson, N. Thomas. "Pagan Practices and the Death of Children: German Colonial Missionaries and Child Health Care in South Pare, Tanzania." *World Development* 26(9): 1763-1772.

[366] See Mirbt, *Mission und Kolonialpolitik*, 161. Carl Theodor Mirbt (1860-1929) was a German Lutheran theologian and church historian, known for his scholarship in mission studies. He edited and compiled historical sources on Christian missions, influencing early 20th century understandings of Protestant missionary work and the ways German missionaries interpreted and justified their work abroad. For further reading on Mirbt's contributions to missiology, see Carl Mirbt, *Die evangelische Mission: eine Einführung in ihre Geschichte und Eigenart* (Leipzig: Hinrichs, 1917).

depicted as a realm of "heathen barbarism," reflecting broader European assumptions about African societies during the colonial period. From this perspective, local medical practices were judged inadequate and portrayed as requiring intervention from external actors.[367] European methods, considered more "civilized," were therefore presented as both corrective and necessary. Such a way of thinking was typical in missionary and colonial discourse and often marginalized the knowledge and value of indigenous healing systems.

Moreover, it is important to note that missionary constructions of African 'inferiority' were rarely articulated in overtly biological or racial terms. Instead, missionaries tended to interpret bodily suffering and vulnerability through environmental and social lenses. Illness was thus framed not simply as an individual physiological condition but as the product of an interlocking set of natural circumstances and everyday practices. Missionary writings repeatedly emphasized how local environments and social habits were believed to shape physical resilience or susceptibility to disease. In missionary medical discourse, high-altitude regions such as the Southern Highlands were frequently depicted as especially inhospitable to human health.[368] Missionaries repeatedly emphasized cold and damp conditions, sharp fluctuations in temperature, and living arrangements they regarded as unsanitary. Practices such as sleeping on the ground, going barefoot, or residing in poorly insulated dwellings with open fires were cited as factors that allegedly increased susceptibility to disease.[369] Through such observations, missionaries framed African vulnerability as situational and contingent, arising from environment and habit rather than from fixed biological characteristics.

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[367] Mirbt, *Mission und Kolonialpolitik*.

[368] Missionary nurses in the Bena-Hehe Synod, such as Gertrud Döhring, Elizabeth Rener, and Alice Franke, frequently reported cold-related illnesses, including pneumonia and bronchitis, at Ilembula and Kidugala, often linking them to inadequate clothing and hygiene. By contrast, reports from the warmer Kyela District among the Wanyakyusa, recorded at Matema Lutheran Mission Hospital, indicate these conditions were comparatively rare, suggesting environmental factors influenced disease prevalence. For this reference, see *BMW Mischband*, 1905–1939, vol. III, no. 5, medical report by Elisabeth Rener, "Vierteljahresstatistik über Kranke am Krankenhaus Ilembula" (Quarterly statistics of patients at Ilembula Hospital), July 1 - September 30, 1934; BMW, *Ilembula Mischband*, 1905–1939, quarterly medical report by Sister Gertrud Döhring, Ilembula, January 7, 1925 (statistics for October–December 1927).

[369] *BMW Mischband*, 1905–1939, vol. III, no. 5.

This mode of explanation played a practical role in missionary thinking. By linking illness to environmental conditions and modes of living, missionaries justified the introduction of European medical practices and portrayed their work as both rational and morally necessary.[370] At the same time, this reasoning positioned European medicine above local forms of healing, presenting it as scientifically reliable, while African practices were often described as unsafe or ineffective. By grounding medical intervention in environmental and behavioral explanations, missionaries reinforced a hierarchy of knowledge that legitimized European authority without overtly relying on racialized biological arguments.

These assumptions are evident in the writings of Erich Schultze, a German Lutheran missionary pastor associated with the Berlin Mission Society and active in German East Africa in the early twentieth century. In his firsthand accounts of German Protestant missionary activity, Schultze portrayed East Africa as a region marked by persistent health risks. Writing from a European perspective, he observed:

> On the whole the natives are exposed to the same dangers to health as we whites, nay, they suffer considerably more than we northerners from the cold, wet, weather and sharp fluctuations in temperature peculiar to the equatorial climate, and this is not only due to poor clothing, housing, [and hygiene]. No wonder that colds are the order of the day with them and tuberculosis claims as many victims as it does with us. The tropical climate also harbors its own particular dangers, which are further intensified by the completely unhygienic way of life of these children of nature.[371]

Schultze's observations show how explanations of disease based on environment and climate were tied to judgments about African culture. Although he avoided openly discussing race, he evaluated African bodies and health according to European standards of proper clothing, housing, hygiene, and daily habits. Illness was often blamed on what he saw as poor living conditions, placing responsibility on African communities. In doing so, he portrayed local practices, like traditional dress, sleeping arrangements, or communal food-sharing, as careless or unhealthy. This reasoning framed European intervention as both necessary and morally superior, giving

[370] See Megan Vaughan, "Healing and Curing: Issues in the Social History of Medicine in Africa," *Social History of Medicine* 7, no. 2 (1994): 287-289; Comaroff and Comaroff, *Of Revelation and Revolution*, 2:349, 354.
[371] Schultze, *Der Njasabund*, 39, see also 41.

missionary's authority not only over health but also over everyday life. By presenting European medical knowledge as universal and African practices as deficient, Schultze's accounts reinforced a subtle hierarchy that justified colonial and missionary control, showing how medical discourse became a tool for cultural dominance.

Within this framework, missionary medicine served both as a means of providing care and as a way of asserting cultural authority. David Hardiman has noted that mission medicine often showed a sense of "arrogance," as European medical knowledge was used to challenge and push aside local healing practices.[372] In missionary writings, European medicine was represented as scientific, rational, and universally reliable, while African healing practices were often portrayed as ineffective, misguided, or based on superstition. Therefore, this contrast reinforced the authority of mission medicine and justified its interventions in African communities.

In their early efforts to instill discipline, modesty, and what they defined as a civilized Christian way of life, medical missions placed particular emphasis on clothing, making it an important part of missionary enterprise. Changing how people dressed was treated as a visible sign of Christian conversion and proper behavior. Missionaries believed that a true Christian should dress in a European style and keep most of the body covered.[373] Local modes of dress and bodily exposure were commonly read as indicators of spiritual weakness and heightened physical risk. Missionary writings often described African bodies as "half-naked," usually covered by only one piece of cloth, and interpreted this condition as evidence of vulnerability to illnesses such as pneumonia, bronchitis, rheumatism, chest infections, and general

[372] Hardiman, *Healing Bodies and Saving Souls*, 14.

[373] Rungwe Archive and Museum Center (hereafter RAMC), *Medical Health Report at Rungwe Mission*, Reg. Vol. 3. no. 134 (1904), n.p. The report links bodily exposure and non-European dress to moral and physical vulnerability, reflecting the missionary belief that proper Christian conduct required European-style clothing and bodily coverage; such assumptions framed health and morality through European cultural norms rather than local understandings.

bodily weakness.[374] European-style clothing was thus presented as a visible marker of moral progress and Christian respectability, while insufficient clothing and body exposure was framed as evidence of moral, social, and bodily deficiency. Efforts to reform dress became a key component of missionary medical work, reflecting a broader assumption that health, discipline, and moral order were deeply interconnected and could be read directly from the body. In this context, scholars such as Jean and John Comaroff have suggested that clothing within African mission spaces functioned as a component of the "politics of the civilized body."[375] Garments came to signify Christian conversion while simultaneously shaping everyday conduct, promoting self-discipline, and reinforcing the authority of missionaries over local bodies and social practices.

Missionaries conveyed the notion that becoming a Christian also meant becoming 'civilized', which, in practice, entailed adopting the behaviors and habits of the missionaries themselves. In an effort to shape and regulate African bodies, they established *Nähschulen*, or sewing schools, within mission stations as instruments for the broader transformation of local communities.[376] Within the Bena-Hehe and Konde Synods, Berliner Lutheran missionaries founded sewing schools in Yakobi, Kidugala, and Ilembula, while the Moravians maintained a similar institution at their

[374] RAMC, *Medical Health Report at Rungwe Mission*. For an illustrative example, see Archiv des Berliner Missionswerk (BMW) 2/530, *Milow, Africa*, depicting a partially unclothed woman receiving dental treatment from a local practitioner in Milow village. Missionaries frequently interpreted such bodily exposure as evidence of both "heathen" custom and heightened susceptibility to illness. See also, Illiffe, *Modern History*, 97.

[375] Comaroff and Comaroff, *Of Revelation and Revolution*, 254-256.

[376] For discussions of the *Nähschule* (sewing schools), see Anna Zeeb, *Nach Deutsch Ostafrika: Reisebriefe von Frau Missionar A. Zeeb* (Herrnhut: Missionsbuchhandlung der Missionsanstalt der Evang. Brüderunität, 1899), 66-67 and Carl Schultze, *Der Njasabund*, 87-90. However, other missionaries, such as Gustav Warneck, held a different view. While he considered clothing an important tool for promoting Christian ideas of modesty, he argued that Africans did not need to adopt European styles of dress. For Warneck, the most important thing was that the body was properly clothed, rather than the specific style or appearance of the clothing. See Gustav Warneck, *Modern Missions and Culture: Their Mutual Relations* (Edinburgh: R. W. Hunter, 1883), 41-43. Gustav Warneck (1834-1910) was a German Lutheran pastor and a central figure in nineteenth-century Protestant mission theory. As a professor of missiology and the founding editor of the *Allgemeine Missionszeitschrift* (*General Missionary Journal*), he played a major role in shaping missionary views on education, morality, and cultural adaptation. On his influence, see Best, *Heavenly Fatherland*, 6, 24; see also Gustav Warneck, *Zur Abwehr und Verständigung: Offener Brief an Herrn Major von Wissmann* (Gütersloh: Bertelsmann, 1890).

headquarters in Rungwe.[377] This form of education was considered most effective when directed at young girls, who were therefore instructed in stitching, cloth-making, and other forms of feminine handiwork.[378] Both Moravian and Lutheran missionaries shared the belief that the most effective means of influencing Africans was to "mould them when young," and enrollment in sewing schools was accordingly prioritized for children.[379] Mirbt observed that "[the sewing] school is for [the missionaries] the means … to gain influence on the youth," further noting that "the mission school, at least in its simplest form, is primarily aimed at young people, although it can happen that people as old as forty wish to take part in the lessons."[380] Education, in this sense, functioned as a tool of evangelization, with children regarded as the most receptive recipients of Christian instruction.[381] Youth education thus formed a cornerstone of missionary strategies to transmit Christian doctrines, shaping both literacy as well as the moral and social formation of young people. Through sewing schools, missionaries regulated clothing, hygiene, and behavior, embedding European standards of civility and piety within local communities. In doing so, they transformed education into a mechanism for broader cultural and religious influence, producing generations aligned with the missionaries' vision of Christian society.

Nevertheless, missionaries reached only a relatively narrow segment of the African population, primarily those who lived in or around mission stations. Sewing schools and similar institutions therefore enrolled mainly orphans, children of former slaves, or girls drawn from families already entangled in missionary networks.[382] In some cases, missionaries pressured African households to send particular children to these schools, especially when they sought to demonstrate the success of their educational programs. Expanding participation in missionary education proved difficult. Some African parents openly distrusted mission schools, viewing them as spaces of cultural

[377] See Merensky, *Deutsche Arbeit am Njaßa*, 171-172 and also Zeeb, *Nach Deutsch Ostafrika*, 6, describing a missionary encounter in Rungwe addressing clothing at Moravian mission station.
[378] Hamilton, *A History of the Missions of the Moravian Church*, 155.
[379] Zeeb, *Nach Deutsch Ostafrika*. See alsoMerensky, *Deutsche Arbeit am Njaßa*,
[380] Mirbt, *Mission und Kolonialpolitik*, 143.
[381] Best, *Heavenly Fatherland*, 66.
[382] A. L. Sakafu, "The pastor: Yohane Nyagava", in *Modern Tanzanians* (Nairobi: East African Publishing House, 1973), 193-194.

disruption or social control rather than opportunity. In response, missionaries sometimes relied on material inducements, such as sweets, biscuits, pieces of cloth, or garden produce, to attract children.[383] At other times, they resorted to coercion, forcibly bringing children to school.[384] These strategies reveal both the ambitions and the constraints of missionary authority. While missionaries sought to reshape African childhood, gender roles, and moral conduct through education, their success depended heavily on negotiation with African families and communities, whose cooperation remained conditional and selective. Christianization and cultural change thus unfolded unevenly, shaped not by missionary intent alone but by local resistance, accommodation, and strategic engagement.

Within this broader context of negotiated missionary authority and uneven participation in mission education, the role of German women acquired particular importance. As missionaries struggled to extend their influence beyond the immediate surroundings of mission stations, sewing schools and girls' institutions emerged as key spaces through which they sought to shape everyday behavior, moral sensibilities, and bodily practices. German women, working as nurses, teachers, and missionaries' wives, occupied an ambivalent position within this project. Their presence lent a distinctly gendered legitimacy to missionary education, especially in matters of domesticity, hygiene, and discipline, which missionaries regarded as essential markers of Christian womanhood.

At the same time, the reach of German women's work remained structurally constrained. By 1914, women constituted only about twenty percent of the European population in East Africa, limiting both the scale and consistency of their engagement.[385] Most German women arrived in the Southern Highlands alongside

[383] Otto Raum, *Changes in African Life* (London: Oxford University Press, 1939), 203.
[384] Koponen, *Development for Exploitation*, 504.
[385] Wolfgang U. Eckart, *Medizin und Kolonialimperialismus: Deutschland 1884-1945* (Paderborn: Schöningh, 1997); Philippa Söldenwagner, *Spaces of Negotiation: European Settlers and Settlement in German East Africa, 1900-1914* (München: Peter Lang GmbH, 2006), 79. See also, Otis Illert, *Settler and Administration Antagonism in Colonial German East Africa, 1885-1925 (Unpublished PhD Diss., University of Cambridge, 2022), 49.*

their husbands,[386] while only a small number traveled independently, primarily as trained nurses. Missionary organizations such as the Nyasa Women's League, closely affiliated with the German medical mission movement, sought to address these limitations by dispatching single women to serve in educational and medical roles. Berliner Lutheran women such as Elise Franke and Anna Böhlau exemplify this cohort.[387]

The operation of sewing schools within German missions highlights the important role of women in shaping both educational practices and moral formation in colonial contexts. Anna Böhlau, stationed at Yakobi in 1911, provides a clear example of this influence, guiding young girls in needlework, embroidery, and garment making (see Figure 1) Pastor Erich Schultze documented Sister Böhlau's account of the sewing classes she oversaw, conveying her enthusiasm in a letter to the Nyasa Women's League: "The young girls are all sewing with zeal and joy; soon we will be able to send you a finished sewing cloth for you to view … If you sew badly, the people in Germany will laugh at you."[388]

It is fair to argue that Böhlau's words convey more than teaching instructions; they reveal a connection between local practice and global audiences, showing how the girls' work was shaped by European moral and cultural expectations. The sewing classes provided the girls with practical skills, social recognition, and a sense of belonging to a network beyond their immediate community, while also instilling discipline, aesthetic refinement, and moral responsibility. Thus, by examining these sewing schools, we can see how the education of girls, the work of women missionaries, and broader cultural exchanges intersected in the colonial Southern

[386] In the early twentieth century, colonial governments banned marriages between Germans and colonial subjects, notably in German Southwest Africa in 1905 and in German East Africa in 1906. These bans coincided with, and contributed to, a rise in the number of German women traveling to the colonies. Officials justified the policies by arguing that interracial marriages would weaken racial boundaries, create uncertain legal statuses for mixed-race children, and undermine white authority and prestige. Within this thinking, German women were expected to help stabilize colonial society by maintaining racial separation and upholding the moral order on which colonial rule relied. For more discussion see Ulrike Lindner, *Koloniale Begegnungen: Deutschland und Großbritannien als Imperialmächte in Afrika 1880-1914* (Frankfurt am Main: Campus Verlag, 2011), 323-24; and Lora Wildenthal, *German Women for Empire, 1884-1945: Politics, History, and Culture* (Durham: Duke University Press, 2001), 125-26.
[387] Schultze, *Der Njaßabund*, 11, 17, and 22.
[388] Schultze, *Der Njaßabund*, 89.

Highlands. These spaces demonstrate how everyday learning and labor linked local experiences with transnational missionary ideals.

Figure 13: Sister Anna Bohlau's Sewing School in Yakobi[389]
Source: Eric Schultze, *Der Njaßabund : Bilder Aus Der Weiblichen Liebestätigkeit Der Berliner Mission in Deutsch-Ost-Afrika* (Berlin: Evangelische Missionsgesellschaft, 1912), 89.

Moreover, letters from missionaries such as Gertrud Döhring of the Kidugala mission further shows the significance of these initiatives. Writing to the Berlin Women's Missionary Association, Döhring emphasized the engagement of girls in the sewing classes: "In the sewing class, the girls remain fully engaged, practicing a variety of sewing and decorative stitches on a piece of fabric that will eventually be

[389] Although sewing was commonly gendered as women's work among Berliner Lutherans communities in the region, this distinction did not apply uniformly in Moravian mission practice, where sewing was treated primarily as a technical and economic skill rather than a domestic one. Therefore, male students were trained to repair garments, produce uniforms, and work as tailors within mission economies. See Appendix, 222.

made into a needlework bag."[390] Her observation highlights how sewing instruction functioned as an educational and social tool, fostering handiwork, creativity, and focus while producing tangible items that reflected accomplishment and moral discipline. These letters also reveal the broader networks of accountability and communication linking local mission activities to European boards, showing how everyday labor in the sewing schools was embedded within transnational missionary expectations and strategies. Beyond skill acquisition, the sewing classes provided spaces for girls to gather, build social relationships, and engage with the moral and cultural ideals promoted by the missions, creating a foundation for wider social and educational influence.

Missionaries consistently recognized women as central to social and medical reform. A Berliner Lutheran nurse stationed at Ilembula observed in her 1936 medical report, "women hold the true strength of the community; the wellbeing of the home and the village depends upon them."[391] Sewing classes, alongside other educational and social initiatives, were part of a broader strategy to empower women as agents of transformation within both the domestic and public spheres. By cultivating practical skills, moral discipline, and social engagement, missions positioned women at the heart of communal wellbeing and the missionary vision of societal improvement. These programs also facilitated women's interaction with medical services, building trust and confidence in spaces previously dominated by male personnel, and thereby contributing to the gradual integration of health, education, and social reform within the local communities. In this way, women became vital intermediaries, linking daily domestic life with the broader moral, educational, and medical objectives of German Protestant missions in colonial Southern Tanzania.

Building on this centrality of women in mission work, the methods by which they were taught further reflected missionaries' pragmatic approach to education and social transformation. Over time, both Berliner Lutheran and Moravian missionaries came to accept that effective teaching depended on what they often described as

[390] BMW 1/6007, *Tagebücher Kidugala*, 1929–1939, p. v; letter from Gertrud Döhring, Kidugala Mission, to the Board of the Berlin Women's Missionary Association.
[391] BMW 1/6026, *Berichte der Missionstation Lwamate*, vol. 1, A.A. Sign. III 9.10 (1913–1914).

educating Africans "by means of Africans."[392] In sewing schools, this approach translated into lessons conducted largely in local vernacular languages, a practice that eased comprehension and helped maintain order among young girls, many of whom had only limited or irregular exposure to formal schooling. A similar pattern emerged in mission primary schools, where instruction in the lower classes relied heavily on local languages, with Kiswahili introduced gradually at more advanced levels.[393] The use of vernacular languages therefore represented a practical teaching strategy rather than a genuine effort at cultural accommodation. Missionaries adopted local languages because they faced limits in authority and needed workable methods for daily instruction. Colonial officials, however, approached this linguistic focus with caution. They regarded literacy training in African languages as less useful, since students educated mainly in vernaculars often struggled with the administrative lingua franca.[394] As a result, officials questioned the value of mission schools as effective training centers for clerks, interpreters, and other colonial intermediaries required by the state.

This pragmatic reliance on vernacular languages drew on broader missionary practices across German Protestant missions in colonial German East Africa. For many missionaries, including those of the Leipzig Mission in northern colonial Tanzania, learning local languages provided the most effective means of communication in everyday life. Missionary records indicate that proficiency in indigenous languages supported preaching, teaching, and routine interaction with local communities, and functioned as a sustained element of missionary practice rather than a temporary measure.[395] A comparable approach shaped missionary work

[392] See the Moravian Bishop Paul Hennig in 1907, as quoted in Wright, *German Missions,* 115. See also Johanna Eggert, *Missionsschule und sozialer Wandel in Ostafrika: der Beitrag der deutschen evangelischen Missionsgesellschaften zur Entwicklung des Schulwesens in Tanganyika 1891-1939* (Bielefeld: Bertelsmann Universitätsverlag, 1970), 111, 137-138.
[393] Eggert, *The School Policy of the German Protestant Missions,* 204-206.
[394] Colonial officials often viewed literacy training in African languages as a limitation rather than an advantage. From their perspective, mission-educated students who lacked proficiency in the administrative lingua franca were less suitable for employment in secular intermediary roles. This raised doubts about the practical value of mission schools as reliable sources of clerks, interpreters, and other colonial auxiliaries. The reference is to, Wright, *German Missions in Tanganyika,* 133.
[395] Döhring, *Hohenfriedeberg*, 4; Albrecht Hofstätter, *Kwarango, die erste Station der Leipziger Ev-Luthersichen Mission in Deutsch-Ostafrika* (Leipzig: Verlag der Evangelisch-Lutherischen Mission, 1895), 30. See also Comaroff and Comaroff, *Of Revelation and Revolution,* 216.

in the Southern Highlands, where Berliner Lutheran missionaries invested considerable effort in learning local languages. This commitment found clear expression in the work of Alexander Merensky, a German missionary and ethnographer whose experience in southern Africa later extended to the Southern Highlands of Tanzania. Merensky prepared explanatory guides and linguistic analyses to support incoming missionaries, including a study of the so-called *Kondesprache*, the language of the Nyakyusa. He presented this linguistic work as part of a broader reflection on effective missionary practice and communication in the region.[396]

Building on their commitment to vernacular education, many missionaries deliberately sought to limit the use of Kiswahili, instead placing local community languages at the center of both schooling and evangelism. They believed that true moral and spiritual transformation could only occur through engagement with the cultural and emotional worlds of African communities, rather than through foreign languages.[397] German Protestant missions, in particular, were among the most determined opponents of Kiswahili for evangelizing purposes. As Iliffe noted, their approach was strongly shaped by Gustav Warneck's *Volksmission* (mission to the people) ideology, which argued that "every human group had a distinctive culture to which Christianity should be adapted."[398] From this perspective, teaching and preaching in people's "mother tongue" was essential for reaching their hearts and minds, while a lingua franca like Kiswahili was seen as insufficient for touching the inner life of converts.[399] Missionaries also feared, especially from 1910 onwards, that

[396] Merensky, *Deutsche Arbeit am Njaßa*, 360-363.
[397] German Protestant missionaries in East Africa created an extensive collection of literature in local African languages, encompassing religious texts, schoolbooks, and periodicals resembling newspapers. The majority of these works were produced at mission-run printing presses. For a detailed catalog of titles produced by all missionary societies as of 1914, see *Führer durch die evangelischen Missionen in Deutsch-Ostafrika* (Wuga, Usambara: Missionsdruckerei, 1914).
[398] Iliffe, *Modern History of Tanganyika,* 218.
[399] See Ali A. Mazrui and Pio Zirimu, "Church, State, and Marketplace in the Spread of Kiswahili: Comparative Educational Implications," in *Case Studies in Bilingual Education*, ed. Bernard Spolsky and Robert L. Cooper (Rowley: Newbury House Publishers, 1978), 431-2. See also Wright, *German Missions in Tanganyika 1890-1940*; 108-111.

the widespread use of Kiswahili could facilitate the spread of Islam, given its strong association with Muslim communities along the coast.[400]

At the same time, figures such as Carl Meinhof recognized the practical limitations of linguistic idealism. Meinhof considered broad instruction in German impractical, recommending it only for a select group of students deemed "exceptionally intelligent and dependable."[401] Similarly, while Kiswahili was deliberately restricted for moral and spiritual instruction, it was not entirely avoided. Most missions incorporated Kiswahili as a language of instruction, particularly for administrative purposes, basic literacy, and communication between communities with different local languages.[402] This careful balance reflects the pragmatic negotiation between missionary ideals and practical realities: missionaries sought to engage deeply with local cultures and languages, while simultaneously recognizing the utility of Kiswahili and German for broader educational, social, and administrative purposes. In this way, language in German Protestant missions became both a tool for cultural connection and a site of negotiation over the proper means of teaching, evangelizing, and shaping community life.

5.2 Christian Villages and Housing as Visible Markers of Moral Progress

When missionaries entered the region and began evangelizing local communities, they soon recognized that reliance on biblical instruction alone rarely generated mass Christianization. Consequently, the provision of medical care emerged as a particularly effective strategy for attracting Africans to mission stations. This shift signaled an early recognition that conversion unfolded through embodied experience rather than belief alone. As discussed in previous chapters, closer engagement with

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[400] Marcia Wright, "Swahili Language Policy, 1890-1940," in *Swahili*, XXXV (1965), 3; See also Anthony Smith, "The Missionary Contribution to Education (Tanganyika) to 1914," in *Tanganyika Notes and Records*, 60, (1963), 94.

[401] Carl Meinhof, *Deutschlands Pflichten in Afrika* (Hamburg: Deutsch Evangelischer Laien-Missionsbund, 1912), 359.

[402] For a more detailed discussion of the language of instruction in colonial German East Africa and its broader social and educational implications, see Marcia Wright, "Swahili Language Policy, 1890-1940," *Swahili* XXXV (1965); Anthony Smith, "The Missionary Contribution to Education (Tanganyika) to 1914," *Tanganyika Notes and Records* 60 (March 1963); and also Edward Alpers, "Towards a History of the Expansion of Islam in East Africa: the Matrilineal People of the Southern Interior," in *The Historical Study of African Religion*, ed. T. O. Ranger and I. N. Kimambo (Berkeley: University of California Press, 1972).

local populations gradually positioned missionaries in competition with established authorities, especially elders, chiefs, and local healers who exercised influence over health and spiritual well-being. However, this contest for authority confined missionary influence largely to Africans living in or near mission stations, where missionary presence could be sustained and supervised.[403]

As missionary ambitions expanded, conversion increasingly appeared as a comprehensive reordering of social life rather than a narrow acceptance of Christian doctrine. Africans who embraced the Gospel and adopted a Christian identity often experienced growing separation from their home communities. Without doubt, many converts faced social exclusion and persecution from non-converted peers, as their new convictions conflicted with practices missionaries categorized as 'pagan'. Altogether, conversion reshaped patterns of belonging, authority, and everyday conduct, producing new moral boundaries within African societies.

In response to these tensions, German missionaries promoted the formation of Christian villages modeled closely on mission stations. In Ubena, Lutheran missionaries intentionally established such villages on mission-owned land, explicitly aiming to separate converts from the wider social environment. These settlements deliberately distinguished converts from non-converts and instituted an alternative social and spatial order grounded in Christian values.[404] Besides offering protection, Christian villages functioned as carefully regulated spaces of moral formation in which missionaries sought to reorder African life through space, routine, and material form. Their layout, housing structures, and every day practices rendered Christianity visible and legible, signaling a distinct Christian identity to residents and outsiders.

However, this approach was not uniform across missionary traditions. The Moravians sought to avoid strict spatial separation and expressed reservations about physically isolating converts from surrounding communities.[405] Nevertheless, among

[403] Wright, *German Mission in Tanganyika,* 86; see also Iliffe, *A Modern History of Tanganyika*, 228.
[404] Wright, 79-84; see also, Iliffe, 231.
[405] Musomba, *Historia Fupi Ya Kanisa La Moravian Kusini Tanzania*, 43.

the Nyakyusa, patterns of settlement already favored collective residence, as groups of friends customarily built and settled together. Within this social framework, converts, commonly referred to as "the new people", came to form clearly recognizable communities of their own, even in the absence of formal missionary planning.[406] Altogether, Christian villages emerged through a combination of missionary spatial strategies and existing African settlement practices, shaping how conversion became socially and materially visible. In this setting, housing emerged as a central instrument in the broader civilizing project.

This emphasis on housing reflected a deeper belief that moral transformation required changes in material life. Africans living in Christian villages were encouraged to build permanent houses rather than temporary huts, marking a significant shift in settlement patterns and domestic life. Permanent dwellings introduced stability and regularity into everyday routines, placing families within a spatial framework that missionaries could observe, organize, and regulate. From a theoretical perspective, this process closely resembled what studies of colonial governance described as spatial discipline, in which architecture and settlement design functioned as tools for shaping behavior and producing compliant colonial subjects.[407]

Housing built from durable materials facilitated the introduction of standards related to cleanliness, ventilation, and interior organization. Missionaries associated these features with improved health, moral discipline, and Christian respectability. Besides this, permanent housing enabled reforms concerning hygiene, family relations, labor habits, and religious observance to become embedded in daily routines. Fixed residences supported the extension of medical and religious services alike, as they allowed missionaries to conduct regular visits, establish predictable schedules, and monitor household practices. Over time, the built environment itself became a

[406] For the Nyakyusa pattern of settlement, especially the *age-village* residential system and the founding, movement, and internal organization of villages, see Monica Wilson, *Communal Rituals of the Nyakyusa*, 166-74; and also Monica Wilson, *Good Company: A Study of Nyakyusa Age-Villages*, esp. chap. 2, "Village Organization" and chap. 7, "Characteristics of an Age-Village Organization."
[407] For more discussion about this see, Comaroff and Comaroff 1992, 279-280 and Koponen, *Development for Exploitation, 216.*

medium through which Christian norms structured space, organized time, and reshaped community life.

Christian villages were designed not only as spaces of instruction and moral formation but also as visible models intended to attract non-converts. Missionaries believed that orderly streets, well-maintained houses, and the material stability of village life would communicate the benefits of Christianity in concrete and observable ways.[408] The appearance of cleanliness, regularity, and permanence was expected to signal spiritual transformation as well as social progress. In this way, the built environment itself functioned as a form of evangelization, presenting Christian life as orderly, desirable, and materially grounded, and encouraging outsiders to engage with the mission and its message.

Within these settlements, residents were expected to wear European-style clothing; practice regular hygiene such as washing clothes[409] and builds latrines for each household. These practices were presented as markers of moral and spiritual improvement. At the same time, missionaries used housing reform to address what they described as the moral weakness among African men. In missionary discourse, traditional dwellings appeared as poorly ventilated, smoke-filled, and unhygienic, and such environments were closely linked to illness, particularly eye diseases frequently cited in mission medical reports.[410]

Conditions that were likely caused by dust, indoor smoke, and inadequate ventilation were thus reinterpreted through a moral and spiritual lens. Poor health was framed not as the result of environmental exposure but as evidence of ethical disorder and cultural backwardness. By producing this knowledge about African housing, missionaries sought to justify their interventions and reinforce their authority over both bodies and spaces. The transformation of domestic architecture was therefore

[408] See Schultze, *Der Njaßabund*, 83.
[409] See Figure 14, photograph depicting a female missionary, Elizabeth Marie Bachmann, with local residents at Isoko engaged in everyday laundry work. IMPA,University of Southern California Libraries, Tanzania. https://coilink.org/20.500.12592/7f6pvt
[410] With nearly 600 cases of eye problems recorded at Ilembula alone in 1937. See BMW *Mischband* 1905-1939, vol. III, No. 5. "Report on the Sick in Ilembula from 15 July to 30 September 1935," by Nurse Gertrud Döhring.

expected to achieve multiple goals: improving health, enforcing Christian morality, reshaping gender relations, and producing disciplined communities aligned with missionary ideals.

Converts living in Christian villages were actively encouraged to adopt what missionaries described as more "civilized" ways of life, which were presented as visible markers of a new Christian identity. These expectations included adherence to European standards of cleanliness, personal hygiene, domestic arrangements, dress, and the regulation of daily time through punctuality and structured routines.[411] Such practices were framed not only as moral or spiritual improvements but also as tangible evidence of conversion and discipline.

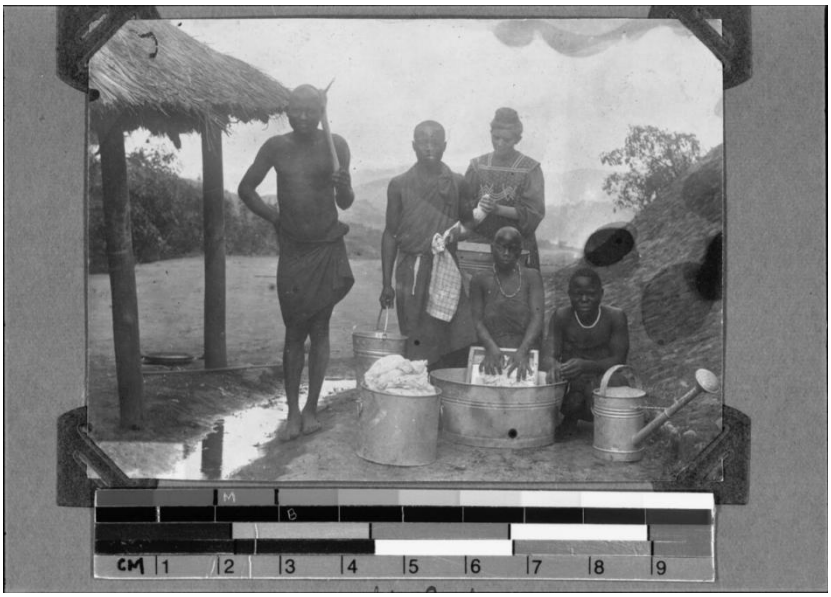

Figure 14: Laundry Work Performed by Local African Women under Missionary Supervision of Elisabeth Bachmann in Isoko, ca. 1908–1916.

Source: International Mission Photography Archive, University of Southern California Libraries.

Besides signaling religious identity, missionaries justified these standards as solutions to perceived medical and sanitary challenges. To ensure compliance,

[411] See Schultze, *Der Njaßabund*, 86-87.

Christian villages were placed under the supervision of African deacons. These men, selected from among respected converts, received religious instruction and were regarded as morally reliable and socially disciplined.[412] Their responsibilities extended beyond spiritual leadership to the supervision of daily village life. They monitored cleanliness, housing standards, attendance at worship, work schedules, and general conduct, ensuring conformity with missionary expectations.

Medical missionaries relied on African deacons for both practical and ideological reasons. Practically, missionaries depended on intermediaries who possessed cultural familiarity and continuous presence. Ideologically, deacons embodied the claim that Christianity produced African subjects capable of self-regulation and moral authority. This arrangement shifted discipline inward, as converts increasingly policed one another. Altogether, deacons became central figures in the governance of Christian villages, mediating between missionary authority and local social structures.[413]

Writing from within the mission field of the Bena-Hehe Synod, Gröschel described deacons as key actors in village governance rather than assistants limited to religious instruction. His account emphasizes their administrative authority and disciplinary responsibilities:

> The office of deacon is an unpaid helper position. The main task of the deacons is to see that everything is done honestly and orderly within the station village, especially the huts of Christians and catechumens. They have to settle and resolve small incidents there. If I am absent, they have to hold the short public morning service. I also want them to advise and assist me in choosing catechumens for the baptismal class. This is the beginning of an orderly community, care of its members from within.[414]

Gröschel's description highlights how missionary governance depended on localized leadership. Deacons exercised authority grounded in social familiarity as well as

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[412] Hans Weishaupt, *The German Protestant Missions in German East Africa* (Leipzig: Evangelisch-Lutherische Mission, 1913), 50ff.
[413] Richard Mathew Lubawa, *"The Missing Link: Indigenous Agents in the Development of the Iringa Diocese of the Evangelical Lutheran Church of Tanzania (ELCT), 1899–1999"* (PhD diss., School of Theology, University of Natal, Pietermaritzburg, 2003), 132ff.
[414] Gröschel, *Zehn Jahre Christlicher Kulturarbeit in Deutsch-Ostafrika*, 139-140.

religious legitimacy. Their role illustrates how Christian villages relied on African actors to translate missionary ideals into everyday practice. In this way, African agency operated within missionary frameworks, shaping how Christian norms were applied, negotiated, and enforced.

For missionaries, the establishment of Christian villages represented a visible measure of success. Missionary satisfaction increased as settlements came to resemble European towns in layout and architecture. Square-shaped houses built in European styles symbolized order, discipline, and progress, reinforcing the belief that Christianity and civilization advanced together. Observations by Christian Schumann at Lupembe reflect this conviction, as he linked proximity to mission stations with improved health, housing, dress, and agricultural productivity. Schumann lamented that;

> The closer one gets to a mission station, the more one notices that the natives enjoy better health, that the huts are better built, the people are more decently dressed, and the fields are more diligently cultivated. This is indeed the case: the natives on the station itself very quickly provide themselves with clothing, that they build better huts, and that they gladly accept all kinds of seed from the Europeans and try to sow it. The relatives living further away then imitate this with more or less skill. Added to this is the influence and example of the helpers on the outlying sites.[415]

Within this missionary framework, improved housing became closely associated with moral and cultural advancement. Converts began to modify how they built their homes, replacing grass huts with structures made from wood, stone, and brick. Many acquired these building techniques through hands-on participation in the construction of mission buildings alongside European missionaries.[416] Through this practical involvement, they gained new skills that they adapted and applied to their own dwellings.[417] Over time, these changes reshaped the appearance of villages and

[415] Schumann, *25 Jahre Berliner Mission in Deutsch-Ostafrika*, 50.

[416] See, for example, Figure 15, which depicts members of the Moravian congregation of Utengule constructing a new house for their local preacher, Sakalija Mwakasungula.

[417] For missionaries, changes in building materials and construction practices signaled the emergence of organized Christian communities. Missionary writings from the early period consistently emphasized these material developments as indicators of religious and social transformation. For illustrative examples, see Martin Klamroth, *Auf Berg Pfaden in Deutsch Ost-Afrika: Bilder aus den Anfängen evangelischer Missionsarbeit unter den Pangwa am Nyassa* (Berlin: Buchhandlung der Berliner evangelischen Missionsgesellschaft, 1904), 58-61. Likewise, Sundkler and Steed note that

reflected broader social and cultural transformations shaped by both missionary influence and African choices about how to live as Christians.

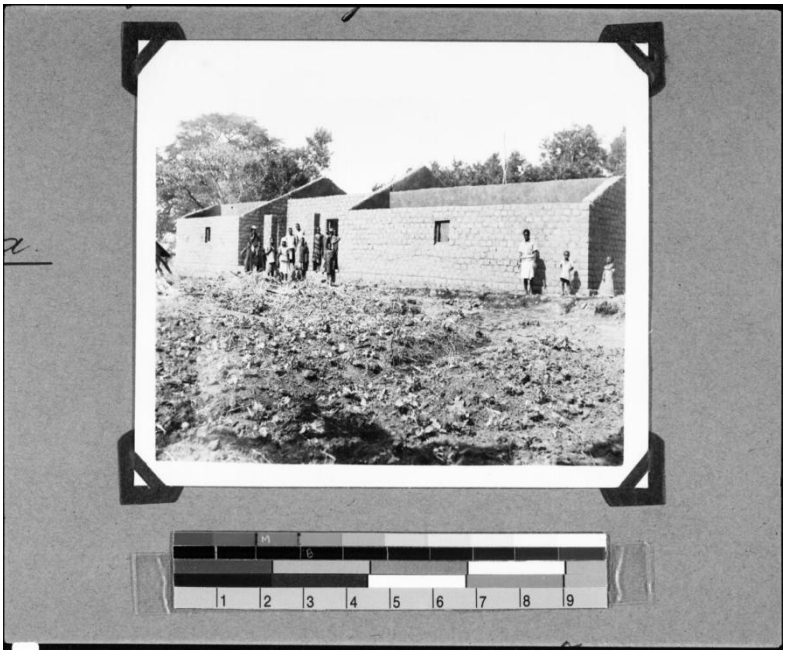

Figure 15: People in Front of a Newly Built House, Utengule, Mbeya region, January 1937[418]

Source: International Mission Photography Archive, University of Southern California Libraries.

Interview from retired pastors strongly supported what archival materials revealed about Christian social change in the colonial southern Highlands of Tanzania. An interview with Yohana Lupenza, a retired pastor of the Bena-Konde Synod, now in his mid-eighties, confirmed that by the late 1950s and following Tanganyika's

Shambaa villages in the Berlin III mission field were distinguished by their well-constructed brick houses. See also *The History of the Church in Africa*, 546.

[418] The photograph shows men, women, and children of the Moravian congregation in Utengule standing before the brick walls of a newly constructed house in 1937, still without a roof, built collectively for their local preacher, Sakalija Mwakasungula, illustrating communal labor and congregational support within Moravian mission life. See Theodor Tietzen, *People in Front of a Newly Built House, Utengule, Tanzania*, January 1937, photographic print, International Mission Photography Archive, Moravian Church (Herrnhut subcollection), https://doi.org/10.25549/impa-m11573

independence in 1961, Christian conversion was closely associated with visible changes in everyday life. Lupenza recalls that, when a person converted to Christianity, the change was expected to be clearly visible in behaviour, dress, and domestic life. Converts were expected to abandon older customs and adopt what was understood as a Christian way of living. Clothing became more modest and cleaner, and personal conduct was expected to reflect Christian values such as discipline and order.[419]

Most importantly, Lupenza emphasizes that conversion was understood to require visible change, beginning with the house itself. A Christian household was expected to reflect new moral and social standards, including order, cleanliness, and adherence to Christian norms of conduct. He recalls that Christians often lived in designated areas known in the Bena language as *lugelele*, meaning streets or settlements where Christians resided together. These spaces were deliberately organized to encourage collective discipline and mutual accountability. Each *lugelele* was overseen by a deacon, whose responsibilities included supervising daily behavior, ensuring participation in prayer and instruction, and reporting serious misconduct to church authorities.[420] In this way, religious life was closely embedded in the spatial and social organization of the community. These *lugelele* existed in many parts of Ubena where Christianity had a strong influence. Living in or near a *lugelele* implied an obligation to adopt Christian standards of housing and lifestyle. Houses were organized in new ways, with separated rooms and an emphasis on cleanliness, order, and permanence.[421] In this sense, space and settlement functioned as tools for shaping Christian identity.

A similar memory is shared by Gordon Mwakapeje, a retired minister of the Konde Synod and a member of the Nyakyusa community in Kyela District, now also in his mid-eighties. He recalls that during the late British colonial period of the 1950s,

[419] Yohana Lupenza, interview by the author. Kidugala, Wanging'ombe District, June 18, 2025.
[420] Such cases were reported to church leaders and discussed within the Congregational Church Council. In this council, the names of African Christians who were found to have violated church principles or committed sins were formally presented for hearing and judgment. The council examined these cases, determined appropriate disciplinary measures, and reinforced moral accountability within the Christian community.
[421] Yohana Lupenza, interview by the author. Kidugala, Wanging'ombe District, June 18, 2025.

Christian villages were deliberately used to attract non-converts.[422] These villages stood out because residents were well dressed, particularly on Christmas Day, when people wore new clothes and attended church services together. Houses in these villages were well organized and typically included latrines, kitchens, separate rooms, and raised beds.

Mwakapeje stresses that such housing standards were found mainly in areas where Christians lived. He recalls that houses had proper windows, wooden doors, toilets, and clearly arranged domestic spaces. This was completely different from the houses of non-converts, which were usually small grass-thatched huts.[423] However, he notes that during the late 1950s up to independence most roofs were still made of grass, although from the 1970s iron sheets became increasingly common.[424] According to Mwakapeje, missionaries strongly encouraged this style of housing and were pleased to see Christian homes displaying such features.[425]

When considered together, these memories are closely aligned with earlier German Protestant missionary practices. Over roughly four decades of evangelization in the region, German missionaries introduced Christian villages and promoted specific housing forms as part of moral and religious discipline. Although these missions were taken over by Swedish missionaries after 1940, this chapter argues that the ideas introduced by the German missionaries did not disappear. Instead, African Christians themselves continued to value and reproduce these housing styles and

[422] Gordon Mwakapeje, interview by the author. Uyole, Mbeya Distict, 14 July, 2024.
[423] Gordon Mwakapeje, interview by the author. Uyole, Mbeya Distict, 14 July, 2024.
[424] This observation is consistent with research conducted in rural Kilombero District, which indicates that iron sheet roofed houses began to appear only in the 1970s. Their construction was largely confined to Christian households, as others feared that those who built such houses could be bewitched. These fears were based on accounts that people who constructed iron sheet roofed houses experienced unexplained misfortunes, including illness and death. Such interpretations persisted into the 1990s, leading many non-Christian households to continue avoiding the construction of well-built houses with iron-sheet roofs. See Luoneko Kaduma, 'Rural to Rural Migration and Local Economies: A Case Study of Kilombero District, Tanzania, 1960-2000' (Unpublished M.A thesis, (History), University of Dar es Salaam, 2019), 83-84.
[425] In addition to the retired Lutheran pastors, retired Moravian pastors articulated comparable perspectives on the establishment of Christian villages and the role of German Protestant missionaries in transforming the social life of local communities in the region. These views suggest a shared understanding among Protestant clergy regarding missionary strategies and their social implications. This analysis is based on interviews with retired Moravian pastors, notably *Mzee* (the elder) William Mwakikato, Iwambi, Mbeya District, February 29, 2023 and Angubwike Mwakatobe Lufilyo, Rungwe District, July 4, 2024.

settlement patterns. By the 1940s and even after independence, Christian villages and Christian housing remained powerful symbols of faith, progress, and respectability, even in the absence of direct German missionary supervision.

5.3 African Agency: Pastors, Evangelists, and the Mediation of Knowledge

5.3.1 Ambilishiye Mwachanila: African Evangelist and Cultural Mediator

Building on the broader discussion of missionary medicine and moral reform in the colonial Southern Highlands, this section shifts attention from institutional ambitions to the everyday actors who translated these projects into lived social practice. While European missionaries articulated the theological, medical, and moral frameworks of the mission enterprise, their realization on the ground depended heavily on African evangelists, pastors, and teachers embedded within village life and customary authority structures. These intermediaries did more than facilitate the transmission of missionary doctrine; through preaching, ritual negotiation, healing, and pastoral care, they actively interpreted, adapted, and at times reshaped Christian expectations in dialogue with indigenous moral worlds. Their work unfolded in intimate arenas of healing, family life, and communal discipline, where missionary ideals were negotiated against existing social norms.

It is primarily through the writings of Johann Traugott Bachmann that these processes of mediation and negotiation can be traced in the historical record. A Moravian missionary, Bachmann was dispatched to the region following the death of George Martin, a fellow missionary who was among the four earliest missionaries to enter the area and who died on 10 October 1891.[426] Bachmann served at the Rungwe mission station from November 1892 to 1899 and, in June 1899, founded a mission station in Mbozi, where he remained until 1915.[427] His missionary career was ultimately brought to an end during the First World War, when he was detained by British soldiers and compelled to cease his work and return to Germany.[428]

[426] See Musomba, *Historia Fupi Ya Kanisa La Moravian Kusini Tanzania,* 19. See also Mdegella Owdenburg, Samwel Kilimhana, and Obadiah Kasumba, *Karne Ya Kwanza Ya Injili, 1891-191: Kanisa La Kiinjili La Kilutheri Tanzania Ukanda Wa Kusini*, 16.

[427] See Musomba, *Historia Fupi Ya Kanisa La Moravian Kusini Tanzania*, 20-21.

[428] Periodic Accounts, Second Century (London: Moravian Church, 1905), 155; See also Musomba, *Historia Fupi Ya Kanisa La Moravian Kusini*. For discussions of the fate of German missionaries in German East Africa following the outbreak of the First World War, including their detention and

Bachmann left behind a substantial body of ethnographic observation that illuminates the everyday dynamics of the missionary encounter. Although his accounts were shaped by his position within the mission hierarchy, they nonetheless provide valuable insight into the ways African evangelists, teachers, and pastors enacted and reworked missionary ideals in local contexts.

In his correspondence and reports, Bachmann repeatedly emphasized the significance of African evangelists as cultural interpreters and social mediators within the missionary enterprise. He portrayed them as crucial knowledge brokers who bridged the gap between European missionary ideals and African social realities. As indigenous evangelists, pastors, and teachers, they translated Christian teachings into forms that resonated with local customs, moral expectations, and everyday experiences. Their work involved not only the transmission of religious doctrine but also the negotiation of meaning between distinct cultural worlds.

This mediating role is particularly evident in a letter sent to Bachmann on 29 January 1911 by Ambilishiye Mwachanila, an African evangelist stationed in Mbozi since 1904.[429] Although numerous African evangelists operated within the missionary field (see Figure 12), this study focuses on Ambilishiye because his correspondence provides an unusually rich and explicit articulation of the roles African evangelists played as cultural interpreters and social mediators. In his letters and reports, Ambilishiye did more than document missionary activities: he reflected critically on the spiritual, moral, and social conditions of his community and considered how Christian teachings might be meaningfully integrated into local life.

Throughout this study, he is referred to by his first name, 'Ambilishiye,' as this is the form most consistently used in the missionary records. In Kinyiha, the language spoken by communities in the Mbozi District in the Songwe region, the name means

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internment by British colonial authorities, restrictions on movement and communication, the confiscation of mission property, and eventual forced removal to Germany. See Wright, *German Missions in Tanganyika*, 143ff.; Iliffe, *A Modern History of Tanganyika*, 255; Owdenburg, Kilimhana, and Kasumba, *Karne ya Kwanza ya Injili*, 23ff.; Robert Strayer, *The Making of Mission Communities in East Africa* (London: Heinemann, 1978), 69; see also Herman Neuberg, *Historia Fupi ya Miaka 75 Sinodi ya Kusini, 1891-1966* (Peramiho, 1966), 15.

[429] See Traugott Bachmann *and Paul O. Hennig, Ambilishiye: Lebensbild eines eingeborenen Evangelisten aus Deutsch-Ostafrika. (Herrnhut: Verl. D. Missionsbuschh., 1921);* See also Hamilton, *Twenty Years of Pioneer Work in Nyasaland*, 138-139.

"he has called me loudly from far away."[430] This meaning resonated strongly with Christian notions of divine calling and vocation, a resonance that likely contributed to missionaries' preference for retaining and using the name in their records. Ambilishiye's name thus functioned as a point of convergence between local linguistic meaning and Christian interpretive frameworks.

Figure 16: Ambilishiye (on the right in the back) with fellow evangelists, Mbozi, Tanzania, 1911

Source: Traugott Bachmann, *Ambilishiye and Other Evangelists, Nyasa, Tanzania*, ca. 1899-1915, photograph, IMPA, University of Southern California Libraries, https://coilink.org/20.500.12592/wxnr4f

[430] This interpretation is based on an interview with Meshack Njinga, Assistant Bishop of the Evangelical Lutheran Church in Tanzania, Konde Diocese (Tukuyu–Rungwe), conducted on 9 October 2024, as well as conversations with Ndimbumi Mwambene in Tukuyu on 14 October 2024. See also, Traugott Bachmann, *Ambilishiye and Other Evangelists, Nyasa, Tanzania*, ca. 1899-1915, photograph, University of Southern California Libraries, https://coilink.org/20.500.12592/wxnr4f.

Working under the jurisdiction of Chief Mukoma, Ambilishiye described how Christianity was gaining acceptance among villagers. One convert, a woman named Ndonolilwe, had gained recognition following her baptism. Ambilishiye recounted an incident following her death on 1 January 1911. Before dying, Ndondolilwe expressed a final wish: she wanted to be buried in the white baptismal dress she had worn at her baptism.[431] This request provoked conflict between Christian ritual expectations and local burial customs enforced by the chief. As Ambilishiye explained, "In Chief Mukoma's land it is not allowed to bury anyone clothed in foreign cloth." In local understanding, "foreign cloth" referred to Western-style, mission-provided garments, which were traditionally prohibited in burial practices.[432]

Faced with this clash of ritual logics, Ambilishiye assumed the role of cultural and religious negotiator. He approached Chief Mukoma to request permission for burial in the baptismal dress, explaining that Ndondolilwe had died as a committed Christian and therefore deserved a Christian burial.[433] From the missionary perspective, the baptismal garment symbolized moral and bodily transformation into a new Christian identity. Medical missionaries of the period frequently linked dress reform to health reform. Converts were encouraged to wear clean, modest European-style clothing as protection against disease and exposure. Missionary efforts to instill values of cleanliness, domestic order, and proper dress were framed as benefiting both body and soul.[434] Ambilishiye would have been keenly aware of these symbolic and practical meanings embedded in the baptismal garment.

After a long discussion, Chief Mukoma granted permission for the burial to proceed according to Christian custom, temporarily setting aside the customary restriction on the use of foreign cloth. Ndondolilwe was laid to rest in her white baptismal dress, an act that carried deep symbolic weight within both the Christian and local moral

[431] Traugott Bachmannand Paul O. Hennig, *Ambilishiye: Lebensbild eines eingeborenen Evangelisten aus Deutsch-Ostafrika. (Herrnhut: Verl. D. Missionsbuschh., 1921), 27ff.*
[432] Bachmannand Hennig, *Ambilishiye.*
[433] Hamilton, *Twenty Years of Pioneer Work in Nyasaland*, 136-139.
[434] Jennings, "Healing of Bodies, Salvation of Souls". 27–56; see also, Linda Maria Ratschiller Nasim, *Medical Missionaries and Colonial Knowledge in West Africa and Europe, 1885–1914: Purity, Health and Cleanliness* (Cham: Palgrave Macmillan, 2023).

landscapes.[435] Therefore, in one way or another, this episode was not simply about clothing; it was about negotiating religious authority and moral legitimacy. An African evangelist successfully persuaded a traditional ruler to accommodate Christian ritual obligations without abolishing customary authority.

From the Ambilishiye account it revealed how African evangelists actively mediated between indigenous customs and the moral and medical regimes introduced by missionaries. Ambilishiye did not attempt to undermine the chief's authority or erase local custom. Instead, he engaged in procedural brokerage, a gradual process of negotiation grounded in dialogue, adaptation, and mutual recognition. Such encounters demonstrate that local evangelists and pastors were not passive recipients of missionary directives but active participants shaping the encounter between European health modernity and African social life.

The letter also reveals how Ambilishiye navigated competing explanations of illness and death. When rumors circulated that Ndonolilwe had died as a result of witchcraft, he challenged this dominant interpretation by reframing her death within a Christian narrative. He urged the community, "do not think … she died from sorcery." Instead, he presented her passing as a "good Christian death," marked by prayer and the singing of verses from John 11: 21-25, the biblical account of resurrection and eternal life.[436] Thus, Ambilishiye subtly displaced witchcraft as the primary cause of death without directly confronting local beliefs. Rather than condemning existing cosmologies, he reworked the logic of causation itself, transforming the death from an act of sorcery into a testament of divine providence. Therefore, this rhetorical move allowed him to maintain social cohesion while simultaneously reordering the moral and spiritual framework through which death was interpreted.

Through such acts of translation and negotiation, we can argue that local evangelists like Ambilishiye occupied a central, yet often under acknowledged position in the formation of missionary modernity. Rather than functioning simply as intermediaries who relayed missionary directives, they acted as interfacial figures who actively

[435] Hamilton, *Twenty Years of Pioneer Work in Nyasaland*, 138.
[436] Hamilton, *Twenty Years of Pioneer Work in Nyasaland*, 138.

mediated between ritual law and colonial mission legality, and between local cosmologies and Christian doctrines of health, death, and salvation. Thus, local evangelists should be understood not as passive conduits of missionary authority, but as critical agents who shaped how Christian moral and medical ideas were interpreted and enacted on the ground.

The work of figures such as Ambilishiye further demonstrates that the circulation of medical and moral ideas in colonial Southern Highlands of Tanzania was not a one-way process in which Europeans instructed and Africans received. While missionary discourse often framed African evangelists as assistants or auxiliaries, the evidence points to a more dialogical exchange shaped by adaptation, contestation, and reinterpretation.[437] Through practices such as conducting burials, participating in healing, and comforting the sick and dying, African evangelists actively shaped how Christianity and missionary medicine took root in local life. By linking Christian teachings to African understandings of health, suffering, and death, they assumed roles that were simultaneously spiritual, social, and epistemic. Thus, their actions transformed missionary medicine into a locally embedded practice shaped by African realities and lived experience.

5.3.2 Becoming Pastors: African Evangelists, Ordination, and Ecclesiastical Authority in Interwar Southern Tanzania

Before 1914, missionary work in the Southern Highlands of Tanzania had made significant progress. By this period, Berliner Lutheran mission had established 19 main stations, each supported by a network of smaller outstations in surrounding villages. Two Bible schools were already operating: one at Manow in the Konde Synod and the other at Kidugala in the Bena-Hehe Synod.[438] In addition, a total of 135 schools had been founded, enrolling approximately 6,000 students. Missionary activities also extended beyond evangelization and schooling to include vocational and technical training, most notably through the establishment of a shoe-making

[437] Oliver, *The Missionary Factor*, 195; see also Iliffe, *Modern History*, 172.
[438] In missionary archives, the Bena-Hehe Synod applied to the mission stations located in present-day Njombe and Iringa regions, whereas the Konde Synod referred to stations situated in what is now the Mbeya region. The reference is to, Kidugala Lutheran Seminary Archives, Bena-Hehe Synod Iringa 1936 and Minutes of Konde Synod 8-15/10/1926.

workshop and a printing press at Kidugala.[439] Moreover, in terms of church growth, 1,428 individuals had been baptized in the Bena-Hehe Synod, while the Konde Synod recorded a higher figure of 2,226 baptized converts.[440] This disparity can be explained by the fact that missionaries first established sustained contact with the Konde population upon entering the region in 1891, and also there was relatively strong involvement of local communities in mission activities in the area. Beyond the numerical growth of church membership, missionaries placed considerable emphasis on preparing converts for baptism. As a result, a total of 2,624 students across both synods were enrolled in baptismal instruction classes.[441]

Just as the evangelical work was expanding throughout the region, the First World War broke out in Europe and subsequently reached German East Africa. The German mission stations were affected from the early stages of the conflict. British forces attacked from the north and southwest, and eventually they managed to occupy all mission stations of the Bena-Hehe and Konde Synods without facing resistance. Meanwhile, the missionaries had gathered with their families, Berlin missionaries at Magoye in the Uwanji area, and Moravians at Rungwe. On 10 May 1916, they were deported.[442]

After the First World War ended in 1918, the German colony of East Africa was divided: Britain received a portion, which it renamed Tanganyika in 1922 under a League of Nations mandate, while Belgium was granted control of Rwanda and Burundi under similar terms.[443] With the expulsion of all German missionaries, there was no one left to supervise the Christian communities. The background reason for this situation is that throughout the pre-war period, German missionaries often regarded Africans as inferior and believed that they could accomplish little without European guidance.[444] As a result of that, when the German missionaries were forced

[439] Samwel Kilimhana, *Karne ya Kwanza ya Injili (100 Years of the Gospel), 1891-1991* (Dar es Salaam: Dar es Salaam University Press, 1991), 23-24.
[440] Mwaihabi, Mwaijega, and Mwampeta, *Miaka 100 ya Injili*, 16.
[441] Mwaihabi, Mwaijega, and Mwampeta, *Miaka 100 ya Injili*.
[442] Musomba, *Historia Fupi Ya Kanisa La Moravian Kusini Tanzania*, 56-57.
[443] Isaria Kimambo and Anorld Temu, *A History of Tanzania* (Dar es Salaam: East African Publishing House, 1969), 151. See also Koponen, *Development for Exploitation*, 560.
[444] Kimambo and Temu, *A History of Tanzania*, 131.

to leave, the urgent need for trained African leaders became clear. At the time, African clergy were limited to roles as evangelists and teachers, leaving the church without fully ordained pastors.[445]

Since neither the Moravian nor the Berliner missionaries had ordained indigenous pastors, the Scottish Missionary Society saw an opportunity to expand its influence in the region. Later that same year, following the expulsion of the German missionaries, James Hether Wick, Superintendent of the Scottish Missionary Society based in Blantyre, Malawi, wrote to the British colonial authorities requesting permission for the Scottish mission to take over the former German mission stations in Tanganyika.[446] The American Lutherans, who were active in northern Tanganyika at the time, also expressed interest in entering Iringa.[447]

Consequently, from 1916 to 1924, British colonial authorities allowed all Moravian and Berliner Lutheran mission stations in the region to come under new European supervision. In the Bena-Hehe Synod, for instance, stations such as Milow and Yakobi were temporarily administered by the Universities' Mission to Central Africa (UMCA), while the Free Church of Scotland assumed control of kidugala, Ilembula, Brandt, Lupembe, Pommern and Iringa stations. Meanwhile, the Scottish Mission Society took over Bulongwa, Tandala, Itete, Manow, Mwakaleli, Magoye, and Matema stations in the Konde Synod.[448] Nevertheless, the British administration, keen to ensure smooth governance, warned all incoming missionaries that the Lutheran and Moravian character of the former German churches had to be retained.[449] This directive came after local Christians in the Konde Synod resisted the

[445] Sakafu, 'The Pastor: Yohane Nyagava', 199.
[446] The Scottish intervention reflected earlier cooperation: in 1906, Moravian missionaries in Rungwe requested teachers from the Free Church of Scotland to fill a shortage, and the request was granted. See, Moravian Church, *Proceedings of the Society for Propagating the Gospel*, (Bethlehem: Moravian Publication Office, 1907), 110.
[447] Wright, *German Mission in Tanganyika*, 148.
[448] Owdenburg, Kilimhana, and Kasumba, *Karne Ya Kwanza Ya Injili, 1891-191*, 23. See also, Wright, *German Mission in Tanganyika*, 143-144.
[449] Dayosisi ya Kusini, *Jubilii ya Miaka 100 ya Injili: Kumbukumbu*, (Southern Diocese, *One Hundred years of the Gospel: Jubilee* (Njombe: ELCT, Southern Diocese, 2000), 13ff.

Scottish missionaries' attempts to impose Presbyterian practices on their congregations.[450]

In 1924, leaders of the Berlin Lutherans Church, the Leipzig Mission, the Moravian Church of Herrnhut, and the Bethel Mission entered into negotiations with the British government and representatives of the Scottish Mission Society regarding the return of their missionaries to Tanganyika. These discussions were complex, as they had to address wartime grievances and reconcile differing administrative visions.[451] After careful deliberation, an agreement was reached, and in 1925, German Protestant missionaries officially resumed their work in the Southern Highlands.[452]

Upon returning to their former stations, the missionaries faced the urgent task of rebuilding and strengthening the Church. The shortage of pastors made it imperative to ordain indigenous leaders, creating new opportunities for African leadership within the church, a development accelerated by the disruptions of the war. Missionaries also feared losing their established stations and worried that local converts might be drawn to the rival Roman Catholic Church.[453] In response to these challenges, the Berliner Lutherans decided to train African evangelists for pastoral roles.[454] This decision was formalized at the Kidugala Conference in 1930, where plans for the ordination and training of African pastors were confirmed.[455]

In 1932, eight indigenous Lutheran evangelists were selected by their respective local congregations and sent to Kidugala for theological training: Yohana Nyagawa (Malangali), Lutangilo Melele (Kidugala), Ludzabiko Kihupi (Lupembe), Mtenzi

[450] Mwaihabi, Mwaijega, and Mwampeta, *Miaka 100 ya Injili*, 17-18.
[451] TNA G1/25 Tanganyika Secretariat Correspondence on Missionary Returns (1924).
[452] See Mwaihabi, Mwaijega, and Mwampeta, *Miaka 100 ya Injili 1891-1991*, 18; Musomba, *Historia Fupi Ya Kanisa La Moravian Kusini Tanzania 1891-1976*, 60; Wright, *German Mission in Tanganyika*, 156; and Charles Pelham Groves, *The Planting of Christianity in Africa* Vol. 1 (London: Lutterworth Press, 1964), 88.
[453] See, lliffe, eds. *Modern Tanzanians*, 57.
[454] Similarly, the Moravians Church took deliberate steps to recognize African religious leadership by ordaining five (5) local evangelists as pastors. This ordination was carried out by the missionary Felix Oskar Gemuseus, who served as executive bishop of the Moravian Church in the Southern Highlands from 1930. The ordination marked an important moment in the institutional development of the Moravian Church, as it reflected a growing acknowledgment of indigenous agency and pastoral competence within the church's leadership structures. See Musomba, *Historia Fupi Ya Kanisa La Moravian Kusini Tanzania*, 66-69.
[455] KLSA, Missionary Conference of 1930, *Kidugala quarterly report*, III/34.

Kyelula (Lupembe), Ananidze Chungu (Kidugala), Josefu Mpogolo (Brandt), Ludzabiko Nyato (Lupembe), and Alatuvanga Msitu (Pommern).[456] On 5 May 1934, these evangelists completed their training and were ordained as pastors, becoming the first group of African pastors.[457] Later, in 1938, another group of five evangelists, Israel Mwipopo, Lunodzo Kahale, Elioth Kiwale, Yonathan Kyambile, and Tuperilwe Sanga, were ordained, followed by Pastor Sifike Ngajilo in 1939.[458] A comparable pattern emerged in central and eastern Kenya, where the postwar period saw a marked acceleration in the ordination of African pastors.[459] Their rise to leadership reflected a gradual transition from European supervision to African ecclesiastical authority.

The interwar years marked a period of significant expansion for mission activities in Tanganyika, particularly within the Lutheran Church. By the time the Second World War erupted in 1939, the churches had become more resilient and experienced less disruption than during the previous conflict. Additionally, Swedish and other foreign Lutheran missionaries stepped in to replace the German missionaries who had been interned by 1940, allowing the church's development to continue uninterrupted.[460]

Beyond spiritual guidance, African pastors actively promoted discipline and a clear framework of Christian moral conduct that closely aligned with missionary ideals. They emphasized ethical behavior, personal responsibility, and adherence to church norms, shaping congregations in ways that reinforced the moral and social vision of the missionaries. Their influence extended into the realm of health and healing as well. In regions where mission medicine had become central to evangelization, these pastors operated at the intersection of two healing worlds. They introduced communities to missionary ideas of hygiene, disease management, infant care, and hospital treatment, while simultaneously drawing upon local understandings of

[456] The locations in parentheses indicate the local churches or mission stations from which each evangelist was nominated. For more information see H. Kobler, *Jubilee of 100 Years of the Gospel* (Njombe: ELCT, Southern Diocese, 1998), 12; Mwaihabi, Mwaijega, and Mwampeta, *Miaka 100 ya Injili,* 20.
[457] Owdenburg, Kilimhana, and Kasumba, *Karne ya Kwanza ya Injili, 1891-191,* 25.
[458] Owdenburg, Kilimhana, and Kasumba, *Karne ya Kwanza ya Injili, 1891-191,* 24-25.
[459] Robert Strayer, *The Making of Mission Communities in East Africa* (London: 1978), 69.
[460] Myrtle Langley & Tom Kiggins, *A Serving People* (Nairobi: Oxford University Press, 1974), 82.

sickness, misfortune, and spiritual imbalance. Acting as crucial knowledge brokers, they translated biomedical concepts into culturally meaningful practices and mediated African social expectations to European missionaries.

The significance of the first generation of African pastors examined in this chapter is underscored by their later commemoration within the institutional memory of the church. This retrospective recognition is materialized in the memorial monument erected in 1998 by the Evangelical Lutheran Church of Tanzania (ELCT), Diocese of Konde, at Kidugala (see Figure 13). While the monument formally marks one hundred years of Lutheran presence at the Kidugala mission station since 1898, its deeper historical meaning lies in what it implicitly acknowledges: that the endurance and consolidation of Lutheran Christianity in the region were sustained through the leadership of African evangelists who, during the interwar period, became ordained pastors and assumed central roles in shaping and guiding the church.

As this chapter has demonstrated, these pastors exercised authority through moral discipline, mediation between missionary norms and local social realities, and the translation of biomedical and theological knowledge into everyday practice. Their leadership during moments of crisis, particularly in periods of wartime disruption and epidemic outbreaks, reveals their central role in sustaining Christian communities. By commemorating these legacy decades later, the ELCT reframes the colonial missionary past to foreground African resilience, agency, and ecclesiastical legitimacy. Figure 3 thus functions as historical evidence of how the first generation of African pastors has come to be recognized as foundational to the church's identity and continuity.

Figure 17: Memorial monument at Kidugala, erected in 1998 by the ELCT, Diocese of Konde,commemorating 100 years of the Lutheran presence since 1898.

Source: Photograph by the author, Kidugala Lutheran Mission, 12 June 2025.

From the late twentieth century onward, several Lutheran churches in Tanzania have commemorated one hundred years since the arrival of the first missionaries in their respective regions. The Konde Diocese of the Evangelical Lutheran Church in Tanzania marked this milestone in 1991; the Maneromango Parish of the Eastern and Coastal Diocese in 1995; the Southern Diocese in 1998; and the South Central Diocese in 2000. [461] These centenary commemorations resonate with the memorialization of the first generation of African pastors discussed above, reflecting a sustained engagement with the church's early history and formative leadership. As noted by Bishop Geoffrey Mwakihaba, the celebrations acknowledge both the beginnings of missionary work and the enduring contributions of African evangelists and pastors who nurtured Christian communities and ensured the continuity of the

[461] See Mwaihabi, Mwaijega, and Mwampeta, *Miaka 100 ya Injili*, 1891-1991 and Owdenburg, Kilimhana, and Kasumba, *Karne ya Kwanza ya Injili*, 1891-1991.

church.[462] Viewed in this light, such commemorations provide insight into how Lutheran churches in Tanzania remember their past while affirming the foundational role of African pastoral leadership in shaping the church's identity over time.

5.3.3 After Ordination: African Pastoral Authority and Knowledge Brokerage, 1935-1940

Moreover, the significance of African pastors ordained in May 1934 becomes particularly evident when examined through missionary reports from the subsequent years. Between 1935 and 1940, these records provide a revealing perspective on how African clergymen interpreted, enforced, and negotiated moral conduct within mission communities in the colonial Southern Highlands of Tanzania. Rather than acting as passive conduits of European norms, these pastors operated at the intersection of missionary discipline, moral reform, and therapeutic knowledge, actively reshaping these frameworks to align with local social realities.

As an African pastor trained within the German missionary system, Yohana Nyagawa expressed concerns that closely aligned with the moral vision promoted by European missionaries. His reports emphasized the regulation of behavior, safeguarding the congregation's moral integrity, and enforcing a Christian order rooted in discipline and spiritual purity. Stationed at Malangali and Lupembe, Nyagawa claimed to have "devoted all his energies to shepherding the congregation."[463] Yet his pastoral work faced a lot of challenges. In a quarterly mission report written in Swahili and later translated into German by Pastor Martin Priebusch, Nyagawa identified what he termed "four grievances" troubling the Christian communities under his care: drunkenness, fornication, European-style dancing, and superstition.[464]

These practices frustrated both African pastors and European missionaries, who shared a strong interest in ensuring that converts conformed to Christian teachings.

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[462]Interview with the Reverend Bishop Geoffrey Mwakihaba, whocurrently serves as Bishop of the Evangelical Lutheran Church in Tanzania, Konde Diocese, Diocese Headquarters, Tukuyu-Rungwe, 9 October 2024.

[463] BMW 1/6007, Yohana Nyagawa, *1st Quarter Report from January 1st – March 31st 1938*, Vol. 3 (1937-1947), 1-2.

[464] Nyagawa, 1st Quarter Report.

For Nyagawa, however, such behaviors were not isolated moral lapses or individual failings. Rather, he understood them as signs of a deeper instability that threatened the moral and spiritual foundations of the emerging Christian communities. German missionaries aimed to achieve not only mass conversion but also to establish a new moral order, in which converts were expected to demonstrate visible evidence of genuine Christian commitment. Therefore, when Christians drank beer, consulted *traditional healers* for healing or spiritual power, or participated in dances that encouraged close physical intimacy between men and women, Nyagawa interpreted these actions as deviations from this moral framework and as a reversion to practices that missionaries deemed "heathen," morally hazardous, and spiritually corrupt.[465]

To address such offenses, both the Moravian and Berliner Lutheran missions established institutional mechanisms of discipline. Central among these was the *GemeindeKirchenrat* (G.K.R.), or Congregational Church Council. The G.K.R. served as the main body for local church governance and moral oversight. The council was comprised the missionary or an ordained pastor, together with African elders, catechists, and other lay leaders.[466]

In practice, the G.K.R. functioned as a moral council within the mission community. African Christians accused of violating church norms, such as consuming alcohol, engaging in sexual misconduct, participating in traditional dances, practicing polygamy, or seeking treatment from traditional healers, were summoned before the council.[467] The individuals in question underwent formal inquiry, after which disciplinary measures were applied in certain cases, including temporary suspension from Holy Communion or exclusion from church fellowship.[468] While missionaries presented these procedures as essential for fostering a disciplined Christian community, the G.K.R. can also be understood as a contested space in which African agency, negotiation, and subtle forms of resistance were regularly exercised.

[465] Nyagawa, 1st Quarter Report.
[466] BMW 1/6007, Yohana Nyagawa, *2nd Quarter Report from April 1st – June 31st 1938*, Vol. 3 (1937-1947).
[467] Nyagawa, *2nd Quarter Report*.
[468] Nyagawa, *2nd Quarter Report*.

This dynamic was particularly visible in April 1938, when a special G.K.R. meeting was convened at Malangali mission station to address what African pastors and missionaries perceived as a growing moral crisis: the return of many Christians to drinking local beer and bamboo wine.[469] Although only a few council members attended the meeting, sources indicate that their authority within the mission structure was substantial.[470] More than thirty men, many of them long-standing Christians, were summoned before the council for violating a pledge to abstain from alcohol.[471]

Nyagawa responded with a firm pastoral directive, requiring the men to undergo six months of instruction. During this period, they were expected to study biblical passages condemning drunkenness and moral disorder. Only after completing this period of disciplined learning, repentance, and moral reform would they be readmitted into full Christian fellowship.[472] Nevertheless, this approach closely resembled the therapeutic logic of the mission hospital, where illness and disorder were treated through diagnosis, instruction, and corrective intervention. Nyagawa reported that "when they heard what I had told them, they willingly submitted to my instructions so that they could become Christians again, as they were before they gave in to drink."[473] Therefore, by enforcing these regulations, Nyagawa effectively merged pastoral authority with moral and health reform. His insistence on study, reflection, and scriptural engagement as corrective measures demonstrates how discipline, knowledge, and healing were inseparable within missionary pedagogy.

Pastor Martin Priebusch, a Berliner Lutheran missionary stationed at Ilembula, similarly observed that African Christians were constantly navigating two overlapping moral worlds. First of all, they were expected to adhere to the ethical

[469] Missionary records note that the ban on drinking local bamboo wine (*ulanzi*, in Swahili) caused tensions between missionaries and African Christians. Long before colonial rule, *ulanzi* was culturally significant and also functioned as a key food resource, especially during rainy-season, when food shortages were common. Therefore, *Ulanzi* together with various wild fruits formed a crucial part of the local diet. The reference is from, BMW 1/6004, J. Oelke, *Diaries of Kidugala Station*, Fourth Quarter 1933, Vol. 2, (1929-1939).
[470] Nyagawa, *2nd Quarter Report*.
[471] Nyagawa, *2nd Quarter Report*.
[472] Nyagawa, *2nd Quarter Report.*
[473] Nyagawa, *2nd Quarter Report.*

teachings and behavioral standards promoted by the Christian mission, which emphasized obedience, piety, and visible signs of spiritual transformation. Secondly, they continued to rely on their traditional cultural practices that had deep historical meanings. Priebusch argued that this coexistence inevitably generated moral tensions, as converts struggled to reconcile the demands of their new Christian faith with the obligations imposed by their communities.[474] As Priebusch explained:

> Such cases of sin do not remain hidden for long in our congregations. Our faithful elders and deacons are on guard. It does not take long, however, before they discover the sinners' tricks, confront them, and bring them to the church council meeting. In most cases, they are then repentant. Not a single G.K.R. meeting goes by without a number of previously fallen Christians being readmitted, even those who have stayed away from the church for ten or twelve years return repentant and ask to be readmitted to Christian community. Thus it is with us, too, between falling and rising again.[475]

Therefore, this repeated cycle of transgression, repentance, and reintegration reveals that Christian communities in the colonial Southern Highlands were neither stable nor uniformly moral spaces. Rather, individuals and families continually navigated the competing demands of Christian teachings and deeply local social obligations. Missionaries often imagined conversion as a condition that could be secured through the imposition of rules, disciplines, and moral regulation. However, in practice, the lived realities of conversion were far more complex and contingent. Although African converts were central to the success and expansion of the missionary enterprise, their participation was not straightforward. Instead, they occupied an ambivalent position, constantly negotiating between church doctrines and enduring cultural practices that shaped the totality of local social life.

The contribution of African pastors to the shaping and transformation of healing practices in the Southern Highlands became most visible during periods of acute medical crisis. This was particularly evident in the Bena-Hehe Synod during the influenza epidemic of 1935, which struck the Ilembula mission station and its surrounding mission outposts. Examining this episode reveals how African pastoral

[474] BMW 1/6007, Martin Priebusch annual report at Ilembula Station, Vol 3. (1937-1947), 2-3.
[475] BMW 1/6007, Martin Priebusch annual report at Ilembula Station.

leadership operated as a critical intermediary between missionary medicine and local communities. In moments of epidemic emergency, African pastors translated biomedical instructions into socially meaningful practices, mobilized communal trust, and coordinated care in ways that missionaries alone were unable to achieve.

According to missionary nurse Gertrud Döhring, the epidemic first emerged at the Iyayi mission station, where "almost all the school children and adults were sick."[476] The speed and scale of the outbreak quickly overwhelmed the limited medical resources available to the mission. In response, Döhring worked closely with Pastor Nyagawa, and together they treated more than thirty patients in a single day.[477] From Iyayi, the disease spread rapidly across Benaland and came to dominate hospital work throughout the month. Although Döhring stressed that the epidemic was "not as severe as 1918," when influenza had devastated much of East Africa, the 1935 outbreak nevertheless posed serious clinical challenges. Severe pneumonic and abdominal complications required prolonged and intensive care, placing sustained pressure on mission facilities and personnel.[478]

Mission medical reports recorded only two deaths among patients treated at the mission hospital. At the same time, they noted a markedly higher mortality among non-Christian populations who avoided hospital treatment.[479] The reported difference in mortality was not only a medical outcome but also reflected missionary ways of seeing and recording the epidemic. Missionaries often read the deaths of non-Christians as confirmation of the effectiveness of hospital treatment and Christian discipline, reinforcing the idea that survival was closely linked to conversion and compliance with mission life. However, many non-Christian patients avoided the hospital for practical and cultural reasons, including distrust of mission institutions, reliance on local healing practices, fear of being separated from family, and discomfort with the moral and religious rules attached to hospital care. Higher mortality among non-Christian communities therefore points less to the inherent

[476] BMW *Mischband* 1905-1939, Bd. III, Nr. 5
[477] BMW *Mischband* 1905-1939.
[478] BMW *Mischband* 1905-1939.
[479] BMW *Mischband* 1905-1939.

success of missionary medicine and more to its limited reach. The epidemic exposed clear social and religious boundaries in access to care, showing how medical crises intensified divisions between Christian and non-Christian communities rather than overcoming them.

At the peak of the epidemic, all mission schools were closed, and the normal routines of mission life were put on hold. Missionary teachers, African evangelists, and pastors were reassigned to support medical work, helping to distribute medicines to patients in their homes and to those admitted to Ilembula mission hospital.[480] African pastors played a particularly important role in encouraging the sick and their families to seek treatment, addressing fear, stigma, and doubts about biomedical care. Their position as trusted religious leaders, and their close ties to local communities, enabled them to present hospital treatment as both a practical and moral response to illness.

Similarly, at the Brandt mission station, when the influenza epidemic caused severe illness among the local population, even the trained German medical assistant fell sick and had to be transferred to Ilembula Hospital.[481] According to the mission medical report covering July to September 1935, the responsibility for caring the sick at Brandt was taken over by the newly ordained Pastor Josefu Mpogolo. This African clergyman during the transitional period from 1916 to 1924, he worked as evangelists, a school teacher and had basic medical training, which enabled him to assume this critical role in the absence of European medical personnel. Thus, Pastor Mpogolo's involvement in missionary medicine shows that African pastors were central to transmitting biomedical knowledge to local communities, and their role in shaping and transforming medical mission work cannot be overlooked.

Seen through practices of discipline, repentance, and medical intervention, African pastoral authority after ordination emerges as an active and generative form of power

[480] BMW *Mischband* 1905-1939.
[481] BMW Mischband 1905-1939, Vol. III, No. 5. "Report on the Sick in Ilembula from 15 July to 30 September 1935," by Nurse Gertrud Döhring.

rather than a subsidiary extension of missionary oversight. Moral regulation, enacted through church councils and pastoral instruction, operated as a process through which Christian identity was continually shaped, evaluated, and restored. Healing, moral guidance, and correction formed a shared pastoral logic that linked bodily affliction, ethical failure, and spiritual imbalance within a unified interpretive framework. Through this logic, African pastors exercised authority by sustaining communal coherence during periods of moral uncertainty and medical crisis, translating missionary expectations into forms of care and accountability that resonated within local social worlds. Therefore, it is fair to argue that Christianity in the Southern Highlands took shape through every day practices within mission communities rather than through fixed rules imposed by missionaries alone. Moral discipline, care for the sick, and the reintegration of believers who had broken church norms were central to how Christian life was organized and sustained. Through these practices, African pastors exercised significant authority, shaping how Christianity was lived and understood at the local level and mediating between missionary ideals and local social realities during the period of German Evangelical mission presence in the region.

5.4 Conclusion

Taken together, this chapter argues that Protestant mission activity in the Southern Highlands operated through an integrated framework in which bodily care, moral regulation, and knowledge formation reinforced one another. Medical facilities, educational programs, sewing instruction, and planned Christian settlements formed interconnected arenas through which missionaries sought to shape conduct, belief, and everyday routines. Health services drew people into mission spaces, where standards of cleanliness, dress, housing, labor, and social order were actively cultivated as signs of Christian life and progress. Within this setting, biomedical ideas carried cultural and moral authority and were closely associated with European visions of religious and social advancement. These initiatives reshaped life within mission-centered communities and established durable institutional forms that structured Christian experience in the region.

Moreover, the outcomes of mission medicine and discipline were produced through continuous interaction among multiple actors. African evangelists, deacons, and pastors played decisive roles in interpreting medical ideas, enforcing moral expectations, and guiding communities through moments of illness, death, and social tension. Their work connected mission stations, villages, and households, allowing Christian teachings and medical practices to circulate across different social spaces. Authority over healing and morality emerged through dialogue, mediation, and adaptation rather than unilateral direction. In this process, missionary goals and African initiatives influenced one another, generating locally grounded forms of Christian life that blended discipline, care, and spiritual meaning. The legacy of this interaction persisted in religious organizations, healthcare practices, and moral frameworks that continued to shape the Southern Highlands well beyond the period of German missionary presence.

CHAPTER SIX
CONCLUSION

This dissertation has examined the emergence, expansion, and social consequences of Protestant missionary medicine in the Southern Highlands of Tanzania from the late nineteenth century to 1940. By tracing the evolution of medical missionary activity across German and early British colonial rule, it has argued that healthcare in the region was neither a straightforward imposition of Western biomedicine nor a passive reception by African societies. Rather, missionary medicine developed through prolonged processes of negotiation, contestation, adaptation, and selective appropriation involving missionaries, African healers, chiefs, evangelists, pastors, families, and local communities. Within these encounters, healing became a critical site through which religious authority, cultural identity, moral discipline, and colonial power were articulated and contested.

This dissertation has shown that missionary medicine functioned simultaneously as a response to illness, a tool of evangelization, and a mechanism of social regulation. Missionaries sought not only to heal disease but also to refashion African bodies, households, and moral worlds. Medical practice was embedded within broader civilizing projects aimed at regulating dress, hygiene, housing, childrearing, sexuality, and labour.[482] In his discussion of labour and missionary medical intervention, Merensky maintained that the sustainability of a settlement colony depended on what he termed the 'labour question,' a problem he believed missionaries could not evade. He argued that the presence of missionaries within colonial societies inevitably drew them into regimes of labour discipline, which he described as "*Erziehung … zur Arbeit,"* translated as 'educate ... to work.'[483]

[482] See Ann Beck, "Medicine and Society in Tanganyika, 1890-1930," 6; Fiedler, *Christianity & African Culture*, 159. Lubawa, *"The Missing Link*, 128 and 244; Gustav Warneck, "Die christliche Mission und die überseeische Politik," *Allgemeine Missions-Zeitschrift* 28 (1901): 179-180, Julius Richter, "Die evangelischen, besonders deutschen Missionen in den deutschen Schutzgebieten,*" Allgemeine Missions-Zeitschrift* 21 (1894) 435; Edward Graham Norris, *Die Umerziehung des Afrikaners: Togo 1895-1938* (Munich: Trickster Wissenschaft, 1993), 92-93; Caleb Kualii, *On Earth as It Is in Heaven: The German Protestant Missions in German East Africa, 1887-1914* (MA thesis, North Carolina State University, 2023), 112ff.

[483] See Alexander Merensky, "Welches Interesse und welchen Anteil hat die Mission an der Erziehung der Naturvölker zur Arbeit?*" Allgemeine Missions-Zeitschrift* 14(1887): 147-148.

Therefore, medical ideas became central to this vision: bodily health, physical strength, and moral behaviour were seen as closely connected and essential for productive labour. Illness, laziness, and moral failure were frequently treated as manifestations of the same problem, allowing missionaries to use medical work to justify the regulation of African bodies, daily routines, and patterns of work.

One of the central findings of this study is that the introduction of biomedical healthcare in the Southern Highlands preceded the systematic expansion of colonial state medical services and was largely driven by Protestant missions. Chapter two demonstrated that missionary engagement with medicine emerged gradually out of evangelical necessity rather than from premeditated medical planning. Faced with widespread disease, physical suffering, and limited success in conversion through preaching alone, missionaries increasingly embraced medical care as an indispensable component of their religious vocation. Medical practice offered tangible evidence of Christian benevolence and provided missionaries a means to gain trust, visibility, and permanence within local communities.

However, this transformation was neither linear nor uncontested. Missionaries operated within a social and cultural landscape in which healing was already deeply embedded in local cosmologies, ritual practices, and systems of authority. Illness and misfortune were understood through moral, spiritual, and relational frameworks that did not easily align with biomedical explanations. As a result, missionary medicine did not simply displace existing therapeutic systems, nor did it operate as a one-way transfer of medical knowledge.

The dissertation has shown that African communities were never passive recipients of missionary healthcare. From the earliest encounters, Africans evaluated missionary medicine pragmatically, assessing its effectiveness in relation to indigenous therapeutic practices and incorporating it selectively into existing healing repertoires. This dynamic is particularly evident in chapter three, which examined the ideological foundations and practical implementation of mission medicine during the German colonial period. Mission regulations such as the *Platzordnung* sought to

impose moral discipline, suppress traditional healing practices, and reorder African social life within mission stations in pursuit of mass conversion.

Yet these regulatory ambitions were only partially realized. African patients and communities engaged with mission medicine on their own terms, negotiating, adapting, and at times resisting its disciplinary aims. The selective uptake of biomedical treatments reveals how medical encounters became sites of contestation as well as exchange, where missionary authority was continually tested and redefined. Taken together, these findings underscore that missionary medicine functioned not simply as an instrument of colonial control or evangelical strategy, but as a complex social practice shaped through ongoing interaction between missionary ideals and African agency. This study therefore contributes to broader historiographical debates by highlighting the contingent, negotiated, and locally embedded nature of colonial medical encounters.

By foregrounding African agency, this dissertation challenges interpretations of colonial medicine that emphasize one-sided domination and cultural discontinuity. Instead, it aligns with scholarship that views colonial encounters as relational processes shaped by multiple actors with divergent agendas. While medical missionaries sought conversion, discipline, and moral reform, African communities pursued effective healing, social continuity, and spiritual protection. These competing objectives did not always align, but their interaction generated hybrid practices that reshaped healthcare in enduring ways.[484] Patients moved between therapeutic worlds, combining prayer, herbal medicine, divination, and biomedical treatment in ways that reflected local logics rather than missionary prescriptions.

The examination of healing practices in the Southern Highlands reveals persistent tensions and differentiations within African communities in the ways illness was understood, managed, and resolved. As this dissertation has shown, illness was not treated as an individual condition but developed as a communal event that mobilized kin, neighbors, elders, and ritual specialists. These social actors shaped decisions

[484] This interpretation is closely aligned with recent unpublished work by Kimani, "Creating Health Futures."

about care, mediated interpretations of sickness, and negotiated the terms under which missionary medicine was engaged. Even when patients entered mission hospitals, healing extended beyond institutional walls through food provision, emotional labor, ritual observance, and social counseling carried out within households and the culture of neighbourhood. As shown in chapter four, such practices limited the reach of missionary authority and sustained indigenous values within emerging medical spaces.

This study has also demonstrated that access to care and therapeutic outcomes in the colonial Southern Highlands were uneven, shaped by kinship ties, social standing, and material resources. Households with strong social networks, higher status, and greater economic means were better positioned to secure care and sustain healing, while poorer and marginalized families faced greater constraints. As a result, experiences of illness and recovery often reproduced existing social inequalities across households.

Oral histories played a crucial role in recovering these dynamics. Rather than treating collective memory as a methodological limitation, this dissertation approaches it as a historical source in its own right, one that reveals how missionary medicine was experienced and remembered not primarily as a clinical intervention, but as a moral and social practice. Accordingly, collective memories transmitted across generations emphasized themes such as care, tension, discipline, and cooperation, demonstrating the extent to which medical mission was embedded within broader frameworks of belonging, authority, and communal identity. While missionary medicine introduced new forms of knowledge and authority, this study argued that these memories showed it was not experienced simply as something imposed from above. Instead, they point to more complex relationships shaped through everyday interaction, care, and negotiation.

This dissertation has further shown that mission medicine was driven by intersecting agendas linking healing, discipline, and knowledge production. Missionaries mobilized medical facilities, schools, sewing classes, housing reforms, and moral instruction as interconnected sites of intervention aimed at producing disciplined

Christian subjects. Cleanliness, appropriate clothing, punctuality, and domestic order were framed as outward signs of both spiritual progress and bodily health, while biomedical knowledge was endowed with moral authority and presented as superior to indigenous explanations of disease. Yet this authority was never absolute. African intermediaries, including pastors, evangelists, and medical assistants, engaged mission medicine for their own social, economic, and spiritual purposes. Through processes of translation, adaptation, and contestation, they reshaped missionary knowledge and practice, demonstrating that mission medicine was not a unilateral imposition but a negotiated project fundamentally dependent on African expertise and local social worlds.

The dissertation has also highlighted significant internal divisions within missionary and colonial structures. Missionaries frequently disagreed over the proper balance between evangelization and medical work, the degree to which African healing practices and social norms should be accommodated, and the feasibility of enforcing strict regimes of moral discipline. These disagreements reveal that missionary medicine was not a coherent or unified project, but a contested field shaped by theological differences, material constraints, and the pressures of local conditions.

Social differentiation emerged as a central and persistent theme throughout the dissertation. Access to missionary medicine, nutrition, and education varied according to class, gender, and proximity to mission stations and hospitals. Individuals who lived in or near the mission compounds, such as local eveangelists, pastors, teachers, medical assistants, and converts, often enjoyed more stable livelihoods and more reliable access to healthcare than those who lived farther from mission stations and were burdened by taxation, labor migration, and chronic economic insecurity. Their interactions with mission medical interventions therefore differed significantly. However, these inequalities were not incidental but were, in various ways, produced and reinforced by colonial and missionary structures.

Despite profound inequalities in access to colonial and missionary medical resources, this dissertation has shown that, African societies retained significant autonomy in shaping their therapeutic worlds. Indigenous healing systems neither vanished nor

were simply displaced under colonial medical pressure; instead, they adapted, persisted, and coexisted with missionary medicine in complex and negotiated ways. This endurance speaks to the depth of African medical knowledge and its embeddedness within social, spiritual, and moral life. By foregrounding the coexistence of multiple healing systems, this study challenges Eurocentric narratives of medical modernization and highlights the necessity of medical pluralism as a framework for understanding health and healing in colonial contexts.

In historiographical terms, this dissertation contributes to African medical history by redirecting scholarly attention from colonial state-centred healthcare systems to the role of missionary and community-based medical practices. It advances existing scholarship at the intersection of religion, medicine, and social history by demonstrating that healing constituted a critical point of engagement between missionary objectives and African lived experiences. By foregrounding processes of negotiation, African agency, and everyday medical practice, the study challenges conventional binaries of tradition and modernity, resistance and collaboration, and imposition and acceptance. Instead, it argues that colonial medicine was not simply imposed from above but was continuously co-produced through interaction, adaptation, contestation, and compromise between missionaries and local communities.

The significance of this dissertation extends beyond the Southern Highlands of Tanzania, offering insights relevant to broader historical and contemporary discussions of health and medicine. By looking at the everyday interactions between missionaries, African communities, and indigenous healers, the study provides a conceptual framework for understanding missionary medicine elsewhere in Africa and across the Global South, where similar processes of negotiation, adaptation, and medical pluralism shaped healthcare encounters. Rather than viewing bio-medicine as a uniformly imposed or uncontested system, this research highlights how medical practices emerged through dialogue, compromise, and resistance, producing hybrid forms of care that reflected local priorities and social realities.

While this dissertation has offered a historically grounded analysis of German protestant missionary medicine in the Southern Highlands of Tanzania, it also opens up a number of questions that remain insufficiently explored and warrant further scholarly attention. Future research could examine more closely the experiences and agency of specific social groups, particularly women, children, the elderly, and chronically ill patients, whose encounters with missionary healthcare were often shaped by gendered expectations, generational hierarchies, and unequal access to resources. Further work might also trace the postcolonial trajectories of missionary medical institutions, personnel, and therapeutic practices, exploring how they were transformed, appropriated, or challenged in the context of late colonial reforms, independence, and the expansion of national health systems. Comparative studies across different regions of Africa, missionary denominations, or colonial regimes would further illuminate the extent to which the dynamics identified in this study were distinctive or representative of broader patterns in African medical history.

Although these questions form part of a broader future research agenda, this dissertation also seeks to encourage greater scholarly engagement with the social, cultural, and moral dimensions of health and healing in Africa. By placing everyday medical encounters, negotiation, and medical pluralism at the centre of analysis, the study demonstrates that an exclusive focus on institutions, policies, and official medical discourses provides only a partial understanding of how healthcare functioned in practice. Attention to everyday experiences, local memories, and community responses reveals the active role that African communities played in shaping, negotiating, and reinterpreting missionary medicine within their own social and cultural contexts. Ultimately, this dissertation underscores the importance of understanding colonial and missionary medicine as dynamic and contested processes that both influenced and were reshaped by local social worlds. In doing so, it contributes to a more nuanced understanding of the historical relationship between medicine, religion, and society in Africa and highlights the enduring legacies of these interactions in the postcolonial period.

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APPENDIX

A. Mission Bell and Early Christian Foundations at Kipangamasi

As discussed in chapter two, on 25 September 1891 Berliner Lutheran missionaries, led by Alexander Merensky, entered the Unyakyusa region, an area that today forms part of Kyela District. Traveling on foot along the valley of the Lufilyo River, they searched for a location less prone to malaria. After reaching a more favorable elevation, they settled at a site near the foot of the Livingstone Mountains, known locally as Pipagika. On 2 October 1891, Merensky and his companions renamed the site *Wangemannshöhe* in honor of Wangemann, the long-serving director of the Berlin Missionary Society, who had overseen the expansion of the mission field and later died in 1894. Because the German name was difficult to pronounce, local communities referred to the station as Kipangamasi..[485]

By Christmas 1891, the missionaries had completed construction of the first mission buildings at Kipangamasi, making it the earliest mission station of the Konde Synod. In 1892, they installed a mission bell that soon became central to daily life at the station. More than a practical device, the bell played a foundational role in the early history of evangelical mission work in the region by regulating daily routines and introducing a new conception of time, one that emphasized regularity, punctuality, and discipline. As a material object that continues to embody layered histories of encounter, control, and adaptation, the mission bell constitutes an important element of local cultural heritage. It is this heritage value that draws the attention of the present study and justifies a separate, detailed discussion of the bell in the appendix.

Through its repeated sounding, the bell structured worship, labor, instruction, and communal obligations, calling residents to work and worship according to fixed schedules. [486] In this sense, it functioned as a tool of discipline, embedding

[485] Interview with a retired Moravian Pastor, Mzee William Mwakikato, Iwambi-Mbeya, 29th February, 2023, and also Bibi Zena Mwambyale, Kalobe-Mbeya, 22nd February, 2023. See also Mdegella Owdenburg, Samwel Kilimhana, and Obadiah Kasumba, *Karne Ya Kwanza Ya Injili, 1891-191: Kanisa La Kiinjili La Kilutheri Tanzania Ukanda Wa Kusini* (Dar es Salaam: Dar es Salaam University Press, 1991), 16, see also Julius Richter, *Geschichte Der Berliner Missionsgesellschaft 1824-1924* (Berlin, 1924), 640–41.

[486] See A. L. Sakafu, "The Pastor: Yohane Nyagava," in *Modern Tanzanians* (Nairobi: East African Publishing House, 1973). Sakafu, then a student at the University of Dar es Salaam, interviewed

missionary ideals of order, authority, and moral regulation into everyday life. This temporal discipline operated as an ideological project, reflecting missionaries' broader conviction that moral reform and social transformation required the reorganization of time itself.

This study argues that the temporal order introduced by the mission bell was deeply connected to the broader missionary project of moral, social, and bodily discipline. From the outset, missionaries understood time as central to the reshaping of African life, an emphasis that later became fundamental to missionary medicine. As Zedekia Njogela, a senior medical officer in charge of Kidugala Mission hospital, explained that the biomedical practice is actually inherently structured by time. Therefore, the effective treatment requires patients to understand time intervals for administering medication, monitoring symptoms, and adhering to prescribed treatment schedules. As Dr. Njogela observes, medicine "is structured by time," and therapeutic success depends on regularity and temporal awareness.[487]

Seen in this light, the mission bell laid the groundwork for medical discipline long before any formal health center was established in the region. By habituating communities to clock-based routines and auditory signals that organized daily life, the bell functioned as an early technological instrument through which Western medical knowledge would later become intelligible and practicable. The evaluation of illness, recovery, and even death increasingly came to be understood within these temporal frameworks.[488]

By 1894, Kipangamasi had become the first mission station in the region to initiate the formal training of local evangelists under the leadership of Pastor Carl Nauhaus. He referred to these trainees as *Wasaidizi Sharikani* (literally translated as

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Yohane Nyagawa in 1970, which enhances the reliability of the account. Yohane Nyagawa was among the first African evangelists to be ordained, receiving ordination in 1934 at the age of thirty-four. In 1939, he assumed church leadership as the first local bishop, serving from 1939 to 1940. However, his broader service within the church is not examined in detail in this study.

[487] Zedekia Njogela, interview by the author. Kidugala hospital, Wanging'ombe District, 14th June, 2025.

[488] See Mwaihabi, Mwaijega, and Mwampeta, *Miaka 100 ya Injili*, 15.

'evangelists') underscoring their role as assistants in the work of evangelization.[489] The beginnings of this effort reflected a broader Protestant educational approach.

In describing the Berliner Lutheran initiative to train local evangelists at Kipangamasi, mission Superintendent Alexander Merensky presented a report from the society's missionaries that clearly illustrates this Protestant educational approach:

> On March 22, 1893, the brothers opened the first school. "We had," they write, "presented this important work before the Lord in prayer from the very beginning, and had asked for His blessing upon it, just as the school day is opened in prayer. Likewise, students have been told, and are told again and again, that the purpose of learning to read is to acquaint them with the Word of God, that they may come to know and do His will.[490]

This pedagogical approach proved decisive in shaping a cohort of local evangelists who would later serve as vital intermediaries between foreign missionaries and local communities. Grounded in local languages, cultures, and social norms, these evangelists translated missionary theology into forms that resonated locally, while simultaneously transmitting emerging moral and medical ideas to the wider population.[491] With their assistance, Nauhaus also undertook extensive research on local customs and the Kinyakyusa language. In the same year, he completed the translation of the New Testament into Kinyakyusa[492], a milestone that significantly expanded the reach of Christian teachings and reinforced the mission's educational and cultural influence.

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[489] Wright, *German Missions in Tanganyika*. 13-14.
[490] Merensky, *Deutsche Arbeit am Njaßa*, 171-172.
[491] Harald von Sicard's report on his visit to Tanganyika between 25 May and 24 August 1944 highlights the foundational role played by African evangelists in the development of ordained church leadership. Sicard, a German-Swedish Lutheran missionary, church historian, and ethnographer, argued that these early evangelists laid the groundwork for the emergence of ordained African pastors. One notable example is Yohane Nyagawa, who became a recognized leader within the Bena-Hehe Synod of the Lutheran Church by 1939. For more details see See Harld von Sicard, A Report about his visit to Tanganyika 25 May -24 August 1944 in Niwagila Wilson, *From the Catacomb,* 267; see also Lubawa, *"The Missing Link*, 313.
[492] Missionary Nauhaus, together with other Lutheran missionaries such as Christian Schumann, translated Christian hymns into local vernacular languages with the assistance of regional elders, evangelists, and pastors. For accounts of Christian songs translation and local collaboration in the Southern Highlands, see Hans M. Köbler, *Miaka 100 ya Injili Dayosisi ya Kusini: Kumbukumbu* (100 Years of the Gospel in the Southern Diocese) (Njombe: Evangelical Lutheran Church in Tanzania, Southern Diocese, 2000); Lubawa, "The Missing Link," 72; S. von Sicard, "The Understanding of Church and Mission among the Berlin Missionaries in the Southern Highlands of Tanzania," *African Theological Journal* (Makumira Publications, 1991).

Figure 18: The Mission Bell Erected in 1892 at Kipangamasi[493]

Source: Photograph by the author, Kipangamasi-Busokelo District, 02 July 2024.

In addition, the daily practices of instruction were increasingly regulated through fixed schedules. Scripture reading, catechism, and classroom teaching were coordinated by the mission bell, which structured time and discipline within the mission community. Thus, the bell at Kipangamasi stands as one example of the mission bells introduced by Protestant missionaries in the region; from its very introduction, it marked the imposition of Christian time, missionary discipline, and the foundations of a biomedical order. Long before hospitals and clinics were established, the bell had already begun to reorder modes of daily life, preparing local communities for the structured demands of mission education, worship, and medical practice.[494]

[493] The bell continues to be used today, symbolizing both the inception of missionary activities in the region and a complex shared historical legacy.

[494] For a detailed discussion of the role of bells within Moravian missionary activity, see Tertius de Wet, Jef L. Teugels, and Pieta van Deventer, "Historic Bells in Moravian Missions in South Africa's Western Cape," *Historia* 59, no. 2 (2014), https://www.scielo.org.za/scielo.php?script=sci_arttext&pid=S0018-229X2014000200004

B: Missionaries who died in the Southern Highlands of Tanzania

Although medical missionaries played an important role in introducing Western medicine to the region, historical records suggest that their work involved considerable difficulty and risk. Many missionaries operated in unfamiliar environments, faced limited resources, and were exposed to diseases for which effective treatments were often unavailable. In the course of pursuing broader medical and religious objectives, some missionaries died while working in the field.[495]

Table 1: List of Protestant Missionaries who died and buried in the Southern Highlands of Tanzania, 1891–1907[496]

N0	Name	Date of Death	Buried
1	George Martin	10 September 1891	Kapugi
2	Jean Ledoux	10 February 1896	Ipyana
3	Christian Hafner	27 January 1897	Ipyana
4	Getrud Schumann	05 August 1899	Kipangamasi
5	Helen Stolz	13 January 1899	Ipyana
6	Anna Bohme	12 February 1902	Rungwe
7	Agness Zickmantel	09 September 1903	Lutengano
8	Lydia Meyer	27 September 1907	Rungwe

[495] See Owdenburg, Kilimhana, and Kasumba, *Karne ya Kwanza ya Injili,*, 19; see also Hamilton, *Twenty Years of Pioneer Work in Nyasaland*, 185.

[496] Although Mereseky and his companion attempted to settle in an elevated area believed to be free from malaria, three graves remain as evidence that the missionaries nevertheless succumbed to diseases that also claimed the lives of local inhabitants. One of these graves bears a cross inscribed *"Frau Gertrud Schumann,"* who died on August 5, 1899. She was the wife of the missionary Christian Schumann (1864–1938). For further details, see Schultze, *Der Njaßabund*, 9.

C: The First Moravian Grave in Tanzania: George Martin (1891)

On 16 April 1891, missionaries of the Moravian Church, Theophile Richard, Paul Theodore Meyer, George Martin, and Johanne Haefner, set out on their journey from Germany to Central Africa. They arrived in Karonga, Malawi, on 24 June 1891. Upon reaching Karonga, they learned that two of their colleagues, George Martin and Johanne Haefner, were seriously ill with severe fever, to the extent that they were no longer able to walk. As a result, the missionaries were forced to hire porters to carry the sick men, and on 7 July 1891 they reached Kapugi.[497] At Kapugi, Dr. Kerr Cross of the Free Church of Scotland (Presbyterian) had established a rest house, where the missionaries stopped to recover.[498] The missionaries who were not ill, namely Theophile Richard and Paul Theodore Meyer, continued their journey, and on 21 August 1891 they established their first mission station at Rungwe.[499] Before returning to Kapugi to bring their sick colleagues, they received a letter written in a trembling hand that read, "Come, come! George is no longer alive." The letter had been written by Johanne Haefner, who himself was gravely ill at the time.

During their illness, George Martin and Johanne Haefner were cared for by local people,[500] that reflected the crucial role of indigenous knowledge and community support at the earliest stage of missionary activity, when Western medical facilities were still extremely limited. Besides that, this care represents one of the earliest encounters between local healing practices and European missionary medicine in the region. George Martin died on 10 September 1891 and was buried in Kapugi village (see Figure 19). His grave has endured as a historical witness to the beginnings of the Moravian mission in the region. Consequently, George Martin became the first Moravian missionary to be buried in what is now mainland Tanzania.

[497] *Periodic Accouns* (1891), 217.
[498] See Musomba, *Historia Fupi Ya Kanisa La Moravian Kusini Tanzania*, 12-14.
[499] Musomba, *Historia Fupi Ya Kanisa La Moravian Kusini Tanzania*, 13.
[500] Musomba, *Historia Fupi Ya Kanisa La Moravian Kusini Tanzania*, 14.

Figure 19: The Grave of Moravian Missionary George Martin at Kapugi

Source: Photograph by the author, Kapugi-Tukuyu, 10 July, 2024.

D: Missionary Ernst Otto Giersch sitting at a sewing machine in Mbozi Mission,

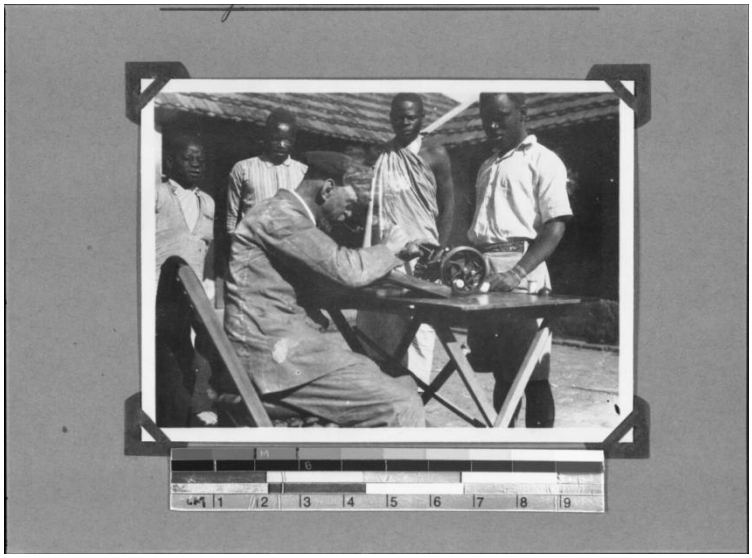

Figure 20: Ernst Otto Giersch sitting at a sewing machine, Mbozi, Tanzania, ca. 1927 – 1929

Source: *International Mission Photography Archive, University of Southern California Libraries*, Retrieved from https://doi.org/10.25549/impa-m6738