Disease, Science and Religiosity: A Case Study of Leprosy in German East Africa

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Abstract

Leprosy generated an intense amount of interest (and activity) in German East Africa in the immediate years before the First World War. It was an interest quite different from the economic and demographic considerations of most other diseases. This is not a judgement specific to this location. Across time, across diverse cultures, across the globe leprosy often functioned as a metaphor for wider concerns and metaphysically diverse discussions. When John Iliffe published The African Poor in 1989, he devoted a whole chapter to leprosy; no other disease received this preferential treatment in his book. Two years later Megan Vaughan used the same device in Curing Their Ills, a more focused study of illness and disease on the African continent. This essay is more specific. It traces the narrative thread of this disease from a specific metropolitan perspective in the German Reich down to actions at a territorial and district level in German East Africa. It looks at the diversity of responses in that space, including the differential involvement of Christian missionary societies. It considers the possibility that the proposals for expanded care of lepers arrived at a time when Roman Catholic nuns in particular were looking for a role that could fit their more

restricted and cloistered status. It also looks at leprosy care in the parallel context of an increased African awareness of European bio-medicine, an acceptance that would have long-term consequences for the shape of medical care in Tanzania.

Key words: Disease, Leprosy, Christian missionaries, Tabora, Mahenge, German East Africa

1. Introduction

This essay has two broad interconnected themes. First, it seeks to establish the intellectual and organisational background to a significant change in official leprosy policy in German East Africa in the years before the First World War, a major shift in thinking about carcerality, of how far governments were prepared to physically segregate the afflicted and place them in remote locations.[1] What did emerge was the adoption of a more territorial, decentralized model, albeit one that developed on the ground with significant regional diversity.[2] That model did not

[1] For a more global coverage of the carcerality debate around leprosy at this time, see Reinaldo Guilherme Bechler, *Leprabekämpfung und Zwangsisolierung: im ausgehenden 19. und frühen 20. Jahrhundert: wissenschaftliche Diskussion und institutionelle Praxis* (Chisinau: Südwestdeutscher Verlag für Hochschulschriften, 2011). Bechler combines his global analysis with a Brazilian case study.

[2] A useful coverage exists in Wolfgang Eckart, *Medizin und Kolonialimperialismus*: *Deutschland 1884–1945* (Paderborn: Ferdinand: Schoningh, 1997), 319-340. His specific East African leprosy coverage is based on an earlier approach in Wolfgang Eckart, *Leprabekämpfung und*

deliberately encourage the participation of Christian missionary societies, yet that is exactly what happened, and on a significant scale. It is that missionary involvement provides the focus for an additional line of analysis, one that examines the role that the female missionary figure often played in the operational administration of leprosy initiatives. It suggests that this experience was an important training platform for the subsequent transformation of Christian medical care in the interwar period, a transformation that continued well into the post-independence period.

To aid us in our wider analysis, it may be useful to initially isolate one leper settlement that we can use as a comparative benchmark. The chosen location is numerically significant, created relatively early and significantly involved with Christian missionaries. In a more symbolic fashion, it sits at the geographical centre of the region we are considering.[3]

Aussätzigenfürsorge in das ostafrikanischen 'Schutzgebieten' des Zweiten Deutschen Kaiserreiches, 1884-1914 (Leverkusen: Heggendruck, 1990). A more recent study that puts German strategies in a more regional perspective is Susanne Harflinger, "Die Geschichte der Lepraarbeit in Ostafrika – ein Vergleich der Entwicklung in Tanzania, Uganda und Kenya" (Diss., Rheinischen Friederich-Wilhelms-Universität., 2012). For a specific (and later) Ugandan perspective, see the work of Kathleen Vongsathorn, for example "'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.

[3] In a similar fashion, the 'Morogoro' settlement near Peramiho is used as a recurring reference point in Richard Hözl, "Lepra als *entangled disease*. Leidende afrikanische Körper in Medien und Praxis der katholischen

2. That Other Tabora

In 1909 the Benedictine missionaries based at the Kwiro mission in the Mahenge Highlands of southern German East Africa proposed the establishment of a joint government-mission leprosy project. The proposal was framed locally and presented to the *Bezirkschef* of the Mahenge military district situated a few kilometres from the mission. The military station was not ignorant of the local existence of leprosy; since 1907 its own officials had done various investigations in the vicinity, and even considered the possibility of a leper settlement. However, the mission's proposal was initially rejected on economic grounds. The missionaries waited patiently for a few months and successfully re-submitted their proposal to a new district administrator. Once the military station had decided to participate in the project it moved swiftly. In October of the same year, orders were issued to all *majumbe* (district leaders) to bring in all their subjects suffering from what we now call Hansen's disease. A special village was laid out by government soldiers to receive them, not too far distant from the Kwiro mission station and district headquarters. It was christened Tabora, for reasons

Mission in Ostafrika, 1911-1945" in *Der afrikanische Körper als Missionsgebiet. Medizin, Ethnologie und Theologie in Afrika und Europa, 1880-1960,* eds. Linda Ratschiller and Siegfried Weichlein (Cologne: Böhlau Verlag, 2015), 95-121. Hözl's comprehensive analysis makes extensive use of missionary sources in a way that is lacking in Eckart's work.

that are obscure.[4] By the end of the year, 441 people had arrived to occupy the site. In the following year a second village was begun adjacent to the first, and the number of inhabitants increased. By the beginning of the First World War a total of 1,381 people had been entered in the registration book of the settlement; 782 were actually surviving at that time. It might be considered to be the largest settlement of its kind in German East Africa.[5]

This was a community that rapidly built its own identity.[6] The original intake consisted of individuals who were often

[4] Tabora was a major commercial settlement of 30,000 inhabitants in the centre of the German East Africa, located along the older central caravan route and – at the time of the establishment of this leper settlement – adjacent to the newly-constructed Central Railway. This almost certainly supplied the inspiration for naming the new settlement. Indeed, the contemporary leper settlement (Linduzi) near Songea was to acquire the designation of 'Morogoro' quite quickly after its founding and was to use this name for the next century. It was not uncommon for new settlements (or new suburbs) in the interior to be named after more prestigious (often coastal) settlements. Kilwa was probably the most ubiquitous example. To avoid any ambiguities, I have enclosed the name of our leper settlement in single brackets.

[5] There are some definitional caveats that could be attached to such an assertion. They will be considered later in the context of a territorial discussion of leper settlements.

[6] Unless otherwise indicated the missionary perspective for the 'Tabora' leper settlement derives from the following contemporary sources: two registration books of the settlement exist within the Mahenge Diocesan Archives [MD]. Within the same repository see specifically Sr. Beatrix Pfäffel, "Kwiro" MD1/1; Fuchs to Spreiter. 31 May 1912. MD/1. Two published descriptions are by Bishop Thomas Spreiter in "Ein Ausssätzigenheim im Bezirk Mahenge von Deutsch-Ostafrika," Missionsblätter 14 (1909-10): 81-83 and "Das Ausssätzigenheim Tabora,"

more elderly and in advanced stages of the disease; they were the 'obvious' afflicted. They had often been further weakened by a long journey to reach 'Tabora'; the initial high death rate reflected this reality. However, subsequent arrivals tended to be younger and were often accompanied by members of their family who had no obvious signs of the disease. The presence of children created a local demand for education. A school was built by internal labour and staffed by resident teacher-catechists who had previously been trained by the mission. A stone church materialized in the same fashion. The members of the settlement expanded geographically across the area assigned to them on the plateau and soon brought surplus agricultural land into production. It was now easier to talk of a distributed agricultural settlement pattern rather than fixed villages. The Mahenge military station assigned a *jumbe* to administer the settlement on a

Missionsblätter 15 (1911):115-19. See also "Ein Ausssätzigenheim im Bezirk Mahenge von Deutsch-Ostafrika," *Gott will es!* (1910): 129. There is additionally an early summary, often based on primary sources, in a study written shortly after the end of the First World War. See Kaplan Franz Szczypior, "Die sozialwirtschaftliche Arbeit der Benediktiner Missionäre von St. Ottilien fur auswärtige Missionen in Apostolischen Vikariat Dar es Salaam, seit der Gründung daselbst bis zur Auswiesung durch die Engländer (1888 bis 1920)." (Diss., Würzburg,1923). Useful data on the initial settlements is also contained in Eduard Desax, "Entwicklungshilfe der katholischen Missionsgesellschaften in Tansania, ihr Beitrag zur wirtschaftlichen Entwicklung des Landes, dargestellt an den Diözesen Ndanda, Songea und Mahenge." (Diss., Freiburg/Friborg, 1975), specifically 143-151.

day-to-day basis. The inhabitants soon became self-sufficient in agriculture and were additionally cultivating bananas as a cash crop. They petitioned for their own *duka* (shop) in 1911, which was duly opened and run by two educated Christians.[7] That led to the existence of a regular market on the edge of the settlement where crops could be sold or exchanged with the wider area.

The primary external input—and it was an important one—was the regular medical visitation of the Benedictine nuns from the Kwiro mission. As the leper community expanded geographically, the nuns found it increasingly difficult to return home before dark, and movement after dark was known to be dangerous in terms of leopard attacks. A mission rest-house specifically for the nuns soon joined the school and the church. The demands of the leper settlement were beginning to push subtly at the more formal definitions of female claustration within the Benedictine orders! 'Tabora' was a striking experiment but it now must be placed in a global and regional context.

3. The Wider Context of Leprosy

In 1884 Berlin was the venue for a conference of colonial powers that resulted in the nominal division of Africa into spheres of influence. Germany acquired Togo, the

[7] Fuchs to Mahenge Station. 17 September 1911; Von Grawert to Kwiro Mission. 17 September 1911. MD1/5.

Cameroons, German South-West Africa (now Namibia) and German East Africa (now Tanzania). The subsequent hosting of the 10th International Medical Congress in Berlin in 1890 had been a spectacular showcase for scientists of the new German state. Professor Rudolf Virchow, one of Germany's most distinguished and versatile scientists, was one of the three keynote speakers along with Joseph Lister and Robert Koch -- the latter emerging as the new German star in the field of contagious diseases. Virchow had spent significant time in his earlier career in the field of leprosy and had tried to establish a standard global methodology for gathering basic data on this disease. Koch's reputation at the time was based on his work in tuberculosis, for which he was to receive a Nobel Prize in 1905. It is very possible that one of the 5,500 physicians at the conference was a newly-qualified medical doctor by the name of Hugo Meixner, who had just joined the Prussian army. He chose to do his advanced medical dissertation on leprosy in East Africa, the earliest academic study of the disease in this geographical area. In 1901 he transferred to the colonial army in East Africa, the *Schutztruppe*, and from 1903 until the end of the First World War he was the chief medical officer for this force as well as the effective chief medical advisor to the territorial colonial government.[8]

[8] "Meixner" in Heinrich Schnee, ed., *Deutsches Kolonial-Lexikon,* II

In 1897 Berlin played host to another major event highly pertinent to our study, the First International Leprosy Conference.[9] Professor Rudolf Virchow was again present and chaired the proceedings. The German Emperor hosted a reception and the German Minister of Health addressed the proceedings. At the most general level, the active official support of the conference was part of a general showcasing of German science by the German state. Yet there was a completely unexpected metropolitan resonance. It had been generally believed that the last sufferer of leprosy in the German lands had died in 1712; none of the constituent German states mentioned the disease in their current public health legislation. However, in the late part of the nineteenth century, leprosy had been discovered anew within the boundaries of Germany, on the edges of the Russian territories and specifically in the area of the Baltic port of Memel.[10] The Prussian state government, with some alarm, sent a series of experts (Robert Koch among them) to investigate the situation. By 1904 the investigators had tracked down sixty-eight individuals whose infection history

(Leipzig: Quelle & Meyer, 1920), 537. His dissertation from the University of Leipzig was published in 1904. He probably gathered the data in 1902-03. Hugo Meixner, *Beitrag zur Kenntnis der Lepra in Deutsch-Ostafrika* (Leipzig: Bruno Georgi, 1904).

[9] One view of this conference is contained in Shubhada S Pandya, "The First International Leprosy Conference, Berlin, 1897: the politics of segregation," *História Ciências Saúde-Manguinhos* 10 (2003):161-77.

[10] The Baltic territory of Memel, although part of East Prussia at this time, incorporated a significant number of ethnic Lithuanians. It is now part of Lithuania and Memel is now known as Klaipėda .

dated back as far as 1848; only ten of those individuals were still alive.[11] These few surviving individuals were not off-shored to an island in the Baltic; eight of them lived out their lives in sheltered accommodation in the pleasant suburbs of a German village.

Although the investigations recognized that the main entry point for the German infection was the bordering Russian territories on the Baltic coast, it did acknowledge that some of those afflicted had contracted the disease overseas, primarily in Asia (modern Myanmar, Malaysia and Indonesia) as well as South America (Brazil, Venezuela and Columbia). This understanding of the extra-territorial dimensions of leprosy in an era of expanding global trade also drew academic attention to the recently acquired German colonies. There were two government-sponsored leprosaria on the East African coast that dated roughly from the year of the Berlin leprosy conference. (There was also another off-shore settlement administered by the Zanzibari government.)[12] The settlement at Bagamoyo (1897) serviced the northern coast and Kilwa (1898) and Lindi (1901?)

[11] The best analysis of these metropolitan investigations is contained in M. Kirchner, "Die Verbreitung der Lepra in Deutschland und den deutschen Schutzgebieten," *Klinischen Jahrbuch* 14 (1905): 1-18. This includes coverage of Meixner's initial leprosy research in East Africa

[12] Stephen Pierce, "The Leper Settlement at Walezo, Zanzibar: a case study of a colonial-era state-society partnership," *Les Cahiers d'Afrique de l'Est / The East African Review* 45 (2012):117-29.

serviced the southern coast. Hugo Meixner's 1904 medical dissertation focussed specifically on the southern settlement of Noro, an island off Kilwa. In its format the dissertation closely resembled the reports issued on the leprosy outbreak area in Germany, closely detailed medical examinations of each named individual with information about their geographical origin. In the same way that the Prussian investigations focussed on suspected regional and global origins of infection, Meixner's report did a similar analysis for the Kilwa settlement.

> What is worth noting is the large number of Nyasa people, who make up more than a third, 20 of the total of 46 sufferers. That contrasts with only 13 coastal people (Swahili).[13]

Given that both Bagamoyo and Kilwa were two of the most important coastal terminal points for trade from the interior, Meixner didn't think that it was unusual that the Kilwa settlement might reflect the substantial flow of human porterage across the territory and potentially predict hotspots for leprosy within a regional perspective. There was, however, an additional factor for considering a high endemic occurrence in the Nyasa area, and that was the type of leprosy that dominated in that Nyasa group at Noro.

[13] The total categorization was Swahili (13), Nyassa (20), Yao (7) and Others (6). Note that one of the 'Other' category was a Bisa man from Northern Rhodesia. Meixner, *Kenntnis*, 31. The Yao themselves could have originated from a very wide area, both within or without the boundaries of the German colony.

Meixner's suppositions were coincidentally reflected in the same year, when a visiting scientist in that western Nyasa area posited a 20% infection rate among the local population.[14]

Meixner's analysis of Kilwa was his last substantive foray into leprosy studies; he was rapidly distracted by other priorities in his new role as the effective chief medical officer for the colony. The initiative for pursuing the study of leprosy was to devolve into the hands of one of his subordinate medical officers in the *Schutztruppe*, Dr Otto Peiper.[15] Between 1908 and 1911 Peiper (operating initially from a Kilwa base), gathered district-level information from across the colony, subsequently buttressed by a baseline dataset established by issuing a standardized leprosy questionnaire to all districts in 1912. The results of his extensive research were published in

[14] Theodor Bechler, *200 Jahre ärztlicher Missionsarbeit der Herrenhuter Brüdergemeine: Missionärzte, Chirugen, ärztlich tatige Missionare, Diakonissen und Schwestern* (Herrenhut: Missionsbuchhandlung, 1932), 173. Professor D. G. Haussleiter of Halle University, besides being a high-ranking participant in German evangelical movement generally, also came to periodically document their global medical activities. He originally visited the Nyasa area in 1904.

[15] Peiper began his colonial career in 1908 as district medical officer in Kilwa before being transferred to Dar es Salaam. Evaluated in terms of his published epidemiological and ethnographic studies, he was arguably the most innovative medical mind in the colonial service in East Africa.

1913.[16] Before we look at his findings (and recommendations) in more detail it might be useful to look at some contemporary territorial perspectives. For example, the number of medical personnel that could act as Peiper's informants had grown substantially. In 1889 only two doctors had been appointed in the region; in 1900, twenty-six doctors; shortly before the outbreak of the First World War, fifty-five doctors were on the ground. In a recent article Bauche has expressed distinct reservations about the ability of such limited personnel to provide reliable and accurate medical data.[17] I would suggest, more optimistically, that this number of interlocutors – concentrating on a very precise line of enquiry – could provide very useful data both absolutely and relatively. The 1912 questionnaire was also not an isolated event in terms of applied methodology. Indeed 1912 can almost be characterized as the year of the

[16] See Otto Peiper, "Die Bekämpfung der Lepra in Deutsch-Ostafrika, "*Archiv für Schiffs- und Tropen-Hygiene* 17 (1913): 1-105. All references in this essay are to this extended presentation; the specific correspondence with the Mahenge station is highlighted on pgs.65-9. A subsequent abridged version was published as Otto Peiper, "Die Bekämpfung der Lepra in Deutsch-Ostafrika," *Lepra* 14 (1914): 192-250. This shorter presentation is often used in summaries by other historians. See, for example, the chapter on 'Leprosy ' in John Iliffe, *The African Poor* (Cambridge: CUP, 1987).

[17] Manuela Bauche, "Doing Research with Colonial Sources: Deconstructing Categories in German East Africa's Medical Reports," in *Sources and Methods for African History and Culture,* eds. Geert Castryck, Silke Strickrodt and Katja Werthmann (Leipzig: Leipziger Universitätsverlag, 2016), 337-9.

Fragebogen; district authorities were also sent questionnaires on issues ranging from Islam to education. The need to gather local data to inform territorial policy may be seen as a sign of a more confident colonial administration recovered from the upheaval of the 1905-07 Maji Maji rebellion. There had also been another earlier, very specific, incentive to gather leprosy data, one that originated from outside the colony. The Second International Leprosy Conference was scheduled for Bergen, Norway in 1909 and the German delegates did not want to appear totally ignorant of the situation in their colonies, or inactive in their policies, given that they had hosted the first international conference.

4. Patterns of Local Involvement

It is now time to look at the diversity of responses revealed by the 1912 exercise. Before we examine the statistical highlights, it might be useful to look at the new 'best practice' thinking laid out by Peiper. At its simplest, it was a choice between centralisation and decentralisation, with the latter becoming the new official preference. The belief was that the creation of widely distributed leper settlements throughout the colony had several advantages. They would incorporate far more individuals identified in local contexts. By binding settlements to local environments and communities, the threat of leakage would be reduced. Local settlements would also encourage practical support from

families and communities, and reduce the pressure on government budgets. Peiper had the power to institute his new ideas in the district of Kilwa. In 1909 he closed down the off-shore settlement of Noro and created five new on-shore settlements scattered throughout the district; the most distant from Kilwa was at the settlement of Madaba on the Mahenge district boundary, ten days' journey on foot from his district headquarters. Peiper himself was not an advocate of missionary involvement in the leprosy campaign and, within the confines of his district domain, it was a moot point. Kilwa was the one southern district devoid of any missionary effort at that time.[18] The neighbouring coastal district of Lindi would also change its operational policy in a nod to decentralisation but in a manner that would generally be seen as disastrous. It would also close its off-shore facilities but its new mainland location was far south in the Kionga Triangle, near the border with Mozambique. It broke one of Peiper's basic decentralisation rules by being distant from any African population settlements that could give support. Its remote distance from the Lindi district office meant that any official medical support was extremely limited. The Noro settlement had scheduled a medical visit every two months; Kionga was scheduled to get one annual visit. The demonstrable chaos of Kionga triggered the creation of a second settlement at Nahinga which, despite

[18] The Benedictine station of Kipatimu was created in the Matumbi hills in 1912 but effectively always functioned as a 'daughter' station of Dar es Salaam.

being closer to Makonde and Mwera settlements, never seemed to have the stability predicted by Peiper.

The questionnaire registered 6,633 sufferers of Hansen's disease in the colony, some 3,809 within established leper settlements and 2,824 without. It would be naïve to think these figures were comprehensive. The 'residency' areas that comprised modern Ruanda and Burundi did not report at all and neither did the neighbouring district of Bukoba. Four other districts replied that investigations were still in progress. It would also be naïve to consider that even the reported district statistics were close to complete. Comprehensive medical statistics requires self-reporting and self-reporting only tends to happen with the promise of a cure. And the initial promise of a cure for leprosy didn't begin to materialize until after the First World War.[19]

[19] There was some experimentation with variations of the drug Nastin, and some of that activity took place at 'Tabora'. However, the territorial consensus was that Nastin treatment needed a technical medical oversight that was operationally unsustainable. At 'Tabora' four inmates in the early stages of leprosy were treated with Nastin and subsequently released. That small experiment is documented in Dr Schumacher, "Zur Behandlung der Lepra mit Nastin," *Archiv für Schiffs- und Tropenhygiene*, 17 (1910): 15-17. Indeed, that territorial judgement was very soon confirmed by a rapid global abandonment of Nastin as an effective treatment. Hugo Rée, " From Turkey with Love: Deycke's Nastin Treatment of Leprosy in Queensland, 1909 to 1913," *Health & History:*

There was also a territorial skew to the reporting; more activity was reported in the South of the colony than the North. The district of Langenburg (the modern Mbeya region) dominated the geographical picture with over 43% of interned lepers within its boundary, its importance curiously 'predicted' by the ethnic analysis done by Meixner off Kilwa a decade earlier.[20] We will return to that area, but it might be interesting to consider the district that ranked second at around 20%, that of Morogoro. It has an additional interest in that it does have an indirect connection with Memel! The epidemiologist Robert Koch had arrived in German East Africa in late 1904 to look at a variety of disease issues, largely connected with cattle. In the course of those investigations, he decided to make a quick trip to Uhehe. On his return journey he made a brief detour at Morogoro to investigate a significant concentration of leprosy.[21] This was almost certainly the settlement of Harrarani in the eastern Uluguru mountains already being investigated by the district

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[20] One is very aware of the dangers of making confident assertions on the basis of these datasets. For a broader statistical context, see Sarah A. Walters, "African Population History: Contributions of Moral Demography," The *Journal of African History* 62, no.2 (2021):183-200.

[21] Robert Koch, "Vorläufige Mitteilungen über die Ergebnisse einer Forschungsreise nach Ostafrika," *Deutsche Medizin* 31, no. 47 (1905): 1865. There is no evidence that a fuller report on this diversion was ever published. The Robert Koch Institut in Berlin only has a short note from local medical staff dated 10th February 1905 attaching a sketch map showing 'probable' leprosy concentration in the southeast quadrant of the Uluguru mountains.

administration in 1904. Although delayed by the events of the Maji Maji rising, seven settlements had been established in the more populous area of the eastern Ulugurus, with four more smaller entities created further west under the supervision of the Kilosa sub-district office. Despite the Uluguru area being the main operational base for the Holy Ghost Fathers, there is no evidence that they became operationally involved. In short, Morogoro may be one of the few places that conformed closely to Peiper's 'best practice' guidelines.

Despite Peiper's reservations, Christian missionary societies started to become involved in leprosy care in the colonial period before the First World War and that involvement was often a joint enterprise with local district authorities, but it was also an engagement where the missionary societies soon took effective control of the day-to-day administration. The earliest Protestant societies in the area that was to become German East Africa were British: the Universities Mission to Central Africa (UMCA) was the first in 1869 followed by both the Church Missionary Society (CMS) and the London Missionary Society (LMS) in 1879. After the formal acquisition of the territory by Germany in 1884 a total of eight German missionary societies began to arrive in the colony. The geographical 'hotspots' of evangelical Protestant activity were two: the northern Lake Nyasa area in the

Langenburg district as well as a northern territorial strip that started at Tanga on the coast and then extended inland along the Pangani Valley to Mount Kilimanjaro. These disparate Protestant missionary groups held their first conference in Dar es Salaam in 1911 to discuss common concerns and strategies. The three Roman Catholic missionary societies (the White Fathers, the Holy Ghost Fathers and Benedictines) operated across a number of designated geographical areas (vicariates or prefectures) assigned by the *Propaganda Fide* in Rome. These Roman Catholic societies held their first territorial conference in 1912. Less than half of all the missionary societies became engaged with leprosy projects by 1912 and not all of those engaged in a significant way. The statistically significant involvement with leprosy occurs in two geographical areas. One is that northern Nyasa area identified earlier and involves the Berliner and, even more significantly, the Moravian Herrenhuter, missionary societies; that involvement effectively begins as early as 1904.[22] The second area was also based in the South, a Roman Catholic initiative

[22] See Marcia Wright, *German Missions in Tanganyika, 1891-1941: Lutherans and Moravians in the Southern Highlands* (Oxford: OUP, 1971); K. Fiedler, *Christianity and Culture. Conservative German Protestant Missionaries in Tanzania, 1900-1940* (Leiden: Brill, 1996). Unfortunately, neither of these works considers the leprosy engagement. Indeed, the medical mission in general receives sparse attention. See, instead, Bechler, *200 Jahre*, 173-177. The very earliest engagement is documented specifically in "Aussätzgeheime," *Monats-Blatt der Norddeutschen Missionsgesellschaft* (1905): 83 and "Aussätzigen-Kolonien am Nyassa," *Missionsblatt aus der Brüdergemeine* 69 (1905): 8.

illustrated by that Benedictine example described in the opening paragraph of this essay.

The initial assertion that 'Tabora' was the largest leper settlement in German East Africa now needs to be made more specific. If one were to count just the number of settlement residents afflicted with leprosy, then that statement is indeed accurate. However, if one were to include *all* residents within the boundaries of a settlement, whether ill or healthy, then 'Tabora' would drop to third place. Expressed statistically (in terms of resident lepers) the top three missionary rankings would appear thus in 1912: Herrenhuter (26.91%), Benedictine (16.64%), Berliner (16.33%). The total percentage involvement by all missionary societies was 61.07%. The district dominance of Langenburg with its ten settlements provided another variation on the decentralisation vs centralisation theme.[23] In many ways the primary geographical terrain resembled that south of Morogoro. With a few exceptions, the settlements were situated in a concentrated zone at the northern end of Lake Nyasa, never that far distant from the district headquarters or a mission station. The large settlement at Rutengano was near to the Herrenhuter station of the same name and only two hours' distance from the district headquarters. In a

[23] The official discussion is laid out in Peiper, *Lepra*, 70-84.

sense, it resembled the Mahenge-Kwiro-Tabora triangle. That proximity facilitated medical support from the district station and mission personnel. 'Tabora' had a significant female component but—in Langenburg—women were overwhelmingly in the majority in the two largest settlements and roughly equal in the third. On the offshore island of Noro, lepers had been exclusively male, serviced (occasionally) by male medical practitioners. The new gender composition of settlements (along with the inclusion of children) might suggest that female religious figures were increasingly better positioned to deal this new mixed environment.

The 1912 snapshot obviously documented a work-in-progress. There were further developments over the next two years before the chaos of the First World War refocused energies, and we are able to examine some of those within our southern sphere of attention. Within the four informal operative regions overseen by the Benedictines, three (Kwiro, Madibira, Peramiho) had participated in the initial leprosy initiative, and it was probably not completely coincidental that those three stations were headed by priests who had received basic training in tropical medicine. There were also distinct differences in initial initiatives. In the Songea district, it was the district officials who took the first step to approach Peramiho in mid-1911. A fourth centre, Ndanda, became involved slightly later and that involvement was partly in reaction to the chaotic leprosy strategy by the

Lindi district administration. When missionary priests from Ndanda paid a visit to Muhinga at the beginning of 1911 they were shocked at the conditions and the lack of care provided to residents. A petition to the district administration to transfer responsibility to the mission remained unanswered for six months. Then it was agreed. In 1913 the lepers were transferred to a site called Mwena near Ndanda; the numbers at the site initially peaked at about eighty. The missionary sisters assumed immediate medical supervision.[24]

There was also a third thread of engagement with leprosy in German East Africa that had little to do with European actors and which has probably been insufficiently acknowledged. The early leper settlement at Bagamoyo, while under the administrative control of the German administration, had a unique financial underpinning. The Ismaili merchant Sewa Haji Paroo (1851-1897) had carved out a lucrative commercial niche at Bagamoyo controlling goods and labour that flowed across the central trade route.[25] Shortly before his death he endowed a series of projects (schools, wells and a leper settlement in Bagamoyo) as well

[24] Siegfried Hertlein, *Ndanda Abbey Part I: Beginning and Development up to 1932* (St. Ottilien: EOS Verlag, 2008), 226-227. Also see Walter, *Sustained*, vol II, 285-302.

[25] A good summary of his commercial career is contained in Stephen Rockel, *Carriers of Culture: Labor on the Road in Nineteenth-Century East Africa* (Portsmouth, N.H: Heinemann, 2006), 90-2.

as the construction of the first major hospital in Dar es Salaam. He left a portfolio of property in trust to the colonial government to provide long-term funding for these projects. It was an act of pure philanthropy that did not recognize race or creed.[26] The declining economic importance of Bagamoyo, however, created a school of thought within the territorial government that argued that the merchant's financial bequest could be spent, not just within Bagamoyo itself, but also across the trading network in which he had operated, effectively envisaging a 'virtual' Bagamoyo that extended across the central swathe of the colony. This imaginative re-interpretation of the bequest would potentially create a source of funding for additional leper settlements, a source that did not impact on existing government budgets.[27]

5. The Passion Flowers: A View of a Missionary Woman

The scientific journey of leprosy interest, from Berlin to Mahenge, might be conjoined with another journey of interest that leads from Bavaria to the Kwiro mission station on the Mahenge plateau.

Before the First World War, only one German Catholic missionary order maintained a presence in Africa. The

[26] The historical role of Asian philanthropy is discussed in Robert Gregory: *The Rise and Fall of Philanthropy in East Africa*: *the Asian Contribution* (Piscataway, NJ, 1991). It is a discussion that has its limitations. It does not mention Sewa Haji Paroo.

[27] For a discussion of this interpretation see Peiper, *Lepra*, 8-11.

Benedictines of St. Ottilien were a new entity established with some difficulty in the late nineteenth century within the context of the anti-clerical *Kulturkampf* atmosphere of German politics.[28] In 1887 the *Propaganda Fide* assigned it a huge, vaguely defined area in southern East Africa known initially as the Apostolic Prefecture of South Zanzibar, its name a reflection of the ambiguous relationship between the Sultanate of Zanzibar and the German East African Company who had extracted a concession to administer the coastal strip from 1884. The Benedictines arrived to set up a station at Pugu, inland from Bagamoyo, and their work initially focussed on freed slaves. The heavy-handed activities of the chartered company touched off a coastal rebellion in 1888 in which the Benedictines were collateral victims; their station was destroyed and three of their members killed. They were forced to retreat to Germany. During 1889 and 1890 members of the missionary order gradually filtered back to a new base at Dar es Salaam; in 1891 this became the territorial capital of the new German colony of German East Africa (now Tanzania). Suffering from a prolonged leadership crisis, a chronic shortage of personnel, and endemic malaria, they were able to make little headway in the years immediately following, concentrating with limited success on freed slave

[28] For the details of the order's convoluted origins see the first volume of Frumentius Renner ed., *Der fünfarmige Leuchter*, 2 vols. (St. Ottilien: EOS Verlag, 1971).

settlements and orphanages around the capital. Only under the energetic leadership of a new Apostolic Prefect, Maurus Hartmann (1894-1902), did the Benedictines receive new life---just in time to follow on the heels of the German military as they conquered the southern interior. In rapid succession, mission stations were established at Lukuledi (1895) and Nyangao (1896) in the Lindi hinterland; Tosamaganga (1897) and Madibira (1897) in the Southern Highlands; and Peramiho (1898) and Kigonsera (1898) among the Ngoni polities of the southwest. The mission station at Kwiro in the Mahenge Highlands, re-established in 1902, was the last of these pioneer regional 'mother' stations. The Benedictines had initially arrived in East Africa with one priest, five lay brothers and four sisters. By late 1913 that had risen to 23 priests, 39 lay brothers and 56 sisters.[29]

The metropolitan confinement to one German base at St. Ottilien in Bavaria, and to a restricted initial activity on the coast, helped to disguise the reality that the 'Benedictines' actually consisted of two distinct organizations based on gender. This perception started to change shortly after the initial burst of territorial expansion in East African interior. One of the first nuns at Lukuledi, Sister Birgitta Korff, was

[29] The best overview of this initial period see Frumentius Renner, "Die Benediktinermission in Ostafrika," in *Der funfärmige Leuchter, Beiträge zum Werden und Wirken der Benediktinerkongregation von St. Ottilien*, ed. Frumentius Renner (St. Ottilien: EOS, 1992),13-118. One might also consult Sebastian Napachihi, *The Relationship between the German Missionaries from St. Ottilien and the German Colonial Authorities in Tanzania 1887-1907* (Ndanda: Benedictine Publications, 1998).

pulled back to Germany to take up the new post of Prioress General, an act that in itself started to more formally differentiate the roles of the male and female religious at St. Ottilien. This was followed in 1902 by a decision to geographically relocate the sisters to the Bavarian lakeside town of Tutzing, a task that had been completed by the beginning of 1904. Tutzing began to consider requests for its female personnel from Roman Catholic organizations other than St. Ottilien. In 1903 it sent its first contingent to Brazil, in 1906 to the Philippines. A growing sense of their own distinct identity also led to the publication of a history in 1905 (updated in 1921) that detailed their initial work in Africa and then in other parts of the world.[30] In some sense, one can see the Tutzing sisters as 'contractors', comparable to the many male overseers that worked in the large corporate plantations around Lindi or up the Pangani Valley.

It is also necessary to construct a broad overview of the developing operational strategy of the Benedictines in German East Africa. There had to be an acceptance early on

[30] *Passionsblumen aus dem fernen Süden: kurze Darstellung der Arbeiten, Leiden und Erfolge der St. Benediktus-Missions-Schwestern in Deutsch-Ostafrika* (Tutzing, 1905). A later edition in 1921 covered a more global reach. *Passionsblumen und Pfingstblüten in dem Wirken der Missionsbenediktinerinnen von Tutzing* (Tutzing, 1921). For more recent internal scholarship see Bernita Walter, *Sustained by God's Faithfulness: The Missionary Benedictine Sisters of Tutzing*, 2 vol. (St. Ottilien: EOS, 1985 and 1992).

that there would be no immediate large-scale conversion of the adult population. The primary emphasis then switched to the vehicle of the 'bush' school to build a Christian population from the bottom up starting with the youth. It was a long-term strategy, but in the short-term it was held back by the wait for trained African catechist/teachers to materialize and, in the medium term, by the need for more priests who could create 'daughter' stations that would begin the process again. This was a demand for 'male' personnel. Benedictine literature might speak of hospitals and leper settlements as the means for influencing adults and saving the souls of those in danger of death – yet, typically, it was a more practical reason which motivated the initial application of the Father Superior at Kwiro in 1909; he wanted to protect his expanding school network from contact with the disease.[31]

The arrival of Bishop Thomas Spreiter in the colony in 1907, however, contributed to a re-thinking of various approaches to the missionary effort. He was an initial advocate of the increased involvement of the female contingent of his organization, seeing them as the tools that would interface with the adult female African population and do so particularly at the pivotal ceremonies of birth, puberty and marriage. His thinking did not take place in a vacuum. He was aware of the historical efforts of the UMCA, including their extreme reluctance to involve female personnel until a

[31] Fuchs to Mahenge Station. 29 April 1909. MD1/7.

very late date.[32] Within several years Spreiter would come to admit that he had been overly-optimistic in his considered role for women; that it was no simpler for nuns to interface with adults than it had been for his male priests. This left Roman Catholic sisters with limited options. They could teach female students at the mission station; they could even try (not entirely successfully) to maintain a 'cloistered' *Internat* for young women awaiting marriage to Christian spouses. However, attention repeatedly returned to the exercise of a medical mission administered from a fixed base. The leper experiments substantially helped to enable this trend.

There was another trend of mission interaction with an adult African population that did tie very specifically to the leper settlements and was particularly marked in the early years of the 'Tabora' settlement. Individuals in the advanced stages of leprosy, usually physically disconnected from their family, were obvious candidates for inclusion in the Roman Catholic

[32] The UMCA environment is described Terence Ranger, "Godly Medicine: The Ambiguities of Medical Mission in Southeastern Tanzania," in *The Social Basis of Health and Healing in Africa*, eds. Steven Feierman and John M. Janzen (Berkeley, Los Angeles & Oxford: University of California Press, 1992), 25-84. This had initially appeared in *Social Science & Medicine. Part B: Medical Anthropology* 15, no.3 (1981): 261-77. It can be usefully paired with a recent treatment of UMCA medicine in a more extended geographical area. Charles M. Good. *The Steamer Parish: The Rise and Fall of Missionary Medicine on an African Frontier* (Chicago: University of Chicago Press, 2006).

Christian community at the moment of death, *in periculo mortis*, and this was a rite that did not need a priest present; it could be (and often was) administered by a sister.[33]

6. A Wider Definition of Medical Attention

The focus on leper settlements may be somewhat restrictive unless we consider the wider perspective of the emerging acceptance of Western biomedicine by an African population. It might be useful to return to the Kwiro mission station. In the year before the creation of 'Tabora'—in the absence of any missionary sisters—the mission station had spent just 22 rupies on dispensed medicine. This changed dramatically after 1909. In 1913 there were 3,940 house visits made by the sisters to offer medical assistance. In the course of those visits 10,317 treatments were made (bandaging, teeth-pulling, etc.) as well as 6,183 issuances of medicine.[34] Even if one factors in the activity within the leper settlements, this is still a significant medical interaction with the local Pogoro population surrounding the Kwiro mission,

[33] The linkage between leper settlements and Christian conversion is key to Manton's studies of Irish Catholic missionaries in Nigeria. See in particular John Manton, "Global and Local Contexts: the Northern Ogoja Leprosy Scheme, Nigeria, 1945-1960," *História, Ciências, Saúde-Manguinhos* 10 (2003): 209-23; "Administering Leprosy Control in Ogoja Province, Nigeria, 1945–67: A Case Study in Government–Mission Relations," *Clio Medica/The Wellcome Series in the History of Medicine* 80, no.1 (2006): 307-31.

[34] "Statistik betr.Krankenfürsorge in Kipatimu, Kwiro u. Ifakara". Appendix to Szczypior, "Arbeit".

one that was conducted on a peripatetic basis rather than a service offered from a central location. If one were to consider Peramiho in the Songea district, where missionary sisters arrived in 1901, then that peripatetic pattern was already evident quite early. In that particular location, there was the presence of a missionary sister who had worked in a nursing capacity in Dar es Salaam since 1891 and had subsequently had further training in a German hospital between 1898 and 1900. There was a similar nursing presence in the new station established at Ndanda in the Lindi hinterland in 1907, again with a peripatetic regime.

It may also be instructive to look at several other contemporary examples that are not mission-centred. In 1909 a German woman arrived in Lindi to join her husband who was a contract overseer on a plantation near Lindi. They had planned a two-stage hunting trip that was to encompass the northern and southern borders of the Lindi district. Margarethe von Eckenbrecher was a teacher, a published diarist and a veteran of another German colony in Africa. Just before the trip she had engaged in an intensive course in practical tropical medicine. The first stage of her trip traversed the Mbwemkuru River that served as the effective physical boundary between the Kilwa and Lindi districts. This was not an established commercial route and it appears to have had little touring attention from the staff of either the Lindi or Kilwa district administrations. Certainly, no

European woman had ever travelled in this area before. As she headed westward towards the Mahenge district boundary she began to minister to the occasional medical needs of their porters. Almost immediately, the news of a female *mganga* began to spread along her route and she was besieged for days by those seeking medicine, the majority of the supplicants were women and their children.[35] It was actually not the first time von Eckenbrecher had encountered a female demand for medicine! On her arrival in Lindi she was temporarily housed in a ward of the local hospital because of a shortage of hotel space in town. On the following morning she was awakened by a loud clamour. Her enquiry elicited the response that "... six hundred native women had already gathered for the purpose of obtaining a vaccination, since smallpox was having a strong impact on the natives of Lindi." [36] Sadly, we know little else about this intriguing event. But the demand for smallpox vaccinations tied into a local public consciousness; a major smallpox epidemic had ripped through the South almost a decade earlier and triggered a massive emergency response. The re-appearance of smallpox in 1909 initiated a more territorial initiative; some 400,000 additional people are said to have been vaccinated in that year, about 10% of the total

[35] Margarethe von Eckenbrecher, *Im dichten Pori: Reise- und Jagdbilder aus Deutsch-Ostafrika* (Berlin: Ernst Siegfried Muller, 1912), 64-86.
[36] Von Eckenbrecher, *Pori*, 26. Yet another health scare emerged in Lindi town several weeks later. An individual died of the plague (*Pest*), and infected rats were identified. As a result, increased regulatory measures were enforced on shipping arriving and departing from the port.

population.[37] Indeed, the ubiquitous Dr Otto Peiper was engaged in a major smallpox vaccination tour in 1909 along the northern boundaries of the Kilwa district, close to the time when Margarethe von Eckenbrecher was travelling along the southern boundary.[38] His Lindi counterpart was engaged in a parallel operation at the same time, presumably along the Lukuledi valley.[39]

And leprosy does specifically figure in the observations of this female traveller. As she sailed up the Lukuledi on the Ruvuma leg of her trip she passed the recently abandoned leper settlement at Kisiwa. But she also observes "several hundred" leprosy sufferers being transferred on *dhaus* from the interior. This suggests a much more complex operation unfolding in 1909 than a simple transfer from Kisiwa to Kionga. It indicates a second temporary island settlement that was being fed by a renewed district initiative to flush

[37] "Pocken-Bekämpfung in Deutsch-Ostafrika," *Deutsch-Ostafrikanische Zeitung* 27, no. 22 (1910), 361.

[38] Otto Peiper, "Über Säuglingssterblichkeit und Säuglingsernährung im Bezirke Kilwa Deutsch-Ostafrika," *Archiv für Schiffs- und Tropenygiene* 14 (1910): 233–59. This is arguably the first major study of infant mortality in Tanzania.

[39] "Gesundsverhältnisse in den Bezirken Kilwa und Lindi," *Deutsch-Ostafrikanische Rundschau* 3, no. 9 (1910). On the same page as this article, there is a separate reference to 7,000 people being vaccinated for smallpox on the border of the Mwanza and Tabora districts.

out leprosy sufferers from across the district.[40] And this was taking place at almost the exact time that the 'Tabora' settlement was being initiated. Von Eckenbrecher mused on what she saw and fused it with other conversations she had on her trip.[41]

> There is much leprosy in East Africa. The *jumbe* or *akida* of every location has the responsibility to produce all of their leprosy sufferers for the purposes of isolation and treatment by the government. This action will reduce the expansion of infection. The natives strenuously resist such measures; they seek to disguise their illness as long as possible and to hide any sufferers.

Within days von Eckenbrecker came to terms with leprosy on a personal level. As her Swahili comprehension increased, she eventually became aware that her personal cook was a leper in remission. He was dismissed, sent to Lindi, where it is highly probable, he was transported southwards to Kionga.

7. The Philanthropic Effect: A Global Context

In 1914 a pamphlet entitled *Sorgenkinder*, written by the most senior Benedictine cleric, was published in

[40] The renewed leper identification initiative may well have been facilitated by the smallpox vaccination tours undertaken in both Kilwa and Lindi districts in 1909.

[41] Von Eckenbrecher, *Pori*, 131

St.Ottilien.[42] A second edition appeared in 1918 and yet a third in 1922. It was a treatise on the three earliest leper settlements in which the missionary order had been involved in East Africa. It bears examining from a variety of perspectives. First, it was obviously part of an extensive publicity portfolio that existed to extract funding from the Roman Catholic faithful of (primarily) Bavaria. Indeed, the front and back covers of the pamphlet provide a comprehensive listing of all the periodic and occasional items of that portfolio. Only one earlier pamphlet seems to deal explicitly with East Africa and that is a best-selling, harrowing account of death and destruction within the early mission environment![43] In short, death, destruction and disease are universal topics for stirring charitable impulses.[44]

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[42] Norbert Weber, *Sorgenkinder: Rundgang durch die Aussätzigendörfer im Süden von Ostafrika* (St.Ottilien: Missionsverlag, 1914). This sits as the eighth publication in the *Im Kampf fürs Kreuz* series.

[43] Linus Leberle, *Martyrerblut ist der beste Same für neues Christentum. Ein Gedenkblatt an die Ermordung der Benediktinermissionäre von St. Ottilien in Ostafrika, an die wiederholte Vernichtung und das wiederholte herrliche Aufblühen der dortigen Mission der Benediktiner.*(St. Ottilien: Missionsverlag, 1913). This sits as the seventh publication in the pamphlet series. It was to be repeatedly published through to 1930.

[44] Outside of the Benedictine environment, the German-language periodical *Gott will es!* seemed to specialize in 'shock' stories (famine, epidemics, and locusts) from the mission environment. It was utilized by all the East African Roman Catholic missionary societies, not just the Benedictines. For a wider contextual discussion see Richard Hölzl," 'Mitleid' über große Distanz: Zur Fabikation globaler Gefühle in Medien der katholischen Mission, 1890-1940," in *Mission global? Eine*

The pamphlet is constructed as a connected journey across the East African landscape. Since the author himself never made such a journey in the timeframe indicated, it suggests a reconstruction from published and archival sources. The shaping of a story around suffering children could not have been realized without the drastic organizational changes in the leprosy model that had been made in East Africa in the years just leading up to 1914.

The narrative journey shares certain specific observations that have either local or global relevance. In the leper settlement near Peramiho, the traveller notes that hoes have been obtained for the lepers from local Matengo ironsmiths, but immediately follows up with a comment on how that will impact the local mission budget. In the Mahenge Highlands the importance of acquiring souls for Christianity is again emphasized, indeed it is specifically quantified. It is suggested that of the first 300 lepers to die at 'Tabora', some 172 individuals had accepted Christian last rites. The same location is used to highlight the fact that the papal authorities made the first donation to fund the construction of the leper chapel. The author would also throw out the name of an author ('Stoddard') and a place ('Molokai') and assume his audience would know the wider context, that he was talking about a Belgian missionary priest who died of

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Verflechtungsgeschichte seit dem 19. Jahrhundert, eds. Rebekka Habermas und Richard Hölzl, (Cologne: Böhlau, 2014), 265-94.

leprosy on an island in the Hawaiian complex.[45] The global references can be seen in conjunction with a decision in 1922 to produce an English version of this pamphlet.[46] The additional use of the English medium might obviously be seen in the contemporary struggle of the German Benedictines to re-establish their physical presence in their previous territory in East Africa, a territory now controlled by the British. It might also be seen in the context of the scattering of Benedictine personnel into a wider South African context. But there is probably a more specific reason. In 1921 Archabbot Norbert Weber launched a major fundraising initiative in the United States. His initial emissary was P. Michael Heinlein, a priest who, from 1912, had acquired his initial East African experience at Kwiro in the Mahenge Highlands. He was soon joined in that

[45] The reference (and embedded quotation) almost certainly refers to Charles Warren Stoddard, *The Lepers of Molokai* (Notre Dame, Ind.: Ave Maria Press, 1886). American audiences might have been even more familiar with a more concise (and later) pamphlet by the same author. Charles Warren Stoddard, *Father Damian: the martyr of Molokai* (San Francisco: Catholic Truth Society, 1901). German discussions of this same location and individual would already be appearing as early as 1892. The global 'Damien effect' is discussed in the last chapter of Rod Edmond, *Leprosy and Empire: A Medical and Cultural History* (Cambridge: Cambridge University Press, 2006).

[46] Nobert Weber, *The Children of Sorrow:A Walk through the Leper Stricken Villages in Southern East Africa* (St. Ottilien: Missionsverlag, 1922). The proposed publication date must be seen in the wider context of four other existing pamphlets being translated into English in 1922.

endeavour by Bishop Thomas Spreiter, now operating from a base in Natal. One of the concrete outcomes of their American initiative was the establishment of a Benedictine presence at Newton, New Jersey in 1924.[47]

One might return to the pamphlets concerned for one last observation. The advertising content on the sleeves of *Sorgenkinder* emphasizes the role of "heroic Sisters". Yet the internal textual narrative is carried by a senior male missionary figure who on occasions overrules the actions of local female missionaries. This is visually reinforced by the cover artwork that shows a patriarchal figure bestowing blessing on a group of (oddly adult) supplicants set against the palm trees of a coastal landscape. The translated content of *The Children of Sorrow* remains true to the original but the cover artwork has been substantially changed. It now shows the figure of a single female nun crouching protectively over a single child. The background to that scene is now evocative of the Mahenge Highlands. The year 1922 is also a convenient trigger point for additional scholarship, as well continuing our localized discussion of leprosy. [48]

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[47] Maximin Mayr, "St. Paul's Abbey in Newton, New Jersey/USA," *Der fünfarmige Leuchter* II, 110-115.

[48] John Iliffe uses it as the effective start of his examination of African medical personnel in East Africa. John Iliffe, *East African Doctors* (Cambridge: Cambridge University Press, 1998). The same is true for an extensive outsider analysis of the Benedictine environment. Christine Eggers, *Transnationale Biographen: Die Missionsbenediktiner von St.Ottilien in Tanganyika 1922-1965* (Cologne: Böhlau Verlag, 2016). This is

8. What Happened Next

That proposed connection over time can be briefly examined in a variety of retrospective views that might start with the three initial leper settlements established by the Benedictines. In 1998 the Benedictine sisters at Peramiho issued an annual medical report, slightly extended to transform it into a centennial issue.[49] Within that report, the leper settlement still existed at Lunduzi/Morogoro, now extended and adapted to incorporate those afflicted with AIDS and tuberculous. However, the bulk of the centennial report succinctly describes the contemporary existence of a massive and sophisticated medical network that stretched from centralized hospital facilities to decentralized dispensaries spread over a wide geographical area. Whereas Bishop Spreiter might have subtly used the leper experiments to appeal to an audience of German-speaking

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synthesized in Christine Egger "The importance of difference in the making of transnationality: biographies and networks of the Benedictine mission in Tanganyika (1922–65)," *European Review of History: Revue européenne d'histoire* (2018) 25 no.3-4: 450-71.

[49] *St. Joseph's Mission Hospital Peramiho: 100 Years Peramiho Mission 1898-1998*. (Peramiho: Benedictine, 2019). A specific view of the local demographic impact in the immediate post-war period is contained in Eginald P. Mihanjo, "Reconstructing Causes of Death in Songea District in Songea District, Tanzania during the Early Colonial Period: Peramiho Parish Register 1900-1925," *Tanzanian Journal of Population Studies and Development* 8, nos.1/2 (2001): 70-83. Mihanjo does not use any wider German sources for his leprosy comments. He relies on Kurt Baslev, *A History of Leprosy in Tanzania* (Nairobi: AMREF, 1989).

donors, a century later those international connections are additionally extended to a wide range of specialized NGOs and international agencies. Yet another centennial publication appeared in 2019 to celebrate the activities of the Italian Consolatas in the Southern Highlands.[50] The section that details the advent of the Consolata sisters immediately launches into a lengthy discussion of the abandoned leper settlement at Madibira, and its centrality to the renewed Consolata medical effort in the 1920s. There exists no similar centennial account of what used to be the Mahenge *Militärbezirk*, yet we do have an academic study that intimately documents the re-connection of Swiss Consolata sisters to the site that opened our discussion. In 1922, a contingent of Swiss missionaries disembarked from a train at Kilosa ready for a 14-day southward journey on foot that would terminate at Kwiro. Among them was Sister Innozenz Hürlimann, who had just spent a year in the Roman Catholic medical facilities in Dar es Salaam. When Margarete von Eckenbrecher made her 1909 trip, she never anticipated the demand for her medical services. The Swiss sister does anticipate and packs her medical gear accordingly. On the night of their first camp, they are swamped with medical supplicants and that picture is replicated throughout their entire journey. Soon after her arrival at Kwiro, she was

[50] Francesco Bernardi, *Like the Baobab: Wamisionari wa Consolata Tanzania, 1919-2019* (Dar es Salaam: Consolata Procura, 2019). The summary is derived from Alessandro di Martino, *Carteggio di un prestito per il Regno, 1919-1935 Tanganyika*, (Turin:Edizioni Missioni Consolata, 1987).

presented by the local administration with formal responsibility for 'Tabora' and she was to retain that position for the next eight years.[51] The material support for the 'Tabora' settlement by both civil and missionary participants would subsequently decline during the Depression and the Second World War. By around 1948 the institution had virtually ceased to exist, leaving a few stone buildings to commemorate its origins.[52] The deterioration of support at that site was paralleled by a shift of the Swiss missionary medical efforts off the Mahenge plateau down to the commercial centre at Ifakara on the Kilombero river, a site consistently considered by the British (and German) administration to be too 'unhealthy' for European habitation. The extensive medical (and research) facilities that emerged

[51] Edgar Widmer, *Zur Geschichte der schweizerischen ärtzlichen Mission in Africa unter besonderer Berüchsicthtigung des medizinischen Zentrums von Ifakara, Tanganyika* (Basel: Benno Schwabe, 1963), 30-32.

[52] This shift in material circumstances is documented in Marcel Dreier, *Health, Welfare and Development in Rural Africa: Catholic Medical Mission and the Configuration of Development in Ulanga/Tanzania, 1920-1970* (Basel: Bommer, 2019) 48-56, 185-92. The leprosy developments are also considered within his specific wider discussion of the female missionary practitioner. Marcel Dreier, "'Wer möchte da nicht krank sein in den sorglichen Armen von Schwester M...': Schweizer Ordensschwestern und der Wandel von Fürsorge- und Pflegeidealen in Ostafrika 1920-1990 " in *Geschichte der Pflege - Der Blick über die Grenze*, eds. Vlastimil Kozon, Elisabeth Seidl and Ilsemarie Walter (Vienna: ÖGVP, 2011), 203-25. Also see Marcel Dreier, " 'Europäisch gebären'. Katholische Mission, Mutterschaft und Moderne im ländlichen Tansania1930-1960," in *Der Schwarze Körper*, 153-74.

at Ifakara attracted substantial academic and philanthropic investment from Switzerland in a similar way that the Benedictines exploited their metropolitan German connections. [53] The Ifakara site would eventually spawn a new leprosy treatment centre in the 1950s linked to the existence of modern drug treatments.

The settlement at Mwena near Ndanda had been the last Benedictine leprosy initiative during the German period. Receiving some government support as late as 1915, it was arguably the site most impacted by the conflict and privations of the war. By 1918 it had virtually ceased to exist. As the Benedictines began to rebuild their infrastucture, the effort at Mwena also began to revive. Three Benedictine sisters would provide continuous oversight between 1927 and 2000. The resident numbers would grow from 49 (1927) to 651 (1950). However, there was an additional organizational resource at Ndanda that was unique. Sister Thekla Stinnesbeck was the first qualified medical doctor to operate within the Benedictine jurisdiction and was to do so continuously between 1926 and 1959. The combination of her medical qualifications and her longevity provided the ideal ethical and operational environment for the application of curative experimentation to supplement the palliative care offered by the other sisters. And as such she established an

[53] To Dreier's work cited above, one can add Lukas Meier, *Swiss Science, African Decolonization and the Rise of Global Health, 1940-2000*. (Basel: Benno Schwabe, 2014). This work makes no reference to leprosy.

internationally-recognized scientific recognition for leprosy care at Mwena.[54]

The silent gap in our retrospective is that Nyasa corridor that so dominated the 1912 survey. In 1926 a conference of German evangelical missionary societies decided to initiate another survey of the medical mission, a task last done in 1914. The resulting work devotes little more than a sentence to the Nyasa region, a suggestion that a 'nursing station' was established near Isoko in the later 1920s to deal with the renewed care of lepers.[55] At the beginning of the Second World War, the German evangelical component would effectively disappear from the colony.

As a territorial infrastructure was rebuilt in the 1920s, and then battered by the Depression and yet another global war, it was often the presence of the medical component that provided the important re-instituted contact between an African population and European missionaries. On a broader scale, the missionary medical infrastructure started to form a greater importance than anything provided by the nascent British colonial administration, and indeed the immediate

[54] Siegfried Hertlein, *Ndanda Abbey Part II: The Church Takes Root in Difficult Times 1932-1952* (St.Ottilien: EOS Verlag, 2011), 248-52.
[55] *Die Deutsche Evangelische Àrztliche Mission nach dem Stande des Jahres des Jahres 1928*. (Stuttgart: Evang. Missionsverlag, 1928), 121.

post-independence government. [56] And that expanded structure would continue to make room for leprosy. The figure of Dr Leader Stirling, Tanzania's first minister of health, somewhat illustrates many of the structural changes and continuities. He arrived in southern Tanganyika to work as a doctor for the UMCA in 1935. Converting to Catholicism in 1949, he would subsequently construct a massive medical infrastructure for the Benedictines at Mwena. At the age of ninety, he would write a small appreciation of his considered Tanzanian medical heroes.[57] Two of them (Edith Shelley and Robin Lamburn) would be specialists in leprosy care.

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[56] The later development of the medical infrastructure in the South is complex and is addressed in considerable detail by other scholars. See, for example, Michael Jennings, " 'Healing of Bodies, Salvation of Souls': Missionary Medicine in Colonial Tanganyika," *Journal of Religion in Africa* 38, no 1 (2008): 27-56; *Idem*, "A Matter of Vital Importance: The Place of Medical Mission in Maternal and Child Healthcare in Tanganyika, 1919-1939", in *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa* ed. David Hardiman (Amsterdam & New York: Clio Medica, 2006), 227-50. Southeast Tanzania specifically is covered in the work of Bruchhausen, for example, Walter Bruchhausen, *Medizin zwischen den Welten: Geschichte und Gegenwart des medizinischen Pluralismus im südöstlichen Tansania.* (Göttingen: Vandenhoeck & Ruprecht, 2006); a useful overview is contained in his "Medicine between religious worlds: The Mission hospitals of South-East Tanzania during the twentieth century," in *From Western Medicine to Global Medicine: The Hospital Beyond the West*, eds. Mark Harrison, Margaret Jones and Helen Sweet (New Delhi: Orient Black Swan, 2009), 172-97.

[57] Leader Stirling, *Heroes of the Faith in Tanzania: Seven Witnesses from the Central African Mission 1880-1993.* (Ndanda/Peramiho: Benedictine Publications, 1997). The fact that Stirling's leprosy heroes sit in the UMCA environment should remind us of still relatively undeveloped research areas!