Colonial Power in Development: 
Tracing German Interventions in Population 
and Reproductive Health in Tanzania

A thesis submitted to the University of Manchester for the degree of 
Doctor of Philosophy in the Faculty of Humanities

2012

Daniel Bendix

School of Environment and Development, 
Faculty of Humanities
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Abstract

Colonial Power in Development: Tracing German Interventions in Population and Reproductive Health in Tanzania

Daniel Bendix

For the degree of Doctor of Philosophy at the University of Manchester, December 2012

This thesis examines the impact of the colonial past on contemporary Development. More specifically, it investigates how colonial power – conceived as discourses which emerged during colonisation and their interconnectedness with the material world – continues to shape present-day ideas and practices of Development actors from the global North that intervene in the lives of people in the global South. The colonial legacy of German Development cooperation is under-researched, and postcolonial Development Studies have yet to examine specific policies and their implementation in detail. This study focuses on German Development intervention with a focus on population and reproductive health issues in Tanzania, a former German colony.

In order to investigate the influence of colonial modes of thought and practice on contemporary Development, this thesis develops and implements the methodology of genealogical dispositif analysis. Genealogy traces the historical emergence of policies and examines their present-day persistence, while dispositif analysis is an extension of discourse analysis enabling the research of discourses and their relationship with practices, institutions, and political-economic conditions. The study thus analyses the emergence of German interventions in what is now Tanzania with regard to population and reproductive health during Germany’s colonisation of “German East Africa” and compares these interventions to present-day German Development cooperation in Tanzania, where reproductive health is one of the focal areas.

Drawing on archives, interviews, and observations in Germany and Tanzania, this research finds similarities between contemporary German policy and practice regarding population control and colonial-era interventions. In particular, it shows how racialised, gendered discourses are connected to philanthropic legitimising strategies and the political economy of population control. In addition, policies and practices regarding obstetric care in contemporary German Development aid reflect hierarchies between Western and East African practices which are similar to those formed during colonial rule. Since the colonial period, East African obstetric care has been constructed as in need of catching up with German childbirth practices. In terms of how and with what effects colonial power is challenged in contemporary German Development cooperation, this research found that while narratives of German professionals reveal some doubt and uncertainty regarding dominant Development thinking and practice, they do not represent a fundamental threat to the persistence of colonial power. Colonial power tends to take effect in the face of and despite opposition. The thesis concludes that colonial power continues to significantly shape present-day Development policy and practice.
Declaration

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

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Acknowledgements

This doctoral thesis would not have been possible without the help and support of the wonderful people around me. First and foremost, my utmost gratitude goes to my exceptional supervisors, Uma Kothari and Encarnación Gutiérrez Rodríguez. Uma and Encarna were always there for me, guided me through the mysterious world of academic research and writing, and helped me to express my thoughts in a language that is not my mother tongue. I greatly appreciate their ability to provide tough but honest criticism when necessary, while never failing to offer encouragement when I desperately needed support. Both Uma and Encarna contributed to making my PhD experience immeasurably richer and more rewarding than I could ever have hoped. I will forever be grateful for all they have invested in me.

I am most grateful to those who funded my doctoral research: the Economic and Social Research Council, the School of Environment and Development, and the Institute for Development Policy and Management. I would like to acknowledge the academic and technical support of the University of Manchester and the staff of the School of Environment and Development. In particular, I thank Tony Bebbington, Monique Brown, Carole Dougedroit, Elaine Jones, Tanja Müller, Wendy Olsen, Chris Rees, and James Walker. I am exceedingly grateful to the Tanzania Commission for Science and Technology (COSTECH) for allowing me to conduct research in Tanzania. I owe sincere and earnest gratitude to all those in Germany and Tanzania who were willing to support my research; spend their time with me; share their knowledge, experience, and food; and be interviewed by me.

It is a pleasure to thank the many teachers, colleagues, and friends who made this thesis possible. I am particularly grateful for the advice and help of Rob Ahearne, Joshua Kwesi Aikins, Lotte Arndt, Susan Arndt, Jan Bachmann, Paul Bendix, Walter Bruchhausen, Chambi Chachage, Sharad Chari, Samuël Coghe, Chandra-Milena Danielzik, Helene Decke-Cornill, Maria Eriksson Baaz, Mechtild Exo, Minu Hashemi Yekani, Susanne Hofmann, Brigitte Kerchner, Kornelia Kilian, Kai Koddenbrock, Cheryl McEwan, Kum’a Nдумбе III., Lorraine Pannett, Carolin Philipp, Lisa Ann Richey, Musa Sadock, Julia Schäfer, Susanne Schultz, Natasha Shivji, Ruth Stanley, Laura Stielike, and Aram Ziai. Many other friends have offered their unequivocal support throughout the process. In particular, I would like to thank Christoph Bendix, Renate Decke-Cornill, Felix Dahmen, Teboho Edkins, Tillmann Fiehn, glokal & friends, Wilfried Grauert, Jan Hanson, Paula Herm, Richardi Milanzi, Kathrin Ohlmann, Sophie Perry, Martha Areli Ramirez, Schlachtensee, and James Vybiral.

I thank my fellow PGR students for their constant support: Michael Atkins, John Childs, Carolina Cravo, Sumana Datta, Thomas Frederiksen, Siobhán McGrath, George Holmes, Kirsten Howarth, Philip Kargbo, Sithembiso Myeni, Georgios Tsopanakis, Mike Upton, Elizabeth Wardle, and Yoon Seok-jin. Finally, I thank Ann Greenberg for editing and proofreading my entire manuscript.
About the author

Daniel Bendix grew up in Berlin, Germany. He studied one year of high school in Maseru, Lesotho, and spent one year and a half doing voluntary service with marginalised youth in Cape Town, South Africa. He studied Political Science at the Free University of Berlin, in Germany, and the University of Lausanne, in Switzerland. During his studies, he interned with the Oxfam International Advocacy Office in Geneva, Switzerland, the Truth and Reconciliation Commission for Sierra Leone in Freetown, Sierra Leone, the AfricAvenir Foundation in Douala, Cameroon, and the German Embassy in Conakry, Guinea. He joined the Cameroonian-German NGO AfricAvenir as an active member for seven years. After completing his studies, Daniel worked as research assistant on “Democratic Participation in Security Sector Reform” at the Free University Berlin, funded by the German Foundation for Peace Research. He also worked as a teaching assistant on “Security Sector Reform and Development” at the Free University of Berlin and on “Development as Historical Change” at the University of Manchester. Daniel works for glokal e.V., a development education NGO based in Berlin, carrying out workshops, training, consulting, and doing conceptual work on postcolonial perspectives in Development, anti-bias and anti-racist critique/critical whiteness, gender, transcultural learning, and critical perspectives on globalisation and international trade. He is also on the Editorial Board of the academic journal PERIPHERIE - Zeitschrift für Ökonomie und Politik der Dritten Welt. Daniel has published widely on topics including local ownership and gender in security sector reform, German colonialism, racism and exoticism in Development and advertising, and postcolonial perspectives in political education.
## Acronyms

<table>
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<th>Description</th>
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<tr>
<td>BMZ:</td>
<td>Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung (German Federal Ministry for Economic Cooperation and Development)</td>
</tr>
<tr>
<td>BRIC:</td>
<td>Brazil, Russia, India, and China</td>
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<tr>
<td>BUKO:</td>
<td>Bundeskoordination Internationalismus (Federal Coordination of Internationalism)</td>
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<tr>
<td>CBD:</td>
<td>community-based distributor</td>
</tr>
<tr>
<td>CCM:</td>
<td>Chama Cha Mapinduzi (Party of the Revolution)</td>
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<tr>
<td>CIA:</td>
<td>Central Intelligence Agency</td>
</tr>
<tr>
<td>CIM:</td>
<td>Centrum für internationale Migration und Entwicklung (Centre for International Migration and Development)</td>
</tr>
<tr>
<td>CONCORD:</td>
<td>European NGO confederation for Relief and Development</td>
</tr>
<tr>
<td>DED:</td>
<td>Deutscher Entwicklungsdienst (German Development Service)</td>
</tr>
<tr>
<td>DHS:</td>
<td>Demographic and Health Survey</td>
</tr>
<tr>
<td>DSW:</td>
<td>Deutsche Stiftung Weltbevölkerung (German Foundation for World Population)</td>
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<td>EU:</td>
<td>European Union</td>
</tr>
<tr>
<td>FRG:</td>
<td>Federal Republic of Germany</td>
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<td>GDP:</td>
<td>gross domestic product</td>
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<tr>
<td>GDR:</td>
<td>German Democratic Republic</td>
</tr>
<tr>
<td>GIZ:</td>
<td>Deutsche Gesellschaft für Internationale Zusammenarbeit (German Agency for International Cooperation)</td>
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<tr>
<td>GNI:</td>
<td>gross national income</td>
</tr>
<tr>
<td>GTZ:</td>
<td>Deutsche Gesellschaft für Technische Zusammenarbeit (German Agency for Technical Cooperation)</td>
</tr>
<tr>
<td>HQ:</td>
<td>headquarters</td>
</tr>
<tr>
<td>ICF Macro:</td>
<td>Inner City Fund Macro</td>
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<tr>
<td>InWEnt:</td>
<td>Internationale Weiterbildung und Entwicklung (Capacity Building International)</td>
</tr>
<tr>
<td>JSI:</td>
<td>John Snow, Inc.</td>
</tr>
<tr>
<td>KfW:</td>
<td>Kreditanstalt für Wiederaufbau (German Development Bank)</td>
</tr>
<tr>
<td>MDG:</td>
<td>Millennium Development Goal</td>
</tr>
<tr>
<td>MSD:</td>
<td>Medical Stores Department</td>
</tr>
<tr>
<td>NGO:</td>
<td>non-governmental organisation</td>
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### Transcription conventions for interviews

- **((xyz))** nonverbal aspects of the interview, e.g. laughter, tone of voice
- [...] some of the transcript has been omitted
- [xyz] clarifying insertion or information
- [[[DB: xyz]]] intervention by researcher
- .. short pause
- ... long pause
1 Introduction

1.1 Research goals, questions, and objectives

German Tanzanian Cooperation in Health can be followed back to the 19th century and is linked to the names of famous medical researchers like Robert Koch. (TGPSH 2008)

When I began my research in 2008, I was surprised to find this allusion to the colonial period on the website of the Tanzanian German Programme to Support Health (TGPSH), the most significant German Development programme on health in Africa, because there is a general opinion in Germany that Development cooperation is not connected to the colonial past. As it turned out, the reference to the period of German colonial rule was the product of a short research project initiated by a former senior manager of the German health programme in Tanzania. In my interview with him, he recounted his fascination for the German activities in health care during the colonial period. At the same time, he mentioned that Germany’s colonial past has been a delicate topic for the German government:

Well, it was new to me how systematically the German colonial medical personnel or the German Colonial Office had already acted in the establishment of a health system back then. That was really exciting. [...] The German government, well, I know that BMZ [German Federal Ministry for Economic Cooperation and Development, DB] was, of course, never interested and very reluctant when it came to dealing with German colonial times, research-wise or other. That was politically taboo. [...], but one would have to, I think, ask again from time to time, whether the times are not changing; that it just becomes more of a historical thing, and not political. (Interview 10, October 21, 2010)¹

German Development staff may have had similar political considerations when relaunching their website recently: all references to the colonial history connecting Germany and Tanzania have disappeared. It appears that non-recognition of the colonial past and denial of colonial legacies is characteristic of international Development in general (e.g. Biccum 2002; Kapoor 2008; Kothari 2011).

¹ All translations of interviews are my own.
Whereas the German manager quoted above thought it best that the topic of German colonialism be consigned to the past, this research follows an understanding of history as put forward by Foucault (1977, 1981). It seeks to understand history as an open field, to refrain from treating colonialism as historical in the sense of being over and in the past, and to acknowledge that this past affects our times. Such an approach is referred to in the following quote by German postcolonial scholar Ha, in which he calls for an exploration of Germany’s current postcolonial situation:

As long as the overlapping of sediments of time and society is not acknowledged and academic reappraisal remains purely historical, the influences of colonial effects on the racist imprints of present German society cannot be focused on. To not comprehend history as an open and dynamic field means to disallow the question of the topicality of colonial presences.

(2005, 106; transl. DB)

Such a treatment of colonial history is fundamentally political as it questions contemporary ideas and practices of inequality and domination. The aim of this study is to examine the connections between contemporary Development and the colonial past by investigating how colonial power is articulated in present-day ideas and processes of individuals and institutions from the global North that intervene in the lives of people in the global South. Colonial power here is conceived as discourses which emerged during colonisation and their interconnectedness with the material world. In order to explore the colonial legacy in contemporary Development, this study examines whether and, if so, how and with what effects contemporary German Development policy and practice in Tanzania in the field of population and reproductive health is shaped by colonial power. It addresses institutionalised interventions by bilateral agencies and NGOs of the global North in the global South, and thus explores Development as deliberate efforts aimed at

---

2 “Global North” and “global South” refer to those countries and world regions regularly called developed/industrialised and developing/underdeveloped, respectively, while trying to avoid the hierarchy inherent in such terminology. Countries of the global South share a common history of having been subjected to colonial imposition. The “West” is used interchangeably with global North in this study. “Western” and “European” as adjectives are regularly used in this thesis to denote thinking and acting characteristic of the global North and marked by “Enlightenment”, “modernity” and colonialism. For a discussion of the problems with, and pitfalls of, these terminologies, see Mohanty (2002).
improvement (Cowen and Shenton 1996). In this thesis, Development defined as intentional practice is written with a capital “D”. It is thus differentiated from an understanding of “development” as referring to historical, capitalist processes of social change. This latter notion has been termed “immanent development” (Cowen and Shenton 1996) or “‘little d’ development” (Hart 2001) and is in this study spelled with a lower case “d” and set in quotation marks. Development interventions here are not only understood to be economic and political, but also deeply cultural, emerging out of specific times and places, and framed by “institutionally generated narratives and constrictions” (Kapoor 2008, 21).

This study provides an understanding of the relationship between power, postcolonialism, and Development intervention in population and reproductive health. Based on this, it generates conceptualisations and methodologies for researching colonial power in Development. It also provides empirical insight into the relationship between current Development and colonial power by identifying and interpreting similarities and differences between colonial-era and ongoing German interventions in the area of population and reproductive health in “East Africa”.

1.2 The significance of this study

This research contributes to Development Studies by providing new insights into the relationship between Development and colonial power. It also localises and historicises colonial power in contemporary Development by putting forward the specific, largely under-researched area of Germany’s engagement in Development, and focusing on policy and practice in the field of population and reproductive health.

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3 Quotation marks generally indicate that I question the terminology and its associations, but resort to such terms, given their wide use in the literature.

4 In this study, East Africa refers to Tanzania as well as to “German East Africa”. Germany had colonised this area from the mid-1880s until approximately 1920. In terms of territory, “German East Africa” not only included present-day Tanzania, but also Rwanda, Burundi, and parts of Kenya and Mozambique (see Chapter 4 and Figure 1). When I speak about the colonial era, the African inhabitants of the territory are referred to as “East Africans”; when the study deals with the present period, I speak of Tanzanians. In the case of referring to both periods, this study also employs the term “East Africans”.
health in Tanzania. Based on this, it develops and applies the methodology of
genealogical dispositif analysis to examine the continuation of colonial modes of
thinking and acting in contemporary Development.

Despite ample criticism, there appears to be much faith by governments, NGOs, and
the general public in Development cooperation as a philanthropic, altruistic
endeavour by the rich nations of the global North to support the “development” of
poor countries in the global South. Multi- and bilateral donor agencies and NGOs in
the global North present their objectives as selfless improvement of the economic,
social, ecological, and political conditions in so-called developing countries (GTZ
2009; OECD DAC 2009). However, such an understanding of Development is also
contested (Ferguson 1994; Sachs 1992). Some scholars suggest that Development
perpetuates asymmetrical power constellations that serve economic interests of the
global North (Duffield 2006; Kapoor 2008). Others have highlighted that societies in
the global South are evaluated, and Development policies implemented, on the
basis of a racialised and gendered “modernity”-“tradition” dichotomy (Crush 1995c;
Escobar 1994; Noxolo 2006). This study acknowledges these critiques and explores
whether contemporary German activities in the field of population and reproductive
health, commonly portrayed as guided solely by philanthropic considerations, are
pervaded by German self-interest (Chapter 5). It adds to existing studies by asking
how and with what effects racialised and gendered notions of “modernity”
interconnect with the political economy of population control and philanthropic
justification for contemporary German Development intervention.

International Development is fundamentally normative, as it refers to a
universalising notion of what societies should be like (Tucker 1999; Ziai 2004a). From
the beginning of Development aid in the 1940s, the specific state of “development”
of countries in the global North has served as a reference point (and at times as the
ultimate goal) of Development policy and practice (Escobar 1994). This research
examines the inherent power of Development to imagine, prescribe, and promote a
specific path of social change, in which the global North’s “development” remains
the unquestioned norm. It builds on existing studies by exploring continuities
farther back than the post-WWII era and into colonial times. It addresses policy and practice regarding population control and explores whether similarities exist between colonial-era intervention and contemporary German Development assistance (see Chapter 5). Moreover, this research scrutinises interventions in obstetric care during colonial rule and in current Development cooperation in order to explore similarities in the way knowledge, skills, and attitudes of East African health practitioners are understood by Germans working in “German East Africa”/Tanzania (see Chapter 6).

International Development policy has stressed notions of people-centeredness and cooperation based on partnership since the mid-1990s, in response to critiques regarding donor dominance in aid relationships. Principles such as “local ownership”, “participation”, and “partnership” are put forward as fundamental in the interaction between actors from the global North and South (OECD DAC 1996; OECD 2005, 2008). Nonetheless, colonial discourses persist in contemporary ideologies of people-centeredness and cooperation in Development (Noxolo 2006; Slater and Bell 2002) and are evident in accounts of professionals (Eriksson Baaz 2005). My approach is inspired by studies that question the aptitude of Development policy and practice to fundamentally change the context of dominant knowledge configurations, asymmetrical power relations, and subjectivities shaped by the colonial past (Cooke and Kothari 2001; Heron 2007; Kapoor 2008). Informed by existing feminist critiques of international population and reproductive health policy (Hodgson and Watkins 1997; Schultz 2006), this study explores the contradictions within German Development aid between people-centred principles on the one hand and demographic goals on the other by linking current policies to colonial-era interventions (Chapter 5). It further analyses Development professionals’ doubts regarding the value of their work, their criticism of German Development cooperation, and resistance by Tanzanian partners, in order to assess whether these have the potential to pose serious challenges to colonial power (Chapter 7).
This study underlines the context-specificity of colonial power in Development policy and practice by highlighting particular histories and geographies. It puts forward the specific case of German Development interventions in reproductive health and population in Tanzania as an example of the legacy of colonialism in contemporary Development cooperation. Previous studies have focused on activities by British (Biccum 2005; Kothari 2006c; Noxolo 2006; Power 2009; Slater and Bell 2002), and to a lesser degree Canadian (Heron 2007) and Scandinavian (Eriksson Baa 2005), agencies, institutions, and professionals. Despite Germany being the European Union’s largest, and the world’s second largest, aid donor (Global Humanitarian Assistance 2012) and also one of the principal colonising nations in Africa, colonial power in German Development aid remains largely under-researched. Previous analyses inspired by postcolonial theory have examined charity advertisements (Kiesel and Bendix 2010; White Charity 2012), self-portrayals of faith-based Development organisations (Philipp 2006), Development volunteer programs (Kontzi forthcoming), and narratives on gender and “sexual and reproductive health and rights” in Development aid (Deuser 2010). Particular German Development policies and their implementation and Germany’s engagement in specific countries of the global South have as yet not been thoroughly scrutinised. Moreover, the focus of this study – reproductive health and population – seems pertinent to furthering our understanding of colonial power in Development policy and practice in general. While Deuser (2010) has examined German policies on gender and population from the colonial era to the present day, her research focuses on discourses and does not explore implementation, heterogeneity of actors involved, or German professionals’ ability to question orthodox approaches. Consequently, this study focuses on Germany’s practice in the context of a specific country (Tanzania), it examines the plethora of German actors in Development, and it addresses the agency of German professionals. Moreover, through attention to actual practices and the integration of interviews with German professionals, this study also takes into account the political economy of population control as well as legitimising strategies for interventions in German Development cooperation in the field of population and reproductive health (Chapter 5). Whereas Deuser concentrates on gender and population control, this study also takes into
account obstetric care – a focus of interventions during the colonial era, as well as currently – as another important area of reproductive health (Chapter 6).

Present-day Tanzania, which previously formed part of Germany’s largest colony “German East Africa”, seems a particularly fitting case as it is currently a focus of German Development cooperation. In addition, health, and more specifically population and reproductive health, is one of German Development cooperation’s priority areas in Tanzania (BMZ 2011c; TGPSH 2009c). Population and reproductive health only recently received special support when, in May 2011, the Federal Ministry for Economic Cooperation and Development launched an “Initiative on Rights-based Family Planning and Maternal Health” (BMZ 2011d). Equally, questions of population and reproduction in what was then referred to as German East Africa were discussed by German politicians, administrators, missionaries, and physicians from around 1905 to the end of German colonisation approximately 1920 (Chapter 4). Some of these actors cautioned against a population decline and perceived East Africans as a resource in need of protection and enhancement. However, Germany’s colonial past is seldom deemed significant in German Development aid and, on the rare occasion that a connection between the period of colonial occupation and contemporary Development cooperation is alluded to, it is typically mentioned in a positive light, as in the initial quote taken from the opening paragraph of the web page of TGPSH on the history of the “German Technical Cooperation in the health sector” in Tanzania.

To explore German intervention in East Africa in the field of population and reproduction, this study develops and applies a particular methodology for studying the articulation of colonial power in present-day Development. Development cooperation is largely driven by the need for efficiency and achievement of tangible results, as mirrored in contemporary Development Studies with its focus on practical interventions (Bernstein 2006). This goal- and target-orientation implies that international Development tends to be preoccupied with the future without critically analysing the past (Kothari 2011). Recently, however, scholars have shown increasing interest in the history of Development policy and practice (Bayly et al.
2011; Woolcock et al. 2011). For Woolcock et al. (2011), history (in the sense of the past as well as of an academic discipline) is important as a resource of critical and reflective self-awareness regarding the nature of Development as a discipline, its current focuses, why those focuses and not others have come to take their particular form in the present, and how they differ from past motives and goals. Taking up this call for critical inquiry into present-day Development, this study develops a methodology to “provide critical responses to the historical effects of colonialism and the persistence of colonial forms of power and knowledge into the present” (Kothari 2011, 69). Studies to date tend to either analyse contemporary Development without undertaking historical analysis (Eriksson Baaz 2005; Heron 2007; Kapoor 2008), or explore colonial-era ideas and practice without linking it to the present (Cowen and Shenton 1996; Hodge 2007; Koponen 1994). Other studies focus on continuities and ruptures in post-WWII Development, but do not address the emergence of current interests in the colonial past (Brigg 2002; Ziai 2007). The present study builds upon others which examine colonial-era policies and link these to contemporary Development (Noxolo 2006; Wainwright 2008; Deuser 2010). There is, however, a lack of methodologies for carrying out such an examination.

Inspired by Foucault (1989a, 1989b), this study uses genealogical dispositif analysis and, through its application, underlines the need to draw on a variety of methods. It combines the approach of genealogy (Foucault 1977; Kerchner 2006) with the methodology of dispositif analysis (Bührmann and Schneider 2008; Foucault 1980). The genealogical approach, as used in this study, rests on an understanding of history as change from one situation of power to another, rather than on an understanding of history as a teleological, linear process. This allows for relating German colonial-era policy to contemporary interventions in issues of population and reproduction without examining the times between these two periods. The dominant motives for, and reasoning within, ongoing policies and practices, such as those regarding issues of population and reproductive health in German Development aid, are commonly taken for granted by the general public. Yet, exploring the emergence of interventions in population and reproduction in East Africa and comparing this with contemporary German policy and practice may lead
to a new, sensitised position towards previously unquestioned German Development activities. This historical approach de-familiarises perspectives on policies and practices which, on the surface, appear to be given and natural. At the same time, such an examination of the field of population and reproductive health during colonisation makes it possible to grasp the specificity of colonial power in this sphere and analyse contemporary policy and practice on this basis.

Dispositif analysis is an extension of discourse analysis, and enables an examination of the interrelationship of discourses with materiality and actors (Bührmann and Schneider 2008). Postcolonial approaches to Development interventions tend to focus on narratives in Development aid documents (Bicum 2005; Noxolo 2006) or on the manifestation of colonial discourse in the subjectivities of Development professionals (Eriksen Baaz 2005; Heron 2007). They pay less attention to material effects and the global political economy. Some critical Development Studies have sought to bring together an analysis of discourses, materialities, and actors by referring to dispositif analysis (Brigg 2001; Ziai 2007). Inspired by these studies, the dispositif-analytical methodology of this research explores discourses and their material manifestations as well as agency of actors through a combination of archival and textual research, interviews, and observation. This combination of methods helps to provide a broad and differentiated picture of interventions as it addresses speech, practical interventions, and agency. Sensitivity to different dimensions of power also allows for accounting for shifts in discourses and practices between colonial times and today (Chapters 5 and 6), as well as for actors’ space to manoeuvre within discourses and challenge colonial power in current Development (Chapter 7). The contribution of this thesis to Development Studies is hence the development and implementation of the methodology of genealogical dispositif analysis, which facilitates exploration of colonial power in contemporary Development policy and practice.
1.3 Theoretical approach and outline of the thesis

This study draws on the insights of three bodies of literature – power, postcolonialism, and Development interventions in population and reproductive health – in order to highlight the colonial underpinnings and effects of current German Development policy and practice in population and reproductive health in Tanzania.

First, it draws on a Foucauldian conceptualisation of power that takes into account discourses and how they are embedded in the material world, and is sensitive to the agency of actors (Foucault 1980). Discourses are time- and place-specific knowledge configurations which order people’s thinking and actions (Foucault 1981, 1991). In the context of Development aid, they structure how Development issues are perceived and implemented. Discourses are manifested materially in practices, institutions, and political-economic conditions (Foucault 1989b) which, in turn, allow certain discourses to become prominent and particular interests to be served. Discourses and materialities take effect in the world through actors who speak and act. While actors are positioned by enduring discourses and social relations (Isaac 1992), they also have room to manoeuvre, and their agency has stabilising or transformative effects on discourses and materialities (Scott 1990).

Second, I rely on insights of postcolonial studies in order to understand the particularities of colonial power. “Colonial power” is understood as an analytical concept for examining power that emerged during colonial times but which transcended the historical period of formal territorial occupation and remains operative in the present (Mbembe 2001; Mignolo 2000; Quijano 2000). Colonial power takes effect in the present through the persistence of colonial discourses and their relation to institutions, material conditions, and actors (Gutiérrez Rodríguez 2010; Ha 2003). Colonialism was legitimised by establishing “difference” between colonisers and colonised with regard to religion, biology, culture, stage of “development”, and so on (Mignolo 2000). These categorisations, grounded in ideas of “race”, transcended the period of formal colonial rule (Mbembe 2001; Quijano
Moreover, colonial power is based on the assumption that societies “develop” in a linear and teleological manner, that the West constitutes the epitome of “development”, and that other societies lag behind and should follow a prescribed path (Dussel 1995). Accordingly, European epistemology (scientific, technical rationality) and ways of economically, politically, and socially organising society have been projected globally throughout the course of colonial-era occupations and have led to the reconfiguration of other knowledge systems and societal arrangements (Hauck 2003; Mignolo 2000). It is necessary to consider that colonial power in the present is enabled and upheld by political and economic asymmetries and dependencies between the global North and South that have their origins in colonial-era conquest and exploitation (Quijano 2007). At the same time, due to the variety of actors and the instability of power constellations, colonial power is ambivalent and fragmented (Bhabha 1994; Parry 2004). This implies that transformation is always possible. The conceptualisation of colonial power as outlined here allows for scrutinising traces of colonial ideas and practice in contemporary Development (Biccum 2002; Kothari 1996; McEwan 2009).

Third, this thesis draws on studies of intentional Development and those that examine population and reproductive health policy and practice during formal colonialism and the post-WWII era. It conceptualises Development as deliberate intervention by agents from the global North – who perceive their societies as being more “developed” – in the lives of people in the global South (Cowen and Shenton 1996). These interventions emerged during colonisation, were legitimised as improving people’s living conditions, and served as strategies to contain people in the global South in order to benefit the global North economically and politically (Duffield 2005; Hodge 2007). The present research challenges those studies of population politics and Development which hold that population control began in the post-WWII era, and instead understands interventions to control the population size of colonised societies and “modernise” childbirth practices as having emerged at the beginning of the 20th century (Colwell 2001; Hunt 1999; Vaughan 1991). Development policy has since been characterised by demographic goals defined by Western norms and interests (Schultz 2006) and by assessments of health and
obstetric care practices which are based on, and establish, colonial difference (Ram and Jolly 1998).

The study proceeds as follows: In Chapter 2, I critically review ongoing discussions in Development Studies regarding power, postcolonialism, and the field of population and reproductive health in order to generate the theoretical and conceptual framework for this study. Chapter 3 presents the methodological approach and research practices of the data collection and analysis carried out in this study. Chapter 4 provides the background for the empirical analysis by sketching the particularities of German colonialism and the colonisation of German East Africa, examining the emergence of Development interventions in population and reproduction during German colonisation of East Africa, presenting “development” and health care in Tanzania, and outlining contemporary German Development cooperation with a focus on Tanzania and the field of population and reproductive health. Chapter 5 provides findings and analysis regarding the issues of population control and fertility. Whereas “population decline” was the point of departure for discussions in colonial times on population and reproduction, population size has today seemingly become less significant, but is nonetheless continually invoked in debates on reproductive health. I examine how issues of population size and fertility are understood in colonial and current German interventions. This study suggests that the articulation of colonial power is evident in the interplay among racialised, gendered discourses of “modernity”, the political economy of population control, and strategies justifying interventions. Chapter 6 provides more detail by focusing on the topic of obstetric care. Nowadays, maternal health is a focus of German activities in the broad area of population and reproduction. In Tanzania in particular, German Development professionals concentrate on improving prenatal care and hospital deliveries. In colonial times, German commentators also criticised East African obstetric care and made suggestions for improvements. As such, the issue of birthing provides a useful lens through which to investigate the form and extent of colonial power in the present. Building on Mbembe’s (2001) argument that Africa has been depicted as inferior and deficient since colonial times, this study suggests that colonial power in contemporary Development is primarily evident in the
manner in which German professionals establish a fundamental difference between themselves and Tanzanians with regard to knowledge, planning skills, and attitudes. While Chapters 5 and 6 explore dominant discourses and practices in German intervention in “German East Africa”/Tanzania, the interviews also evidence that some German professionals currently involved in Development challenge these. This can be understood as a sign of uncertainty and doubt, but also as reflection of, and response to, the agency of Tanzanian counterparts. Chapter 7 analyses such challenges and examines their potential to disrupt colonial power. Finally, Chapter 8 summarises the study and discusses its theoretical, empirical, and methodological contributions to Development Studies.
2 Conceptual framework

This chapter provides a review of three interrelated bodies of literature in order to develop a theoretical framework to examine how, and with what effects, contemporary German Development interventions with regard to population and reproductive health in Tanzania are shaped by colonial power. Section 2.1 examines understandings of power in the study of Development, suggesting a conceptualisation of power which takes into account discourses and their embeddedness in the material world as well as the agency of actors. Section 2.2 reviews postcolonial approaches to Development in order to conceptualise colonial power. I understand colonial power as having emerged in the context of colonisation and, having transcended this historical period, operating in the present. In Section 2.3, understandings of Development as wilful interventions – particularly those involving health, population, and reproduction in the global South – are examined. A review of existing studies suggests that such interventions emerged during colonialism in the early 20th century and have since been characterised by the primacy of population control as well as by transformations of reproductive practices based on Western norms.

A large body of literature exists on what constitutes power and how it operates in the context of Development. Much useful research has been undertaken on empowerment, for example by feminist scholars (Parpart et al. 2002; Parpart 2002), as well as on power dynamics between donors and recipients (Crewe and Harrison 1998; IDS Bulletin 2006; Long 2001). However, the focus in this study is on Germany’s Development policy and practice. This chapter thus emphasises those studies of power and Development which focus on discourses and practices of external intervening actors.

2.1 Power and Development

The volume “Power of Development” (Crush 1995c) usefully highlights the difficulty of conceptualising power in the context of Development:
In attempting to conceptualize development as a *discourse*, as an interwoven set of languages and practices, [...] it [is] also [seen] as a modernist regime of knowledge and disciplinary power. [...] Power in the context of development is *power exercised*, *power over*. It has origins, objects, purposes, consequences, agents, and, *contra* Foucault, much of this seems to lie quite patently within the realm of the economic and the political. [...] In the case of development, it would be a mistake to view power as emanating exclusively from one space and being directed exclusively at another. (Crush 1995a, 7–8, 1995b, xi–xii)

Here Crush relates power to “language”, “knowledge”, and “discourse”. Power and knowledge are interrelated in Development and crucial to understanding the power of Development. However, it is not clear whether discourses as such constitute power and whether power as lying “within the realm of the economic and political” is distinct from discourse. Moreover, Crush speaks of power as having agents, which seems counter-intuitive: is it not rather that agents wield power? This section examines different approaches to power and Development and their relative usefulness to the study of colonial legacies in Development.

I suggest that in order to understand colonial power in contemporary German Development cooperation on population and reproductive health in Tanzania, it is useful to conceptualise power as discourses interconnected with the material world and activated by actors who are able to transform them. This study proposes to focus on the concept of discourse in order to analyse power (2.1.1). Discourses structure how issues are perceived and implemented. They are time- and place-specific knowledge configurations that order people’s thinking and actions. Such a perspective is necessary to understand the logic underpinning German intervention in issues of population and reproduction in East Africa. A focus on discourses is crucial for a historical perspective as they allow for tracing knowledge configurations over time. However, discourses must be understood to be intertwined with the material world (practices, institutions, political economy) and as producing material effects (2.1.2). Discourses take effect in the world through people’s speech and actions, and people are themselves positioned by discourses and material conditions. Yet, people also have the ability to choose how to deal with discourses
and their environment; this agency in turn has stabilising or transformative effects on discourses (2.1.3). Power in this study is thus understood as discourses and their relationship to materiality and people’s agency (2.1.4). This perspective on power is useful for examining the legacy of colonialism in present-day Development as it allows for addressing knowledge configurations and their material manifestations without disregarding the agency of Development professionals, and for linking analysis of interventions during colonialism to an examination of present-day German Development cooperation in Tanzania.

2.1.1 Discourses

According to Foucault (1981), discourses are expressions as well as producers of knowledge (cf. Bührmann and Schneider 2008). They underlie thinking and actions of agents. Thus, discourses should not be understood as language reflecting an a priori reality but rather as forming reality (Parr 2008). In the 1980s, during the so-called lost decade in respect of “development”, and in the context of a linguistic and cultural turn in the social sciences, an approach to Development emerged seeking to understand Development as discourse:

[W]ithout examining development as discourse we cannot understand the systematic ways in which the Western developed countries have been able to manage and control and, in many ways, even create the Third World politically, economically, sociologically and culturally [...]. (Escobar 1985, 384)

Proponents of this so-called anti- or post-development approach analyse international Development as a cultural meaning-creating practice and examine Development discourses to gain insights into the power of Development. It is, however, necessary to differentiate between those approaches that analyse Development by conceptualising discourses as reality-forming, and those that expose the vocabulary in international Development as veiling a hidden agenda (Ziai 2004b). The latter current tends to regard Development as a myth that hides a neocolonial, imperial, and capitalist project of domination and imposition of Western norms (Rahnema 1991; Sachs 1989, 1990, 1992; Tucker 1999). These proponents commonly perceive Development discourse as monolithic and do not acknowledge
the multiplicity of discourses within the field of Development (cf. Simon 2006). Tucker (1999), for instance, presents Development as a mystifying discourse and assumes that something essentially more real exists behind such discourse.

According to post-structuralist ideas, discourses themselves produce truth and form reality. The more “sceptical” (Ziai 2004b) approaches of the anti-/post-development school (Brigg 2002; DuBois 1991; Escobar 1994; Ferguson 1994; Ziai 2004a, 2006) ascribe to such a Foucauldian conceptualisation of discourses as orders of knowledge in a particular temporal-spatial context (Foucault 1981). They thus explore dominant knowledge configurations in order to highlight the controlling (Escobar 1994), de-politicising (Ferguson 1994), normalising, regulating, and disciplining effects of Development interventions (Brigg 2002; DuBois 1991; Goldman 2005). Following these approaches, I adopt a Foucauldian notion of discourse as a “socio-historically specific practice of knowledge found in a social field” (Diaz-Bone 2006, para. 14). This study, rather than trying to discern whether discourses are true or false, explores the basis and effects of discourses in German interventions in population and reproductive health in East Africa. A focus on discourses implies sensitivity to “concepts [...], procedures [...], and norms” (Scheurich and McKenzie 2005, 846) that render possible the constitution of population and reproduction issues as a field of knowledge and intervention. For instance, when German colonial and Development professionals invoke the notion of population decline or growth, this is based on a construct of people as population, implies statistical measurement of fertility rates, and is related to other concepts such as resources (Chapter 5). To comprehend colonial power in contemporary Development, it appears useful to focus on discourses, as this allows moving away from regarding population and reproductive health policy as products of deliberate decisions and actions by Development agents. While an actor-centred approach would restrict the focus to a specific, confined period in time, discourses travel, persevere, or come to life again in different settings. Thus colonial-era policy and practice can be compared to contemporary Development at the level of discourse.
While the studies mentioned thus far tend to concentrate on hegemonic discourses in the context of Development, scholars have also highlighted discourses which challenge dominant ones. Eriksson Baaz (2005), for instance, highlights questioning attitudes and criticisms of Development aid in Scandinavian professionals’ accounts of their work in Tanzania. She relates these to recent shifts in international Development towards principles of partnership, participation, and ownership, implying that Development professionals should deal with partners in a culturally sensitive manner and question their own cultural baggage. This means that “the image of superiority coexists with a counter-discourse that questions such assumptions” (Eriksson Baaz 2005, 152). In order to elucidate heterogeneous and contradicting discourses, the present study draws on Scott (1990) who differentiates between “public transcripts” and “hidden transcripts” in analysing power. According to Scott, the hidden transcript “contains [...] gestures, speech, practices [... which are] excluded from the public transcript by the ideological limits within which domination is cast” (1990, 28). This transcript may be found in interactions among peers and people in similar socio-political and professional positions. While public and hidden transcripts are “produced for a different audience and under different constraints of power”, this does not imply that the former are “false and what is said offstage true” (Scott 1990, 5). Chapter 7 of the present study focuses on German Development professionals’ accounts of their work that question and modify dominant Development policy and practice, in order to examine whether these actually challenge colonial power.

### 2.1.2 Interconnectedness of discourses with the material world

As Lemke (1997) argues, a conceptualisation of discourse as self-regulating and not connected to non-discursive dimensions leads into an analytical cul-de-sac. Discourses interact with “material events and circumstance, the forms through which discourse is, as it were, entangled in the material world” (Young 2001, 387). Discourses take effect in the material world, are expressed in actions, located in institutions, and brought to life by people. However, in some approaches to Development, a tendency of regarding the social in terms of self-contained
discourse is evident. Eriksson Baaz (2005), for instance, conceptualises speech, action, and economic relations as solely discursive. While I concur with her argument that discourses define how phenomena may be understood and circumscribe a certain type of practice, I believe that taking for granted the primacy of discourses is theoretically flawed and politically problematic. This is evident in Eriksson Baaz’s conclusion; she suggests that “the possibility of change is located primarily in the issue of representation, in providing alternative meanings” (2005, 173–4). Trying to understand all phenomena in Development as discursive reduces the usefulness of discourse as an analytical tool (Crewe and Harrison 1998). It also runs the danger of diverting attention away from pivotal issues in Development such as actual practices, institutions, and the global political economy.

According to Crush, the power of Development is not restricted to discourses as linguistic phenomena. Rather, discourses are located in, or seen as emanating from, non-discursive dimensions: material activities, institutions, and broader geopolitical contexts:

Development discourse is constituted and reproduced within a set of material relationships, activities and powers – social, cultural and geopolitical. To comprehend the real power of development, we cannot ignore either the immediate institutional or the broader historical and geographical context within which its texts are produced. (Crush 1995a, 6)

This study regards the internal formation of discourses as important to understanding the logic underpinning Development policy and practice. However, rather than being autonomous, self-referential producers of knowledge, discourses are conceived as materially embedded and yielding effects. If this study had restricted its attention to knowledge configurations, it would not have been able to take into account crucial aspects of power; for instance, contemporary discourses on curbing population growth in Tanzania are connected to the political economy of so-called modern contraceptives (Chapter 5). While contraceptives can certainly be regarded as discursive since people accord meaning to them, they can also be conceived as distinct from discourses: Contraceptives are produced, sold, distributed, and applied or ingested. They are embedded in a political economy in
which only certain transnational companies are in positions to win tenders offered by governments and donors to provide such products (Chapter 5). In turn, the material omnipresence and market dominance of “modern” contraceptives (as opposed to so-called natural and traditional family planning) has effects on family planning discourses because family planning becomes synonymous with use of “modern” contraceptives. To give another example, biomedical discourses are deeply intertwined with the hospital as biomedicine’s foremost institution (van der Geest and Finkler 2004). Thus, colonial-era discourses on birthing, based on differentiation between “traditional” and “modern” practices, promoted deliveries by biomedically trained health professionals. This went hand in hand with calls for building of health facilities in “German East Africa”, and with their actual construction (Chapter 6). Particular birth practices regarded as appropriate at the time, such as delivering in the supine birth position, take place in the institutional setting of the hospital and depend on its particular equipment, such as delivery beds (Chapter 6). Institutions and “socially conventionalised ways of acting” (Keller 2007, para. 44; transl. DB) are thus based on and supported by particular discourses, and in turn generate discourses. In addition to material practices and institutions, “the broader historical and geographical context” (Crush 1995a, 6) of discourses in Development must be considered. For instance, capitalist exploitation of the global South during colonialism and asymmetrical trade relations since decolonisation, among other factors, have enabled Germany to become an economic and political force, and to act as a donor to Tanzania today (cf. Chachage 2006; Koponen 1994). While discourses that determine which society is “developed” and which is “developing” are important in the global positioning of Germany and Tanzania, the latter nation also materially depends on the former in terms of foreign aid (see Chapter 4). Withdrawal of German foreign aid from Tanzania would have practical consequences for the work of Tanzanian professionals paid with this money as well

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5 In this study, the terms “biomedicine”, “modern” health care, “biomedical”, and “medicalise” are used to refer to the dominant Western model of understanding disease and health. It emerged in Europe in the mid-19th century, is based on scientific reasoning, and was disseminated worldwide by missionaries and colonisers (van der Geest and Finkler 2004). Its counterpart in this study is non-biomedical, “traditional” medicine and health care “which emerged in relation to the spread of biomedicine in eastern Africa” and “served as a catchall category indexing forms of healing, kinds of affliction, and types of experts that were not officially included in missionary or colonial health care” (Langwick 2008, 437, fn. 1).
as for provision of health care to Tanzanian clients. This asymmetry further allows for an entrenchment of notions of Tanzanian “underdevelopment” and German “development” (Chapter 7).

The present study focuses on discourses to understand power since such a focus facilitates a connection of the colonial past with the present. Discourses have effects on, and are interconnected with, the material world with regard to practices, institutions, and the global political economy.

2.1.3 Actors and agency

In an attempt to demonstrate the pervasiveness of power, realist approaches (e.g. Hacking 2004; Isaac 1992) criticise liberal understandings of power as an individualistic exercise “according to which A exercises power over B when A affects B in a manner contrary to B’s interests” (Lukes 2005, 30). Such approaches see power as “distributed by the various enduring structural relationships in society” and as describing “the capacities to act possessed by social agents in virtue of the enduring relations in which they participate” (Isaac 1992, 52, 47). Discourses and material conditions grant people the position to speak authoritatively about an issue or to intervene practically (Foucault 1991). People do not hold positions individually, but rather due to their societal role. For instance, German Development professionals are in a position to decide whether the Tanzanian population and reproductive health situation is problematic or not, and to suggest measures so as to increase availability and use of so-called modern contraceptives (Chapter 5).

While the possibility of agency is circumscribed by particular societal positions, “the exercise of these powers [...] is contingent, determined by the way particular individuals and groups choose to deal with their circumstances” (Isaac 1992, 48). In compliance or non-compliance “with discursively established standards of conduct [...] lies the actualization of agency” (Heron 2007, 10).

Studies emphasising the importance of analysing discourse to understand Development (Crush 1995c; Escobar 1994; Ferguson 1994; Ziai 2004a) have been
criticised for neglecting the role of Development professionals in reinforcing dominant discourses and, more importantly, in questioning and transforming them (Lie 2007; McKinnon 2008). Recently, an increasing number of contributions to the debate on power and development have focused on the role of Development professionals (Brigg 2009; Eriksson Baaz 2005; Heron 2007; Kapoor 2008; Kothari 2005b; Lie 2007; McKinnon 2008). While some scholars attempt to understand Development professionals’ subjectivities (Brigg 2009; Eriksson Baaz 2005; Heron 2007), this study is not concerned with identities in Development aid. Rather, it focuses on actors in order to facilitate a better understanding of a particular field of policy – population and reproductive health – and its shifts in a historical perspective. It builds upon research that examines professionals’ narratives to gain a deeper understanding of Development policy and its transformations (Kothari 2006c; McKinnon 2008). Such a focus on agents allows for “complement[ing] and critiqu[ing]” official versions and teasing out “nuances and ambiguities” of Development intervention (Kothari 2006c, 133). A notion of agency that takes seriously societal embeddedness of actors as well as their capacity to act is useful for questioning the image of all-embracing Development discourses (Crewe and Harrison 1998; Lie 2007; McKinnon 2008). Consideration of the actors of Development and their agency is important to this study as it allows for gaining a more detailed and comprehensive picture of German intervention in Tanzania (Chapters 5 and 6), including its heterogeneity and challenges to dominant ideas, as addressed in Chapter 7.

The present study is concerned with how actors reinforce, challenge, and transform dominant Development discourses (cf. Lie 2007). This affirms Kothari’s argument that Development professionals are not “passive transmitters of particular discourses and practices about modernity and progress”, but “agents who influence processes of change as they negotiate and mediate […] conventions” (2006c, 120). Agents of Development intervention are neither completely determined by discourses, institutions, and the global political economy nor set apart from them, “but operate with, through and against them” (Brigg 2009, 1421). Such consideration of actors prevents one from perceiving social constellations in
Development aid as “locked into unbreakable lines of force which would impose definitive contours” (Deleuze 1992, 160–1). Chapter 7 of this study examines how German professionals doubt the value of their activities in Tanzanian hospitals, and how they criticise the unequal influence of Tanzanians and Germans in Development cooperation.

Development practice is not only questioned by donor staff but also challenged by so-called aid recipients. Rottenburg (2009), in his study on German aid in Tanzania, has, for example, highlighted the non-uniformity of Development interventions and attributes this to the diversity of agents with conflicting cultural norms and agendas. The Development project he analysed did not show results according to donors’ plans because Tanzanian partners consciously and unconsciously switched among discourses, subverting the techno-scientific norms of donors. Rottenburg’s research is part of a recent strand of ethnographies of Development which focus on the context-specificity and complexity of interactions in Development interventions and which have sensitised Development Studies to aid recipients’ capacity for undermining policy planning and donor desires (Mosse 2005, 2011; Quarles van Ufford and Giri 2003). Chapter 7 of this study focuses on evidence of Tanzanian counterparts’ resistance to German professionals’ work.

To summarise, discourses take effect in Development through actors’ speech and actions. Actors, in turn, are positioned in society by discourses, institutional set-ups, and political and economic conditions. Within the space prescribed by discourses and material realities, actors have room for manoeuvring (agency), and this agency has stabilising or transformative effects on discourses and structures. In this study, I concentrate on the role of German Development professionals in sustaining dominant discourses with a colonial legacy (Chapter 5 and 6), as well as in challenging these (Chapter 7).
2.1.4 Dispositif

Brigg (2002) has argued for a strict differentiation between power in the post-WWII era and power during formal colonial rule. According to him, colonial power was repressive, while the power of Development is productive, as it “fosters, organises, incites and optimises life” (Brigg 2002, 423). However, Brigg does not take into account that power during colonial rule was not exercised solely “through deduction, through the right to extract a portion of wealth, labour, goods and services” (2002, 423), but also through the imposition of Western culture and epistemology, as discussed in detail below (Dussel 1995; Young 2001). As will be highlighted in Chapter 5, colonial-era intervention in population and reproduction in “German East Africa” was, for instance, also marked by philanthropic discourses of bringing civilisation to the colony and improving life through a change in beliefs and practices (see Chapters 5 and 6). Furthermore, it is difficult to maintain that post-WWII Development is not also partially about “extract[ing] a portion of wealth” from countries in the global South. It does not make sense to distinguish between repressive and productive power since power is always about enabling certain aspects and disabling others and is always both repressive and productive (Ziai 2007).

It is commonly believed that power is limited to the action of agents. This idea is appealing since it portrays power as straightforward and therefore containable (Foucault 1989a). Drastic inequality exists with regard to economic assets between the global North and South, making it plausible to locate power – in the context of Development intervention – in actors or institutions of the global North. Such a straightforward perspective has been disputed by several Development scholars (Brigg 2002; Goldman 2005; Ziai 2007) who describe power as “diffuse, fragmented and reciprocal” (Crush 1995a, 8) and therefore not solely attributable to actions of agents. The focus is diverted from power-wielding actors to complex strategic constellations in particular societal contexts. Rather than being the capacity of agents, it seems useful to think of power in Development as relational (Brigg 2002; Ziai 2007). Thus power is neither contained within an institution (such as, for example, the World Bank) nor does it emanate from it (Goldman 2005). It is neither
the property of certain actors nor is it a single structure or system. Power rather operates as a combination of, and relationship among, discourses, practices, institutions, and people (Bublitz 2008; Foucault 1989a). In this conceptualisation, there is no centre of power; rather, power exists relationally and is structured as a net (Foucault 1989a). Although power cannot be traced to a single origin or to conscious decisions and actions, it still operates strategically in that it enables specific outcomes and serves the interests of certain actors (Foucault 1989a). In the realm of Development, such a conception of power allows for understanding shifts in policy and practice as transformations of specific power relations, rather than as conscious, rational policy changes (Brigg 2001; DuBois 1991).

In order to distinguish power from societal relations and conditions, it is useful to understand those constellations as power which have developed in an asymmetrical manner for a considerable amount of time (cf. Brigg 2002). Foucault (1989a) describes such development of societal conditions as resulting from the intensification of relations of force and discourses, and introduces the concept of dispositif (or apparatus) to understand the interactions between discourses and non-discursive phenomena (Foucault 1980, 1989a; Parr 2008). The term dispositif highlights “the sedimentation of force relations and the inertia of discourse” (Deleuze 1992, 165). Foucault provides the following definition of dispositif:

What I’m trying to pick out with this term is [...] a thoroughly heterogeneous ensemble consisting of discourses, institutions, architectural forms, regulatory decisions, laws, administrative measures, scientific statements, philosophical, moral and philanthropic propositions – in short, the said as much as the unsaid. Such are the elements of the apparatus. [...] what I am trying to identify in this apparatus is precisely the nature of the connection that can exist between these heterogeneous elements. [...] In short, between these elements, whether discursive or non-discursive, there is a sort of interplay of shifts of position and modifications of function which can also vary widely. (Foucault 1980, 194–5)

The concept of dispositif thus refers to discursive and non-discursive elements as well as to their interplay as an ensemble (cf. Bührmann and Schneider 2008). According to Foucault, dispositif should also be understood as a formation that has
the “strategic function [...] at a given historical moment [...] of responding to an urgent need”, such as, “for example, the assimilation of a floating population found to be burdensome for an essentially mercantilist economy” (1980, 195). Such a formation is in itself stable, which means that shifts in discursive and non-discursive aspects may occur while the dispositif as a whole continues to operate similarly.

Some Development scholars have found this conceptualisation of power pertinent to understanding international Development (Brigg 2002; Escobar 1994; Ziai 2007). Translating the French dispositif as apparatus, Escobar describes Development as an “efficient apparatus that systematically relates forms of knowledge and techniques of power” (1994, 10). For Brigg, the notion of dispositif is useful for describing the “development project” as a complex set of “institutions, funding and resource flows, philosophical propositions regarding the possibilities and desirability of social change modelled on the West, professional development practitioners, scientific efforts [...] and government and non-government organisations dedicated to development” (2002, 427). Ziai (2007) understands power in Development aid through the concept of dispositif because discourses, institutions, and practices are related to each other and form strategic constellations in order to address particular Development issues.

In the present research, it seems useful to conceptualise power in Development as dispositif: as the interconnectedness of discourses and non-discursive phenomena. Understanding power in this manner is pertinent for integrating the different ways in which power plays out in Development, as discussed above – through discourses, practices, institutions, and political-economic conditions. This conceptualisation allows for taking into account the interplay of these elements in German interventions in the field of population and reproductive health in “German East Africa”/Tanzania. Furthermore, in both periods under scrutiny in this thesis, population and reproductive health policy can be understood as a response to an “urgent need” and serving a “strategic function”: During Germany’s colonial rule over East Africa, this policy had the function of responding to the need for labour and for legitimising colonisation in the aftermath of brutal wars against the
colonised people (see Chapters 4 and 5). In contemporary Development aid, population and reproductive health policy serves to address German concerns with regard to high population growth in Tanzania (see Chapter 5).

2.1.5 Summary
Section 2.1 has reviewed and discussed conceptualisations of power in Development, suggesting a concept of power consisting of discourses and their connectedness to the material world. Power is thus understood to be a socio-historically distinct arrangement of knowledge configurations, conventionalised ways of acting, institutions, and political-economic circumstances. Discourses are regarded as time- and place-specific knowledge configurations that underlie and order people’s thinking and, for example, structure how Development issues are perceived and implemented. This study distinguishes discourses from non-discursive phenomena. Discourses produce material effects such as social practices and institutions, and are themselves affected by such material realities. While such a conceptualisation of power grants equal weight to discursive and non-discursive dimensions, the focus of this study is on discourses. Their examination facilitates an empirical connection between German interventions in the colonial past and current Development cooperation. My conceptualisation of power resonates with Young’s insistence on analysing colonial power through “institutional performative discourse[s] of power-knowledge” (2001, 410). However, the Foucauldian notion of power must be complemented by a conceptualisation of actors in Development as being capable of agency. These actors are positioned by discourses, but they also activate discourses and are able to choose how to deal with the way society positions them. This approach to power in Development enables an analysis of the complex policies and practices relating to population and reproduction in their various dimensions in different temporal settings without disregarding agency. The following section examines the particularity of colonial power and its relation to Development.
2.2 Colonial power and Development

In this study, “colonial power” does not exclusively refer to the era of formal colonisation but is rather employed as a concept to characterise the kinds of power that emerged during European colonialism in the Americas, Africa, Asia, and Oceania and which is still operative in the present (Gutiérrez Rodríguez 2010; Ha 2005; Mbembe 2001; Quijano 2000). While “[s]ituating colonialism outside Europe and the North Atlantic enables a division of the world into modern/developed and traditional/under-developed societies” (Gutiérrez Rodríguez 2010, 53), colonial power needs to be understood as effective not only in former colonies but also in thinking and practice in former colonising societies. In Latin American academia, the persistence of colonial modes of thinking and colonial economic, political, and social relations has been discussed with reference to the notion of “coloniality” (Mignolo 2000; Moraña et al. 2008; Quijano 2000). While the present thesis is inspired by this debate, it acknowledges that the concept of “coloniality” is closely related to the particular context of Latin America. I have chosen to use the term “colonial power” for my analysis of German-Tanzanian relations, so as to underline the specificity of that context. Employing “colonial power” as an analytic term “may help us to understand how colonial thinking [...] survived colonialism, and how the specifics of the German colonial and postcolonial experience facilitated the survival of thought structures that are still discernible today” (Friedrichsmeyer et al. 1998a, 29). The notion of colonial power facilitates a scrutiny of thought, practices, institutions, and political-economic conditions that continue to affect everyday life due to traces and effects of colonial history (cf. Gutiérrez Rodríguez 1999a). More specifically, this concept makes it possible to link an exploration of the emergence of intervention into population and reproduction during German colonialism in East Africa with an examination of present-day policy and practice. By not reserving the notion of colonial power to refer to the period of actual territorial occupation, the difference between the period of formal colonial rule and the contemporary, post-colonial era can be examined “as the reconfiguration of a field, rather than as movement of linear transcendence between two mutually exclusive states” (Hall 1996, 254). Colonial power is thus understood as having emerged during colonial rule, and as
having transcended this historical period. It continues to take effect in the present through the persistence of colonial discourses and their interconnectedness with practices, institutions, and the global political economy. Such a conceptualisation allows for examining to what extent and in what ways colonial power shapes contemporary German Development interventions in Tanzania.

Postcolonial analyses of Development promise “critical responses to the historical effects of colonialism and the persistence of colonial forms of power and knowledge into the present” (Kothari 2011, 69). Postcolonial approaches are distinct in their theoretical and epistemological perspectives as they provide “critiques of the process of production of knowledge about the [colonised, DB] other” (Williams and Chrisman 1994, 8). Refuting the differentiation between colonisation “as a system of rule, of power and exploitation, and colonisation as a system of knowledge and representation” (Hall 1996, 254), postcolonial approaches to Development examine the colonial imprint on knowledge, subjectivities, practices, institutions, and political economy (Kapoor 2008; McEwan 2009). In addition to general deliberations on why and how postcolonial theory can be fruitfully applied to the field of Development Studies (Biccum 2002; Kothari 1996; McEwan 2001, 2009; Simon 2006; Sylvester 1999), scholars have explored the continuation of colonial-era relationships between donor and recipient countries (Biccum 2005; Karagiannnis 2004; Noxolo 2006; Power 2009; Slater and Bell 2002), the impact of racialisation in Development (Kothari 2006a; White 2002), the intertwining of gender and “race” (Heron 2007; Syed and Ali 2011; White 2006), subjectivities of Development workers (Eriksson Baaz 2005; Heron 2007), and geographical imaginations and practices (Noxolo 2006; Wainwright 2008). These studies bring to the fore various dimensions of the persistence of discourses, practices, and political-economic structures from the colonial era in contemporary Development. Drawing on their insights and postcolonial theory, the following sections discuss the characteristics of colonial power in the context of Development.

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6 In the light of debates regarding the meaning and usefulness of the term postcolonial (Ahmad 1995; Hall 1996; McClintock 1992; Shohat 1992), I employ post-colonial with a hyphen to refer to the chronological phase after formal colonialism, and postcolonial without a hyphen to refer to the set of critical theoretical approaches (Kapoor 2008).
2.2.1 Constructing “colonial difference”

Postcolonial perspectives on Development are concerned with the manner in which Development aid is based on, and establishes, differences and hierarchies between the global North and South (Heron 2007; McEwan 2009). Scholars have argued that principles of Development cooperation such as partnership, which suggests equality between donors and recipients, are called into question by the self-conception of Western nations as superior (Eriksson Baaz 2005; Noxolo 2006). Noxolo (2006), for instance, suggests that the impossibility of “partnership” between the United Kingdom and its former colonies has its roots in colonial-era racialised, gendered hierarchies that continue to operate in the present. Drawing on colonial-era representations of Africans as idle and irrational, Eriksson Baaz (2005) highlights the manner in which the self-conception of Development professionals as different from and superior to their counterparts in the global South leads them to interpret resistance of these partners to their proposals as passivity rather than as a sign of autonomy. Colonialism was enabled and legitimised through the establishment of difference between the colonising Self and the colonised Other (Mudimbe 1994; Said 1978), and thus, the colonised were discursively and materially positioned as fundamentally different from, and inferior to, the colonisers (Fanon 1980).

Scholars from Latin America in particular have argued that “colonial difference” has been the essence of colonial power ever since the conquest of the Americas (Dussel 1995; Mignolo 2000; Quijano 2000). Allowing for differentiation, classification, and hierarchisation of the colonised vis-à-vis the colonisers, “colonial difference” assumed different forms under “different global designs” (Christianisation, “civilising mission”, post-WWII Development, neoliberalism, and so on). However, “[b]arbarians, primitives, underdeveloped people, and people of colour are all categories that established epistemic dependencies” (Mignolo 2002, 84–5). Whether difference was established on the basis of religion, biology, “civilisation”, “modernity”, “culture”, or “development”, these concepts shared an underlying construct of “race” and racialised difference among groups of people. Racism needs to be understood as an originally European ideology according to which people can be categorised into “racial” groups based on arbitrary physical markers (Arndt and
Ofuatey-Alazard 2011; Gomes et al. 2008). Such racialised groups are constructed as intellectually, morally, culturally, and socially distinct. Since the beginning of colonialism, “white” people have used racialisation to justify conquest, exploitation, annihilation, and subordination of people constructed as “racially” inferior. Colonial racialisation commonly also operated via reference to gender relations. The following quote by Kant is a telling example of how the discussion of relations between men and women was used in Europe to construe colonised people as inferior “racial” groups:

If we examine the relation of the sexes in these parts of the world, we find that the European alone has found the secret of decorating with so many flowers the sensual charm of a mighty inclination and of interlacing it with so much morality that he has not only extremely elevated its agreeableness but also made it very decorous. [...] In the lands of the black, what better can one expect than what is found prevailing, namely the feminine sex in the deepest slavery? (Kant, 1764, cit. in Wolrad 2005, 66)

Ever since the beginning of colonialism, agents from the global North have made reference to oppressive gender relations in the global South to establish racialised superiority and justify intervention (Mohanty 1991; Spivak 2003). A considerable number of studies have shown that racialisation continues to operate in contemporary Development aid (Duffield 2006; Goudge 2003; Kothari 2006a, 2006b; Power 2006, 2009). For instance, analysts have observed that other concepts “such as ‘tribalism’, ‘ethnicity’, ‘tradition’, ‘religion’ and, perhaps pre-eminently, ‘culture’” (White 2002, 408) often stand in for “race”, but that the referents of these categorisations have not changed; “people of colour”, “black” people, and the global South are still differentiated from “white” people and the global North (Kothari 2006a; Ziai 2008). Thus, “rather than indicating its irrelevance, the silence on race is a determining silence that both masks and marks its centrality to the development project” (White 2002, 408). This research develops these insights and, in Chapter 5, explores the establishment of colonial difference in German endeavours to control population in “German East Africa” and in Tanzania. It inquires as to how German thinking and practice on issues of population and reproduction established a difference between colonisers and colonised during German colonial rule, and
examines whether colonial difference is articulated in a similar manner in ongoing German policy and practice. In Chapter 6, the notion of colonial difference is also made use of in order to understand how knowledge, skills, and attitudes in East African midwifery were comprehended by German professionals during colonial rule as well as in present-day Development.

The dichotomous logic of colonial difference is expressed by associating colonised people with certain characteristics (Fanon 1980). Colonial difference may, for instance, be enacted by primitivising, in which the colonised people become the personification of another form of humanity that is seen as backward. Another manner in which colonial difference is established is through infantilisation, which suggests that the colonised people cannot live without the help, guidance, and trusteeship of the colonisers (Fanon 1980). According to postcolonial scholar Mbembe, “in relation to Africa the notion of ‘absolute otherness’ has been taken farthest” and “the simplistic and narrow prejudice persists that African social formations belong to a specific category, that of simple societies or of traditional societies” (2001, 2–3). In this manner, Africa is typically associated with resistance to change, “‘absence’, ‘lack’, and ‘non-being’” (Mbembe 2001, 3–4). Here, “to differ from something or somebody is not simply not to be [similar, DB]; it is not to be at all (non-being). What is more, it is being nothing (nothingness)” (Mbembe 2001, 4).

Chapter 6 touches on this argument and discusses such associations in German perceptions of, and interventions into, obstetric care in East Africa. The mechanism of establishing colonial difference often went hand in hand with the colonial strategy of negating any difference between colonisers and colonised, which enabled the colonisers to turn a non-transparent other into something that is already known (Barthes 1964). Thus Dussel maintains that “Europe never discovered (des-cubierto) this Other as Other but covered over (encubierto) the Other as part of the same: i.e. Europe” (Dussel 1995, 12). This study explores how such a mechanism operates in the manner in which German professionals make sense of East African obstetric care practices which they have encountered during colonisation and during current Development cooperation.
To summarise, colonialism was legitimised through the establishment of colonial difference between colonisers and colonised people. This construction of colonial difference took different forms (religion, biology, “culture”, and so on) and was based on racialisation. Colonial difference transcended the period of colonisation and continues to exist in contemporary Development aid.

2.2.2 Linearity of “development” and imposition of European thinking

In international Development, the global North and global South are commonly seen as being at different stages of a single universal time (Eriksson Baaz 2005; Kothari 2011). There is a tendency to perceive all phenomena in the global South in terms of the history of the global North (Robinson 2006). This is epitomised in modernisation theory, which has dominated post-WWII Development thinking and practice. The idea that people, societies, and world regions inhabit different yet continuous temporal spaces dates back to the period of colonial rule; colonial thinking entailed an assumption of history, social change, and “development” taking place in a linear manner (Dussel 1995). Western Europe was seen as the culmination of history and “development”; other regions allegedly lagged behind (Dussel 1995; Kebede 2004). Africa in particular was perceived by Europeans as a place of stagnation. This assumption was first and foremost formulated and propagated during the European “Enlightenment” by philosophers such as Hegel (1822). Europe and “white” people were construed as the human norm and associated with “progress”, “development”, and mandated to subdue other regions of the world and other peoples (Farr 2005). This study addresses whether notions of linear, teleological societal “development” are invoked in German discourses and practices on population and reproductive health in Tanzania. For example, it discusses whether such assumptions were evident in interventions regarding population size and fertility rates during formal colonisation and explores whether current German Development cooperation displays similar ideas and practices (Chapter 5).

The idea of linear, teleological “development” is connected to the practice of imposing Western epistemology and “modes of organization on the non-West”
Scholars have criticised Development policy and practice for privileging and universalising European epistemology, by which they mean postulating Western positivist, scientific rationality as the only legitimate means of knowledge production (Briggs and Sharp 2004; Escobar 1994; Goldman 2005; Wainwright 2008). According to Briggs and Sharp, the prevailing conviction in international Development is “that either Western science and rationality are more advanced or refined than other positions or, more simply, that they are the norm – ‘knowledge’ in the singular form – from which others deviate in their fallibility” (2004, 662). These authors highlight that donors tend to incorporate indigenous knowledge in the name of “ownership” as a mere complement to scientific and expert solutions, thereby reducing it to technical knowledge without taking underlying social norms and world-views into account (Briggs and Sharp 2004). Scholars have shown that, by employing force to subjugate the rest of the world, Western societies have attempted to shape the non-Western world according to their desires (Hauck 2003). Mignolo (2000) holds that local European knowledge and modes of organisation have thereby been projected across the globe. Such universalisation entailed the destruction of other knowledge systems through annihilation and transformation of societies and institutions and the parallel installation of Western institutional and epistemological apparatuses (for instance, Western education and schooling, or hospitals and health care). In this manner, colonial power operates not only through the conviction that non-Western societies should follow the European model, but also through putting this into practice on a material level. As is explored in Chapter 5, German colonial policy and practice on issues of population and reproduction attempted to change “customs” and “traditions” in East Africa through coercive laws as well as less coercive means (Christianisation, “education”) in order to ensure a large and healthy labour force. In contemporary German Development cooperation, this is evident in education on, as well as promotion and provision of, “modern” contraceptives (Chapter 5). Colonial power in Development is characterised by an understanding of “development” as linear, with the West at the top, as well as by the spread of European epistemology and forms of social organisation across the global South.
2.2.3 Continuity of global political and economic inequalities

Various scholars have criticised postcolonial approaches because they neglect the material realities of global capitalism (Ahmad 1995; Dirlik 1997; Kapoor 2008). Postcolonial studies have generally been accused of a “culturalist bias” – that they undertake “critical analysis of literary and other discourses, of social mentalities and subjectivities, ideologies and symbolic practices” and thereby run “the risk of concealing or neglecting the materiality of the social and political relations that make possible, if not inevitable, the reproduction of those discourses, ideologies and symbolic practices” (Santos 2010, 234). However, in the light of the continuity as well as reconfiguration “of the divisions in economic and political power created by the processes of colonialism” (Biccum 2002, 37), recent postcolonial approaches in Development Studies have taken material inequalities and global power relations into account (McEwan 2009; Wainwright 2008; Ziai 2010). The continuity of colonial-era economic and political dependence has been noted in African countries in particular, where “continuing economic hegemony [...] means that the postcolonial state remains in a situation of dependence on its former masters, and that the former masters continue to act in a colonialist manner towards formerly colonized states” (Young 2001, 45).

Principles of Development cooperation that emerged since the mid-1990s, such as “participation”, “ownership” and “partnership” (OECD DAC 1996; OECD 2005, 2008), suggest a break with the imposition of interventions characteristic of the colonial past and imply a level playing field between donors and recipients of Development aid. Postcolonial approaches to these seemingly new policies and practices have, however, drawn attention to the fact that fundamental transformations of Development relationships are impossible when economic and political inequalities between donors and recipients persist. Cooke (2001), for instance, shows how the seemingly empowering agenda of “participation” is impossible in the context of economic and political asymmetries between the global South and North, and how a disregard for these inequalities is subservient to donors’ self-interest in Development agendas. Instead of challenging dominance and hegemonic norms, the credo of “participation” thus rather “masks and perpetuates social and
economic structural inequalities” (Cooke 2001, 20; see also Kapoor 2008). Chapter 5 of this study explores whether contemporary German Development intervention regarding population control serves German economic interests, and Chapter 7 examines whether political and economic inequalities between Germany and Tanzania inhibit challenges to colonial power. The operation of colonial power in contemporary Development is thus also marked by social, political, and economic structural inequalities between global North and South which stem from the period of colonisation.

2.2.4 Heterogeneity and challenges

The above studies on the operation of colonial power in Development tend to homogenise colonial power. Yet, postcolonial critics such as Bhabha (1990, 1994) have suggested that power during formal colonial rule was inherently unstable. Postcolonial approaches are able to explore heterogeneity and challenges to colonial power by “demonstrating the dispersed space of power and a disseminated apparatus, wielded by diverse agents and effecting multiple situations and relations” (Parry 2004, 14). Scholars of Development have also highlighted that colonial discourse in contemporary Development is not monolithic and uncontested (Eriksson Baaz 2005; Heron 2007; Kapoor 2008). For example, Eriksson Baaz (2005) considers questioning attitudes and criticism of Development aid in Scandinavian professionals’ accounts of their work in Tanzania. When interventions do not yield the expected results and recipients behave contrary to how Development workers believe they should behave, doubts may be raised regarding the “location of rationality” in the “developers” (Eriksson Baaz 2005, 153). Development professionals are able to take different stances with regard to dominant discourses (McKinnon 2008). This means that established Development discourses and power relations can be transformed by donor agents (Eriksson Baaz 2005; Kapoor 2008). Moreover, aid recipients may also challenge colonial power through their actions. Working towards recuperation of agency of people of the global South is one of the key objectives of postcolonial approaches to Development (Yeboah 2006). Chapter 7 of this study focuses on the “hidden transcripts” (Scott 1990) in Development.
professionals’ accounts of their work that highlight doubts and criticism and thus contest dominant conceptions of Development. Furthermore, “hidden transcripts” are scrutinised for indication of challenges by Tanzanian counterparts. Nonetheless, this study also considers structural inequalities and pervasive discourses of German superiority that inhibit transformations of colonial power (Chapter 7).

2.2.5 Summary

By reviewing postcolonial Development Studies and drawing on postcolonial theory, this section has argued for a particular understanding of colonial power, as having emerged during formal colonial rule but also having transcended this historical period. Colonial power takes effect in the present through the persistence of discourses that emerged during colonial conquest and their relation to material practices and structural political and economic inequalities. The notion of colonial power is thus employed as an analytic category that can be used to examine contemporary Development policy and practice. Several characteristics of colonial power are important to this study: The construction of difference was essential to establishing and upholding dominance during colonial rule, and continues to shape the present. It can take various forms but always entails racialisation. The construction of colonial difference operates in unison with the assumption of linear, teleological “progress” that places societies in different stages of “development”. In this context, the West serves as the epitome of “development” – a state which other societies are supposed to follow. Colonial power in the present is enabled and upheld by unequal political and economic power relations between the global North and South that have their origins in colonial-era conquest and exploitation. While colonial power is pervasive, it is not monolithic but rather heterogeneous, as it operates through a range of agents and in different sites. Actors are able to contest and challenge its articulation. Such an understanding of the operation of colonial power allows for scrutinising traces of colonial thinking and practice in contemporary Development. In order to find out how and with what effects contemporary German Development interventions in population and reproduction are shaped by colonial power, further exploration is needed to conceptualise
intentional Development and identify its particular form in issues of population and reproduction.

2.3 Development interventions and issues of population and reproductive health

This part of the conceptual framework reviews studies on Development interventions, particularly those relating to health, population, and reproduction. First, the emergence and nature of Development interventions are discussed (2.3.1). Then the emergence and characteristics of Development policy and practice on issues of health, population, and reproduction are discerned, and the different phases of such interventions traced over time (2.3.2). I conclude that Development interventions regarding the above-mentioned issues emerged during colonisation at the beginning of the 20th century, and have since been characterised by the primacy of population control as well as by the propagation of Western reproductive norms and practices.

2.3.1 Development interventions

Mainstream as well as post-development scholars tend to equate Development policy and practice with post-WWII Development (Matthews 2004). While colonial-era connections between the global North and South are acknowledged, Development is generally regarded as fundamentally different from colonialism (Brigg 2002; DuBois 1991; Escobar 1994; Ziai 2008). However, scholars of colonialism and Development have noted that the idea and practice of “developing” the colonies and colonised people arose during colonial occupation, thus destabilising the notion of a clear break between colonial-era and Development policy and practice (Cooke 2001; Cowen and Shenton 1995; Hodge 2007). Cowen and Shenton argue “that the conditions which gave rise to intentional development as a redress to progress arose first” in Europe (1995, 41–2). According to these authors, Development must be understood as a “state practice rooted in the 19th century” when people who regarded themselves as “developed” held the conviction
that they “could act to determine the process of development for others deemed less-developed” (Cowen and Shenton 1995, 28). In Europe at the time, capitalist “progress” was associated with disorder in the form of proletarianisation, overpopulation, diseases, etc. Development interventions were meant to ameliorate and bring “order” to such capitalist “progress”. According to this view, Development is not an invention of the global North to retain its control of the global South in the wake of decolonisation, as some post-development scholars seem to suggest, but rather the transferral of 19th century European domestic state policies to colonised territories. According to Hodge (2007), ideas to improve land and people have always existed in colonialism, but the real story of Development began at the end of the 19th century. Concentrating on British colonial rule from the turn of the 20th century until its demise, the author examines agrarian doctrine and argues that “development as a framework of ideas and practices emerged out of efforts to manage the social, economic, and ecological crises of the late colonial world” (Hodge 2007, 2). This approach was new because it consciously and systematically aimed at “developing” or “modernising” colonised societies, and because of the central role afforded to technical and scientific solutions aimed not only at “opening up” the colonies to trade but also targeting the moral and material situation of its inhabitants (Hodge 2007). As will be shown in Chapter 4, this transition to Development policy and practice was also evident in German colonial rule towards its African colonies, and applied to issues of population and reproduction. Chapter 5 and 6 explore the emergence of Development interventions towards the specific aspects of population control and obstetric care. In this study, Development is thus understood as intentional interventions by agents from the global North – who perceive themselves to be “developed” – in the lives of people in the global South. Development is meant to improve people’s moral and material situation, inter alia as an antidote to the destruction wrought by “modernisation” and capitalism. In the following sections, I examine studies of the emergence of Development interventions in population and reproductive health and of their historical phases and their emphases to the present day.
2.3.2 Interventions in population and reproductive health in a historical perspective

European thinking on “population” has its origin in the 17th and 18th centuries (Foucault 1989a). The 18th century also witnessed the advent of increasing academic work on population and reproduction – with Robert Malthus' famous “An Essay on the Principle of Population” published in 1798 (Ferdinand 1999). This was situated in the context of mercantilism, and the development of capitalism would not have been possible without the adjustment of population to economic processes (Foucault 1989a). According to Duden, conceiving “people” as “population” reduced “persons to bloodless entities that can be managed as characterless classes that reproduce, pollute, produce or consume, and for the common good, call for control” (1997, 149). People were henceforth conceived in terms of indicators such as birth rate/fertility, mortality, health, and so on, that need to be statistically measured and regulated in order to align with capitalism (Foucault 1989a, 2001).

The emergence of policies by countries of the global North with regard to population and reproduction in the global South is commonly dated to the 1940s and 1950s, when population growth in colonised and newly independent territories began to be viewed as problematic and birth control was propagated as necessary (DuBois 1991; Hartmann 1997a). In such an understanding of the history of interventions in population and reproduction, United States and European domestic policies directed towards the working classes, such as the promotion of birth control, were applied to the global South (Rainer 2003). Even though shifts in international Development policy and practice on population and reproduction towards the global South after the Second World War were not clear-cut, scholars have discerned different phases and emphases (Halfon 1997; Schultz 2006): The first period, ending in the late 1950s, was dominated by the fear of overpopulation which was thought to threaten global resources and national security (mainly of the United States). The 1960s and 1970s constituted the high point of population politics, centring on the relation between economic growth and population size (Halfon 1997). The demographic transition theory was strongly influenced by the
ideology of modernisation, holding that capitalist “development” would naturally lead to a decline in birth rates. This theory was joined in the 1960s by the so-called orthodox position:

Translated into policy, the orthodox position holds that lowering population must be achieved directly by supplying modern contraceptives to people in the Third World. This position is called the “population control” framework in international policy, which is characterized by a focus on contraceptive delivery and target-driven birth-reduction efforts. (Halfon 1997, 128)

During the 1960s and 1970s, addressing what was considered to be overpopulation in the global South became central to international organisations and governments of the global North. However, the assumptions and interventions of policy makers and researchers from the global North were also frequently criticised (Mamdani 1972). In the 1980s, “new” topics such as environment and migration emerged on the international population policy agenda (Schultz 2006). Some demographic approaches put forward a causal relationship between natural resources and population which implied that less people would mean less resource consumption and environmental degradation (Hummel 2007). The more sophisticated idea of a “carrying capacity” acted on the assumption that the number of people, characteristics of ecological space, and social, cultural and spatial forms of organisation are interrelated in a non-causal, complex manner (Hummel 2007).

International Development agendas have continued to be shaped by the “demographic transition theory”, the “orthodox position”, concerns about the environment, and migration (Halfon 1997). The present study provides evidence of such focuses and concerns in contemporary German Development cooperation in Tanzania and explores similarities with rationales for population control during German colonial rule (Chapter 5).

Due to an alliance between women’s health NGOs and organisations comprising the “population establishment” (Hartmann 1997b), the outcome of the 1994 International Conference on Population and Development in Cairo (known as the Cairo Consensus) shifted the focus of population policy on health and rights (Schultz 2010). While the change in approach towards reproductive health is widely
regarded as radical, scholars have pointed to the persistence of demographic goals after the *Cairo Conference* (Rao and Sexton 2010). According to Schultz (2006), a compromise between the contradicting paradigms of demographic control and people’s right to freely decide on their number of children was achieved through promotion of individualised, neoliberal politics. Thus, international organisations, states and NGOs grant women the right to have as many children as they desire, but focus on “educating” them on the health risks and economic disadvantages of having “too many” children, and having them “too early” and “too close to one another” (Schultz 2006). With reference to women’s responsibility for their own well-being, child-bearing is thus discouraged and use of contraceptives encouraged. Rather than challenging demographic goals, the *Cairo Consensus* resulted in their persistence and a dilution of originally radical feminist stances against population control (Sexton and Nair 2010). While arguments for reducing population growth in the global South have changed since the 1940s, demographic considerations have always taken centre stage: population size is still regarded as a variable that may be deliberately manipulated in order to influence social conditions and vice versa (Schultz 2006). International policies and practices on population and reproduction propose small families and fewer but healthier children (Schultz 1994). This has been referred to as “reproductive Westernisation” (Frey 2007; transl. DB). It has been argued that transnational firms and Western governments have political and economic stakes in population control through establishing consumer markets for “modern” contraceptives as well as through the “containment of a superfluous or redundant labour force, the maintenance of political stability, and the perpetuation of dependent social relations” (Kuumba 1999, 455). My research of German Development aid acknowledges these observations, but further explores the colonial legacy in such traits of present-day population and reproductive health policy (Chapters 5).

Colonial historiography has suggested that discussions by colonial administrations regarding population decline had already been initiated by the turn of the 20th century in the context of colonial reforms towards “rationality” and “efficiency” (Colwell 2001; Koponen 1994; Widmer 2008). Colonised people were perceived in
economic terms as part of the wealth of colonising nations, and European colonial reformists began to discuss ways of increasing population growth (Grosse 2000). These historiographic insights are in line with this study which explores German colonial-era interventions to foster population growth (Chapter 5). Rather than beginning the story of population politics of the global North in the global South in the 1940s, this study thus suggests the need to examine the emergence of the West’s concern with population size and reproductive practices of colonised societies at the turn of the 20th century. It holds that in order to understand contemporary focuses in policy and practice, research should not concentrate on the issue of overpopulation, but rather trace back the concern with population regulation in the global South (Chapters 4 and 5). This study considers that in order to explore colonial power in contemporary Development, it is useful to retain the notion of the primacy of demographic considerations in interventions on population and reproductive health issues in the global South. Yet, research should not be restricted to a focus on “anti-natalist bias” (Schultz 2006, 25; transl. DB) but should remain open to identifying demographic policies and practices prior to the 1940s.

Historical studies have also alerted us to the fact that Western intervention into birthing and child-rearing began during colonial occupation (Hesselink 2011; Hunt 1999; Nestel 1998). Class-based policies in many European countries and in North America were mirrored by projects in the colonies (Jolly 1998). Experiences of motherhood, birthing practices, and obstetric care in the colonies – just like healing and therapeutic practices in general (Langwick 2011) – were transformed by missionaries and colonial state policies in the name of “civilisation” and “modernity” (Hunt 1999; Ram and Jolly 1998; Vaughan 1991). In the “Belgian Congo”, for example, missionaries and colonial government officials tried to medicalise African reproductive practices by founding health facilities, training Africans to be nurses and midwives, and promoting childbirth in hospitals (Hunt 1999). According to Vaughan, colonisers and missionaries in particular were set on gaining access to the realm of birthing because they “realized that African midwifery practices and associated ideas regarding fertility and childcare were the locus of the reproduction of many strongly-held beliefs [and that] African ‘midwives’ […] exercised a large
degree of social and moral control which had to be broken if Christianity was to succeed” (1991, 66). Scholars of health and medicine have pointed out that colonial-era interventions were based on a hierarchical categorisation of bodies, societies, systems of thought, and practices along the lines of colonial difference (Ferzacca 2003). Colonial government and missionary health interventions “played an important part in constructing ‘the African’ as an object of knowledge, and elaborated classification systems and practices which have to be seen as intrinsic to the operation of colonial power” (Vaughan 1991, 8). While a range of analogies to European gender and class hierarchies were expressed in health policies during colonial rule, so were “distinctive features of the colonial poetics of pollution” which meant that colonisers drew lines that “traced more explicitly than in Europe the boundaries of race” (Anderson 2000, 236). After decolonisation, colonial-era categorisations of people and societies became measures of “progress” and “development”. Non-Western health practices were judged by their “proximity in both time and space to modernity using the contrasting category of tradition” (Ferzacca 2003, 187). Decolonisation commonly did not entail a turning-away from the Western biomedical model, but rather an expansion thereof “as a result of the growing dependence of developing nations on Western aid and the parallel growth of international health and development agencies, [...], which work within a Western biomedical paradigm” (Packard 2000, 97–8). This study builds upon these insights into policies and practices on health and midwifery practices and explores interventions in obstetric care by German actors during the occupation of “German East Africa”, as well as currently (Chapter 6). It also addresses the establishment of colonial difference by German professionals in their involvement in transforming midwifery practices.

2.4 Conclusions

This chapter has argued for an exploration of colonial-era and contemporary German intervention into population and reproductive health in East Africa through discourses which are interconnected with, and have effects in, the material world. Such an understanding of power as dispositif allows for an analysis of German
interventions in their complexity and multi-dimensionality. Furthermore, it allows for a comparison between colonial-era and contemporary German policy and practice. While this study primarily focuses on discourses, these are conceptualised as fundamentally bound up with actual practices, institutions, and the political-economic environment. At the same time, attention is paid to actors and their agency which is conceptualised as circumscribed by dominant knowledge configurations and material circumstances, but not wholly determined by these. In addition, through a review of postcolonial approaches to Development, this chapter has suggested understanding “colonial power” as an analytic concept. This means that colonial power is understood as having emerged during colonial rule and – given its articulation through knowledge configurations that persist over time – having transcended this period to take effect in post-WWII Development cooperation. The operation of colonial power is characterised by various dimensions. These include the establishment of colonial difference between (former) colonisers and (former) colonised, which may take different forms in different times and contexts, but is always based on racialisation. Moreover, colonial power in Development is marked by the assumption of linear, teleological historical and societal “progress” with the West at the upper end. Societies of the global South have been and continue to be transformed based on Western epistemology and modes of organisation. These aspects of colonial power take effect in the context of global political and economic inequalities which have their origin in colonial-era conquest and exploitation. Colonial power in Development is not monolithic but rather heterogeneous, and is challenged by aid donors as well as recipients. Furthermore, the discussion of literature on the history of Development policy and practice and on intervention in population and reproductive health has shown that such endeavours emerged at the turn of the 20th century. Whereas contributions to the history of population politics commonly mention the 1940s as the time when the West came to regard overpopulation in the global South as problematic, this study considers it more useful to focus on the emergence of the West’s concern with population size as such. This was evident during colonialism at the beginning of the 20th century, and has since been characterised by the primacy of population control. Development interventions into reproductive practices such
as childbirth similarly have their roots during European colonial occupations. Colonisers, particularly missionaries, sought to transform reproductive practices based on Western norms. Interventions aimed at medicalising birthing in the global South have since been characterised by categorising practices according to the dichotomy of “modernity” and “tradition”.

Having put forward a conceptual framework for exploring colonial power in Development through the lens of intervention into population and reproductive health, this thesis now turns to developing a methodological framework for examining colonial power in current Development.
3 Methodology and methods

3.1 Introduction

In order to explore empirically how and with what effects contemporary German Development interventions in reproductive health and population issues in Tanzania are shaped by colonial power, the methodological framework must address discourses and their connection to materiality – historically and in the present – as well as the agency of actors involved. Moreover, it must allow for a comparison between colonial-era and contemporary intervention. In this chapter I review contributions to discourse analysis in Development Studies (3.2) in order to outline the methodological approach of this study, genealogical dispositif analysis (3.3). Subsequently, I present research practices for collecting (3.4) and analysing data (3.5).

As mentioned in Chapter 1, Development cooperation tends to be driven by the need for tangible results. This is mirrored by the focus of Development Studies being on practical interventions (Bernstein 2006). Hence, Development Studies is largely future-oriented and scholars tend to refrain from critically analysing the past (Kothari 2011). Recently, however, scholars have shown increasing interest in the history of Development policy and practice (Bayly et al. 2011). Woolcock et al. consider the history of “development” as a “vantage point for framing and viewing the nature of development” in the long term (2011, 82). They regard history to be important as a resource for critical and reflective self-awareness as to the nature of Development as a discipline and its current focuses: why certain issues are focused on and not others, why these issues have come to take their particular form in the present, and in which ways present motives and goals differ from those in the past.

Historical research in Development Studies has attempted to make sense of institutional change and economic “development” (Amrith 2008; Bayly 2008; Moradi 2008; van de Walle 2009) and has traced the emergence of Development as intentional intervention (Cowen and Shenton 1995; Hodge 2007; Koponen 1994).
For example, Cowen and Shenton (1995) argue that Development is a 19th century European state policy that emerged to ameliorate the perceived chaos caused by progress in European nation states and was then reapplied in the context of colonial occupation. In a similar vein, refuting post-development’s assumption that “[d]evelopment as theory and practice [...] began sometime in the decade following the Second World War”, Hodge examines “the way development as a framework of ideas and practices emerged out of efforts to manage the social, economic, and ecological crises of the late colonial world” (2007, 2). In this perspective, debate over control and exploitation of natural and human resources in the global South merely culminated in the post-WWII era (Hodge 2007). Koponen (1994) examines how the doctrine of “development” became hegemonic in “German East Africa”. These historical studies investigate the ways in which ideas and practices of Development emerged during colonial rule. Building on such historical research as well as postcolonial analyses of contemporary Development (Noxolo 2006; Wainwright 2008; Deuser 2010), this study attempts to “provide critical responses to the historical effects of colonialism and the persistence of colonial forms of power and knowledge into the present” (Kothari 2011, 69). However, there is a lack of methodologies guiding such an examination.

In consequence, this study proposes the methodology of genealogical dispositif analysis, drawing on Foucault (1977, 1980). Genealogy is a historical approach which, in this case, makes possible an alternative reading of seemingly self-evident German Development policy and practice on population and reproductive health in Tanzania in the present. This is achieved by investigating how and with what effects the issues of population and reproduction have been discussed and intervened into in the past. The genealogical approach enables people to distance themselves from a specific gridlocked perspective on present issues (Owen 2003). The genealogist closely examines the ground on which s/he stands and digs under their own feet, questioning the assumed truths of their own present (Oestreich 1995; Vogl 2008). Dispositif analysis is an extension of discourse analysis and examines the multi-dimensionality of power as highlighted in Chapter 2. The following section reviews
discourse-analytical approaches in Development Studies, and the section after then outlines genealogical dispositif analysis.

3.2 Discourse analysis in Development Studies

Approaches which analyse discourse mainly found their way into Development Studies via the post-development school (DuBois 1991; Escobar 1994; Rahnema 1991; Sachs 1992). Post-development scholars have convincingly argued that discourse analysis is a suitable methodology for understanding Development and North-South relations (Escobar 1985; Ziai 2004b). Postcolonial Development Studies commonly builds on such an approach to Development and scrutinises similarities between colonial-era and contemporary discourses. For example, Biccum (2005) highlights that the language of the United Kingdom’s new Development agenda is “repackaging and marketing the nineteenth-century civilising mission” (1006) and serves the purpose of “imperial subject creation” (1018). Similarly, Noxolo (2006) criticises the infantilisation and gendering of the concept of partnership as put forward in the UK White Paper of 1997 and links this back in time to the metaphor of the Commonwealth family of nations. Slater and Bell (2002) also employ discourse analysis to examine UK White Papers and find that “partnership” in New Labour’s overseas Development strategy is similar to trusteeship. My research builds on these studies’ attempts to understand the colonial trajectories of contemporary Development through an analysis of discourse.

Discourse analysis allows for discerning dominant ways of thinking and seeks to reconstruct the acceptable, legitimate speech around the issues under scrutiny (cf. Diaz-Bone 2006; Kerchner and Schneider 2006). In order to determine how issues of population and reproduction are perceived by German actors during colonial rule and today, it is thus necessary to identify the discourses surrounding them (Foucault 1981; Saar 2003). Discourses are not simply sentences, arguments, or speech acts (Gehring 2008), but only those modes of speech which – after emerging at a certain point in time – have effects by appearing in a repetitive, constant, and enduring manner (Foucault 1981). They are characterised by a certain “permanence”
(Foucault 1981, 152), which means they may be found again and again in a temporal and spatial context and are integrated into society and institutions (Landwehr 2001).

The aforementioned studies of Development tend to concentrate on discourse and pay less explicit attention to material conditions. According to Wainwright, such methodological approaches tend to not “adequately analyze how development discourse is articulated through concrete socioeconomic practices” (2008, 9). Postcolonial approaches to Development which empirically analyse such materiality are rare. Wainwright (2008), for example, examines how the Maya were subjected to authoritarian control by the colonial and post-colonial Belizean state (previously British Honduras), and analyses the practical outcomes and economic effects of Development projects aimed at settlement of the Mayas and at reforming their agricultural system. By taking into account discourses as connected to materiality, Wainwright is able to understand Development as interconnected with colonial forms of knowledge as well as with the spread of capitalist social relations. While not exploring materialities in detail, the present study also examines how knowledge configurations are connected to “the realm of materiality […] [and to] the domain of objects and specific historical practices” (Young 2001, 399).

While analysing discourses is important for understanding Development policy and practice, discourses should not be perceived as self-referential producers of knowledge (see Chapter 2). Neither should they be analysed as an abstraction from reality which clouds what is really occurring (Young 2001). Rather, discourses mediate reality, affect what is seen as true, are linked to actual practices, and are connected to institutions and to the political-economic environment. They should thus be examined as deeply interconnected with non-discursive phenomena. While Foucault’s *Archaeology of Knowledge* mainly addressed the internal structuring of discourses, he revised this in later studies to examine how institutions, buildings, and practices – “socially conventionalised ways of acting” (Keller 2007, para. 44) – were connected to orders of knowledge. The visible, physical dimensions are the basis of discourse as well as the forms in which discourses manifest themselves in the real world (Keller 2007). In the case of my field of study, contemporary German
aid discusses the topics of population size and fertility rates with reference to lack of so-called modern contraceptives. Contraceptives are seen as key to regulating population and achieving reproductive health. While correct population development is thus linked to fewer children, this discursive dimension takes visible effect in the real world: “modern” contraceptives are distributed or sold, and companies produce them and profit from their provision (see Chapter 5). In the case of birthing, German professionals suggested that East African women give birth in health facilities during the colonial era because these were construed as the proper place for “modern” birthing. Knowledge around birthing was, however, intertwined with actual hospitals built and with physical practices of introducing new birthing positions (see Chapter 6).

Other discourse-analytical methodologies in Development Studies are more concerned with questions of agency (Eriksson Baaz 2005; Heron 2007). They analyse how Development professionals “negotiate power relations and enact resistance” (Heron 2007, 18). Focusing on agents is useful for understanding Development, because “individuals and groups are [ ] positioned in relations of power and are [...] the] vehicles” of power (Heron 2007, 10). In complying or not complying “with discursively established standards of conduct [...] lies the actualization of agency” (Heron 2007, 10). With such a methodological approach, Heron is able to take into account “multiple and shifting subject positions, the effects of discourse, and the possibility of refusing dominance” (2007, 10–1). Eriksson Baaz also looks at Development workers and how they position themselves within discourses. Thus, she is able to point out that “the image of superiority coexists with a counter-discourse that questions such assumptions” (Eriksson Baaz 2005, 152). In general, approaches to power which pay tribute to the agency of Development professionals find that agents are not pre-determined by dominant discourses and material conditions, but may put forward different narratives which challenge hegemonic norms (McKinnon 2008).

Through attention to German Development actors’ relationships to knowledge configurations, institutions, and practices, this study can ascertain their agency. As
theoretical studies on dispositif analysis have pointed out, discourses do not speak by themselves, but become alive through social agents within institutional settings (Bührmann and Schneider 2008; Keller 2007). A focus on agency is useful for this study as it addresses the manner in which individuals in specific locations deal with the way they are positioned (Goffman 1971; Hacking 2004). Even though “[we] push our lives through a thicket in which the stern trunks of determinism are entangled in the twisting vines of chance [...] you can choose what you can do, under the circumstances” (Hacking 2004, 282). Chapter 7 thus addresses the ways that German Development professionals manifest agency by challenging discourses. As mentioned in Chapter 2, such an examination of agency can be facilitated by following Scott’s (1990) proposition of differentiating on the one hand between “public transcripts” which constitute the dominant narratives and practices in a given context, and on the other “hidden transcripts” which challenge and disrupt these. This study focuses on challenges to Development intervention, either because Development professionals themselves doubt their effectiveness as Development experts, or due to the fact that Tanzanian counterparts block the German professionals from acting according to plan (Chapter 7).

3.3 Genealogical dispositif analysis

Following from the discussion of existing discourse-analytical approaches in Development Studies, and in keeping with the conceptualisation of power as discourses which are interconnected with materialities and in which agents are afforded agency (see Chapter 2), this thesis uses the methodology of dispositif analysis to analyse German policy and practice on population and reproductive health issues during colonial rule and today. Dispositif analysis is a more recent development in the field of Foucauldian discourse analysis, expanding the discourse-analytical focus to also consider the interplay among discursive and non-discursive elements of power (cf. Gutiérrez Rodríguez et al. 2007). By exploring German interventions with this methodology, the present study expands its scope beyond discourses and also takes into account how orders of knowledge are grounded and take effect in non-discursive practices (acting) and conditions (institutions, political-
At the same time, it is sensitive to the capacity of agents to question and subvert discourses. This methodological approach allows for taking into account the different dimensions of German interventions in population and reproductive health in “German East Africa”/Tanzania. For instance, during colonial rule, German doctors, missionaries, and administrators saw East African childbirth-related practices as backward and thus promoted childbirth in hospital. Such discourse went hand in hand with founding biomedical health facilities and training East Africans to be nurses and midwives (see Chapter 6). Analysing power as a dispositif also allows for identifying shifts among discourses, practices, and political-economic circumstances. In colonial times, German economic interests in increasing population in “German East Africa” were voiced explicitly, and measures to counter “population decline” were put into effect. Today, economic profitability for Germany is not mentioned in German Development cooperation on issues of population and reproductive health. Yet, the material practice of procuring contraceptives from German companies is evident (see Chapter 5).

In this thesis, the methodology of dispositif analysis is combined with the genealogical approach laid out in the introduction of this chapter. The use of genealogical dispositif analysis allows relating German colonial-era interventions in the field of population and reproduction to contemporary Development aid in this area without needing to examine the times in between. In order to de-familiarise our present perception of German intervention in population and reproductive health in Tanzania, this methodology seeks to identify the emergence of such intervention in the past. It thus examines the historical coming-into-being of knowledge, truth, and reality (Schindler 2007). A genealogy addresses the “emergence” and “moment of arising” of a phenomenon which “is always produced through a particular stage of forces” (Foucault 1977, 148–9). Therefore, it appears fruitful to analyse the emergence of German interest and intervention in issues of population and reproduction in “German East Africa”, and to relate this examination to the present.
Genealogical dispositif analysis is not concerned with sketching an evolutionary process but rather with identifying and examining “the different scenes where they engaged in different roles” (Foucault 1977, 140). Foucault (1977) was primarily interested in ruptures of thinking. However, the objective of this study differs from that of Foucault, as it attempts to challenge the common perspective in Development Studies according to which a clear rupture in thinking, practice, and institutions exists between colonialism and post-WWII Development. Bringing Foucault’s approach into dialogue with the postcolonial project of deciphering the re-enactment and re-articulation of colonial modes of thinking and practice in the present (Hall 1996), this study employs genealogical dispositif analysis to highlight similarities as well as dissimilarities between German intervention in the past and the present. This is justified, since, in contrast to Foucault, I am not concerned with historicising that which is seemingly universal, such as morality, emotions, and bodily states (Vogl 2008). The point is rather that contemporary German population and reproductive health policy and practice appear to be self-evident, inevitable, and positive. Writing a history of the politics of German intervention in population and reproductive health in Tanzania with the aim of finding out about colonial power in the present requires a sensitivity to similarities and continuities rather than a primary focus on ruptures, but it still encompasses the task of de-familiarising the present. I should stress that genealogical dispositif analysis is not a method per se, but rather a methodological framework – the strategy of, and reflection on, the research process (Diaz-Bone 2006) – for analysing discourses and their interconnectedness with the material world. The following two sections put forward practicalities of implementing the methodology of genealogical dispositif analysis; that is, how to gather and analyse data in German policy and practice on population and reproductive health in East Africa in two specific periods.

3.4 Conducting this research

Although it is artificial to separate the planning and writing phase from data collection, for the sake of clarification, this section concentrates on the phase of my study in which I gathered material for analysis. Fieldwork is open to many types of
data collection methods, such as interviews, quantitative data, historical and present-day documents, and so on (Lüders 2008). It refutes demands for formalisation and standardisation of the research process, as “the art of fieldwork” is not about applying a particular method, but about the flexible implementation of a general methodological approach (Lüders 2008). The suitability of the chosen methods to the planned research is the ultimate criterion. In the case of this study, a combination of archival and published material, interviews with professionals, and observation seems to be best suited to exploring discourses and their material manifestations as well as the agency of actors. As it addresses written and spoken language, practical interventions, and German professionals’ differing ideas, this ensemble of methods helps to provide broad, differentiated insights into policies and practices in the realm of population and reproduction in the context of colonial-era and current German intervention in East Africa. The historical approach determines that archives and document research are key practices for collecting material for both periods. Adding interviews and observation to textual material allows me to draw a comparatively richer picture of the contemporary period, since the “stress on taken-for-granted social routines, informal knowledge, and embodied practices can yield understandings which cannot be obtained either through standardised social science research methods (e.g. surveys) or through decontextualised readings of cultural products (e.g. text-based criticism)” (Gupta and Ferguson 1997, 36). In the following sections, I provide a justification for my choice of these methods and explain how I conducted my research. I begin by delineating the manner in which I encountered the field (3.2.1), present why and how I acquired written sources (3.2.2), and describe methods used for interviews and observation (3.2.3).

3.4.1 The field
Postcolonial approaches in the Social Sciences, and particularly in Anthropology, have urged us to account for the positionality of the researcher in relation to the field and people investigated (Gupta and Ferguson 1997). It is necessary to bring to the forefront the ways in which researchers are “historically and socially [...] linked with the areas we study” (Gupta and Ferguson 1997, 38). The choice of the field and
how I encountered it was influenced by my social position as a “white” German male as well as by my socialisation in Development aid circles. My father worked as a Development professional in Germany, South Africa, and Lesotho. I worked extensively as a volunteer and as an intern in Development organisations in various African countries as well as in Germany, and have worked as seminar facilitator for German Development agencies and NGOs while carrying out this research. Therefore, from an early age, I learned how to talk the Development talk and walk the Development walk. I thus partly consider this study to be an “insider ethnography” (Gupta and Ferguson 1997, 30) in which I draw upon my experience of growing up and moving around in the “culture” of German Development aid. My desire for a critical inquiry into the colonial legacy of Development cooperation has its roots in my experience of consciously living “whiteness” in Lesotho during my teens. Having had the uneasy feeling that something was fundamentally wrong in encounters and relationships between “white” Development professionals and the inhabitants of Lesotho (the Basotho), my subsequent engagement with Afrocentric, Black, postcolonial, and critical “white” perspectives provided me with the tools to investigate my uneasiness by digging into the politics of Development and its connection to colonialism and racism. My wish to decolonise my own and others’ minds and actions drove me to investigate my “culture” and pursue the question of colonial imprints on Development.

Politically, it was clear for me that, as a German citizen who grew up in Germany and was socialised into German Development aid, I wanted to engage with German Development cooperation and German postcolonialism. Contemporary population and reproductive health policy seemed suitable for an analysis of colonial power because, after the 1994 Cairo Conference, this field was commonly portrayed as having rid itself of Western domination. For my Master’s Thesis, I had analysed German colonial-era population policy across colonies and had noticed that debates on fertility, population size, birthing, and so on were particularly heated in “German East Africa”. When I learned that the Tanzanian German Programme to Support Health (TGPSH) was Germany’s most significant health programme in Africa, the choice was made. I am aware that focusing on the (former) colonisers and their
agency poses ethico-political problems, given that one of the key aims of postcolonial studies is, in fact, to centre the global North and its people. Postcolonial studies have at times been accused of exaggerating the influence of colonialism (Ahmad 1995) and, instead of decentering history, recentring everything around colonialism (McClintock 1992). This is said to reinforce colonialism’s universalising tendencies and to overlook indigenous agency (Loomba 2005). I would, however, maintain that a critical perspective on the (former) colonisers (e.g. Scott 1995) and their decentering through a focus on the (former) colonised people (e.g. Chakrabarty 2000) are not mutually exclusive. Both moves are necessary for destabilising colonial power and are essentially part of the same decolonising strategy (McEwan 2009). In this thesis, I follow Kapoor’s assertion that critique is not a “navel-gazing exercise that reinforces Western ethnocentrism”, if it is explicitly “carried out in order to clear the way for an ethical relationship with the Other” (Kapoor 2008, 57).

I had been connected to the field of Development aid for a considerable time before developing an academic interest. I am therefore not able to tell a clear-cut story of my entry into the field which is typically expected in order to “authenticate and authorize the material that follows” (Gupta and Ferguson 1997, 12–3). Furthermore, postcolonial anthropological perspectives on fieldwork have urged scholars to question the boundaries between “home” and “abroad” (Gupta and Ferguson 1997). During the research process, I moved between various different spaces and contexts: my desk in Manchester; the German Federal Archives and the State Library in Berlin; the BMZ, Development agencies, NGOs, and companies in Bonn, Frankfurt, Berlin, and Heidelberg; people’s private homes and offices in Germany and Tanzania; TGPSH headquarters in Dar es Salaam; hospitals in the Tanzanian countryside; and bars and restaurants in Tanzania in which I met German Development professionals. I spent six months conducting fieldwork in Germany, two and a half months of which were devoted to examining and gathering original historical sources in the Federal Archives and the State Library. The remainder was spent speaking to Development professionals in various institutions across Germany. Subsequently, I travelled to Tanzania where I spent three and a half months. Over
the course of my stay in Tanzania, I spent six weeks in Dar es Salaam interviewing various German Development professionals, visiting NGOs and Tanzanian institutions connected to German aid, and establishing contacts with potential interviewees across the country. The remainder of the time was spent travelling across Tanzania, visiting German professionals at their places of work, and speaking to Tanzanian professionals. The interviews were conducted in the Dar es Salaam, Kilimanjaro, Arusha, Lindi, Mtwara, and Tanga regions (see Figure 2 for a map of Tanzania).

My positionality and socialisation significantly shaped the way I accessed and encountered the field. Resonating with the experiences of other “white” researchers who have carried out fieldwork on their country’s Development aid interventions in Africa (Eriksson Baaz 2005), it was striking how easily I was able to make contacts and forge relationships with German (and other “white”, non-German) Development professionals I met in Tanzania. While German professionals occasionally invited me to their homes in Germany, the openness increased considerably in Tanzania: We met up on weekends at the beach, they took me along on tourist activities, invited me to their homes, let me stay overnight, had me look after their children, and so on. Being on a first-name basis, which is a lot less common in Germany than in the Anglo-American world, was almost a given – and when Germany beat Argentina in the 2010 Football World Cup, I found myself receiving high fives from German interviewees who were twice my age and with whom I personally had little in common. I experienced what Heron observed in her study with Canadian women working in Development aid in East Africa: “dissimilarities that might have loomed large in Canada vanish in the face of the real difference, that of the culture of the African Other” (2007, 79). My positionality as “white” and “academic” also facilitated my attendance at staff meetings and access to Tanzanian hospital wards alongside my interviewees. While “concerns for the privacy of patients in African and Asian hospitals is much less an issue, allowing researchers easier access to the wards” (van der Geest and Finkler 2004, 1999), this

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7 Coincidentally, to prepare for my volunteer service a decade ago, I had taken the same course at InWEnt as many of my interviewees.
position of power cannot only be attributed to my status as researcher, but also has
to do with “whiteness”. Entering hospital settings as a “white” person and in the
company of a German Development professional had the effect that I was regularly
mistaken for a doctor.

### 3.4.2 Archives and publications

In order to discern how population and reproduction were problematised in
colonial-era and current interventions, it is useful to turn to archival records,
documents, and publications. These discuss reasons for particular phenomena, put
forward solutions and modes of action, and examine and evaluate interventions. If
we dissociate documents from the individual humans who produced them, they
allow us “to characterize a system of thought, or rather, its verbal incarnation”
(Hacking 2004, 278). These material traces left behind by agents of a particular
historical period and culture constitute the sedimentation of hegemonic ideas and
practice. Documents produced and preserved in a particular societal context on
particular issues thus provide us with the specific rules of what could be thought,
said, and practiced (Foucault 1981). Furthermore, they provide insight into which
institutions were deemed important and which agents were granted the positions to
make authoritative statements about the issues in question. In this study, archives
and documents are thus understood as “an outstanding location for [understanding,
DB] the production of knowledge”, rather than as a “dry paper cemetery” (Ebeling
2008, 222; transl. DB). For this thesis, it was compulsory to consult original sources,
go to actual archives, and adopt the methods of historians, as “there tends to be
little real value added to knowledge of the past when social scientists ‘synthesize’
published works” (Vitalis 2006, 12). While documents, especially official ones, can
enlighten us with regard to the dominant knowledge and social relations in German
colonial-era and contemporary interventions, they can also be used to investigate
doubts and uncertainties, “the ground lying between the resiliency and fragility of
categories, in the moments when reasonings went awry” (Stoler 2010, 216).

Historical and contemporary documents are thus used in this study to discern
colonial power, but also moments of its destabilisation.
As Development is a fundamentally textual arena (Crush 1995a), critical Development and post-development studies commonly examine Development through publications. The essays in Crush’s seminal edited volume *The Power of Development* (1995c), for instance, primarily focus on the texts and words of Development to understand the power relations they underwrite and reproduce. Scholars of Development commonly resort to policy papers, project reports, evaluations, and promotional material to understand the knowledge represented and produced, the practices proposed and undertaken, and the agents constructed and invoked (e.g. Crush 1995c; Escobar 1994; Grillo and Stirrat 1997). Critical historical studies of Development have consulted primary sources such as renowned academic publications (Cowen and Shenton 1996) or undertaken research in archives (Hodge 2007; Koponen 1994). In postcolonial approaches to contemporary Development, a great deal of studies concentrate on key policy documents (Biccum 2005; Noxolo 2006; Slater and Bell 2002). Others consult project reports, job descriptions, or newsletters, or examine personal reflections by Development workers (Eriksson Baaz 2005). Original historical sources and archives are less regularly studied (Wainwright 2008).

In order to analyse colonial-era policy and practice on population and reproduction, my research relies on archival sources and other original historical publications. The realm of population and reproduction was mainly dealt with in German political-scientific journals, official publications, and internal communications of the colonial administration. This mix of documents facilitates drawing a broad and differentiated picture of policy and practice. Political-scientific journals and official reports are to a large extent accessible in the *Berlin State Library*, and unpublished internal administrative communications can be accessed at the *German Federal Archives*. While some of the documents of the German colonial administration in German East Africa are also located in the *Tanzania National Archives* in Dar es Salaam, most of the archival material of the *Medizinalabteilung (Medical Department)* of German East Africa has been lost. Thus, for the area of health, the majority of archival material is to be found in the *Federal Archives* (Bruchhausen 2006). I reviewed archival material that addressed health care provided by missionaries in German East Africa (archive reference: R1001/5673), health conditions and health stations in
German East Africa and Zanzibar (R1001/5750-5753, 5792-3), missionary activities (R1001/6893-6902, 6909-6910), medical missionary activities (R1001/6037-6038), the Deutscher Frauenverein für die Krankenpflege in den Kolonien (German Women’s Association for Nursing in the Colonies) (R1001/6032a, R1001/6032m), settlement of nurses in the colonies (R1001/6032n), control of venereal diseases in the colonies (R1001/6040), nursing in the colonies (R1001/5645), statistics on nursing in the colonies (R1001/5647), Medizinal-Berichte über die Schutzgebiete (Medical Reports on the Protectorates) (R1001/6004-6009), Medical Congresses (R1001/6023), the Institut für Schiffs- und Tropenkrankheiten (Institute for Marine and Tropical Diseases) (R1001/5965), and many more. While archival research at the German Federal Archives proved fruitful, my visit to the Tanzania National Archives yielded hardly any useful material.

Academic journals, often including political commentaries and personal reports, were published by colonial-political organisations, scientific institutes, and government departments. Publications which I reviewed, ranging from approximately 1900 until the end of formal German colonisation, were the Koloniale Rundschau – Monatsschrift für die Interessen unserer Schutzgebiete und ihrer Bewohner (Colonial Review – Monthly for the Interests of our Protectorates and their Inhabitants) which became the official publication of the Deutsche Gesellschaft für Eingebornenschutz (German Society for the Protection of the Natives) in 1914\(^8\); the Zeitschrift für Kolonialpolitik, Kolonialrecht und Kolonialwirtschaft (Journal for Colonial Policy, Colonial Law, and Colonial Economy)\(^9\), edited by the Deutsche Kolonialgesellschaft (German Colonial Society), the largest (at one stage it had over 43,000 members) and most influential colonial lobby organisation and regular advisor to the German government (Pierard 1987); the Archiv für Schiffs- und Tropenhygiene (Archive for Marine and Tropical Hygiene) and its supplements which were published with support from the German Colonial Society and the Institut für

\(^8\) This society included among its members eminent persons such as Bernhard Dernburg, former State Secretary of the Colonial Office, and Theodor Leutwein, former Governor of “German Southwest Africa” (Deutsche Gesellschaft für Eingebornenschutz 1914b).

\(^9\) In 1913, this journal was renamed Koloniale Monatsblätter – Zeitschrift für Kolonialpolitik, Kolonialrecht und Kolonialwirtschaft (Colonial Monthly – Journal for Colonial Policy, Colonial Law, and Colonial Economy).
Schiffs- und Tropenkrankheiten (Institute for Marine and Tropical Diseases), which formed the centre of German “tropical medicine” and was integrated into the Hamburger Kolonialinstitut (Hamburg Colonial Institute) in 1908 (Möhle 1999; Schupp 1999); and other publications such as the results of the Eduard-Woermann-Preisaufgabe (a contest question, see Chapter 5), which in 1913 sought responses to the following question:

Through which practical measures can one achieve an increase of the birth rate and a reduction of infant mortality in the native population – the economically most valuable asset? (Der Professorenrat des Hamburgischen Kolonialinstituts 1913)

Moreover, my research drew on the following sources: the Deutsches Kolonialblatt (German Colonial Gazette) which was edited as the Amtsblatt für die Schutzgebiete in Afrika und in der Südsee (Official Register for the Protectorates in Africa and in the South Seas) by the Reichs-Kolonialamt (Imperial Colonial Office) and published relevant laws, decrees, and orders of the German colonial authorities; the Mitteilungen aus den Deutschen Schutzgebieten (Notes from the German Protectorates) which were quarterly scientific supplements of the German Colonial Gazette containing long scientific articles and reports of “expeditions”; the Amtliche Jahresberichte über die Entwicklung der deutschen Schutzgebiete (Official Annual Reports on the Development of the German Protectorates) which were edited by the Imperial Colonial Office under the title Die Deutschen Schutzgebiete in Afrika und der Südsee (The German Protectorates in Africa and the South Seas) since 1911; the Medizinal-Berichte über die deutschen Schutzgebiete (Medical Reports on the German Protectorates), annually published by the Imperial Colonial Office; and the Mitteilungen des Berliner Vereins für ärztliche Mission (Notes of the Berlin Association for Medical Mission).

For contemporary German policy and practice on population and reproductive health, I analysed policy papers, reports, programme evaluations, promotional literature, and websites of the German Development institutions, agencies, NGOs,
and consultancies, dating from the beginning of the 21st century until today. These “architects of development knowledge” (McEwan 2009, 166) for the realm of health included the Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung (Federal Ministry for Economic Cooperation and Development, BMZ); its implementing agency Deutsche Gesellschaft für Technische Zusammenarbeit (German Agency for Technical Cooperation, GTZ) – a private-law enterprise primarily commissioned to implement German “technical cooperation” on behalf of BMZ (GTZ has recently merged into GIZ, see Chapter 4); the KfW Entwicklungsbank (German Development Bank) which implements German “financial cooperation” in countries of the global South on behalf of BMZ; evaplan, a German consulting firm in the field of public health that “implements advisory missions, training and curriculum development, and operational research in the context of bilateral and international development cooperation” (evaplan 2011), and which has strong personal, professional, and business ties with German government institutions such as BMZ, GTZ, and the Tanzanian German Programme to Support Health (TGPSH); TGPSH, which initiated activities in January 2003 and “aims at supporting the health sector reform in Tanzania” (TGPSH 2009c); and the Deutsche Stiftung Weltbevölkerung (German Foundation for World Population, DSW), the only German single-issue NGO in the field of reproductive health and population, partner of the United Nations Population Fund (UNFPA), with an office and projects in Tanzania.

3.4.3 Interviews and observations

Interviews with German professionals working in Germany and Tanzania helped to understand how German policy and practice on population and reproductive health in Tanzania is perceived by people active in this field, to discern how policies and practices take shape on different levels of intervention, and to generally have a broader picture of Development intervention. Interviews, informal conversations, and observation provide insight into thought and social practices that documents and surveys cannot (cf. Goffman 1971). Interviews are employed in this study to gain knowledge of the particular policy field of population and reproductive health. It was thus necessary to carry out so-called expert interviews (Bogner et al. 2009) with professionals characterised by an “institutionalised authority to construct reality”
Interviewees were thus not of interest as individuals, but in as far as they filled specific professional positions in which they acquired particular information and knowledge (cf. Meuser and Nagel 2009). Such expert knowledge is characterised by the possibility “to become hegemonic in the policy and practice in a particular organisational context” and to thereby structure “the possibilities for action of other actors […] in a relevant way” (Bogner and Menz 2002, 46; transl. DB). Because semi-structured interviews with professionals may result in being rather formal, it was also useful to engage with people in more informal ethnographic interviews, embedded in everyday conversation, and aim to understand the specific context and practices of the interviewees (Spradley 1979). In face-to-face interactions with people, interviewing and observation merge. Such interactions were useful to this study because they helped me to understand “how the forms of discourse become part of the lives of […] people, or even how they become institutionalized and made part of the structure of institutions at work” (Hacking 2004, 278).

Critical Development Studies have used unstructured and semi-structured interviews to determine professionals’ understandings of Development (Ziai 2004a) as well as of particular policies, projects, and programmes (Goldman 2005; Rottenburg 2009), and of their motives for engaging in Development (Heron 2007; Kothari 2006c). Kothari (2006c) conducted interviews with former colonial administrators who became Development professionals in order to analyse the shift between colonial rule and post-WWII Development. Heron (2007) carried out lengthy open-ended interviews with middle-class “white” Canadian women who had worked in Development in Africa. In both studies, former professionals were interviewed in their home countries, outside their work environment, and without a focus on particular policy fields. Eriksson Baaz’ (2005) study comes closer to my approach, as she interviewed Scandinavian and British Development workers in Tanzania. However, since she was interested in their identity construction, and not in a particular policy, “the interviews were of a general character with the aim of allowing the participants to talk about their experiences” in everyday life and work (Eriksson Baaz 2005, 15). To my knowledge, no postcolonial approaches to
Development aid have to date undertaken expert interviews to examine particular policy fields of Development.

Speaking with professionals responsible for policy-making and implementation enabled me to examine German policy and practice on population and reproductive health beyond the glossy promotional literature or sober policy papers and project reports. I conducted interviews with professionals from BMZ, GTZ, KfW, Deutscher Entwicklungsdiensst (German Development Service, DED), CIM\textsuperscript{11}, DSW, and evaplan in Germany as well as in Tanzania (see Appendix 1 for anonymised table of interviews). In addition, I included conversations with Germans working (or who have worked) for secular and faith-based NGOs and mission hospitals in Tanzania. Even though some missionary health professionals did not consider themselves to be Development professionals, their work is closely related to secular German Development aid intervention, is often financed by the German government, and many staff members move between secular and Christian Development assistance. Professionals included in this study worked on different levels of policy making, implementation, consulting, and evaluation. Such a plethora of actors with a variety of functions was chosen in order to encounter diverse perspectives (cf. Meuser and Nagel 2009). In Tanzania, I particularly focused on professionals working for TGPSH, the most significant German health program in Africa. GTZ, DED, CIM and KfW have been involved in this programme. Over the course of my research in Tanzania, I also had the opportunity to interview several Tanzanian professionals working for German agencies or as partners of German professionals. In addition, I spoke with professionals whose work was linked to German interventions in population and reproductive health, such as representatives of the NGO PSI (Population Service International), staff at Tanzania’s Medical Stores Department which is an autonomous department of Tanzania’s Ministry of Health and Social Welfare responsible for furnishing drugs and medical equipment to Tanzanian institutions, and Bayer HealthCare which supplies contraceptives to Tanzania.

\textsuperscript{11} The Centrum für internationale Migration und Entwicklung (Centre for International Migration, CIM) is a recruiting organisation for German Development cooperation financed by the BMZ. It is a joint operation of GTZ and the International Placement Services of the German Federal Employment Agency.
I conducted interviews of one to two hours with 59 professionals from 2009 to 2011. They were carried out in a semi-structured manner with the help of an interview guide (cf. Meuser and Nagel 2009), recorded and transcribed. While some of the questions addressed the content of policies and practices on population and reproduction and sought explanations for conditions in Tanzanian population and reproductive health as well as for rationales of interventions undertaken, others questioned the professionals as to their opinions regarding Germany’s engagement in Development aid in general and their own activity in particular (see questions 1 and 3 of the interview guide, Appendix 2). I asked them about the problems they perceived and the solutions they envisioned, and about their experiences in their own work (see questions 2 and 3). I also confronted interviewees with viewpoints which were critical of international Development on population and reproduction (see question 4). Finally, I asked them whether they perceived links between Development and colonialism (see question 5). Informal settings such as being hosted in private homes, sitting around the dinner table, and talking over drinks proved conducive to voicing doubts, criticism, and opinions challenging the “public transcripts” (Scott 1990) of German Development aid. During the interviews and in the time I spent with interviewees, I tended to refrain from confrontation. I sometimes asked critical, challenging questions, but generally rather listened to my counterparts and encouraged them to express their thoughts. I was wary of bringing my interviewees to the point of closing themselves off, and therefore kept quiet when issues were raised on which I had a decidedly different opinion. I was thus more engaged in establishing an atmosphere of commonality and allowing the interviewees to voice their views. The commonality I developed with many interviewees was not without ambivalence. Interviewees helped me out, confided in me, and we had a good time together. While I adhered to the formal guidelines for ethical research – participant information sheet, informed consent, and right to withdraw at any moment –, I interpret and criticise my interviewees’ accounts and am aware that interviewees might feel offended if they recognise themselves in the thesis. This delicate issue led me to pay particular attention to their anonymisation: For example, I do not include information on interviewees’ gender and I try to keep the information on their position as unspecific as possible (see Appendix 1), because
more information would make it easy to identify certain individuals. I stress that I
discuss my interviewees’ accounts not as expressions of individuals, but as
expressions of bearers of social roles. While conscious of the unpleasant possibility
of offending some of my interviewees, my position is that this is the lesser evil
compared with leaving the broader issue of colonial power in Development
uncriticised. In this dilemma, ethical stances turn out to be not clear-cut, but
relative.

At the outset of my research, I had intended to visit projects and take part in
meetings between German Development professionals and their Tanzanian partners
or with other donor agencies. I inquired as to the possibility of spending several
months with the Reproductive Health Component of TGPSH, but was told that the
programme did not see any value in a study which compares contemporary and
historical German intervention into population and reproductive health. It
apparently did not address their rather practical questions with regard to set-up,
efficiency, and evaluation of specific projects. Furthermore, I was told that any data
acquired during my stay at TGPSH, subsequent analysis, and possible publication
would be subject to TGPSH’s approval. It was thus difficult for me to gain formal
access to German agencies, but communicating with individual German
professionals was relatively easier. I decided to rely on interviews with TGPSH staff
and hoped to join occasional meetings. This proved to be a useful strategy. I was
able to spend considerable time with some German professionals beyond the actual
recorded interviews. I accompanied them to their workplaces and lived at their
homes, and thus was able to informally converse with several of them at length. I
was sometimes shown work agreements, and was able to take notes of German
professionals’ communication with German, other foreign and Tanzanian colleagues
and observe their interaction with patients. I also noted the manner in which my
interviewees interacted with me, how they introduced me to colleagues, what they
wished me to see, and so on. Through my visits to hospitals, I became interested in
what contraceptives were being provided. Noticing that a large proportion
originated from German pharmaceutical companies, I followed the path of their
procurement and dissemination. I consulted the Medical Stores Department, John
Snow, Inc. (JSI) which implements the USAID’s programme to improve the supply of “health commodities” in Tanzania, and Bayer HealthCare. Rather than engaging in participant observation from the position of a person with a function in the field, I undertook what Girtler (1984) describes as qualitative, unstructured observation. I kept a detailed research diary with my observations and thoughts; this also served as an aid for monitoring my progress and findings.

3.5 Analysing the material

While it might appear as though I first gathered all the data and then analysed it, qualitative, ethnographically informed fieldwork and analysis is an interwoven, circular endeavour. Moving among places (Manchester, Berlin, various West German cities, Dar es Salaam, various Tanzanian towns and villages) and settings (Quad C on the first floor of the Arthur Lewis Building of the Institute for Development Policy and Management, the gloomy break room at the archives in Berlin, the hospital ward in Tandahimba, TGPSH headquarters in a high rise building in Dar es Salaam, the screening of the Football World Cup semi-finals at the Southern Cross Hotel in Mtwara) changed the questions, focus, and path of my study. New interviewees came my way, documents emerged, and research plans were made impossible by events beyond my direct influence. Thus, such research cannot be fully controlled by the individual researcher; it is circular and dialogical. I will always recall my supervisors’ comments upon receiving my first draft chapter: “incomprehensible”, “lost in the woods”.

For the colonial period, I assembled publications which touched on health and medicine in the colonies, population, fertility, child mortality, midwifery, hospitals, the role of medical doctors in colonisation, and so on. Having gathered documents that addressed population and reproduction, I chose approximately 40 which dealt with different topics and provided diverse opinions on these. On the basis of these, I generated “mind maps” in order to determine which topics were connected to which, and which topics seemed to take centre stage in the discussions. I then selected ten of these documents which covered the spectrum of publications,
professions, and topics for closer analysis, while always referring to the remaining documents to determine whether they discussed the respective topics in a different manner.

Regarding contemporary Development aid, I assembled all those publications which addressed population, fertility, sexual and reproductive health and rights, maternal health, obstetric care, contraceptive supply, and so on. When narrowing down the material for closer analysis, I made sure to include texts from different organisations, especially those which the institutions themselves presented as central, such as the BMZ policy paper “Sexual and Reproductive Health and Rights, and Population Dynamics” (2008). Along with publications by these institutions, agencies, and organisations, I included the transcribed interviews and notes I had taken during conversations with German professionals. This allowed for an analysis of the conceptual level of planning and policy-making as well as implementation and actual practices. It informed me as to how population and reproductive health were presented and which interventions were proposed and undertaken. Moreover, from interviews and field notes, I was able to discern whether German professionals working in Development had views which diverged from official positions and dominant understandings (Chapter 7). Following a criterion of “saturation”, I ceased scanning the material once further examination did not yield any new topics or perspectives.

Some discourse-analytical approaches such as Critical Discourse Analysis (Fairclough 1995) and Kritische Diskursanalyse (Jäger 1993) are oriented towards linguistic methods and tend to focus on the examination of rhetoric. Such emphasis would not serve this thesis’ interest with regard to the historical coming-into-being of colonial power, its effects in the present, and the connectedness of discourses with material realities. The discourse analytical approach employed in this thesis, which is inspired by Michel Foucault’s (1981, 1989a, 1989b) work, does not restrict its focus to texts, but attempts to understand orders of knowledge as grounded and expressed in the material world (Bührmann and Schneider 2008; Keller 2007). I thus examined the material (documents, interviews, and observation) on the basis of
how issues of population and reproduction were discussed, how they were comprehended, what actions or solutions were proposed, and what interventions took place. In order to focus the analysis, I identified topics within the field of German population and reproductive health policy and practice in East Africa. Topics are understood to be full of “discursive energy” so that they “manage to generate statements in an almost magnetical way” (Link 1999, 152–3; transl. DB). I had to find a way of rendering the two periods under scrutiny comparable. I identified topics which seemed appropriate for a genealogical approach in that they allowed for relating the past to the present. This step of identifying and deciding to examine particular topics is necessarily subjective: it is regulated by the research interest of this study to explore colonial power in the present (cf. Palfner 2006). Contemporary German Development aid evidences concern about population growth and fertility rates in Tanzania. I traced back this German concern with population numbers in Tanzania and found that German colonisers were worried about population decline in “German East Africa” already at the beginning of the 20th century and that similar topics were brought up in both periods. The first set of topics which emerged from my examination were hence population decline and growth, fertility, women’s societal positions, tradition/customs/culture, economic profitability, self-interest and philanthropy. These are analysed in Chapter 5. In contemporary German Development policy on population and reproductive health, issues of fertility are discussed alongside those of maternal health or obstetric care, as evident in the recent “Initiative on Rights-based Family Planning and Maternal Health” (BMZ 2011a). An examination of the period of German colonialism yielded that obstetric care and childbirth-related issues were discussed also during this period. The second set of topics thus comprised birthing, obstetric care, hospitals/health facilities, and knowledge/skills/attitude of East African health practitioners which are discussed in Chapter 6. A great deal of speech and practices in the field of population and reproduction were related to one (or more) of these topics.

For Chapter 5, I began by examining how population “development” was understood, which arguments were used, and which causalities were invoked during colonial occupation and in contemporary Development intervention. I scrutinised
which interventions were discussed and proposed to influence population and reproductive health in “German East Africa” and in present-day Tanzania. With regard to the colonial and contemporary documents, I made use of “mind maps” to visualise which topics took centre stage in the discussions, how topics were connected, which causalities were expressed, and so on. I classified the interview transcripts in a table, according to the different arguments, causalities, and topics expressed. On the basis of these mind maps and tables, I was able to discern the logics underlying the verbal expressions – for example, the constant reference to notions of “modernity” and “tradition”. In addition to focusing on what was said, and how, I made use of information from documents and interviews to gain insight into actual implementation and thus the material dimensions of German intervention. For example, I considered the distribution of leaflets to influence women’s behaviour during colonisation and the practice of propagating “modern” contraceptives today. Chapter 5 not only focuses on how German agents comprehended causes and solutions to problems of population and reproduction, but also scrutinises the motivations invoked for intervention into population and reproductive health in both periods. My examination considers political-economic circumstances in which calls for population control were made, such as the demand for labour in colonial times, and issues of “sustainable development” today. Having analysed policy and practice during both periods, I related the examination of the past to that of the present in order to determine similarities and divergences, and to evaluate the extent to which contemporary policy and practice are shaped by colonial power. For instance, colonial agents were concerned with measures to increase the number of children, such as preventing certain “customs” which they deemed detrimental to fertility and child health (see Chapter 5). Development cooperation today promotes the use of “modern” contraceptives to lower fertility rates and population growth. However, in both periods, discussions and practices were underpinned by the aim to regulate population numbers, and German agents have invoked notions of “modernity” and “tradition” to judge the utility or harmfulness of fertility rates and gender relations. Here, the dispositif-analytical perspective is particularly useful because it can account for non-discursive dimensions of intervention. Aspects that were voiced during colonial times may well
have left the discursive sphere and entered that of materiality. For instance, during colonial rule, German self-interest was constantly voiced, whereas today many German professionals do not describe Germany’s intervention as guided by self-interest. However, German pharmaceutical companies do have stakes in the Tanzanian contraceptive market. While German interests are not evident in discourses, they are discernible at the level of actual practices and the political economy of population control.

For Chapter 6, I focused on issues of birthing. I analysed the emphases of German colonial intervention and those of contemporary Development, and examined the problems that German agents discerned in midwifery practices. The exploration of colonial times relied on archival material and published documents. With regard to contemporary German Development cooperation, I mainly drew on interviews with German professionals, but also on documents of Development organisations. In a way similar to the procedure for Chapter 5, the colonial sources were also analysed with the help of “mind maps”, which enabled me to identify the topics that physicians, administrators, and missionaries saw as connected to one another. The same course of action was applied to contemporary documents. On the basis of these “mind maps”, and the table listing the various topics, arguments, and causalities expressed in the interviews, I was able to discern how German agents have understood obstetric practices of health practitioners in “German East Africa” as well as how they view practices of health workers in Tanzanian hospital staff today; for example, commentators in both periods discussed the knowledge and skills evident in midwifery. Once dominant causalities and arguments had been identified in the material, it was necessary to determine the underlying discourses. For example, biomedical knowledge tended to be opposed to “experiential” knowledge, and notions of “modernity” and “tradition” were invoked to interpret planning capacities and attitudes of the inhabitants of “German East Africa” and Tanzania. In addition to discourses, I paid attention to actual practices such as Germans introducing and teaching birthing positions, and institutional actions such as building hospitals. The dispositif-analytical approach also enabled me to account for shifts in language, action, and institutional circumstances. For example, today
German Development professionals criticise lack of planning in Tanzanian obstetric health care and seek to instil a “planning culture” at different levels of the Tanzanian health system; during colonial times, this did not seem to be in the realm of the verbalisable: planning health care was seen as the domain of the German colonisers, implemented by the colonial administration.

While Chapters 5 and 6 examine similarities and divergences between the period of colonial rule and contemporary Development cooperation and establish to what extent the present is shaped by colonial power, Chapter 7 takes a closer look at German Development professionals’ account of their work today. Interviews with Development professionals were mainly included in the first two empirical chapters, 5 and 6, to complement official documents and reports. These constituted the dominant ideas and practices of intervention (cf. Bliesemann de Guevara and Kühn 2012). From conversations with German professionals concerning issues of population and reproduction in Tanzania, I could also gather how they shifted within and challenged the space provided by discourses, practices, and institutions. Chapter 7 concentrates on those accounts of German agents that seemed to counter the “public transcripts” of German intervention. Interviews with Development actors added nuance to the otherwise seamless, monolithic picture of German intervention, developed from the analyses in Chapters 5 and 6, and pointed to uncertainties and doubts. As Development professionals’ perspectives are not pre-determined by dominant discourses, but rather exhibit different narratives that may contest hegemonic norms (McKinnon 2008), Chapter 7 analyses German Development professionals’ agency to challenge colonial power. For instance, some German professionals doubted the value of their knowledge and practices for teaching in Tanzanian hospitals and nursing schools, and criticised the unequal influence of Tanzanians and Germans in Development cooperation. Chapter 7 also examines German professionals’ accounts for signs of Tanzanian partners’ objection, negotiation, and subversion. Such accounts are complemented by statements from Tanzanian counterparts regarding their working relationship with German Development professionals. Even though private narratives may appear to contradict, mediate, or subvert public ones, they do not necessarily disrupt
dominant discourses. Chapter 7 thus inquires as to whether German professionals’ doubts and criticism as well as Tanzanian challenges have the capacity to unsettle colonial power, or whether they rather end up stabilising it because they do not alter existing discourses or contribute to questioning institutions and political-economic inequalities. The crucial issue here is to determine how German Development professionals come to terms with their doubts, how Development aid is critiqued and what actions flow from such critiques, and how Tanzanian resistance is dealt with in German Development cooperation.

3.6 Conclusions

As put forward above, Development Studies has to date not taken much interest in the history of Development; when it does, it has not often focused on the colonial legacy in present-day international Development. Postcolonial approaches to Development take an interest in colonial histories to further an understanding of the present. Yet explicit methodologies to put this into practice are lacking. Inspired by Foucault, this chapter has developed the methodological framework of genealogical dispositif analysis to study the articulation of colonial power in present-day Development intervention. The genealogical approach traces back a currently salient issue to the moment of its emergence in order to gain a new perspective on the present. Dispositif analysis allows for a comprehensive, differentiated examination of power as it takes account of discourses as related to and embedded in materiality (such as physical practices and institutions), while paying attention to the agency of Development professionals. As an integration of the approach of genealogy with the dispositif-analytical methodology, genealogical dispositif analysis examines the power underlying, and emanating from, the emergence of a phenomenon in the past, and relates this to the analysis of current constellations of power concerning the same phenomenon. The purpose of a genealogical dispositif analysis is to examine parallels and divergences in intervention in order to reveal whether, in what ways, and with what effects contemporary Development policy and practice is imbued with colonial power.
In terms of the practical research process, I first reflected on the ways in which I encountered the field of colonial-era and contemporary German Development interventions in population and reproductive health. I highlighted my personal implication in this field as related to my upbringing and socio-political positionality, and pointed out how my positioning enabled me to gain access to German Development professionals. This chapter then emphasised the need to employ diverse methods of gathering data, ranging from archives and publications to interviews and observation. Such an approach facilitates consideration of different actors and levels of intervention. I argued for an engagement with original historical sources and pointed out the need to consult publications to understand the knowledge configurations which underpin Development. Inclusion of the voices of professionals working in current Development allows for addressing heterogeneity of, and challenges to, interventions. Fieldwork and observation, moreover, ensures that non-discursive phenomena such as actual practices by German professionals and objects used in hospitals are taken into account. In the final section, I laid out how I proceeded in the actual analysis of the material. Analysis is a circular process in which research foci change and new material enters the scene. It is clear that a single dispositif-analytical study cannot do justice to all the aspects mentioned above (discourses, non-discursive phenomena, and actors and their agency) and the researcher must choose aspects on which to focus (cf. Bührmann and Schneider 2008). As became evident, this study primarily places emphasis on discourses, but regards these as taking effect and being grounded in non-discursive phenomena (see Chapter 5 and 6). In addition, this study highlights the agency of German professionals in intervention and examines their impact on the articulation of colonial power (see Chapter 7).
4 From German colonialism to post-independence
Development policy and practice in Tanzania

First they came as explorers, then as missionaries,
after that as colonisers, thereon as development experts.
[...] In that case, what will we leave behind for our children, colonisation?
(Tiken Jah Fakoly 2006; Ivorian reggae artist, transl. DB)

4.1 Introduction

Chapters 2 and 3 provided the conceptual and methodological framework for
researching colonial power in contemporary Development interventions. This
chapter provides the historical and geographical context of German interventions in
population and reproductive health in “German East Africa”/Tanzania. It sets the
scene for subsequent in-depth analyses of the issues of population control (Chapter
5), childbirth-related practices (Chapter 6), and challenges to colonial power in
current German Development intervention (Chapter 7).

In contemporary German society, the colonial past is rarely mentioned, or is played
down and whitewashed (Eckert and Wirz 2002). When mention is made in official
German government and Development cooperation statements, the effects of
colonial rule are presented as negligible, or are considered positive. While German
colonisation of the territory of present-day Tanzania lasted over 30 years and cost
hundreds of thousands of East African lives, the BMZ states that “Tanzania and
Germany are bound to one another by a brief and, in some ways, painful colonial
history” (BMZ 2012d; transl. DB, emphasis added). The German Foreign Office
suggests that this colonial past was largely “amicable” and “unproblematic” in terms
of relations between Germany and Tanzania, often referring solely to Germany’s
engineering interventions during colonial times:

Germany is highly esteemed in Tanzania, where there is a greater public
awareness than here of the country’s colonial past, thanks to the substantial
architectural and infrastructure heritage from the German colonial era. The
good bilateral relations are reflected in Germany’s intensive engagement,
particularly in development cooperation. (German Federal Foreign Office 2012)
Most interviewees also played down Germany’s colonial past in Tanzania, and did not see any negative repercussions for present-day German-Tanzanian relations. However, as this chapter highlights, German colonialism in general, and the colonisation of “German East Africa” in particular, were by no means insignificant to Germany or to the colonised societies. Moreover, German Development policy and practice related to population and reproduction in fact emerged during German colonial occupation. The significance of “German East Africa” for German colonialism is reflected in the centrality of German-Tanzanian relations to this day. It has been argued that among all Germany’s Development partners, Tanzania is the country with which Germany has the broadest and deepest relations (Köhler 2000). This chapter provides evidence that colonial-era as well as contemporary German Development relations with Tanzania are significant, particularly with regard to issues of population and reproductive health.

It should not be overlooked that post-independence relations between Tanzania and Germany were bifurcated. The focus of this thesis is on Development engagement by the Federal Republic of Germany (FRG). However, the German Democratic Republic (GDR) also had extensive relations with Tanzania. The East-West conflict was carried to Tanzania when the newly established United Republic of Tanzania initiated relations with the GDR. The FRG subsequently threatened to discontinue its foreign aid to Tanzania because of the “Hallstein Doctrine” which stipulated that the FRG would not establish or maintain diplomatic relations with any state that politically recognized the GDR (Döring 1999). However, Tanzanian President Julius Nyerere responded by announcing the termination of all FRG Development projects, which was partially prevented only through extensive negotiations between the FRG and Tanzania. While the two Germany’s shared the legacy of a colonial past in East Africa, they practised different approaches in their relations to Tanzania and, more generally, the global South. The GDR, for example, distanced itself from Western foreign aid and “preferred to use terms such as ‘economic socialist assistance’ rather than ‘aid’ which it associated with the neo-imperialism of the Federal Republic of Germany” (Howell 1994, 305). According to Howell, the GDR’s assistance “provided the possibility of pursuing a strategy of development that was founded on radically
different economic, ideological, and political premises” to the “neo-liberal paradigm” (1994, 328). This possibility for alternative South-North relations, which was in fact welcomed by some recipient countries, ended with the “unification” of the two Germanys (Büschel 2010). Germany’s “unification” has been described as “annexation” or even “colonialisation” by some observers (Vilmar and Dumcke 1996), because GDR economic, political, cultural and social life was subsequently interpreted under FRG realities and thus devaluated (Behrend 1995). This included GDR thought and practice on “socialist international solidarity” (Weiter 2000). While I am aware of the danger of reproducing the effacement of the GDR’s history and legacy, this research does not cover the relations between Tanzania and the GDR. In the following, “Germany”, when used for the period of the existence of the GDR, thus only refers to the Federal Republic of Germany.

The next section of this chapter provides a brief history of German colonialism and the colonisation of “German East Africa”/Tanganyika (4.2). Subsequently, the emergence of Development intervention in population and reproductive health during German colonial rule in “German East Africa” is considered (4.3). Post-independence Tanzanian “development” is then sketched, with an emphasis on health (4.4). Finally, German Development cooperation is outlined, particularly in relation to Tanzania and the field of population and reproductive health (4.5).

4.2 German colonialism and the colonisation of “German East Africa”

German colonialism is commonly equated with formal colonisation or “state-sponsored colonialism” (cf. Friedrichsmeyer et al. 1998a, 9), which effectively lasted from the mid-1880s until approximately 1920 (Colwell 2001). However, German colonialism “dates back at least to the 15th and 16th centuries, when thousands of Germans took part in the conquest and colonisation of the ‘New World’ – as adventurers, mercenaries, merchants, scientists, explorers, interpreters” (Friedrichsmeyer et al. 1998a, 8). For example, as early as 1499, the trading families Fugger and Welser financed expeditions and brought miners from Germany as well
as enslaved Africans to South America (Friedrichsmeyer et al. 1998a). The Americas, especially South America, played an important role for early German colonialist aspirations (Zantop 1997). The first independent German occupation, however, took place in 1683 in Africa, on the territory of what is today Ghana. The Brandenburgisch-Africanische Compagnie established the trading colony “Großfriedrichsburg” and trafficked enslaved Africans across the Atlantic (van der Heyden 2001; Stelzer 1984; Weindl 2001). This was followed by conquests in what are now Benin, Mauritania, the US Virgin Islands, Puerto Rico, and the British Virgin Islands. The zenith of German colonialism lasted from approximately 1880 until 1920. In the light of German colonial activities since the 15th century, Friedrichsmeyer et al. conclude that “Germans are a colonizing people with centuries of experience” (1998a, 9). Moreover, German colonial aspirations and endeavours did not end with the loss of the occupied territories to other colonising nations after World War I; the Weimar Republic was replete with revisionists who demanded a return of the lost colonies (Campt et al. 2001), and the subsequent Nazi regime had detailed plans to colonise large sections of Africa (Ndumbe III. 1993). Even after the end of German fascist rule and until the great wave of decolonisation in Africa in the 1960s, Germans continued to envisage a role for Germany as a colonising power alongside England, France, Portugal, Spain, and Holland (van Laak 2004).

During large-scale “state-sponsored” formal colonisation a total of 2,953,000 square kilometres was occupied by Germany, at least five times more than its national surface area (Kößler and Melber 2004; van Laak 2004). In these territories, approximately 25,000 Germans ruled over 12 million colonised people (Kößler and Melber 2004). The focus of German colonial endeavours was Africa. There, the German Empire conquered and occupied “German East Africa” (present-day Tanzania as well as Rwanda, Burundi, and parts of Kenya and Mozambique), “German South-West Africa” (present-day Namibia and parts of Botswana), “Kamerun” (today’s Cameroon), and “Togoland” (present-day Togo and parts of Ghana). The centrality of Africa to German colonisation led to Africa and colonialism becoming synonymous (Eckert and Wirz 2002). However, between the mid-1880s
until approximately 1920, Germany also occupied territories and exploited people in the South Pacific ("German New Guinea", "German Samoa") and in China ("Deutsch-Klautschou" and Chefoo). Compared to that of other colonising nations, German "state-sponsored colonialism" was, however, short-lived. Scholars have pointed out that German colonial rule was nonetheless not dramatically different from that of other colonising nations, such as France and Great Britain (Smith 2011). German private entrepreneurs profited immensely from the colonies, while military, administrative, and infrastructural costs were principally supplied by the German state (van Laak 2004).

In the mid-1850s, before the private German East Africa Company (in 1884) and the German Empire (in 1890) occupied the territories which they then referred to as "German East Africa", German Protestant and Catholic missionaries had already arrived there (Köhler 2000). However, Germans had been involved in colonialism in East Africa even prior to this. In 1505, German commercial agents Hans Mayr und Balthasar Sprenger accompanied Francesco d'Almeida in his attack on and occupation of Kilwa (in the south of present-day Tanzania, see Figures 1 and 2 for maps of "German East Africa" and Tanzania) (Bruchhausen 2006). Opinions vary as to when "German East Africa" was effectively established and when it ended (cf. Colwell 2001). Colonial imposition formally lasted from the mid-1880s until around 1920. Between 1889 and 1896 more than 50 resistance wars were fought against German colonial rule (Kjekshus 1996). Only around 1904 was the German Empire able to fully bring territory and people under its control, with great brutality and ruthlessness, and this was again challenged in the Maji Maji War (1905-1907), in which approximately 300,000 Africans died (Boahen 1996; Koponen 1994). "German East Africa" constituted the largest German colony and, in contrast to the so-called settler colony "German South-West Africa", served as a "plantation colony", facilitating economic exploitation via agricultural enterprises (Marx 2004, 83). German "settlers" (in contrast to administrators, entrepreneurs, and missionaries) played a relatively marginal role in German East Africa, compared to their role in "German South-West Africa", and were mainly confined to the area around the Kilimanjaro and the Usambara mountains (Marx 2004). In 1913, there were 882
German settlers in German East Africa, of a total of over 4,000 Germans, including military personnel, traders, government officials, missionaries, nurses, doctors, and their families, and a total “white” population of 5,336 (Friedrichsmeyer et al. 1998a).

There were diverging opinions within Germany on the legitimacy and form of German colonial rule (Conrad 2008; Gründer 2004; Speitkamp 2005). Criticism was voiced across social milieus and political groups, but was most pronounced among the Social Democratic Party. In a 1889 parliamentary debate, Germany’s leading Social Democrat August Bebel (1889) criticised government support for colonisation, because he believed the “entrepreneurial class” would, due to their racism, exploit
colonised people even more than they exploited workers in Germany. The Social Democratic Party tended to “reject[ ] the colonial civilizing mission as part of its larger refusal of paternalist state socialism” (Zimmerman 2010, 198). While some Social Democrats (including Bebel) at a later stage promoted a socialist colonialism consisting of a supposedly more humane civilising mission (Conrad 2008), this was rejected by others as no better than the reformist colonialism proposed by Dernburg and others (see below) (Zimmerman 2010). The Social Democrat Karl Kautsky went furthest in his critique; he viewed socialist colonial policy as a “logical contradiction” and criticised the view that “there exist[ed] childish peoples unable to rule themselves” (cit. in Zimmerman 2010, 197). Within generally pro-colonial circles, opinions varied. For example, German colonialism was marked by the conflict over modes of colonisation (“settlement” versus “plantations” versus “trade”). “Settlers” and colonial reformists also disagreed over how to economically exploit and treat the colonised people (see Chapter 5). In general, economic reasoning was predominant and the common ground of all stakeholders, but the motive of bringing “civilisation” was also apparent (Pogge von Strandmann 2009). As will be addressed in detail in Chapter 5, self-interested as well as philanthropic considerations marked colonial-era German interventions in health, population, and reproduction.

After Germany had lost the First World War, the United Kingdom was mandated to administer parts of the territory of “German East Africa” conferred to it by the Supreme Council of the League of Nations in 1919. What was formerly “German East Africa” was reduced in size to today’s Tanzania and renamed Tanganyika. Ruanda-Urundi was awarded to Belgium, and the Kionga Triangle to “Portuguese East Africa”.

4.3 The emergence of Development intervention in population and reproductive health during colonial rule

As highlighted in Chapter 2, Development Studies commonly dates the emergence of Development policy and practice to the post-WWII era and in particular after
independence of former colonies. However, some scholars of colonialism and Development challenge the notion of a clear break between colonial-era interventions and Development and note that the idea and practice of “developing” the global South arose during colonisations (Cooke 2001; Hodge 2007; Kothari 2006c). This section explores the emergence of German Development policy and practice in the first decade of the 20th century, focusing particularly on population and reproductive health in “German East Africa”.

1906 is repeatedly mentioned as a turning point in German policy and practice towards its African colonies (Beck 1977; Bruchhausen 2006; Iliffe 1969). German colonialism in Africa was in crisis immediately after the turn of the century. This was in part due to major wars that the Germans fought in “German South-West Africa” from 1904 to 1907, in which they committed the first genocide of the 20th century (Kößler and Melber 2004), as well as in “German East Africa” from 1905 to 1907.12 The Maji Maji War “was a resistance against plantation owners, cash crops’ communal production under supervision of colonial agents, and harsh German colonial rule in general” (Chachage 2006). The German Chancellor at the time utilised the critiques of malfeasance, corruption, and brutality by the Social Democratic Party and the Centre Party against the wars and the colonial administration to have parliament disbanded. In the ensuing electoral campaign, Bernhard Dernburg, who became Secretary of State for the Colonies, emphasised the need to reform economic, legal, educational, and social policy (including questions of health and medicine) with regard to the colonies (Bruchhausen 2006).

The outcome of the subsequent elections changed the balance of political power and paved the way for a new colonial administration, with regard to both structure and personnel: the Kolonialabteilung des Auswärtigen Amtes (Colonial Department of the Foreign Office) was transformed into an independent Reichskolonialamt (Imperial Colonial Office) and Dernburg became the first State Secretary of the

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Imperial Colonial Office in May 1907. In Dernburg’s reformist agenda, the “natives” were “[t]he most important resource in Africa” (1907, 7). With the introduction of wage labour, and measures to force people to take up such labour, Africans were supposed to become “economic persons” who would enable the exploitation of the colony and who would also be able to purchase German products (Gann 1987). Despite opposition from settlers, “the goals for export crops and commercial development” were revised towards a “social policy” and “more favorable living conditions and the improvement of health” (Beck 1977, 22). This turn in policy is well summarised by Dernburg’s vision of an “enlightened colonialism” (Beck 1977, 47):

While one used to colonise by means of destruction, one can now colonise by means of preservation, which encompasses the missionary as well as the doctor, the railway and the machine, i.e. the progressive theoretical and practical science in all fields. (Dernburg 1907, 60)

Such a centrality of science and technology has been identified as characteristic of the emergence of Development ideology during the period of colonial occupations (Hodge 2007). According to Iliffe, it is reasonable to understand the changes in German colonial policy as “stimulated by fears engendered by the Maji Maji rebellion of 1905-07” and thus as a reaction to an African initiative rather than a decision controlled by the Germans (1969, 7). Reforms were continually opposed by European settlers who feared for their economic interests and security (Iliffe 1969). Even though some scholars hold that “the African work force was subsequently treated better” and schooling and health care were expanded (van Laak 2004, 9; transl. DB), the reforms did not “necessarily imply liberalisation, in the sense of developments more acceptable to the African peoples” (Iliffe 1969, 8). Whether intervention actually led to “development”, in the sense of improvement of the lives of East Africans, is debated in the literature (e.g. Colwell 2001). Nonetheless, of concern to this study is the fact that ideas and practices to “develop” colonised people had emerged. German colonial reformist agendas were not specific to the German Empire, but embedded in wider European debates which had commenced prior to the major colonial wars and Dernburg’s appointment (Grosse 2000). Grosse (2000) argues that the new administration was not the vanguard of European
colonial “reforms”, but merely responded to international debate over colonial reform, and reflected internal debates in Germany on social reform as a third path – between uninhibited capitalism and socialist reform.

Systematic health policy by European colonising nations was initiated at the turn of the 20th century, when colonial administrations established the discipline of “colonial medicine” in order to protect the colonisers against diseases and climate previously unknown to them. At the same time, Western physicians created the “specialism of ‘tropical medicine and hygiene’” (Worboys 2000, 70). Germany was no exception to this trend. “Tropical health and medicine” was institutionalised with the 1897 publication of the Archive for Marine and Tropical Hygiene (mentioned in Chapter 3), the 1900 inauguration of the Institute for Marine and Tropical Diseases in Hamburg, and the 1907 foundation of the Deutsche Tropenmedizinische Gesellschaft (German Association for Tropical Medicine) (Eckart 1997). Colonial health policy by European nations followed a similar pattern: Western health care and medicine were first brought to the colonies to ensure the well-being and survival of colonisers; later on, colonised people employed or forced to work by the colonisers were cared for as well; the third stage was the inclusion of the colonised people in general as objects of Western medicine, “hygiene”, and health care (Worboys 2000). This study focuses on the third phase, which Worboys specified as “missionary activity, modernization, and protection of the health and welfare of indigenous peoples” (2001, 207) during German colonial rule.

One example of the reforms in German colonial policy was the 1911 decree by German East Africa’s Governor Albrecht von Rechenberg that the “public outpatient clinics, which have to exist in all military medical institutions of the protectorate, will serve the medical care of the coloured population”; this was intended to “strengthen confidence towards the European administration” (cit. in Bruchhausen 2003, 101; transl. DB). The number of East African patients, attended to by government health facilities, increased steadily after 1907, and the official German statistics for 1912/13 reported 70,327 patients, 93% of whom were Africans (Bruchhausen 2006). The number of German doctors in “German East Africa”
increased to 55 in 1913 (Bruchhausen 2006) and 74 in 1914 (Beck 1977). However, the change in policy proved fleeting: While the replacement of von Rechenberg as Governor in 1912 by Heinrich Schnell can be seen as a step in the direction of additional social measures directed at the East African population, the replacement of Dernburg as State Secretary in 1910 by Friedrich von Lindequist shifted the emphasis towards the cause of the “settlements” who opposed the reformist agenda (Bruchhausen 2006).

Matters of health and medicine were administered by the Medizinalreferat des Reichs-Kolonialamts (Medical Department of the Imperial Colonial Office) in Germany and by the Medizinalreferat des Kaiserlichen Gouvernemens von Deutsch-Ostafrika (Medical Department of the Imperial Government of German East Africa) in Dar es Salaam. Military and civilian medical matters were administered separately, but both were in the hands of these two Medical Departments. “Regierungsärzte” (physicians employed by the civil administration) as well as a number of military medical personnel were deployed to administer services to civilians. Throughout the German colonial period, financial considerations and struggles over government funding played a major role in limiting health care, as this “was only one among several obligations which competed for the limited budget of the Imperial Colonial Office” (Beck 1977, 28). In addition to government involvement, missions had always included medical care as part of their proselytising activities. As from 1905, they began to form specific medical missionary associations to intensify their involvement in this sphere (Beck 1977). The German colonial government also subsidised missions in order to provide medical services in rural communities (Masebo 2010).

With the advent of reformist agendas after the turn of the 20th century, and especially after the Maji Maji War, the German colonial administration in German East Africa became particularly interested in questions of population and reproduction. “Population decline” was identified as a problem; the official German statistics of the number of offspring per family confirmed a “very low reproduction” rate and a “decline” in population for some areas (Medizinalreferat in Daressalam
A perceived depopulation and low reproduction rate was a common point of departure for many scientific and government publications (see Chapter 5). Recent studies, however, suggest that actual “population decline” probably never occurred in “German East Africa” and that the “depopulation”, which the German colonisers claimed to have observed, rather had to do with labour migration and people moving away from the sphere of influence of the colonial administration (Koponen 1994). Nonetheless, as will be expanded upon in Chapter 5, colonial administrators, missionaries, physicians, and scientists cautioned against a “population decline”, and East Africans became considered to be a resource in need of “protection”, “preservation”, and “enhancement” (cf. Stoecker 1991). It is worth noting that population decline was also a German domestic debate at the time. While the 19th century had been dominated by discussions on how to limit an alleged “population explosion” of the working class, low birth rates now became a matter of concern (Usborne 1994). People were seen as “biological capital” (Halling, et al. 2005, 388). Whereas some scholars of colonialism date the emergence of discourses regarding underpopulation to the 1920s (Hodge 2007), the present study demonstrates that such discourses date to the 1900s and 1910s, at least in the case of German colonialism.

At the heart of discussions on population and reproduction in “German East Africa” were birth rates; induced abortions, miscarriages and premature births; and infant and child mortality (Ittameier 1923; Medizinalreferat in Daressalam 1914; Der Professorenrat des Hamburgischen Kolonialinstituts 1913). In addition, aspects such as migration, housing, and diet were blamed for unfavourable health conditions. German colonisers held that the social position of women in East Africa, marital relations, customs, obstetric care, diseases, morals and values, and the labour system introduced by the Germans caused “population decline” and poor health (see Chapters 5 and 6). “Depopulation”, “proletarianisation”, and the “spread of venereal diseases” were associated with a degeneration of the East African colony. Missionaries as well as doctors complained about “pagan” and unhealthy customs and sought to replace them with Christian and scientific practices (Bruchhausen 2006). The primary aim of the colonial administration was to supply German
economic endeavours with a workforce of able-bodied men. Health care was, however, also extended to women, who received treatment in order to raise healthy children and to contribute to a large workforce. The following statement by a military senior staff surgeon is a good example of such a concern with women’s health:

Here in German East Africa as well, the welfare of the infant has to begin with the welfare of the pregnant woman; care for the infant has to encompass that of the mother as well. (Peiper 1912, 256)

As focused on in detail in Chapter 6, German missionaries, physicians, and administrators showed great concern for East African obstetric care and child rearing. This must be understood as part of a larger European project of discussing and intervening into maternity and reproduction of colonised people (cf. Hesselink 2011; Hunt 1999; Ram and Jolly 1998; Vaughan 1991). Before German colonisers began to be concerned about East African birthing, obstetric care in “German East Africa” had in mind female colonisers such as wives of German settlers, missionaries, and administrators. Once doctors, missionaries, and the colonial administration began to take an interest in child and maternal health, they evaluated and assessed practices of midwifery and infant care (see Chapter 6). Moreover, in order to control the sphere of reproduction, they were committed to identifying the prevalence and methods of induced abortions (Feldmann 1923). According to Vaughan’s study on missionary medicine in territories colonised by the British in East and Central Africa, “missionaries realized that African midwifery practices and associated ideas about fertility and childcare were the locus of the reproduction of many strongly-held beliefs [and that] African ‘midwives’ [...] exercised a large degree of social and moral control which had to be broken if Christianity was to succeed” (1991, 66). In East Africa as well, care of mothers and infants was a favoured way of German missionaries to gain access to the colonised people (cf. Walter 1992). In addition, stakeholders with philanthropic self-conceptions such as the German Society for the Protection of the Natives or the German Women’s Association for Nursing in the Colonies pressed for the founding of birthing homes and for education of East Africans as midwives and nurses for the
colonised people (Deutsche Gesellschaft für Eingebornenschutz 1914a; Deutscher Frauenverein für Krankenpflege in den Kolonien 1909).

Fear of “underpopulation” did not disappear with the end of German colonial rule in East Africa, but continued to be an issue for the British colonisers until about 1941 (Bruchhausen 2006). During British rule, colonisers associated “low levels of population [...] with high levels of maternal and infant mortality” (Allen 2002, 20–1) and saw the labour migration system as having negative consequences for the health of the East African population (Allen 2002). The British Medical Administration felt it to be important to “[e]liminat[e] the cultural superstitions and practices surrounding childbirth and child rearing as well as educat[e] mothers in proper nutrition and sanitation practices” (Allen 2002, 20–1). These aspects resonate with evaluations and interventions during German colonial rule. To explain why expecting mothers would not come to mission or government health facilities to give birth (Allen 2002), the “trope of the timid tribeswoman” was invoked as well (Colwell 2001), just as during German colonisation (see Chapter 6). British colonisers began to specifically deal with the health of mothers and children. By the late 1920s, the “issue of medically assisted births and the training of native midwives in Tanganyika received much attention from colonial administrators” (Allen 2002, 27). From the 1940s, British colonial policy began to emphasise “development” in order to maintain legitimacy. Funding of social services was increased, particularly for education, housing, water, and health (Schneider 2006). Apparently, by the 1940s, women in Tanganyika had begun to make more and more use of the colonial medical facilities to give birth (Allen 2002). However, in the late 1940s and early 1950s – due to economic and personnel constraints –, the Medical Services in Tanganyika suggested focusing more on prenatal and postnatal care (with hospitalisation reserved for complicated deliveries), refraining from expanding institutional midwifery services, and encouraging home births for normal cases (Allen 2002).
4.4 Post-independence Tanzanian “development” and German Development aid

Independence was achieved in 1961, and in 1964, following a bloody revolution in Zanzibar, Tanganyika and Zanzibar merged to become the United Republic of Tanzania. Anti-colonial struggles in Tanganyika had been dominated by reference to the failure of the colonial state to bring “development”, and post-colonial Tanzanian political debates continued to be framed with reference to “development” concerns (Ahearne 2011). Soon after Tanzania became a one-party state in 1965, the Arusha Declaration (1967) was passed and widespread nationalisation of existing industries, land, and services as well as a broader reorganisation of society followed (Askew 2006). This marked a shift away from colonial-era policy, and the emergence of a relatively unique African socialist political agenda was set (Askew 2006). Several donors, including the World Bank, subsequently increased their support to Tanzania, mainly due to the official agenda of “self-reliance” (Holton 2005). Between 1973 and 1977, the World Bank doubled its aid, facilitating expansion of social services such as health and education, but also a massive “villagisation” programme (Holton 2005), a term which refers to a large-scale Tanzanian government scheme of the 1970s to reorganise rural life and bring “development”. Despite aims to enhance agricultural productivity, the largely compulsory character of the villagisation programme led to a food crisis. When President Julius Nyerere retired in 1985, he famously admitted that the economic policies of his government had largely failed.

The period following Nyerere’s resignation has been described as a “post-socialist period with significant political-economic changes” (Ahearne 2011, 71; Askew 2006):

His inexperienced successor – Ali Hassan Mwinyi – was left facing a deepening economic and political crisis. With the Tanzanian government facing bankruptcy and with no prospect of aid without reform, Mwinyi was forced to capitulate in the face of the coercive power wielded by the [World, DB] Bank and [International Monetary, DB] Fund (Holton 2005, 555)

The first Structural Adjustment Programme (SAP) was initiated in 1986 (Agrawal et al. 1993). Subsequently, state social service spending was considerably reduced.
International pressure and aid conditionalities not only led to a change in economic and social policies, in line with the hegemonic neoliberal agenda, but also to a transformation of the political system towards multipartyism – even though the majority of Tanzanians were against this (Askew 2006; Chachage 2003). Multipartyism was introduced with the 1995 elections, and the party that had ruled Tanzania until then (Chama Cha Mapinduzi, CCM) has since won all presidential and legislative elections. Since the mid-1980s, in the light of SAPs and neoliberal reforms, NGOs and Development projects have proliferated and replaced many functions formerly provided by the state (Chachage and Mbilinyi 2003). Fifteen years into the SAPs, per capita income and basic human welfare indicators had dropped significantly, and the quality of life for Tanzanians had deteriorated. In 1980, mainland Tanzania had the highest levels of literacy and primary school enrolment in Africa. Furthermore, free health care was then available throughout the country, albeit with variations in quality and access (Askew 2006). Around 2000, primary school enrolment rates had dropped to below 50% (Globalization Challenge Initiative 2000). Even though Tanzania is today not as highly dependent on foreign assistance as during the 1980s and early 1990s, it still heavily relies on aid. In 2007/2008, foreign aid made up 42% of the national budget, by 2010/2011 this had, however, dropped to 28.2% (Policy Forum 2010).

In terms of health care, SAPs resulted in the introduction of user fees in 1991 and many Tanzanians hence found it more difficult to access health provision (Langwick 2007, 2011). Proliferation of private health facilities (Duka la Dawa) in the wake of economic liberalisation in the early 1990s and the inability of many Tanzanians to purchase services had a marked impact on people’s perceptions of their lives (Kamat 2008). According to Lugalla’s 1995 analysis, SAPs “have done [...] more harm than good to the general population [...] the basic right to good health has been curtailed and women and children are suffering most as a result” (1995, 51). Today, Tanzania’s per capita health spending is only about a fourth of that recommended by the World Health Organization (WHO), and health expenditure as percentage of overall government spending has declined in recent years (Policy Forum 2012). According to UNDP (2012), this stands at 3.5% of Tanzania’s gross domestic product.
(GDP), even though the Tanzanian state committed to increasing the health share of the government budget to 15 per cent with the 2001 *Abuja Declaration*. The health sector is heavily dependent on donor money: for fiscal year 2011/12, 41% of the health budget was provided by donors, while 59% came from government funds (Policy Forum 2012). Tanzania ranks 152\textsuperscript{nd} of 187 states in the *United Nations Human Development Index*, and life expectancy at birth is 58.2 years.

Figure 2: Political map of Tanzania (Mapsorama 2012)
After independence, Tanzania did not have an explicit population policy, and in the 1970s, the Tanzanian government resisted the international population control agenda (Richey 2008). The 1980s witnessed a gradual acceptance of dominant international policy due to pressure by UNFPA, World Bank, and USAID (Richey 2008). In 1992, Tanzania passed its first official National Population Policy. Richey (2008) suggests that this process was circumscribed by the interest of donors to reduce population growth and the rejection by the Tanzanian government and public of outright birth reducing measures. However, a population control framework with a focus on provision of family planning has been evident throughout (Richey 2008). In the light of international processes around the 1994 Cairo Conference, feminist narratives which identified women’s rights and social position as the primary problem took hold in policies on population and reproductive health in Tanzania, in competition with demographic policies which focused on population growth (Richey 2008).

According to the United Nations Development Programme (2012), Tanzania’s population in 2012 is approximately 46 million, with an estimated annual growth rate of 2.9% (National Bureau of Statistics 2011). Population has more than quadrupled since independence (National Bureau of Statistics 2011). The latest Demographic and Health Survey (DHS 2009/10) ascertained the total fertility rate to be 5.4 children per woman, which indicates a marginal decline if compared to data from previous Demographic Health Surveys (National Bureau of Statistics and ICF Macro 2010). According to the 2009/10 DHS, 34% of married women use some type of contraception, “including 27 percent [of 100%] who are using a modern method” (National Bureau of Statistics and ICF Macro 2010, xx). Methods used include injectables (11%, of 100%), oral contraceptives (7%), and so-called traditional methods (7%). The survey highlights that “[m]odern method use increased from 7 percent in 1991-92 to 27 percent in 2010” and the use of injectables has increased from less than one percent in 1991-1992 to 6 percent in 1999 and 11 percent in 2010 (National Bureau of Statistics and ICF Macro 2010, xx). Estimations suggest

13 IN August 2012 Tanzania began conducting the fifth population and housing census since independence.
that expenses for pharmaceutical contraceptives in Tanzania will more than double over the next five years (e-mail communication with a representative of John Snow, Inc. (JSI), July 21, 2010), a projection which is significant for arguments made in Chapter 5. Most pharmaceutical contraceptives are distributed in government facilities, and private pharmacies and shops are significant outlets for male condoms (National Bureau of Statistics and ICF Macro 2010). The “unmet need” for family planning is estimated to be 25% of married women and has not changed from the 2004/2005 DHS (National Bureau of Statistics and ICF Macro 2010). According to the CIA World Factbook, Tanzania’s 2008 maternal mortality rate was 790 in 2008, which puts Tanzania in 12th place worldwide (CIA World Factbook 2012). The maternal mortality rate refers to “the annual number of female deaths per 100,000 live births from any cause related to or aggravated by pregnancy or its management” (CIA World Factbook 2012). Maternal deaths account for 17% of all deaths of women between age 15 and 49 (National Bureau of Statistics and ICF Macro 2010).

The Tanzanian health care system consists of six levels: village health services, dispensaries, health centres, district hospitals, regional hospitals, and referral/consultant hospitals (Government of Tanzania 2012). In 2006, an average of only eight physicians practicing “modern medicine” served 100,000 people (CIA World Factbook 2012); according to the WHO, “fewer than 2.3 health workers [including physicians, nurses, and midwives, DB] per 1,000 would be insufficient to achieve coverage of primary healthcare needs” (CIA World Factbook 2012). While 96% of pregnant women seek prenatal care by “skilled providers” (doctors, clinical officers, nurses, midwives, and Maternal and Child Health aides), only about half of births take place in health facilities and are assisted by “health professionals” (National Bureau of Statistics and ICF Macro 2010). The remaining home deliveries are assisted by “[t]rained and traditional birth attendants” (one third) and by “relatives or other untrained people” (two thirds) (National Bureau of Statistics and ICF Macro 2010, 135–6). Despite their name, “traditional birth attendants” (TBAs) are not those women who are bearers of specialised local knowledge concerning birthing, who know about herbal medicine, and who communicate with “nonhumans” (Langwick 2011, 121–2). They are mainly younger women trained in
basic biomedical care in order to oversee uncomplicated births and to encourage women to attend biomedical health facilities.\textsuperscript{14} International donors, including Germany, have until recently supported the training of TBAs in biomedical health care but the desired effect of lowering maternal mortality did not materialise.\textsuperscript{15} As a consequence, international Development and Tanzanian government policy today generally does not include instruction of, and cooperation with, TBAs. Issues of population and reproductive health in Tanzania have since long been framed by the dichotomy of “tradition” and “modernity”, which affects the lives of Tanzanian beneficiaries and professionals working in family planning and maternal health (Langwick 2011; Richey 2008). Nurses and nurse aides in Tanzanian health facilities often mediate between the spheres of “modern” biomedical and so-called traditional healing (Langwick 2008). According to Allen (2002), an evident gap exists between the homogenising tendency of international policy making and the complexity of real-life experiences of health-seeking women in Tanzania. At the same time, provision of reproductive health care for women is marked by poor, unaffordable treatment at health care facilities, where staff are not paid sufficiently and often need to pursue additional income-generating activities (Allen 2002).

4.5 German Development cooperation and health policy

The Federal Republic of Germany officially initiated Development aid in the early 1950s (Ziai 2007). The tendency to perceive Development policy as part of economic foreign policy was expressed in the 1961 founding of the Federal Ministry for Economic Cooperation. This ministry received the addendum “and Development” three decades later. From the outset, and for considerable time, one of the primary foreign policy functions of aid by the Federal Republic of Germany was to prevent

\textsuperscript{14} Since the late 1960s, these midwives have been grouped under the term “traditional birth attendants” by the World Health Organization and other international organisations. For a discussion of the emergence of and politics regarding the TBA as a “radically localized figure and a completely global product”, see Langwick (forthcoming, 2011).

\textsuperscript{15} Issues highlighted towards the end of the training of TBAs were cost-benefit analyses regarding their training; lack of supervision and support by conventionally trained health personnel; major differences among TBAs regarding function, knowledge, and experience; and the fact that policies aimed at changing the behaviour of TBAs in midwifery did not take into account that they often occupied a much broader societal role than merely assisting with birthing (World Health Organization 2005).
decolonising nations from recognising the German Democratic Republic as a sovereign state (Ziai 2007). From the 1980s, German Development policy has pushed for an economic re-orientation in line with neoliberal principles and has asserted such a policy via conditionality (Ziai 2007). After 1998, under the Red-Green coalition government, German Development policy has increasingly shifted from a project and programme approach to what is referred to as “global structural policy”, which aims to promote a development-friendly international policy environment (Ziai 2007). Since Minister Dirk Niebel of the Liberal Party took office in 2009, the BMZ has begun to emphasise cooperation with the private sector (Kuhn 2011).

Germany has a complex and decentralised aid governance structure (CONCORD 2012). The Federal Ministry for Economic Cooperation and Development (BMZ) as “the hub in an organisational network” (Nuscheler 2006, 196; transl. DB) is responsible for 60% of Germany’s official development assistance (ODA) (CONCORD 2012). The second largest portion of aid funds goes towards the budget of the European Union’s (EU) Development cooperation. Other important actors in the aid network are various ministries, government-owned organisations responsible for implementation, and secular as well as faith-based NGOs (Nuscheler 2006). From 1974 until recently, most bilateral Development aid of the BMZ and the other ministries was implemented by GTZ (responsible for technical cooperation) and KfW (responsible for financial cooperation). At the beginning of 2011, after I had completed my fieldwork, the Deutsche Gesellschaft für Internationale Zusammenarbeit (German Agency for International Cooperation, GIZ) was formed by merging GTZ, the German Development Service (DED) which deployed development workers on behalf of BMZ, and InWEnt (Capacity Building International) which was active in “human resource” development and training. The motivation behind this merger was for German Development assistance to have a uniform appearance (Stockmann et al. 2010), to eliminate triple structures, and to make it easier for the BMZ to control the implementing agencies. Today, most German aid is managed by the three implementing agencies KfW, GIZ and Engagement Global. As is the case with most donor countries, German aid policy is
an integral part of the international aid system. Not only is one third of ODA
distributed via multilateral donor agencies, but German aid is also geared towards
fulfilling the *United Nations Millennium Development Goals* and the *Paris
Declaration on Aid Effectiveness* of 2005 (Stockmann et al. 2010).

In 2011, Germany was, in absolute terms, the EU’s largest and the world’s second
largest aid donor (Global Humanitarian Assistance 2012). In 2011, Germany had a
net disbursement of about € 10.5 billion (CONCORD 2012). However, as it
contributes only 0.4% of its gross national income (GNI) (or, according to
CONCORD’s calculation of genuine aid, only 0.34%), it is among the *OECD
(Organisation for Economic Co-operation and Development)* countries which are
farthest from reaching the UN goal of contributing 0.7% of GNI as ODA (CONCORD
2012). Partner countries were reduced from 68 countries in 2000, to 55 in 2008, and
46 in 2011 (Faust and Ziaja 2012). All Germany’s former colonies are now partner
countries, although cooperation with Togo had been temporarily suspended and
only resumed in 2011. Africa is the focal region of German aid, as about one third of
German ODA in 2010 went to African countries, and plans exist to increase this
percentage (German Federal Foreign Office 2011a).

Official aid figures can convey a false message. For example, Kapoor (2008) claims
that donors often cover up aid conditionalities in order to appear benevolent and
generous. According to CONCORD, a confederation of NGOs, “donors still informally
tie aid by biasing supposedly competitive procurement processes in favour of their
own companies, who win an estimated 60% of formally untied aid contracts”
(CONCORD 2012, 21). Even though Germany promotes its aid as almost wholly
untied, less than 50% of its “free-standing technical cooperation […] is channeled
through local procurement procedures”, and the ministry recently expressed the
desire to “strengthen cooperation with the private sector” and “open business
opportunities” to German companies (CONCORD 2012, 21). Such informal tying of
aid is thought to have increased under the present minister of the *Liberal Party*. In
general, bilateral aid has a significant positive influence on German exports to
partner countries (Larch et al. 2007). Chapter 5 will address the stakes of German
companies in the field of reproductive health and population, and how they are intertwined with German Development aid.

Among Germany’s Development aid partner countries, Tanzania is arguably the one with which Germany holds the longest standing, broadest, and deepest relations (Köhler 2000). According to a recent press release on the occasion of 50 years of Tanzanian independence, the German government stated that “Tanzania is one of Germany’s most important and oldest cooperation partners, with development cooperation between the two countries going back to the early 1960s” (BMZ 2011b). It has been one of the focal countries of German aid since the 1970s, and the first German assistance programme to Tanzania was elaborated in 1971 (Bohnet 2000). Total aid commitments since 1962 amount to about € 1.8 billion. In terms of per-capita aid, only Israel has received more aid than Tanzania over the course of the past decades (Köhler 2000). For the period 2009-2011, Germany provided approximately € 170 million to Tanzania (German Federal Foreign Office 2012). In the most recent government-to-government negotiations, Germany agreed to provide € 174 million for the period 2013-2015 (BMZ 2012c). Development cooperation is focused on three priority areas: health care; water supply and sanitation; and decentralisation and local government (Embassy of the Federal Republic of Germany, Dar es Salaam 2012, 7). In accordance with Tanzania’s “national development strategy”, most bilateral aid is given in the form of direct budget support (BMZ 2012d; McGrath 2011, 273). Development assistance further includes the deployment “of development workers and government subsidies for development cooperation measures conducted by the German churches, non-governmental organisations and political foundations active in Tanzania” (German Federal Foreign Office 2012). Moreover, NGOs and faith-based organisations also channel aid to Tanzania. The work of German churches is often mentioned as important for Development cooperation between Germany and Tanzania (Köhler 2000). For example, hundreds of German congregations, associations, and groups maintain bilateral relations with parishes of the *Evangelical Lutheran Church in Tanzania* (Köhler 2000).
The health sector is the fastest growing area within German aid; from 2000 to 2008, annual pledges increased from € 200 million to more than € 700 million (Koppers and Böhmer 2011). According to the German government, its involvement “in healthcare in Africa is guided by the “principle objective [...] to strengthen Africa’s healthcare systems” (German Federal Foreign Office 2011b, 47). German health priorities are stated to be “strengthening women’s rights and choices in relation to contraception, pregnancy and birth”, “strengthening health systems”, and “strengthening the prevention and treatment of HIV/Aids and other infectious diseases” (BMZ 2009, 4–5). BMZ seeks to encourage “ownership” and “build capacities” through specific approaches such as “programme-oriented joint financing” in the form of “sectoral budget support” and “basket funding”16, as well as through facilitating “funding for measures to improve health infrastructure and delivery” and for provision of drugs and “social marketing” (BMZ 2009, 19–20).

With regard to issues of population, family planning, and maternal health, the Federal Republic of Germany significantly expanded its activities in the 1980s and has since been particularly active in Africa (Schlebusch 1994). Germany’s current official Development assistance on issues of population and reproductive health is outlined in the policy paper “Sexual and Reproductive Health and Rights, and Population Dynamics” (BMZ 2008). Therein, the field of population and reproduction is conceptualised with reference to “sexual and reproductive health and rights”, “population growth” and “fertility”, “sustainable development”, “family planning”, and “maternal health”. “Sexual and reproductive health” (SRH) is understood as “encompassing issues of physical, mental and social well-being in matters related to sexuality and the reproductive system” (BMZ 2008, 4). Whilst this shows a very broad understanding of SRH, issues raised as facts to highlight a problematic situation in the global South are narrower and rather pertain to questions of maternal mortality, population growth, and family planning (BMZ 2008, 4).

16 So-called basket funding supports a certain sector such as health. In contrast to budget support, money “is not spent following the beneficiary partner country procedure” but “via a joint bank account held by a group of donors”. Thus, “[b]asket funding is used whenever the donors want to channel the resources directly to specific expenditure of a particular ministry, because they still have insufficient faith in the ability of the Ministry of Finance to earmark the funds for priorities in the poverty reduction strategy” (Belgian Development Agency 2012).
This narrowing of the concept of “sexual and reproductive health and rights” is also discernible in other publications by government agencies as well as NGOs. The majority of these aspects – fertility and contraceptives (Chapter 5), gender relations (Chapter 5), and maternal mortality (Chapter 6) – are explored in this study. The BMZ also highlights as key elements of SRH the “strengthening of private sector distribution channels and marketing strategies to promote sales of (generally subsidised) products that promote health” such as contraceptives (BMZ 2009, 19).

Recently, in 2011, BMZ launched a specific “Initiative on Rights-based Family Planning and Maternal Health”. It places emphasis on “improv[ing] knowledge and acceptance of modern family planning methods”, “expand[ing] access to modern family planning methods and services” (see Chapter 5) and “increas[ing] the number of births attended by health professionals” (see Chapter 6) (BMZ 2011a). Most of the € 400 million pledged in 2010 will be used for this initiative which is aimed at addressing Millennium Development Goal (MDG) 5 (“Improve maternal health”). This MDG seeks to reduce maternal mortality by three quarters between 1990 and 2015, and to achieve universal access to reproductive health by 2015 (United Nations 2012).

In Tanzania, the German government has established its largest health program in Africa, the Tanzanian German Programme to Support Health (TGPSH). Virtually all German Development agencies are involved in this programme (see Chapter 3). It was officially initiated in January 2003, but many activities had already been implemented previously and were then merged into a single programme. German bilateral aid focuses on the regions of Tanga, Lindi, Mtwara, and Mbeya (see Figure 2) which are home to approximately 5.6 million people (German Federal Foreign Office 2012). Currently, this programme includes four main areas of intervention: “sexual and reproductive health and rights, including HIV/Aids prevention”, “health financing and social health insurance”, “human resources and capacity building”, and “decentralised health services” (German Federal Foreign Office 2012). While only one area is explicitly categorised as “reproductive health”, activities in the other three areas address reproductive health issues as well. According to interviewees, reproductive health, especially family planning and maternal health,
constitutes the key focus of TGPSH. German aid considers the general health situation in Tanzania to be highly problematic; it is seen as “precarious with a generalised HIV & Aids epidemic, high maternal mortality ratio, high fertility rate and a high unmet need for family planning” (evaplan 2009, 13). According to TGPSH, the situation with regard to obstetric care is grim and has shown no change since 1996 (TGPSH 2009b). That regarding the use of “modern family planning” is described as equally bleak, having shown little improvement in recent years (TGPSH 2009a).

Concrete examples of deployment of German Development professionals are “hospital advisor and medical doctor in Ruangwa district” (DED 2009a) and “hospital management and quality improvement, Ligula Regional Hospital, Mtwara” (DED 2009b). Other German endeavours in the area of population and reproductive health in Tanzania include activities by NGOs such as the German Foundation for World Population (DSW). German mission hospitals are also active, such as the Ndanda Hospital, founded over 100 years ago during German colonial rule and run by the Benedictine Sisters and the Congregation of St. Ottilien. Relations between German congregations and Tanzanian churches also typically involve health care. For example, the major Tanzanian church project Christian Social Services Commission has long received support from German faith-based aid organisations, as well as from BMZ (Köhler 2000). In addition to faith-based relations, several secular connections also exist between the Tanzanian and German health systems, often with origins in the colonial past (Interview 20, senior manager of TGPSH, May 27, 2010). The Ocean Road Hospital in Dar es Salaam, inaugurated by the German colonial administration in 1897, was renovated with funds from the German government in the late 1990s, closely cooperates with the German Cancer Research Center in Heidelberg, and has been sponsored by the private initiative Tanzania Tumor Aid Association Heidelberg e.V. (Schneppen 2000). The University of Giessen cooperates with the Kilimanjaro Christian Medical Centre in Moshi; the Mbeya Referral Hospital and the Department of Infectious Diseases and Tropical Medicine at the University of Munich collaborate in research; and the University of Heidelberg helped to develop the Master of Public Health course for the School of Public Health
and Social Sciences at Muhimbili University of Health and Allied Sciences (Dar es Salaam). According to a senior manager of TGPSH, hospital suppliers from Germany have also recently attempted to employ the avenues of German Development cooperation – via the Federation of German Industries (Bundesverband der deutschen Industrie, BDI), KfW, and TGPSH – in order to establish cooperation with hospitals in Tanzania and to thus access future markets for hospital equipment (Interview 20, senior manager of TGPSH, May 27, 2010).

4.6 Conclusions

German missionaries penetrated what is today Tanzania as early as the mid-19th century. Later, German businesses and the German Empire occupied East Africa, and the largest German colony – “German East Africa” – was established. The centrality of “German East Africa” to German colonial activities is reflected today in the dominant role of Tanzania in German bilateral, faith-based and secular Development cooperation. In the colonial period and in contemporary Development cooperation, issues of health, population and reproduction have played a prominent role for the German government as well as for faith-based and secular non-governmental organisations. Development ideas and practice with regard to the colonised people in German colonies may be understood as having emerged in Germany in the mid-1900s. Such policy was debated internationally and influenced by domestic changes in colonial administration as well as by devastating wars fought in “German East Africa” and “German South-West Africa”. In the mid-1900s, German administrators, physicians, and missionaries began to deliberate on population, reproduction, gender relations, and obstetric care in “German East Africa”. Today, population and reproductive health occupies a prominent place in German Development cooperation in Tanzania and is included in Germany’s most significant health programme in Africa, TGPSH. The Tanzanian health sector is heavily dependent on foreign aid, and health policies in the postsocialist era have been marked by notions of “tradition” and “modernity” instituted during colonisation, the influence of international donors, and “structural adjustment” and neoliberalisation of health care.
The following chapters explore empirically how and with what effects current German policy and practice on population and reproductive health in Tanzania are shaped by colonial power. They focus on population control (Chapter 5), obstetric care (Chapter 6), and contemporary challenges to colonial power in German Development cooperation (Chapter 7).
5 Shifting policies and practices on population control and reproductive health

Why should experts behave otherwise!
Are they the salesmen of white ideas,
The creators of demand for their countries’ products
(Nchimbi 1977, 167–8; Tanzanian poet)

5.1 Introduction

As mentioned in the previous chapter, at the turn of the 20th century German politicians, physicians, and missionaries began to perceive the people of East Africa as an economic, cultural, and medical issue. One hundred years later, the population of East Africa was still envisioned as a problem, albeit in different ways. In contrast to the German colonial administration’s concerns about “population decline” and “depopulation” in the African colonies, current government and NGO Development policies reflect a concern with “sexual and reproductive health and rights” (SRHR) and “population dynamics”. Although concern for health and rights does not necessarily imply a desire for population control, contemporary policy documents closely link the subject of “sexual and reproductive health and rights” to warnings about population growth. Thus, colonial fears of “depopulation” have transitioned into fears of “population growth”. Regardless of this shift, German government concern regarding population size is consistent over time – whether it be to promote its increase or decrease.

As mentioned in Chapter 1, the general public as well as international and bilateral Development agencies today have much faith in international Development to improve living conditions in the global South. They see such Development as being far removed from colonial-era policies and regard it as a humanitarian endeavour by rich countries of the global North (GTZ 2009; OECD DAC 2009). However, some studies suggest that Development policies and practices reinforce ideas of the global South as being inferior and in need of guidance from the global North (Crush 1995c; Escobar 1994). Postcolonial feminist critiques have highlighted that Western actors tend to specifically refer to women’s inferior social position in order to criticise the
“development” of societies in the global South (Kerner 1999; Mohanty 1991). Studies have also suggested that racialised, culturalised views on women in the global South are reproduced in Development policies on population and reproductive health (Deuser 2010; Schultz 2010). Moreover, scholars have argued that Development aid and intervention into population and reproductive health tend to serve the political and economic interests of the global North (Kapoor 2008; Kuumba 1999). Development assistance on SRHR, particularly since the Cairo Conference, is commonly perceived as people-centred and human rights-based and no longer aimed at population control (cf. Rao and Sexton 2010). However, studies suggest that population control agendas have not disappeared from contemporary Development (Schultz 2006; Wichterich 1994). This chapter builds on these critiques and explores the commonalities between German intervention in population and reproduction in East Africa during colonial rule on the one hand and during contemporary Development cooperation on the other in order to consider the extent to which colonial power shapes current intervention.

This chapter explores continuities and divergences over time by focusing on the way German actors have understood population decline or growth (5.2). It examines the discourses underlying German actors’ analyses of population and reproductive health issues, as well as the corresponding practices. Section 5.2 pays particular attention to the operation of notions of “modernity” and “tradition” and to the importance placed on gender relations in German intervention. I then scrutinise the justification invoked by German agents of both periods for their country’s interventions (5.3). Taking into account the political economy of population control, this examination also raises the question of Germany’s economic interests. The chapter concludes by identifying the legacy of formal colonisation in current German Development policy and practice (5.4). I argue that we may discern the persistence of colonial power in present-day German Development intervention on population and reproductive health in Tanzania by analysing the interconnectedness among racialised, gendered discourses, strategies which legitimise intervention, and the political economy of population control. This empirical chapter substantiates the suggestions made in Chapters 2 and 3 on the usefulness of examining interventions
through a dispositif-analytical perspective in order to understand colonial legacies in contemporary German Development aid in Tanzania: one must explore the interconnectedness and interplay of discourses with actual practices and the wider political economy of population control, while taking into account actors’ potential for positioning themselves within discourses.

5.2 Discourses and practices regarding population numbers, fertility, and gender relations

This section examines the explanations provided by German actors for population decline and growth, as well as practical interventions which have been proposed and carried out in order to control population size. Thereby, the study considers the effects of discourses and their relation to non-discursive phenomena such as material practices. The following paragraphs explore how discourses and practices in the area of reproductive health and population were grounded in the differentiation between “modernity” and “tradition” and how such discourses and practices rely on the idea of a linear, teleological “development” with regard to fertility and gender relations.

5.2.1 During German colonial rule

German colonial reformists did not consider the number of births in “German East Africa” to be “sufficient [...] for the survival or even growth of these African peoples” (Ittameier 1923, 7–8). They identified high levels of infant and child mortality and the prevalence of abortions as key factors contributing to “population decline”. Male “polygamy”, “prostitution”, “venereal diseases”, “tribal customs” regarding the desired number of children, and conventions regarding breastfeeding and cohabitation during pregnancy were all viewed as contributing to low birth rates, infant and child mortality, and abortions. The so-called native question which touched on social and cultural relations between colonisers and the colonised took centre stage in debates on “population decline” (cf. Grosse 2000). German reformist administrators, physicians, and missionaries commonly lamented the negative
effects of colonisation on the East African population (Van der Burgt 1913; Deutsche Gesellschaft für Eingebornenschutz 1914b). “Population decline” or lack of population growth was associated with a transformation in economic and social organisation due to labour migration and consequent disintegration of rural communities on the one hand, and contact with European “culture” on the other.

Some colonial commentators referred to the exploitation of colonised men in German economic endeavours and reasoned that this was damaging to the people’s living conditions and led to “population decline”. The following excerpt is an example of such a stance and refers to the effects of labour migration and exploitation of East Africans:

The youngest and strongest individuals, i.e. those most suitable for procreation, are removed from these areas. Their huts decay, agriculture is reaching a low, family ties are loosened, adultery and polygamy increase, the number of children – already low in polygamist marriages – becomes fewer and fewer. Besides the dissolution of marriage and family ties which formerly, in the primitive state, were strong, there are other negative consequences, among them concubinage, prostitution, abortion, reluctance to give birth and have children, venereal diseases and high child mortality, and an increase of women and child labour. [...] The emergence of a proletariat which is inevitable in the case of such concentrations of people has negative effects on fertility [...] (Peiper 1920a, 433–4)

Otto Peiper, a senior staff surgeon in Kilwa (see Figure 1) from 1908 to 1911, relates the colonisers’ removal of able-bodied men from their homes to work on plantations and in other colonial enterprises to the destruction of subsistence agriculture, the transformation of family organisation, and generally the formation of a proletariat. He regards such socio-economic changes as reasons for a declining birth rate, high prevalence of abortions, and infant and child mortality – in short, factors inhibiting population growth. While German commentators in colonial times did not condemn colonisation as such, several physicians and missionaries criticised the carelessness of German colonial administration, entrepreneurs, and farmers with regard to the way East Africans were exploited as labour.
In addition, European colonial reformists at the beginning of the 20th century were concerned that the imposition of European “culture” might destroy the colonised communities (cf. Grosse 2000). Living conditions perceived by the colonisers to be primitive were allegedly thrown out of balance by the “new era” (Vohsen and Westermann 1914, 66). In the journal Colonial Review – Monthly for the Interests of our Protectorates and their Inhabitants, the German Society for the Protection of the Natives wrote:

Through this [economic and cultural influence of the occidental powers], a flood of new life flows into these countries which are inhabited by a primitive population that is physically and mentally not very resistant: [this “flood of new life” encompasses, DB] unfamiliar, incomprehensible beliefs; hitherto unknown wants and desires, and the means to satisfy them [...] There are tribes in German East Africa which have decreased in number so terrifyingly fast that their survival is virtually endangered. (Deutsche Gesellschaft für Eingebornenschutz 1914b, 2–3)

Here, increasing contact with German “culture” is understood as transforming and threatening East African people’s living conditions, and leading to a halt or decline in population growth.

In addition to the idea that colonial occupation and exploitation caused population decline, German professionals also highlighted problems they saw as inherent to East African societies. German physicians, administrators, and missionaries blamed this population decline on deplorable “customs” and “traditions” such as the “low position of women”, “long breastfeeding”, “too early sexual intercourse”, (male) “polygamy”, and “artificial abortion” (e.g. Peiper 1920a, 420–1). These “customs” and “traditions” in turn were seen as the causes of high rates of venereal diseases (e.g. Külz 1911), low fertility, high child mortality (e.g. Peiper 1920a), and mortality in general (e.g. Ittameier 1923). German colonial physicians and administrators related “population decline” to what they perceived as the low social and economic position of women. The following statement by Carl Ittameier, physician for the Leipziger Mission Society in Moshi, is a good example of such a perception which
links “miscarriages” (one of the reasons given for “population decline”) to women’s societal roles:

[…] the position of women in the social body […] has to be regarded as low. Women are more or less without rights. Without going too far, one may say that the workforce of women is being exploited to the extreme. In the light of the heavy work which one sees women do, it is not surprising that this burden is one of the principal reasons for miscarriages. (Ittameier 1923, 25–6)

In addition to hard labour (here, referring to work on the family homestead rather than in German enterprises), German reformists also highlighted male polygamy, abusive sexual relations of older men with young girls, and other alleged “customs” as reasons for women’s low social position which harmed their health, led to spontaneous and induced abortions, and caused low fertility as well as a high rate of child mortality (Van der Burgt 1913; Peiper 1920a).

These estimations were based on the concept of the “extinction of the primitive peoples” that was formulated by liberal anthropology in the mid-19th century (cf. Grosse 2000). European anthropologists had argued that the transformation of living conditions as a result of colonisation endangered the survival of colonised peoples. These ideas resurfaced in the phase of colonial reform at the turn of the 20th century. As evident in the reasoning presented above, East Africans were seen as living in “primitive”, “natural” conditions which were disrupted by contact with the allegedly complicated, “sophisticated” German “culture”. Such deliberations were based on a distinction between a static “traditional” situation in East Africa and a complex, flexible, moving German “modernity” (cf. Mbembe 2001).

Detrimental effects of “modernity” were similarly discussed within Germany with regard to the domestic situation. Since the end of the 19th century, a decline in births among the “lower classes” had become an issue of public debate: “proletarianisation”, “break-up of families”, and the spread of venereal diseases and abortions were discussed and interpreted as negative consequences of “modernity” (Knecht 1994; Rainer 2003; Sauerteig 2001). Nonetheless, in the colonial context the discussion of “birth decline” was different from that in Germany. As mentioned above, commentators criticised polygamy, child marriages, and the general
oppression of women, and regarded these as intrinsic to the “culture” of East Africans. “Cultural” practices of East Africans were more readily denigrated than those of Europe’s poor, because African societies were regarded as differing more dramatically from the European bourgeois norm (cf. Colwell 2001). Pointing to repressive gender relations among colonised people was a common strategy used in colonising nations in order to establish racialised difference between colonisers and colonised and to legitimise colonial imposition (Oyèwùmí 2005; Spivak 2003).

German colonial stakeholders’ discussions of “population decline” in “German East Africa” established a racialised hierarchy between themselves and East Africans on the basis of “cultural” difference, particularly through reference to allegedly oppressive gender relations in East African societies.

Having ascertained a “birth decline” in East Africa, German reformists deduced that “a strong advocacy for the protection and advancement of the coloured people has never been more necessary than today” (Deutsche Gesellschaft für Eingebornenschutz 1914b, 3). They sought to improve the situation of the colonised and to fight “population decline” “through all available hygienic, social and similar means, especially to increase the birth rate and to lower child mortality” (Reichskolonialamt 1914, 78). Research into the issue of “birth decline” and measures to counter it were encouraged. In 1913, the so-called Eduard Woermann contest question mentioned in Chapter 3 was advertised. The eminent colonial entrepreneur Woermann and his company donated 6,000 German Marks to encourage ideas promoting “increase of the birth rate and a reduction of infant mortality in the native population – the economically most valuable asset” (Der Professorenrat des Hamburgischen Kolonialinstituts 1913). The two winners, Carl Iltameier and Hermann Feldmann, both based their studies on “German East Africa” where they had worked as physicians. Their proposals and those of other commentators ranged from strict regulation and control to those which sought to “civilise” or “modernise” East Africans through less explicitly forceful means. In the following quote, colonial physician and scientist Ludwig Külz, who had led a demographic-medical “expedition” to “German New-Guinea” for the Reichskolonialamt in 1913 and 1914, mentions interventions relying on regulation through
force (he refers to the German “tropical colonies” as a whole):

[The increase of the birth rate through the containment of all harms, DB] entails all measures for a protection of Negro mothers as such: through surveillance and restriction of coloured prostitution, fighting the excesses of polygamy, [...], sparing of women or complete containment from porter services; particularly, however, intervention against abortions, which have become rampant in many places. (Külz 1913, 327)

This quote provides evidence that East African women are paternalistically constructed as needing protection from East African men, from exploitative colonial practices such as “porter services”, and from their own practices of abortion. While missionaries, physicians, and administrators advocated for legally restricting polygamy or discouraged it through taxes, this was not put into effect. “Prostitutes” (as the taken-for-granted cause of the spread of venereal diseases) were required by law to register with the local “inspection of the prostitutes” (Kontrolle der Prostituierten) (Colwell 2001, 92). The recruitment of East Africans for labour on plantations and elsewhere was regulated by decrees by the Governor in 1909 and 1913 and included a ban on enlisting women (Gouverneur von Deutsch-Ostafrika 1913a). This is a reflection of German domestic policies on “maternity protection” (Matzner-Vogel 2005) which relegated women to the domestic sphere and prevented them from active involvement in public life. Furthermore, German commentators were unanimously in favour of prosecuting those responsible for abortions (Van der Burgt 1913; Feldmann 1923). While anti-abortion laws were never codified, the following quote indicates that abortions were persecuted by German administrators responsible for upholding colonial rule in the districts in “German East Africa”: “The punishment that the government sets on these things [abortions, infanticide etc., DB] may prevent the effectuation of a number of these customs” (Feldmann 1923, 110). In the light of the fact that it must have been extremely difficult to actually punish people carrying out abortions – a situation similar to that in Germany at the time (Seidler 1993) – there are no indications in the archives (or in recent academic studies) that such punishments actually took place in “German East Africa”. However, the German staff surgeon Wolff mentioned
that “now and then barks and small pieces of wood, which are allegedly used for abortive treatments, are taken away from native doctors” (cit. in Peiper 1920b, 18).

In addition to these regulations, social policies and interventions aimed at changing belief systems were proposed in order to increase population numbers. The suggested measures included – on the one hand – increasing the number of German doctors and midwives in German health facilities, training East Africans in nursing and midwifery, and building health facilities; and – on the other – propagating Christianity and education on hygiene, maternity, and infant care (Feldmann 1923; Külz 1913). It was also deemed necessary to develop institutions to gather data on births, deaths, and diseases; set up epidemic institutes; and even pay premiums for having children (Feldmann 1923). Interventions furthermore included dissemination of leaflets with behavioural advice for pregnant women (see Chapter 6). The Medical Administration printed and disseminated guides for mothers advising them how to raise their children, how to conduct themselves during pregnancy, and what to do in cases of complications during pregnancy (cit. in Peiper 1912). These were written in Kiswahili and handed out to “village elders”; the Medical Administration was convinced that enough literate people existed to read them to the women concerned (Peiper 1912). While calls for social reform and health care intervention for East Africans were not always implemented, more government physicians and medical officers were hired, missions sent midwives to the colony, and the training of “adequate native women as midwives” was initiated just before the demise of German colonial occupation (Reichs-Kolonialamt 1914, 880; Feldmann 1923).

As mentioned above, policies tended to aim towards a change in women’s social position. A transformation of female (and male) roles was expected to improve the health of women, to yield higher birth rates, and to allow women to better look after their children. Christianity was perceived as particularly apt for transforming relations between men and women. Mission physician Carl Ittameier expressed the all-embracing curative effect of proselytisation as follows:

[...] conveying Christianity to the natives should bear fruit. It should manifest itself in the moral uplifting of the people. The woman should be uplifted from
her low position, in which the man only appreciated her as workforce or effectively as a slave. She would become a companion to the man, who shares the work fairly with her. Attention and care of the children would become more thorough. Practically, the value of an influence through Christianity has to manifest itself in a decline of abortions or miscarriages, in reduced child mortality and an increase in births. (1923, 56)

The ideal of monogamy and certain gender roles was, above all, passed on by missions engaged in schooling boys and girls (Colwell 2001). European notions of what constituted femininity and masculinity were thus introduced and propagated, with a subsequent transformation of gender relations to the disadvantage of women (cf. Oyèwùmí 2005). According to Colwell (2001), for example, advocacy of monogamy – in combination with the spread of male wage labour and thus the absence of men from homesteads – meant that women had less support and had to shoulder field work and other tasks on their own, which had not been the case when they had co-wives. The gender roles promoted were highly patriarchal, reflecting the hetero-normative bourgeois gender relations in Germany at the time.

Senior staff surgeon Otto Peiper described the desired transformation as follows:

The man should and has to learn how to work now; the woman, however, the hitherto workhorse, should receive the position accorded to her by nature’s order: the concern for the upbringing and care of the children as well as keeping house. (1920a, 457)

This should be understood in the light of the domestic German situation in which it was generally agreed that family ties should be strengthened and that the role of housekeeper and mother be fulfilled by women (Usborne 1994).

To summarise, German commentators attributed “population decline” on the one hand to colonial intrusion and subsequent transformation of people’s living conditions and, on the other hand, to East African “customs” and “culture”. These ideas were grounded in the racialised assumption that East African societies epitomised “primitive tradition” as opposed to complex German “modernity”. Even though the concept of gender as referring to women’s and men’s social roles was not yet in hand, German physicians, missionaries, and administrators assumed social relations between men and women as well as women’s oppression to be causes of
“population decline”. These diagnoses served to justify comprehensive intervention by German administrators, physicians, and missionaries – first through forceful legal regulation, and second through social policies and transformation of belief systems. All in all, in “German East Africa” one can discern the attempt – however rudimentary in practice due to limited resources and the demise of German occupation during the First World War – to regulate or influence all aspects of the economic, social, cultural, and medical conditions of East Africans deemed influential to “population decline”. Understandings of, and interventions to prevent, “population decline” were marked by racialised, gendered discourses that were based on an assumed dichotomy between German “modernity” and East African “tradition”.

5.2.2 During German Development cooperation in the 21st century

Having described the prevalence of racialised, gendered discourses in German debates on population control and reproduction during colonial rule, this section examines how the respective issues are understood in the context of contemporary German Development cooperation. Present-day German Development aid considers the “high population growth in Tanzania of 2.9%” as excessive (GTZ 2010b). While German Development agents commonly mention Africa as a whole as cause for concern due to high fertility rates (DSW 2010a), the Tanzanian rate of approximately 5.5 children per woman is considered particularly alarming (DSW 2010b; evaplan 2009). References to gender relations and women’s social position are omnipresent in contemporary policy on population and reproductive health, and one of the three “guiding principles for a comprehensive approach” in this field is termed a “gender-sensitive approach” (BMZ 2008, 6–7). This emphasis on women and gender is attributable to feminist struggles prior to, during, and following the 1994 Cairo Conference (see Chapter 2). German Development aid documents do not explicitly link gender relations to population growth. The connection is rather indirectly invoked through discussion of women’s oppression and SRHR. “Gender-based violence” and oppressive gender relations are associated with women’s lack of “decision-making” ability in issues of sexuality:
Widespread gender-based discrimination against women, deficits in legal certainty and a lack of true gender equality are structural factors which contribute to violence and abuse against women and girls and to their being unable to make their own decisions or protect themselves. [...] In many societies, women are not in a position to make decisions about whether sexual contacts take place in a safe or unsafe, forced or voluntary way. (BMZ 2008, 7)

Whether women’s and girls’ oppression has influence on fertility or population growth is not spelled out in this policy document on “sexual and reproductive health and rights, and population dynamics” which is the key publication in current German Development cooperation. Yet, as discussed in detail below, German Development agents are convinced that if women were to decide freely, they would opt for fewer children. Interviews with Development professionals point to a connection between gender and population growth. German professionals see women in Tanzania as having no say in sexual and reproductive matters, as oppressed by their male partners, and as reduced to child-bearing. In the words of a former senior manager of the German health programme in Tanzania, Tanzanian men do not “give a shit” about whether their female partners feel like having sex or want more children (Interview 10, April 21, 2010). According to interviewees, women in Tanzania have little control over their sexual and reproductive lives due to societal oppression and discrimination, and this leads them to have more children than they desire and can care for (Interviews 08, 31, and 37). It is this reasoning that establishes causality between gender relations and population growth. Societal structures and norms pertaining to gender are thus held responsible for high fertility and population growth.

High birth rates of Tanzanian women and associated oppressive gender relations are generally interpreted as signs of backwardness by German Development actors. This is exemplified by the following statement by a desk officer at the headquarters of the German Development Bank in Germany, who deliberates on reasons for high fertility rates in Tanzania:

And one sees as well that the fertility rates are still high, that, I would say, the whole context in Tanzania is still very conservative with regard to women, with
regard to the societal stance of women. But also, I would say, one looks within
the family and so on, it still is very classical and goes hand in hand with a
certain oppression. (Interview 14, March 18, 2010)

The adjectives “conservative” and “classical” and the adverb “still” point to the
assumption of linear societal progress. In line with the idea of a “demographic
transition”, which every society is supposedly bound to undergo on its way to
“modernity” (Halfon 1997), the German professional assumes that the desire for
fewer children is a natural process which goes hand in hand with “modernisation” in
Tanzanian society. Tanzania is thus constructed as “traditional”. The ideal future is
characterised by low fertility rates – one of the characteristics generally associated
with Western “modernity” (Frey 2007). Not only is a decrease in fertility seen as a
natural outcome of a transformation towards “modernity”, it is also taken for

granted that Tanzanian women (or families) want fewer children once they are
better informed, less oppressed, more urban, and wealthier. The following quote
from my interview with a former manager of the TGPSH reproductive health area is
an example of this assumption:

You don’t need a discussion on population. Rather, well, the demand which is
just, may I say, natural or because the people are also more informed, more
urban, incomes improve, these usual, normal processes, there is just a huge
demand ... for fewer births. [...] People want fewer children. (Interview 11,
March 19, 2010)

Another interviewee also stated that once Tanzanians became wealthier, they would
naturally want fewer children; this occurred elsewhere, so “why shouldn’t it happen
in Africa” (Interview 29, June 08, 2010). Thus, a low fertility rate is not only seen as
“modern”, and characteristic of Western “modernity” (“education”, urbanisation,
economic growth, and so on) but “modernity” is also understood as leading to the
desire for fewer children (see Chapter 2). From any angle, German Development
cooperation makes sense of fertility and population growth with reference to
notions of “modernity” and “tradition”, taking the European experience as
prototype. High population growth and fertility rates as well as associated
oppressive gender relations serve as indicators for ascertaining Tanzania’s lack of
“modernity”. Tanzanians are thus homogenously constructed as “culturally” different from, and inferior to, “modern” people.

According to German Development agents, their own involvement in reproductive health is in accordance with the principles of the Cairo Conference. BMZ, for instance, claims that German Development aid has moved “from a mainly demographically-oriented to a people-centred and human-rights-based approach” (BMZ 2008, 4). In combination with the goal of lowering population growth, this is a contradictory objective which Schultz (2006) refers to as “ideological schizophrenia”; on the one hand, the need for curbing population growth in Tanzania is put forward, and on the other, any engagement should be based on the principle that women and families have to decide for themselves how many children they want. The former manager of the TGPSH reproductive health area cited above voiced that a population reduction policy in Tanzania was not necessary because people wanted fewer children and had a “natural” desire for family planning (Interview 11, March 19, 2010). The dissemination of “modern” contraceptives can thus be presented as a response to demands by Tanzanians, following the people- and human rights-centred approach promoted following the Cairo Consensus. German Development publications as well as interviewees commonly assume that there is a high “unmet need” for contraceptives in Tanzania and that women desire to have fewer children than they actually have (e.g. evaplan 2009). However, this is called into question by recent reports suggesting that the desired family size is 5.4 children for married women and 5.9 for married men, and thus about as high as the actual fertility rate, mentioned in Chapter 4 (Leahy and Druce 2009). When faced with the situation of no explicit “unmet need”, German Development professionals formulate the exigency to create a need for “modern” contraceptives. This is spelled out in the following quote from my interview with a manager of the TGPSH reproductive health area, in position at the time of my research:

Before I came here, Tanzania was a country for me [...] in which the topic population growth was extremely prominent. [...] And that in contrast to that, surprisingly, the interest or the demand for contraceptives, which one can survey through the unmet need, is not that high. This means that the
acceptance of family planning is not yet as high as we would hope. Because
often the argument coming from the area of family planning is that we say:
There is ((she slaps the table)) such a high unmet need and the poor people
have no access to ((she laughs, I laugh along)) .. to the pill and to other
contraceptives. We absolutely have to do something. In Tanzania, the challenge
is that [...]. Well, I think, that is a special case in this country here where we [...] want to better understand why this is not yet demanded that much. And what
can we as German development cooperation do .. well, to support the ministry
and the civil society in generating this demand. (Interview 24, June 02, 2010)

This strategic employment of the concept “unmet need” is consistent with its origin:
it emerged in the context of the Cairo Conference as a means of imposing the
“population establishment’s” desire for population control on the “target groups” (Schultz 2006). Providing “modern” contraceptives could thus be promoted as answering people’s needs.

Consequentially, the various German Development aid institutions and
organisations active in Tanzania work towards increasing the “need”, acceptance,
availability, and use of contraceptives; TGPSH is involved in social marketing of
contraceptives (via PSI)\(^\text{17}\) and in provision of contraceptives via “community-based
distributors” (CBDs). These “lay helpers” (more than 2,000 at the time of my
fieldwork) are trained to provide their own “communities” with information on
condoms and pharmaceutical as well as surgical contraception, and either directly
provide people with contraceptives or refer them to biomedical health facilities. The
idea of CBDs was introduced by German Development aid and such distributors are
now part of the official Tanzanian health system. According to TGPSH (2012b),
“[w]here community-based reproductive health services have been supported by
TGPSH, the use of modern family planning methods surpasses the national average”. TGPSH has also trained health personnel in family planning and contraception in health facilities. KfW, furthermore, made possible the supply of three-month
contraceptive injections to Tanzanian health facilities between 1996 and 2001 (KfW
\(^\text{17}\) During the 2010 visit of the German BMZ minister and the foreign minister to Tanzania, Germany pledged an additional € 8.5 million for purchase and marketing of contraceptives via PSI. While advertising for drugs which are only available by prescription is illegal in the European Union, Tanzanian laws allow PSI to promote these publicly.
More generally, Germany finances the Basket Fund for Health\textsuperscript{18}, from which contraceptives are purchased. According to the head of TGPSH, Germany contributed funds originally meant for buying contraceptives (before the Basket Fund was created) to the Basket Fund so that approximately the same amount would be used to purchase contraceptives in this new system (Interview 20, senior manager of TGPSH, May 27, 2010). Furthermore, TGPSH as well as the German Foundation for World Population educate young people to make use of “modern” contraceptives (DSW 2012; TGPSH 2012a).

German Development actors consider transformation of gender relations and women’s empowerment crucial for lowering fertility rates and population growth. Access to, availability, and use of “modern” contraceptives is seen as one means to empower women, as an “instrument for the self-confident behaviour of women in society” (Interview 10, former senior manager of the German health programme in Tanzania, April 21, 2010). Contraceptives would allow women to freely decide on the number of children they have. The expectation behind this is that free choice would mean fewer children. Proposals to improve women’s situation focus on education such as “information campaigns that are tailored to [...] age and culture” for changing “attitudes and behaviours” (BMZ 2008, 8). The BMZ policy document also calls for a more general transformation of gender relations in society, including through new laws (BMZ 2008). The desire to influence gender relations is also evident in several of my interviews. In the following quote by a physician working for DED in a Tanzanian hospital\textsuperscript{19}, Tanzanian women are portrayed as lacking decision-making power and this German Development professional mentions his attempt to empower them:

\begin{quote}
I always tried to .. have them think of the fact that they can decide how many children they want. Basically, because it’s also the husband who decides, and the family. Only few women who say, ok, please give me the sterilisation now.
\end{quote}

\textsuperscript{18} “The Health Basket is a funding mechanism that has been established in 2000. It is funded by a group of Government and Development Agencies that pool un-earmarked resources to support the Health Sector Reform’s implementation.” (Health Development Partners Group in Tanzania 2011)

\textsuperscript{19} This interview was held in English. Two of my interviewees were non-German Europeans who worked for DED. The interviews with them were carried out in English.
There are many women who say, ok, I’ll come back maybe after two weeks because I have to discuss this with my husband. Most of the time, this is not a decision a woman makes herself. [...] I asked this question many, many times. [...] And of the people who said I’ll come back .. maybe two came back. (Interview 08, February 02, 2010)

Here, it is insinuated that women should decide on their own how many children they want without discussing this issue with their partners or families. Free, individual decisions are in turn associated with women’s desire for having fewer children. It is implied that men are impediments to the women’s free and more “modern” choice. This desire is seen as linked to “education”. According to the German Foundation for World Population, for instance, “educated women have children later and have fewer children” (DSW 2005, 3; transl. DB).

While formal education plays a particularly central role in government and NGO policies, the idea of Christianisation as an antidote to hierarchical gender relations – markedly present in colonial-era debates – is discernible among German professionals working for faith-based NGOs. This is expressed in the following excerpt from a conversation with a German couple – the husband working as a physician in a mission hospital, and both involved in the church life of the German mission running the hospital:

Through the congregation the women get rights, the chaos changes, a whole new social structure develops. Where heart and mind change, and are converted, things become more positive. Then you also see men who affectionately have children sitting on their lap. (Interview 32, June 20, 2010)

The idea that values claimed to be Christian such as love and partnership lead to more equal gender relations is also vividly expressed in the following drawing (Figure 3) from a pamphlet written by a German missionary doctor and circulated in Tanzania (Interview 34, June 21, 2010).
These pictures are intended to demonstrate the change in gender relations towards equality generated by the workshops on “natural family planning” which this doctor provides for Tanzanian couples as part of her proselytising efforts. Evident in these pictures is the temporal, linear, progressive view of change (“formerly”; “now”). In the past (“formerly”) women were oppressed and had to shoulder child-rearing as well as all other work; with the help of the missionary doctor’s workshop, an unburdening of women – a sign of “progress” and “modernity” – is supposedly achievable.

By way of summarising, issues of reproductive health and population are understood in contemporary German Development policy by associating high fertility with backwardness and “tradition”. Reference to gender relations plays a

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This term refers to the *Billings ovulation method* developed by Australian physicians Evelyn and John Billings in the 1950s to determine fertile and infertile periods through changes in cervical mucus. This method was introduced in Tanzania in the 1980s by missionary health professionals working in the *St. Benedict’s Hospital* in Ndanda, in the Mtwara Region. It has since been mainly propagated by Catholic health facilities and is commonly used by those Catholics in Tanzania who do not accept hormonal, “modern” contraceptives or condoms (Interview 34, German missionary doctor working in a large Tanzanian mission hospital, June 21, 2010).
central role as high population growth and fertility rates are seen as related to
general oppression of women. While during the period of formal colonisation low
procreation rates were explained with reference to the low societal status of
women, today it is the excessive number of children that serves as an indicator of
women’s oppression. These ways of explaining population growth are evidence of
the establishment of racialised difference between Tanzania and the West, since
high fertility and gender oppression are seen as linked to Tanzanian “culture” and
society. While propagating the principle of “free choice”, Germans deem it irrational
and a sign of the backwardness of Tanzanian society when Tanzanians do not restrict
their number of children. When a desire and demand for lower fertility does not
exist, German Development cooperation rationalises it as lack of information or
“education”, and sees the need to create such desire. German colonial-era as well as
current Development policy and practice thus subordinate East African people’s
choices to the overall objective of controlling population. The goal of lowering the
fertility rate is primarily pursued via propagation and dissemination of “modern”
contraceptives. In this context, contemporary German Development policy also
accentuates the potential of such contraception to transform gender relations and
empower women. In addition to the spread of “modern” contraceptives, formal
education and Christianisation are proposed as antidotes to gender oppression.
Current German interventions in Tanzania thus not only present the European
experience of a movement towards a small nuclear family as universally desirable,
but also push for this on the material level by spreading “modern” contraceptives
and “education”, as well as by reforming gender relations.

5.3 Justification for intervention and the political economy of
population control

Having analysed the manner in which German actors have understood population
dynamics and fertility rates during the period of colonisation and in current
Development aid, this chapter now examines the justification German actors have
provided for intervening in population and reproductive health matters in “German
East Africa”/Tanzania. While interventions might not be consciously undertaken for
self-interested reasons, they tend to serve certain interests, since population politics are always embedded in political-economic environments. By taking into account the political economy of population control, this thesis also addresses whether population control is linked to German political and economic interests.

German colonial stakeholders tended to legitimise colonial imposition by pointing to the need for exploiting the colonised territory to the advantage of the colonising nations (Pogge von Strandmann 2009). Yet, colonisers also regularly voiced their commitment to the “civilising mission” – to “elevate”, “educate”, and “civilise” the colonised (Melber 2001, 41; transl. DB). According to British colonial officer and theorist Frederick Lugard (1923), colonialism was supposed to be guided by a “dual mandate”, meaning that colonisers had the task of exploiting the colonised territories’ resources for colonial benefit as well as to contribute to the “development” of occupied lands and the welfare of its people. I analyse how population control interventions were legitimised during German colonial rule and whether self-interested and altruistic motivations are discernible. I then explore how German Development agents rationalise their involvement in issues of reproductive health and population in Tanzania today. According to Development aid organisations, contemporary Development primarily serves the interests of recipient countries and people (GTZ 2009; OECD DAC 2009). However, scholars of Development have criticised that due to structural political and economic inequalities, Development aid tends to further interests of countries of the global North (Kapoor 2008). The examination of legitimising strategies for German intervention is thus complemented by an examination of whether German population control policies and practices in both periods have been interconnected with, or accompanied by, political-economic interests.

5.3.1 During German colonial rule

Recruiting workers for various colonial economic endeavours in “German East Africa” – porter services, plantations, construction, and so on – was a primary concern for the German colonial administration (cf. Colwell 2001; Koponen 1994;
Sunseri 2002). Thus, the issue of labour supply became a central policy concern and the “labour question” (Arbeiterfrage) was hotly debated (cf. Conrad 2004). As mentioned in Chapter 3, reformists regarded a “healthy, numerous native population [as] the prerequisite for an effective and continuous exploitation of the tropical territories” (Deutsche Gesellschaft für Eingebornenschutz 1914b, 3). Even though German “settlers” were sceptical of reformist agendas and did not see the need to “care” for East Africans’ health and social situation, all German stakeholders in “German East Africa” were in agreement that labour supply was important to maintain the colony (cf. Koponen 1994). Given the need for labour, policies emerged which began to represent African inhabitants of the colony as “[t]he most important resource” (Dernburg 1907, 7). Administrators, physicians, and missionaries felt that this “resource” was in danger. Colonial reformists formed associations such as the German Society for the Protection of the Natives and advocated for recognition of the problem of “population decline” on grounds of economic rationality. German professionals thus generally put forward self-interested legitimisations for intervention into population and reproductive health, as they understood East Africans as endangered resources on which the success of the colonisation depended.

Such a dehumanising understanding of people was based on the idea that people were “capital” (Dernburg 1907, 7) and had an economic value. After the turn of the 20th century, German scientific and political thinking on the commodification of people had changed from an “unreflected usage of human resources to ideas giving precedence to the biological reproduction of colonial subjects” (Grosse 2000, 143). The “consumption of humans” (Menschenverbrauch) or the “predatory exploitation” (Raubbau) of “human material” (Menschenmaterial) was bemoaned by German commentators (Peiper 1920a, 435; Löbner 1914, 269). As indicated in the previous chapter, in order to understand this specific conceptualisation of population, the German scientific and political landscape at the turn of the 20th century must be taken into account. Debate in Germany had switched from a fear of “overpopulation” (of the working class) to that of a “birth decline”. This had effects on the ideas of the “value of the human being” (Halling et al. 2005, 388; transl. DB).
In his concept of “human economy” (*Menschenökonomie*), Rudolf Goldscheid, for instance, defined human beings as “biological capital” analogous to other means of production of a national economy (cit. in Halling et al. 2005, 388 transl. DB; Eckart 1997). Microeconomic commodification of people went hand in hand with the dominant macroeconomic paradigm. Since the late 19th century, European colonial policy had followed the neo-mercantilist economic paradigm which bound national wealth to the population size of a nation (Grosse 2000). Whereas the German colonies were seen as foreign territories at the beginning of colonisation in the 1880s and 1890s, turn of the century colonial reformists advocated for their integration into the German nation. Thereby, colonial subjects were regarded as economically belonging to the German nation (Grosse 2000). Colonial-era discourse on population in “German East Africa” was based on the idea that people were an economic asset and that their preservation was necessary for profitable exploitation of the colonised territories.

Although the discussion on population during German colonisation mainly referred to Germany’s self-interest, humanist-philanthropic legitimisations for intervention also held sway. For example, the *Medical Department* of “German East Africa” referred to the interests of East Africans to “preserve their race or family” in the face “of the looming danger for their land or tribe due to low procreation” (Medizinalreferat in Daressalam 1914, 443). Such positions on colonisation, and in particular on issues of health and population, highlighted a humanist, altruistic imperative to improve the living conditions of the colonised. This is also explicitly invoked in the following statement by Hermann Feldmann, staff surgeon in Dar es Salaam and editor of the journal *Medical Mission*: “From a medical-humane, from a moral-religious […] standpoint, a comprehensive care for the natives is necessary” (1923, 119–20). Actors with philanthropic self-conceptions such as missionaries and some physicians saw the colonial reform debates during Dernburg’s term in office as an opportunity to implement their ideas and policies. Pastor G. Paul, for instance, mentioned that he hoped the “philanthropic and economic perspectives” would be united and expressed his conviction that their integration would lead to improved health care provision for the colonised people (1908, 98).
To summarise, German colonisers were in need of workers to exploit the colony and regarded East Africans as a resource to be made use of. They regarded population numbers in “German East Africa” as too low for optimal economic exploitation of the colony. This was based on the idea of the economic value of individual human beings as a workforce and on the conviction that the wealth of Germany depended on the number of its economically productive people, which included the colonised people in “German East Africa”. Legitimisation for intervention into population numbers was thus primarily marked by German self-interest. To a lesser degree, some colonial stakeholders, particularly missionaries, voiced philanthropic rationales for engaging in population and health policy in “German East Africa” and placed the interest of East Africans at the centre of deliberations. Whether legitimising strategies referred to self-interest or altruism, population control was clearly embedded in political-economic structures of exploiting the East African workforce.

5.3.2 During German Development cooperation in the 21st century

In contemporary German Development cooperation, intervention in population and reproductive health in Tanzania is primarily conveyed as an altruistic endeavour to support Tanzanian economic and social “development”. In interviews with German professionals working on issues of population and reproductive health in Tanzania, I inquired as to what they saw as the reasons for Germany’s involvement in this area. The following quote is from a conversation with a German consultant who has been working for German aid agencies since the early 1990s and had just begun her deployment in Tanzania at the time of the interview:

Yes, that’s, well, if you connect reproductive health with .. eh .. maternal mortality, or maternal health, and then also with maternal mortality, then I think, then it is definitely a political, humanitarian interest, yeah. [...] (Interview 28, June 5, 2010)

In this quote, the interviewee presents intervention in population and reproductive health as leading to a decrease in maternal mortality, which is Millennium Development Goal 5. Interviewees regularly brought up Germany’s commitment to
reaching the *Millennium Development Goals* and highlighted humanitarian concerns for the well-being of Tanzanian women.

A BMZ officer responsible for the field of population and reproductive health emphasised that Development work in the field of “sexual and reproductive health and rights” primarily followed an “ethical-moral” imperative: “We are doing so well here, we cannot accept that people, I mean, that ridiculous amounts are lacking, to save children, to save women’s lives” (Interview 6b, January 15, 2010). When I asked whether he thought that there were any self-interested motivations for Germany’s involvement in Development aid in SRHR, he replied the following:

I would [...] resist saying that we have any interest to support our German pharmaceutical industry. I really did not come across this in any way in the past thirteen months .. that industry representatives constantly ring the bell ((I laugh)) and say, now you have to market this condom or this drug. That’s not my impression at all. [...] I think it just becomes clear that it [reproductive health and population policy, DB] is one building block to create functioning, long-term functioning societies. [...] (Interview 6b, January 15, 2010)

This reference to “functioning societies” is in line with other interviews and also with documents on German Development aid which primarily connect the need for reproductive health measures and population control to the improvement of social, economic, and ecological conditions in Tanzania. For example, German actors voiced their concern for “sustainable development” in Tanzania in the face of high population growth. The official German press release regarding the 2010 visit of Germany’s BMZ minister, Dirk Niebel, to Tanzania stated the following:

Tanzania accounts among the largest beneficiaries of German development cooperation in sub-Saharan Africa. We will continue to work together in order to achieve our common goal: To fight the still wide spread poverty in this country. The high population growth in Tanzania of 2.9% threatens to undermine our joint efforts. (GTZ 2010b)

Here, population growth in Tanzania is regarded as detrimental to poverty reduction (see also BMZ 2012b). Such an understanding of population and reproductive health is based on the idea of Tanzanians as consumers of limited resources. According to a former senior manager of the German-Tanzanian health programme, countries like
Tanzania “are not able to properly take care of children and social conditions” (Interview 10, April 21, 2010). Whereas such a statement evidences a concern for provision of health care, education, and food, German Development agents also relate population growth to negative impacts on natural resources such as water and forests (DSW 2008b, 2010a). Such reasoning in demographics is known as “carrying capacity” (see Chapter 2), which deals with the relationship among population numbers, characteristics of ecological space, and social, cultural and spatial forms of organisation (Hummel 2007).

While “carrying capacity” is a fairly complex model and allows for solutions other than population control (Hummel 2007), German Development policy tends to reduce the concept to a problem of the number of children per family. In the following quote, the German Foundation for World Population relates resources and well-being to family size:

Many women in developing countries still have more children than they actually want and are able to look after. [...] If women have access to family planning and can plan their births, the whole family profits: In a smaller family, more gets invested into the well-being of each individual child – into food, health, and education. Important prerequisites for breaking the cycle of poverty. (DSW 2005, 2; transl. DB)

Thus, Tanzanian adults are asked to adjust the number of their offspring to their material resources. German Development agents evidently perceive population growth and fertility rates in Tanzania as excessive and problematic for Tanzanian society as well as for families and individuals. German Development cooperation evidences concern for improving SRHR as well as curbing population growth in Tanzania for the sake of individual Tanzanians and Tanzania’s “development” as a whole. Interventions are thus principally legitimised as being altruistically and philanthropically motivated.

In stark contrast to colonial-era policies, at first glance self-interested motivations appear to be non-existent in narratives which legitimise intervention into population and reproductive health. Yet, these do surface at times. For example, the German
government not only understands population growth to be related to resources in countries of the global South, but also to be a “tremendous challenge to sustainable development, at [...] the global level” (BMZ 2008, 5). The concept of “sustainable development” emerged in the 1980s in international debates in the United Nations and other international organisations and suggests that the global South and North have a common destiny – and, therefore, a common interest (Wichterich 1994).

Thus, in the face of limited natural resources and climate change, population growth in Tanzania can be construed as being related to and harming the global community, and therefore also Germany (cf. Wichterich 1994). Albeit indirectly, German Development actors thus also invoke self-interest with regard to intervention in population and reproductive health in the global South. While the BMZ officer responsible for the field of population and reproductive health emphasises “ethical-moral” reasons for German Development aid regarding reproductive health and population and denies the idea that German pharmaceutical companies have direct economic interests in Tanzania, he hesitantly connects SRHR policies and their consequences to German economic profitability:

> I believe .. I would argue that it is difficult to directly deduce an economic interest from this SRHR area. Well, the causal links are much more complex, you see. [...] So, here it is the case, we have an interest in stable countries, in stable partners, yes, I mean, there it becomes, there is an economic cooperation, the offer comes quickly, you see. I mean the countries that function, where, where the people then also have purchasing power, that will in the long term .. eh .. also be of benefit to the former .. still export world champion. (Interview 6b, January 15, 2010)

In this quote, the logic becomes evident that curbing population growth in Tanzania would mean that more resources are available for Tanzanians, that this would lead to “development” of Tanzania, and that “development” means an increase in purchasing power from which the German economy would profit. Such a position is marginal in the interviews but aligns with recent tendencies in the German conservative-liberal coalition government to explicitly voice Germany’s self-interest

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21 Spivak has criticised that such reasoning locates “the entire world’s ills [...] between the legs of the poorest women of the South” and disregards the “fact that one Euro-American child consumes 183 times what one Third World child consumes” (2007, 195).
in Development cooperation (German Federal Foreign Office 2011b; Kuhn 2011). Still, in general contemporary German legitimisations for engaging in issues of population and reproductive health in Tanzania are marked by the primacy of philanthropy and altruism. Voicing of self-interested motivations is secondary.

While the above statement by a BMZ staff member points to the global political-economic structures in which population control in Tanzania is embedded and by which German interests are served, the present study also explores whether more direct German economic interests exist in the area of population and reproductive health in Tanzania. Whereas interviewees commonly stated that they did not believe that German interests were pursued through activities in “sexual and reproductive health and rights” in Tanzania, contraceptives produced by German firms are widely-used in Tanzanian health facilities. Even fairly poor countries such as Tanzania appear to be attractive markets for German pharmaceutical companies. For instance, Bayer HealthCare recently launched its Contraceptive Security Initiative, partially funded by the US Agency for International Development (USAID), to introduce the oral contraceptive Microgynon Fe on the Tanzanian private market, aimed at middle-class women (Bayer HealthCare 2011). Moreover, contraceptives produced by German pharmaceutical companies find their way into Tanzania via the Medical Stores Department (MSD), an autonomous department of Tanzania’s Ministry of Health and Social Welfare, responsible for furnishing drugs and medical equipment to Tanzanian institutions (Interview 48, logistics officer at the headquarters of MSD, July 22, 2010). The necessary funds are provided by the Tanzanian government’s Health Basket, to which all major donors, including Germany, channel their aid (see footnote 18). In addition, two donors supply contraceptives separately: UNFPA (United Nations Population Fund) and USAID (e-mail communication with a representative of John Snow, Inc. (JSI), July 21, 2010). A large portion of donor-funded oral contraceptives which are freely distributed in Tanzanian health facilities are provided by Bayer HealthCare (e-mail communication with JSI, July 21, 2010). In 2010, this company won the bid to supply USAID, the largest donor, with Microgynon (e-mail communication with JSI, July 21, 2010). In addition, Bayer HealthCare provides the oral contraceptive Microlut, the three-
month injectable *Noristerat*, and the hormonal implant *Jadelle*. German economic interests are also served by distributing the three-month injectable *Petogen-Fresenius* via *MSD*; this contraceptive is manufactured by the German pharmaceutical firm *Fresenius* and marketed by the German company *HELM*. *MSD* has also purchased condoms from *HELM*. Contraceptive injections obtained by the NGO *Population Services International (PSI)*, which spearheads “social marketing” of family planning in Tanzania, are also manufactured by *Fresenius* and marketed by *HELM* (*KfW* specifically financed *PSI* to fund the purchase of pharmaceutical contraceptives). This thesis does not attempt to meticulously break down the procurement of contraceptives in Tanzania, but rather to highlight German pharmaceutical companies’ considerable stakes in this area. From my research, it became clear that German pharmaceutical companies have a great investment in the two main pharmaceutical contraceptives promoted and distributed in Tanzania, as injections and oral contraceptives make up approximately two thirds of all “modern” contraceptives used (see Chapter 4).

According to *Bayer HealthCare*, the company gives “preferential treatment” to poor countries such as Tanzania, which means that their selling price is the cost of production (Interview 55, desk officer at the headquarters of *Bayer Healthcare*, April 21, 2011). This appears to be a purely charitable endeavour. However, it is still quite profitable for *Bayer Healthcare* to sell at production cost because this effectively means an increase in production and thus a better utilisation of production capacity. Due to economies of scale, production costs are thus decreased and *Bayer Healthcare*’s products sold on the regular market yield a higher margin and are more competitive. Furthermore, selling at production cost still covers salaries for company staff. However, it is perhaps more significant that increased distribution of pharmaceutical companies’ products establishes these as known brands. The global South is valuable as a future market, especially as these countries are projected to greatly increase their demand for contraceptives in the future. *John Snow, Inc. (JSI)*, responsible for implementation of *USAID*’s project on health commodity supply chains in Tanzania, estimates that expenses for pharmaceutical contraceptives will more than double over the next five years (e-mail communication with a
representative of JSI, July 21, 2010). In India, Bayer HealthCare has already introduced new oral contraceptive products such as Yaz, Yasmin, and Yasminelle at high prices; these have only minor medical improvements over cheaper predecessors, but have dangerous side-effects (BUKO Pharma-Kampagne 2011). In Tanzania, Bayer HealthCare has not yet gone this far, but in addition to the supply to the Tanzanian government and donors at production cost, Bayer now also sells oral contraceptives above production cost via the above-mentioned Contraceptive Security Initiative and thus further strengthens its brands in the private market (Bayer HealthCare 2011). Thus, the economic interests of German pharmaceutical companies in the area of population and reproductive health in Tanzania are obvious.

In summary, Germany today regards Tanzania’s population growth as being too high for the country’s “development” and evokes the self-interest of Tanzanians in order to curb fertility rates. Tanzanians are no longer perceived as the resources they appeared to be during colonial rule, but as resource-consumers. In the light of allegedly limited resources with regard to Tanzania’s environment and social services as well as families’ funds, population growth and high fertility are seen as problematic. Development policy is primarily legitimised through philanthropic rationales in which Tanzania’s interests take centre stage. However, the rationale that intervention in population and reproductive health serves Germany’s economic interests in the long term was also discernible in German Development policy, albeit only marginally. In addressing the economic dimension of SHRH and population control, evidence was found that German pharmaceutical companies are heavily invested in procuring contraceptives for the Tanzanian public and private markets.

5.4 Conclusions

This chapter has focused on continuities and divergences between German policy and practice during colonial rule and contemporary Development cooperation. The focus has been on the manner in which population control and reproductive health have been understood and policies implemented. German intervention in
population and reproductive health in “German East Africa”/Tanzania has been legitimised by discourses of philanthropy as well as self-interest in both periods. Yet, the emphasis has changed significantly. Interventions to regulate population during colonisation were legitimised by voicing Germany’s economic and political benefit; altruistic considerations by some missionaries, doctors, and colonial administrators were of lesser importance. Today the opposite is the case: Contemporary German Development documents and professionals stress philanthropic considerations and only rarely mention economic ones. As with Development cooperation in general, SRHR and population is considered to benefit Tanzania’s “development”. During colonial occupation, it was not necessary for Germans to address and convince East Africans of the advantage of their policy interventions, but merely the public at home and those involved in the colonising efforts. Today, Tanzania is an independent nation and German Development aid must legitimise its involvement in Tanzania with reference to the Tanzanian good. Any Development intervention is now part of a negotiated agreement between the Tanzanian and German governments and their respective organisations responsible for Development issues. Yet, one interviewee mentioned that Germany also has interests of its own, albeit long-term ones, in improving the reproductive health situation and reducing population growth in Tanzania, because this would help to transform Tanzania into a “functioning” society with which Germany could engage in profitable economic exchange. This explanation for Germany’s involvement resonates with Kuumba’s argument that population policies in the global South serve countries of the global North through the “containment of a superfluous or redundant labour force, the maintenance of political stability, and the perpetuation of dependent social relations” (1999, 455).

While this was the only hint at Germany’s self-interest at the level of discourse, attention to the non-discursive phenomenon of contraceptive procurement highlights German stakes in population control in Tanzania. In the light of actual practices of procuring and disseminating “modern” contraceptives and German pharmaceutical companies’ market leadership, whether motivated by philanthropy or self-interest, anti-natalist policies and practices serve the German pharmaceutical industry’s interests. There is no evidence that German Development cooperation
intentionally plays into the hands of German pharmaceutical companies’ agendas, but policies and interests are markedly aligned.

Although legitimising strategies differ considerably between the two periods, discourses on the causes for, and solutions to, “population decline” and “population growth” show striking similarities. For example, colonial continuities are apparent in the way in which notions of “tradition” and “modernity” are invoked in order to understand population “development”. During colonial-era occupation, when Germany aimed to increase the population, low fertility rates were explained by East Africans’ allegedly backward “customs” and “traditions”. At the same time, the spread of “modernity” through colonial occupation was seen as inhibiting the desired population development. These explanations were based on, and reinforced, racialised cultural hierarchies. Today, in the name of curbing “population growth”, high fertility rates are also interpreted with reference to Tanzanian “backwardness” and “traditionality”. High fertility is seen as a sign that Tanzanian society is “not there yet” and in need of assistance in order to “modernise” fertility rates. There is an overall conviction in German Development aid that high fertility and population growth must be curbed, and that this is to be pursued by promoting “modern” contraception. Placing the interests and desires of the “beneficiaries” at the centre of intervention (“people-centeredness”) only appears acceptable to German actors as long as people acknowledge the need for “modern” contraceptives and reducing their number of children. Thus, Tanzanian women (and men) seem merely to be afforded the right to make the “correct” choice. Through assessment of fertility rates, Tanzania is construed as different and lacking “modernity”, and this argument is supported with reference to the state of gender relations. While an insufficient number of children was explained with reference to oppression of women during colonial rule, today, it is the excessive number of children that is called upon to ascertain the existence of such oppression. During both periods, East African gender relations have been racialised as “backward” and women’s low social status has been associated with a fertility rate which is deemed to be unfavourable. Furthermore, current explanations in German Development policy highlight the assumption of historical “progress” and social change taking
place in a teleological fashion (see Chapter 2): German Development cooperation assumes that Tanzanian gender relations and fertility rates will be transformed towards what is perceived as “modern” if assisted by Development aid. This chapter’s findings concord with postcolonial feminist scholars who have argued that Western actors tend to devalue “development” of societies in the global South with reference to the social position of women (Kerner 1999; Mohanty 1991; Oyèwùmí 2005). It demonstrates how racialised discourses of “modernity” which hold “backward” social conditions and gender relations in the global South responsible for allegedly problematic fertility rates persist in informing German policy and practice today. Policies and practices aimed to improve women’s position in relation to men by reducing Tanzanians’ number of children are reminiscent of mechanisms to establish a racialised colonial hierarchy which Spivak described as “white men saving brown women from brown men” (2003, 55).

In her comparison of German colonial-era and Development aid population and reproductive health policy, Deuser (2010) argued that colonial-racist and culturalist assumptions regarding men and women in the global South are reproduced today. While this is affirmed in this chapter, it seemed necessary to expand upon discourse analysis in order to understand power. By taking a dispositif-analytical approach I considered the interconnectedness of discourses with material practices in the field of SRHR as well as with the political economy of population control. During the colonial period, numerous healthy workers were needed for economic exploitation and this was ensured through various means: legal restrictions of “customs” deemed harmful to “population growth”, health care for mothers and children, Christianisation, and “education”. These interventions sought to forcibly increase population growth as well as “civilise” East Africans so that the population would increase. Germany is currently promoting and implementing measures to improve reproductive health and regulate population through less forceful means.

Development aid engages in promoting “modern” contraceptives, “empowering” women, and “education”. In line with existing work in critical Development Studies (Crush 1995c; Escobar 1994), my research shows that German intervention in population and reproductive health continues to reinforce the idea of the global
South as “underdeveloped” and in need of guidance from the global North. Whereas the link between contemporary interventions and German economic interests is not immediately evident, following up on the origin and procurement of “modern” contraceptives in Tanzania has evidenced the way in which German pharmaceutical companies are implicated in Tanzanian “family planning”. Here, the motivation of pharmaceutical companies to enter the Tanzanian private and public contraceptive market should also be understood as linked to the establishment of a future consumer market for “family planning” (cf. Kuumba 1999). There is no evidence of German aid being tied to procuring products from German pharmaceutical companies; yet their market leadership is sufficiently established so as to win open bids by donors, the Tanzanian government, and NGOs. Thus, while it may not be discursively invoked or intentional as during colonial occupation, German aid policy and practice on reproductive health and population in Tanzania feeds into German interests in the political economy of population control. This finding confirms the suspicion of some Development scholars that Development aid and intervention in population and reproductive health tend to serve the political and economic interests of the global North (Kapoor 2008; Kuumba 1999).

Regardless of the fact that German policies under colonial rule highlighted underpopulation while contemporary German Development policy voices notions of overpopulation, population size and fertility rates continue to be associated with a general “backwardness” of Tanzanians and oppressive gender relations. Thus, policy and practice in both periods has been structured by racialised, gendered discourses of “modernity”. The need for German intervention into the area of population and reproductive health, however, has been legitimised in a different manner in each period. Thus, regardless of the strategies which German actors employ to legitimise their interventions, discourses which racialise Tanzanians as “backward” persist. In both periods, such discourses as well as strategies to justify intervention are embedded in the political economy of population control, in which regulation of population furthers German economic interests. Persistence of colonial power in present-day German Development intervention on population and reproductive
health in Tanzania is thus evident in the interconnectedness among racialised, gendered discourses, strategies to justify intervention, and the political economy of population control.
6 Childbirth-related interventions: practices, professionalism, and partographs

These experts bring with them
the marks of their origin!
Prejudices, lack of confidence
in the peoples’ ability;
to think, to want, to know
They thus run the risk
of falling into harmful generosity
Whereby they believe,
They must be the executors
of the transformation
(Nchimbi 1977, 163; Tanzanian poet)

6.1 Introduction

The previous chapter examined similarities and divergences between colonial-era and contemporary German policies and practices with regard to population control and reproductive health. It demonstrated that contemporary intervention, similar to that of the colonial era, is pervaded by racialised, gendered discourses. German actors’ accounts during the colonial period professed that they were motivated by self-interest and, to a lesser degree, by philanthropic considerations. This has today been reversed, and philanthropic rationales are primarily mentioned. Furthermore, Chapter 5 concluded that population control agendas during both periods have been embedded in and served German economic interests. The chapter showed that German Development cooperation with regard to population control and reproductive health is significantly shaped by colonial power. In order to develop this argument, I now turn to another aspect of German intervention in population and reproductive health in East Africa – those interventions related to childbirth.

As mentioned in Chapter 4, German interest in the realm of childbirth was sparked by the colonial reformist agenda after the turn of the 20th century and was entrenched in concerns of a “population decline”, identified in the two previous chapters. Before German agents’ concern for African birthing arose, obstetric care in “German East Africa” primarily focused on wives of German settlers, missionaries,
and administrators. In the context of the growing significance of East Africans as a labour force, as well as due to philanthropic and proselytising considerations (see Chapter 5), German actors came to take an interest in East African childbirth-related practices and mothers’ health (cf. Colwell 2001). Today, “maternal health” and “pregnancy and delivery” are some of the focuses of BMZ’s endeavours in the field of “reproductive health and population dynamics” (BMZ 2011c). In May, 2011, the BMZ launched a specific “Initiative for Voluntary Family Planning and Maternal Health” to contribute to achieving Millennium Development Goal 5 (BMZ 2011d). Today, German Development aid thus continues to be concerned with birthing in Tanzania, but intervention is portrayed to be philanthropically motivated. In German Development circles, the maternal health situation in Tanzania is regarded as problematic, and the purpose of German Development cooperation is to improve pre-natal care and deliveries in hospitals (DSW 2008a; TGPSH 2009b). Given Germany’s concern with birthing in East Africa in the colonial past and today, this issue may provide a useful lens through which to investigate to what extent and in what ways colonial power shapes the present. Accordingly, this chapter examines similarities and divergences between colonial times and German Development cooperation in the 21st century by analysing how obstetric care has been understood in these two periods.

This chapter builds upon postcolonial theory regarding the operation of colonial power (see Chapter 2) to examine how and with what effect German professionals construct differences between themselves and East Africans on the grounds of childbirth-related practices. According to Mbembe, “in relation to Africa the notion of ‘absolute otherness’ has been taken farthest” and “the simplistic and narrow prejudice persists that African social formations belong to a specific category, that of simple societies or of traditional societies” (2001, 2-3). Africa is regularly associated with notions of “‘absence’, ‘lack’, and ‘non-being’” and resistance to change (Mbembe 2001, 3-4). According to Escobar, Development tends to “assume[] a teleology to the extent that it proposes that the ‘natives’ will sooner or later be reformed; at the same time, however, it reproduces endlessly the separation between reformers and those to be reformed by keeping alive the premise of the
Third World as different and inferior, as having a limited humanity in relation to the accomplished European” (1994, 54–5).

The examination of the colonial period is based on scientific and government publications as well as archival sources of the colonial administration, and the examination of present and ongoing Development relies on documents of German Development cooperation as well as interviews with German Development professionals. In keeping with the conceptualisation of power as dispositif, this chapter considers the interconnectedness of childbirth-related discourses with actual practices and institutions, while affording agency to German actors. In Section 6.2, I review the manner in which East African childbirth-related practices were generally perceived by German professionals during colonisation and today. Section 6.3 addresses planning and management in health care. The chapter then explores the manner in which German commentators in both periods have raised the issue of attitudes of East Africans towards health and obstetric care (Section 6.4). The chapter concludes with a reflection on the legacy of colonisation in current German Development policy and practice (Section 6.5). It argues that ever since colonial rule, East African obstetric care has been constructed as being in need of “catching up” with German childbirth-related practices, but as never having achieved that end. In fact, it would have been impossible to achieve this since Germans’ definitions of quality obstetric care have changed continuously, and German practitioners working in “German East Africa”/Tanzania have continuously constructed insurmountable differences between themselves and East Africans on all levels of health care. From a distance, one might argue that German intervention in childbirth-related practices has served to maintain difference and hierarchy. To clarify, this chapter explores differences created by German intervention, and not those existing in “German East Africa”/Tanzania due to other, local power dynamics. I am concerned with the manner in which German agents have legitimised

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22 This is independent of the question of whether and how Tanzanians have aspired to “catching up”, which goes beyond the realm of this thesis. I should stress that this study does not take into account the desires and intentions of East Africans/Tanzanians.
intervention via their assessments of health and obstetric care in “German East Africa”/Tanzania.

6.2 Assessing and transforming obstetric care

During colonial occupation, German physicians, missionaries, and administrators evaluated the state of midwifery in East Africa, and today German Development professionals in Tanzania continue to assess and judge obstetric care practices. This section explores how Germans working in “German East Africa”/Tanzania have comprehended childbirth-related practices during German colonisation as well as Development cooperation in the 21st century, and what interventions they have proposed and undertaken to modify situations which they deemed to be deficient. It addresses whether, and if so, how, differences between East African and German obstetric care and midwifery have been constructed in the past and to what extent this continues in the present.

6.2.1 During German colonial rule

German physicians, missionaries, and administrators assessed the childbirth-related practices they encountered in German East Africa. Some practices were deemed functional, others inappropriate, but most of all, they noted deficiencies in obstetric care. Commentaries such as the following by Otto Peiper, who was employed as a senior staff surgeon in Kilwa (see Chapter 5), may serve as evidence of such examinations and estimations of knowledge and skills in East African midwifery:

In cases of lateral or posterior positions, a correction is undertaken through hand pressure and massage; one also drinks a medicine in such cases. [...] In case of premature bleeding during the pregnancy, one also applies dawa – medicine – internally, bed rest is also prescribed; in serious cases [...], the mother dies unsalvageable due to exsanguinations, since they do not know internal interventions. [...] In case of strong contractions, she [the midwife, DB] massages the body with both hands, stroking from the chest towards the abdomen. In case of lateral positions, mother and child die unsalvageable; the
people do not consider it possible to bring help in such cases. (Peiper 1910, 461–2)

While this quote indicates that the German doctor acknowledged certain practices such as massages and prescribing bed rest as useful, it also maintains that the East African midwives were unable to deal with serious complications. German commentators regularly accentuated perceived deficiencies (Axenfeld 1913; Feldmann 1923; Ittameier 1923; Reichs-Kolonialamt 1913). Evaluations at times amounted to positing a complete “lack of pregnancy and maternity protection” (Peiper 1920b, 19). Supposedly harmful standards of “hygiene” were also underlined by German agents (e.g. Peiper 1910). While some commentators referred to “native midwives” and thus acknowledged the existence of women who specialised in midwifery (Axenfeld 1913, 12), others stated that East Africans did not know of midwives “in our sense” or referred to “women assigned to the midwifery task”, “elderly, experienced women” (Peiper 1910, 461), or “mothers-in-law” (Sister Nikola cit. in Walter 1992, 304), thereby doubting their knowledge and skills.

However, German colonisers did not always speak with one voice. While German physicians, missionaries, and other commentators commonly dismissed African midwifery as deficient or non-existent, some took a slightly different position. For example, Mission Superintendent for the Berlin Missionary Society Karl Axenfeld (1913) considered midwifery the area of health care which was the most developed among East Africans, and the Medical Reports of the German Administration explained the limited use of German hospitals for childbirth (see below, 6.4.1) as in part due to the fact “that the native midwife is quite skilled, knowing the manipulations necessary for all eventualities, so that the European physician is only a last resort” (Reichs-Kolonialamt 1915, 233). Hermann Feldmann, editor of the journal Medical Mission and staff surgeon in Dar es Salaam, even mentioned that in some “tribes [...] quite a number of really useful midwives exist, who stand out in skillfulness and a certain empirically acquired expertise, so that they were even asked to carry out deliveries of European women in some especially favourable cases” (1923, 129). Here, Feldmann refers to so-called “native midwives”, as opposed to East Africans trained as nurses in mission hospitals. All in all, however,
the claim that “the native midwife is quite skilled” was marginal in the broader debate. The emphasis in those quotes which were more favourable towards East African obstetric care suggests that acknowledgement of knowledge and skills did not counteract the conviction of East African inferiority to what commentators took as their benchmark, i.e. the standards of German midwifery.

In order to improve the situation of pregnant and delivering women and to transform obstetric care, the German colonial administration, physicians, missionaries, and colonial “reformist” lobby groups made numerous suggestions. These included increasing the number of German medical doctors and midwives, training East Africans in nursing and midwifery, building health facilities, and propagating Christianity in order to root out the influence of what they called “pagan mothers-in-law” (Feldmann 1923, 142). The call for an increase in “European trained sanitary personnel” entailed dispatching German physicians and nursing staff “in their thousands” and “training [...] nurses for the service of the native population, particularly in the area of midwifery and infant care” on the one hand, and qualifying East Africans as nurses and midwives while discouraging their existing practices on the other hand (Feldmann 1923, 128–9). Some commentators also considered recruitment and training of those East African women who “stand out due to their ability and certain empirically acquired knowledge” (Feldmann 1923, 129). The German Society for the Protection of the Natives and the German Women’s Association for Nursing in the Colonies (see Chapter 4) were convinced that lack of “delivery institutions for natives” was responsible for a poor obstetric situation and pressed for the inauguration of “institutions for the education of native midwives, nurses, and nurse aides as well as the founding of delivery homes for natives” (Deutsche Gesellschaft für Eingebornenschutz 1914a, 132; Deutscher Frauenverein für Krankenpflege in den Kolonien 1909).

Calls for transforming obstetrics and health care in “German East Africa” were matched with practical interventions: More government physicians and medical officers were in fact hired, mission societies sent midwives, and the training of “adequate native women as midwives” started just prior to the demise of German
colonial occupation (Feldmann 1923; Reichs-Kolonialamt 1914). Interventions also included behavioural advice for pregnant women via dissemination of leaflets, as mentioned in the previous chapter. The Medical Administration, for example, printed a leaflet with advice on how to raise children and what to do in cases of complications during pregnancy:

To avoid miscarriages, the mother should already be careful during her pregnancy, should not carry heavy loads and should not hoe on the field extensively. If blood shows, she should lie down in bed until the blood is gone. If the child and mother are ill, they should immediately consult a European doctor for his advice, who will gladly tell them what to do. (Cit. in Peiper 1912, 259)

Ten thousand such leaflets were printed and distributed throughout “German East Africa” at the beginning of 1911 by the respective district administrations (Eckart 1997).

As an example of concrete interventions into birthing, the issue of delivery positions is noteworthy. German physicians introduced a specific type of birthing on a stretcher in the supine position which was the widely accepted practice in Germany at the time (Dziedzic and Renköwitz 1999). According to German reports, East African women often preferred other positions (Axenfeld 1913; Peiper 1910). While my research did not yield evidence of physicians introducing the supine birth position in German East Africa, interviews with German Development professionals currently working in Tanzania (Interview 31, June 08, 2010) and the documentary film “Der lange Weg ans Licht” (“The long way to light”) on midwifery in Germany and Tanzania (Wolfsperger 2006) indicate that German colonisers must have advocated the supine birthing position in German East Africa. A colonial-era report from a German medical doctor in Togo also mentions that “the seating of the woman in labour in a supine position on a clean [...] sheet was made obligatory” in order to lessen the risks for mother and child during delivery (Rodenwaldt 1912, 275). In some areas of Tanzania, to give birth in this position is still today referred to as kuzaa kizungu, which can be translated as “giving birth in the white people’s manner”. A German medical doctor also mentioned that she was told “this was how
you taught it to us back in the days” (Interview 31, June 08, 2010), when she asked why her Tanzanian colleagues resorted to the supine birth position. Such interventions into childbirth-related matters may be understood as a part of what German colonial historian Grosse has described as a “comprehensive medicalisation of the female part of the population” (2000, 142; transl. DB).

The above evaluations and interventions provide evidence that East African midwifery and its practitioners were set in contrast to German midwifery and biomedically Western trained physicians and midwives (whether East African or European). This is underlined by statements such as that by physician Hermann Feldmann, who claimed there was only “one physician for 14,000 natives” (1923, 128), thus denying East African healers the status of a physician. Only women who were educated according to German standards were considered proper midwives. This points to the colonisers’ preoccupation with a specific understanding of professionalisation of medical services in general and midwifery in particular. At the time of German conquest and occupation of East Africa, obstetric care in Germany had already been medicalised to a large degree. In the late 18th century, male physicians had wrested authority over birthing from the hands of so-called wise women in Germany (Beck 1986; Duden et al. 2002; Seidler 1993). Yet, as pointed out above, partial acknowledgement of East African practitioners’ knowledge and skills might be explainable by the fact that obstetrics in Germany had not yet fully entered the sphere of the hospital and the all-male medical profession; home births with the help of female practitioners were still the norm in Germany at the time (Major 2003). Moreover, there was no significant medical advantage of a physician assisting deliveries. As historian Colwell highlights,

> [g]overnment physicians would have been more skilled than the midwives at Caesarean sections, but in the pre-antibiotics era in the tropics, mothers who delivered in this manner were likely to die from sepsis, and their infants, even if born alive, would have to be bottle-fed or wet-nursed and thus were also likely to die. (2001, 101)

A sense of superiority must have been harder to uphold for German practitioners in German East Africa who might have realised that their abilities and skills did not
differ immensely from those of East African practitioners. It is worth noting that commentators at times pointed to the technical expertise that East African women had gained due to their hands-on experience, but that they never mentioned any other knowledge, skills, or functions of East African midwives which were less reconcilable with German biomedicine, such as use of herbs, charms, spiritual powers, and communication with “nonhumans” (cf. Langwick 2011).

In summary, German colonisers largely invalidated East African obstetric personnel and their knowledge and skills, and attempted to replace them with European biomedical practices and encourage East African women to give birth in German health facilities. East African practitioners’ skills were measured against German standards of obstetric care, which at times led to positive appraisal of some East African women’s skills. German commentators only valued empirically observable skills and their own norms (see Chapter 2). This led them to depreciate levels of technical skills and ignore other possible functions performed by these practitioners.

Having explored German perceptions of, and interventions into, obstetric care during the colonial period, I will now examine the manner in which contemporary German Development cooperation comprehends, and intervenes into, childbirth-related care.

6.2.2 During German Development cooperation in the 21st century

German Development aid today finds obstetric care in “developing countries” to be lacking and commonly relates this to restricted “access to skilled birth attendants and to good obstetric care” (BMZ 2008, 9; DSW 2008a). Consequentially, the new German initiative mentioned in the introduction to this chapter aims at increasing the number of “medically professionally accompanied deliveries” (BMZ 2011d; transl. DB). Ongoing German Development cooperation links high maternal mortality and poor maternal health in Tanzania to a high prevalence of home births (see Chapter 4), especially among poor women; according to a staff member of the
German Development Bank, five out of six poor women deliver at home, and even of wealthier women, only 60% make use of biomedical health facilities for delivery (Interview 14, desk officer at the headquarters of KfW, March 18, 2010). German Development professionals regard giving birth to be dangerous because “traditional birth attendants” (TBAs) who often assist home births are perceived as unskilled and relying on “experiential” or “traditional” (Interviews 02, 08, 10, and 28) rather than on “Western-based, evidence-based medicine” (Interview 08, DED physician dispatched to a Tanzanian district hospital, February 14, 2010). As mentioned in Chapter 4, in line with Tanzanian government policy, German Development aid strategy in Tanzania today does not include any cooperation with TBAs. German Development professionals also commonly voiced their opposition to such cooperation. They generally construed a dichotomy between home births by unskilled TBAs on the one hand and deliveries in biomedical facilities by skilled birth attendants on the other. The former is associated with high risks and discouraged; the latter is propagated as desirable and associated with lower risks for mothers and infants.

The stated aim of German Development aid (as well as that of other donors and the Tanzanian government) is hence to have all deliveries performed in biomedical health facilities in order to rule out risks for mothers and children. At the same time, German Development cooperation points out insufficient quality of obstetric care in these Tanzanian biomedical health facilities. Their deficiencies are highlighted as one of the reasons why Tanzanian women do not seek to deliver in official health facilities (Interview 14, desk officer at the headquarters of KfW, March 18, 2010). In the following quote, a German doctor working in a missionary hospital mentions problematic medical and hygienic conditions in one of Tanzania’s nine “referral hospitals”, serving 11 million people and employing 1,000 staff:

Well, delivery ward here, that is .. if you are lucky, there are only three beds in one room, merely separated by curtains. [...] And, but also from the medical standpoint, it is just .. well, I don’t know, well, from the, from the cleanliness, from the medical, it is .. no, no. (Interview 31, June 08, 2010)

Aside from mentioning lack of privacy (see below, 6.4.2), this doctor considered the
medical and hygiene standards to be disastrous. In the interviews, Tanzanian hospital staff were characterised as badly educated and lacking know-how and capacity (e.g. Interviews 18, 35, 43, and 53).

In the following statement, a German doctor working via CIM in a large Tanzanian hospital explains how she perceives nurses’ deficiencies in obstetric care:

[...] there are some, that’s a catastrophe, a real catastrophe. They don’t do anything. But I think that it’s not wickedness, but rather that the people just don’t get what it’s about. That might have to do with their training. You can pose any question from the schoolbook. And you get a whole page rattled out by heart. But in a concrete situation ... no consequence whatsoever, no inklings what kind of situation one faces and what is to be done. (Interview 35, June 22, 2010)

It is evident that this Development professional regards the nurses as being unaware of the fundamentals of biomedical obstetric care. According to several German physicians and nurses I interviewed, Tanzanian hospital nurses were unable to implement their acquired knowledge in practice, and merely capable of mechanically reproducing what they had learned by heart (this aspect will be further explored in 6.3). This perception is particularly evident in the way German professionals talk about the use or non-use of the partograph, a tool for monitoring progress of delivery (see Figure 4). If filled out correctly, the partograph allows nurses or doctors to determine at what stage a medical intervention such as a Caesarean section is called for. This procedure is widely regarded as a sine-qua-non in biomedical obstetric care. Many of the German health workers with whom I spoke reported that Tanzanian nurses commonly did not fill it in at all or did so incorrectly, or that nurses did not take the appropriate actions on the basis of a filled-in partograph (Interviews 08, 29, 37, and 39). A DED professional specialised in obstetrics and gynaecology who worked in a Tanzanian district hospital reports German Development cooperation’s experiences in propagating use of the partograph:

And this lady [his German Development aid colleague, DB] was training this partograph for five years now, and still, every time she went to the hospitals, the same people did not understand the partograph. And she explained again
and she said: because I think this is the best way to deal, and in a very simple way, of how to deal with delivery and how to detect problems. But it did not get.. nobody uses it. (Interview 08, February 14, 2010).

Thus, the inability of Tanzanian hospital staff to use the partograph properly despite repeated training is met with disbelief by this Development professional.  

ANNEX 2: Partograph

<table>
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<tr>
<th>Name</th>
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Figure 4: World Health Organization’s model of the partograph (Inter-Agency 1999)

23 This interview will be cited in detail in Chapter 7 as an example of how Development professionals deal with doubts regarding the value of their work.
As during colonial rule (see above), the issue of birth positions remains a German concern. Several German physicians and nurses complained of the almost exclusive use of the supine birth position in Tanzanian health facilities. They considered it the worst birthing position, “right after a handstand” (Interview 29, German nurse working in a training centre for midwifery, June 08, 2010), and said it was a way of exerting authority over the women giving birth. Consequently, the German physicians working in obstetrics in Tanzania said that they tried to introduce other birthing positions (see Figure 5 for film stills from the above-mentioned documentary “The long way to light” (Wolfsperger 2006) which portrays a “white” German nurse working in Tanzania). Notwithstanding the general perception of deficient skills and knowledge of Tanzanian health care staff, some German professionals acknowledged that they considered some nurses and doctors to be highly skilled. For example, one interviewee said she had “fantastic colleagues, really, who think, act and plan exactly as I am used to ... from back home” (Interview 29, German nurse working in a Tanzanian hospital, June 08, 2010). This remark evidences that standards associated with German hospitals are conceived to be the desirable norm but are fulfilled only by a few. According to my research, one can ask whether German professionals can only imagine Tanzanian health professionals catching up with them if they work just like them, or whether there might not be a possibility for them to work differently without this being perceived as inferior.

In summary, whereas giving birth at home with the assistance of TBAs is seen as dangerous and contrasted with biomedical health facilities and biomedically trained practitioners as the proper way to deliver, this only holds true to a certain extent. Tanzanian hospitals are in fact also perceived as inappropriate and dangerous places, inhabited by unskilled personnel in need of reform. Among the German Development professionals I interviewed, the conviction that Tanzanian obstetric care needs to be reformed is ubiquitous, yet they doubt the success of intervention, because they perceive Tanzanian health professionals to be incapable of understanding the essence of biomedical health care. As the analysis thus far indicates, the assessments of my German interviewees are based on the distinction between fully developed biomedicine as practiced in Germany on the one hand, and
its deficient, superficial adaptation (as in the example of the partograph) or maintenance of outdated biomedical practices (as in the perpetuation of birth positions introduced in colonial times) on the other.

Figure 5: Stills from documentary film “The long way to light” (Wolfsperger 2006)
6.2.3 Summary

These findings resonate with Langwick’s (2011) argument that German colonial-era discourses on East African health and medicine are evidence of the split between “modern” supposedly superior Western biomedical health care and “traditional” inferior East African health practices. During formal colonial rule, German practitioners promoted medicalisation of birthing by introducing Western-style hospitals, training staff, and changing practices such as birth positions. Today, TBAs performing home births are generally seen as dangerous and Tanzanian hospitals advocated as the appropriate place for deliveries. German Development cooperation primarily engages in reforms within the arena of biomedical birthing. Development professionals criticise and attempt to reform the manner in which biomedical obstetric care is carried out in Tanzanian hospitals. My analysis indicates that German practitioners no longer establish difference by opposing “modern” biomedicine to “traditional” practices as during colonial rule. Instead, they express the dichotomisation with reference to the realm of biomedical health care by differentiating fully-fledged biomedical obstetric care from incomplete, outdated, inferior adaptations of this. In contemporary German Development cooperation, biomedically trained Tanzanian health personnel are depicted in a similar manner as were “native midwives” during colonisation: lacking skills and knowledge. Thus, regardless of the hegemony of biomedical health care in Tanzania today, the “dichotomizing system” (Mudimbe 1988, 4) introduced by Germans during colonisation between correct German obstetric care and deficient Tanzanian practices is rearticulated.

The following two sections concentrate on two particular aspects through which German agents have understood and intervened into childbirth-related practices in East Africa during colonial rule and today.

6.3 Planning and thinking ahead

The interviews with German professionals provide evidence that, for these actors, planning and management as well as appropriate attitudes of Tanzanian health
practitioners are crucial for quality obstetric care. While the issue of attitudes will be addressed in the following section (6.4.), this section explores the theme of planning which encompasses German professionals’ deliberations on appropriate management and the capacity of East Africans to think ahead. I first examine how the aspect of planning in health care and obstetrics was understood during German colonial rule, and then turn to ongoing German Development intervention.

### 6.3.1 During German colonial rule

In publications and reports from the colonial era, there is little mention of planning by East Africans in obstetrics or, more generally, health care. Yet, German commentators sometimes explicitly stated that they did not view Africans as able to plan ahead and organise their lives. For example, staff surgeon Hermann Feldmann mentioned what he considered East Africans’ “hand-to-mouth life” and “lack of foresighted planning”, which would make it difficult for them to endure the fight for survival (1923, 139). This as well as the general silence regarding East Africans’ capacity to plan ahead and organise their lives is revealing as it is grounded in the century-old racist assumption that Africans are people without history and incapable of building a future, and that Africa’s capacity for “progress” and “development” is minimal, as mentioned in Chapter 2 (cf. Farr 2005; Kebede 2004; Mudimbe 1988; Taiwo 1998). East Africans were considered to be passive and unambitious. This construct suited the German colonising endeavour to assume trusteeship over East Africans; to “educate” them to become good Christians, good workers, and proper housewives; and to guide them in health matters (cf. Akakpo-Numado 2007; Conrad 2004; Markmiller 1995; Schäfer 2007).

Since East Africans were not seen as capable of planning, thinking about the future, or progress, the German colonisers made it their task to look after them. Consequently, the role attributed to colonial health professionals was to “standardise the living and working conditions of the native workers’ masses” (Eckart 1997, 60). As mentioned in Chapter 4, the maxim among colonial
“reformists” after the turn of the century was to employ “theoretical and applied science” for the task of colonisation (Dernburg 1907, 9). Planning and management were fundamental to Germany’s colonial endeavours. German doctors, nurses, missionaries, and administrators meticulously established statistics (see Figure 6 for an example), planned intervention, discussed infrastructure and financing, and reported on cases of sickness and operations in a lengthy, detailed manner in scientific and government publications (see Chapter 3). For example, the Medical Department of the Imperial Government of German East Africa (1914) implemented a thorough survey of the number of offspring per women, causes of death, and so on. Examples of the most comprehensive examinations, documentation, and planning undertaken by the German colonial rulers are the Medical Reports on the German Protectorates. These were annually published from 1903/04 until the end of German occupation by the Colonial Department of the Foreign Office and its successor, the Imperial Colonial Office, with input from the respective administrations in the colonies and included statistics, reports, challenges, and plans for the future.

The colonial administration also undertook censuses of the population in German East Africa. The final census, published in 1913, was the most comprehensive and “still resurfaces in Tanzanian demography as anchor for current population projections” (Colwell 2001, 121). Moreover, a flurry of local demographic and health

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<td>Stadtrat Dr. Weintzinger (Mohega)</td>
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<td>Stadtrat Dr. P. Dach (Gundam)</td>
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<td>Stadtrat Dr. Bruckhaus (Gundam)</td>
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Figure 6: Statistics of offspring of East African women (Reichs-Kolonialamt 1915, 182–3)
surveys was undertaken after 1909 (Colwell 2001). The most comprehensive health survey was solicited in 1912 and 1913 by Hugo Meixner (1914), *Chief Medical Officer* (the highest medical official) for “German East Africa”, in order to identify the reasons for infant mortality. Meixner requested that all district medical officials submit statistics; the results, based on interviews with 46,503 women, were published in 1914 (cf. Colwell 2001). In order to survey public health issues and make recommendations to the administration, the Governor of German East Africa also decreed the establishment of health commissions for each station in which a German physician was deployed (Gouverneur von Deutsch-Ostafrika 1913b). As highlighted in the previous chapter, medical population planning was deemed essential for the growth of the African population (cf. Schäfer unpublished). Ludwig Külz, government physician for Togo and Cameroon and an influential commentator on colonial health and population issues, demanded exhaustive gathering of vital data as well as periodic censuses of African populations so that the German colonial administration could properly plan intervention into economic, cultural, and medical issues (cit. in Schäfer 2007). Physicians developed quantitative demographic methods to monitor disease prevention and population growth (Schäfer 2007).

In summary, given that German administrators and health practitioners in “German East Africa” did not consider East Africans as being able to plan, they regarded it as their task to manage health services, including obstetric care. They dealt with all aspects considered relevant, such as statistical analyses, training of personnel, and infrastructure. As may have become evident by this point, German colonial stakeholders regarded health care as fundamentally related to standardisation and planning. These issues were also touched on in the interviews with German professionals currently involved in improving Tanzanian health care. How these themes are discussed and understood in current German health care intervention in Tanzania, particularly in obstetric care, will be explored in the following section.
6.3.2 During German Development cooperation in the 21st century

In my interviews with contemporary German Development professionals, poor obstetric care in Tanzania was explained with reference to Tanzanian health professionals’ deficient management skills, sense of planning, and forethought. The perception of a deficit in planning is voiced with regard to government departments, individual health facilities, physicians and nurses, and also expectant mothers and their families.

On the national level, German professionals lament a lack of organisation and systematic planning. According to them, the Tanzanian government lacks capacity and is unable to manage the health system (e.g. Interviews 04, 08, and 32). For example, a former manager of the TGPSH “district health and quality management” area points to the problems he sees in Tanzania by raising the issue of drug procurement:

> It cannot be magic to say we need this and that drug; these 50 drugs should be available in every health centre at all time. That’s not possible, you know. [...] It doesn’t work. And it hasn’t been possible for 20 years, for 30 years. (Interview 04, January 14, 2010)

In other interviews, chaos and lack of coordination were brought up. German professionals regarded administration and management by the Tanzanian government to be chaotic, complicated, bureaucratic, and slow (e.g. Interviews 18, 19, and 20). For example, a German Development professional advising the Tanzanian government on health financing on behalf of KfW stated that she needed “great persistence” to constantly push her Tanzanian counterparts so that they would work properly (Interview 18, May 20, 2010). When she received a Tanzanian government department report that she considered to be of high quality, she assumed that it must have been compiled by Western consultants (Interview 18, May 20, 2010). It seemed to her to be out of the question that Tanzanian government bodies could deliver what she considered high-quality work.

Correspondingly, German Development professionals invoke the conviction that Tanzanian hospital managers or administrators are not competent in management, administration, or planning (e.g. Interviews 37, 38, and 43). This estimation is
extended to most areas of hospital management, such as budgeting, organisation, drug procurement, storage, equipment maintenance, and so on. Several of the interviewees working in Tanzanian health facilities mentioned that there was no proper monitoring of work shifts or planning of operations, and that they had initiated changes in this direction (e.g. Interviews 08, 37, 38, and 43). The following statement by the aforementioned DED physician who worked in a Tanzanian district hospital addresses the deficits perceived by German Development aid in Tanzanian health care:

   But it is not only how to deal with the medical problems, it’s also how to deal with administration. How do you write everything in a file, how do we store these files. I mean it was a big mess in the hospital. How do you .. If a patient was coming to the hospital, was discharged one week ago, all the files were missing because there was no proper storage. So we had to sit together and think of how to deal with that. Make a duty roster, who works this night, who works the other night, who works in the weekend. Before I came it was quite often the case that there was nobody in the hospital [...]. (Interview 08, February 14, 2010)

This quote shows that the German Development professional perceives himself to be instilling order amidst chaos. Correspondingly, a former senior manager of the German health programme for Tanzania mentioned that German Development aid was about creating a “planning culture” which entailed teaching how to systematically plan and implement projects (Interview 10, April 21, 2010). Some interviewees considered expertise in “methods” and “instruments” for planning to be a specific strength of German aid as compared to other donors (Interview 03, consultant for BMZ and GTZ and researcher on reproductive health in Tanzania, January 14).

German physicians involved in clinical work or “capacity building” in hospitals generally complained of a dearth of documentation, systematic thinking, and planning. A physician working in a district hospital for DED summarised German Development cooperation’s difficulty to change this situation with the phrase that
“it’s easy to change the hardware, but hard to change the software” (Interview 43, July 09, 2010). According to him, it was much more difficult to improve Tanzanian staff’s knowledge and skills than to, for example, make amendments to hospital infrastructure. The following excerpt from a conversation with a German nurse working in a hospital as well as a training centre for midwifery in Tanzania (see above, Section 6.2.2) is a telling example of how these German professionals try to make sense of the problems they see in obstetric care. The frequent use of “they” in the quote is indicative of the binary form of othering – “them” and “us”:

Well, I slowly try to figure out what actually is the problem. I believe that the problem is partly that documentation is tedious, you know. Well, ... because ... time-consuming ehm ... I, I discover that, if they actually write something down at times, they wrote down novels. [...] There is somehow no sense of priorities whatsoever. Then they forget half, which also has to do with the utterly unsystematic story that the nurses write down. That means, I may be able to teach it to them and we have gone through the partograph five times, and now during the exam, I see [...]: they still don’t know it. And I think that it has to do with the fact that they just don’t .. after I have gone through it with them .. that they don’t see it in practice, that the nurses don’t fill it in themselves. That’s a problem of time, that .. we have nine beds in the maternity ward, they are actually always and continuously overcrowded, yes, well, it means you do a birth, then you go to the next, and the next, and then you should actually be writing in between. And I always say the way we learned it, you have to write it down promptly. [...] But that also means that I have to look at the watch. This way of systematic association, that’s missing somehow. Ehm, and then, I think, they also don’t consider it important. I believe they don’t see a connection between documentation .. and the actual outcome. (Interview 29, June 08, 2010)

In this interview extract, the German health worker perceives the ability of young nurses to use the partograph as deficient. An absence of nurses who could serve as role models as well as overcrowding in hospitals and workload are mentioned as factors for deficient documentation. This reference to lack of staff corresponds to official statistics regarding Tanzania’s health staff situation, mentioned in Chapter 4.

24 This interview was held in English, because the Development was a non-German European (see footnote 19).
According to the *World Health Organization*, Tanzania has “less than half the workforce [...] require[d] to meet essential health needs adequately” (2006, 19). However, other German professionals argued that lack of staff was not really the problem in the institutions of their respective deployments, but rather that Tanzanian staff were not managed well and did not work efficiently (e.g. Interviews 35, 37, 38, and 43). For example, a German CIM doctor working in a regional hospital in Tanzania said that the area of the hospital for which he was responsible worked well because he properly planned and supervised (Interview 53, July 31, 2010). In the last quote from Interviewee 29, the German Development professional showed some understanding of the deficiencies in organisation when she referred to the time-consuming workload and documentation. However, aside from these structural factors, she mentions that nurses write long narratives (“novels”, “stories”) instead of concise information concerning relevant data of the patients. She notes an inability of her student nurses to think systematically. They are portrayed as unable to connect abstract theory to actual practice. As previously mentioned, the partograph is regarded as a useful technology, but this German professional perceives a lack of ability to think systematically and logically and to transfer technical knowledge to a concrete situation in which action is required.

While aware of the “political incorrectness” of her statement, her overall diagnosis is that Tanzanians (or even more broadly, Africans) somehow naturally do not have the capacity to think and plan ahead, or to anticipate and consider options:

> Well, [...] .. that sounds really racist now perhaps what I’m saying ((laughing)), sorry, but, I believe, it has to do with a lacking, well, to do with time, and a .... not .. prospective .. ehm, prospective thinking, you know, well, the way we and I mean, I believe, this debate has always existed, how, well, Africans, sense of time, there are also ethnological studies regarding this somehow, that you, that they don’t plan, yes. Planning means you are here now and this is your outcome, that’s what you want .. whether it is about, what do I know, that you want to achieve something personally, or as in this case, you want to achieve that the child is doing well and the mother is doing well, and that you .. contemplate beforehand how you can actually get there. And, I believe, we are like that, that we do not only think of one way, but possibly also the other way and the other way and the other way, and that is sort of like making several
plans beforehand. And that is basically what diagnosis signifies; to make a
diagnosis means: Where are we now? And then you make a prognosis, i.e.
something that comes later in time, now what significance does this have? And
then there is the differential diagnosis. And ehm, I have the feeling here that
they are always surprised .. you understand, of course all children get born
somehow, yes. But .. they .. do not think .. ahead. (Interview 29, June 08, 2010)

First of all, it must be noted that such statements were probably voiced so openly
due to my positionality as a “white” European (see Chapter 3). We spoke at length
several times, and finally carried out a recorded interview sitting in a bar in a posh
hotel. She considered me part of the “we” as opposed to the “they”. The German
nurse tried to understand her nursing students’ behaviour through anthropological
categories. In the quote, it becomes evident that Tanzanians were perceived as
living in the present only (“they are always surprised”) and lacking foresighted
thinking. This allegedly makes them fundamentally incompatible with the
biomedical health model which requires abstract thinking and anticipation of
different possible outcomes. Other interviewees also assumed that Tanzanians
somehow naturally did things differently and had a different sense of planning (e.g.
Interview 30, German missionary and nurse who runs her own NGO in Tanzania,
June 08, 2010) and that “Tanzanians cannot think logically” (Interview 32, German
physician and missionary who headed a mission hospital in Tanzania, June 20, 2010).
Here, Tanzanians are homogenised as a group incapable of systematic thinking.

Interestingly, such reasoning was also expressed in relation to health-seeking
behaviour of expectant mothers and their family members. One interviewee who
worked as a consultant for BMZ and GTZ and as researcher on reproductive health
in Tanzania claimed that Tanzanians, especially in rural areas, had a “different
perception of risk” (Interview 03, January 14, 2010). According to her, “our”
understanding of risk, especially in the epidemiological sense, had to do with
“probability calculation” and thinking of options, an “if-then” thinking. She did not
find this in Tanzanians and related the perceived deficit to a “low educational
background” and “traditional beliefs”. Deficits in or nonexistence of planning
capacities are thus either explained by socioeconomic circumstances such as
educational infrastructure or poor pay, or related to the character of Tanzanians and Tanzanian/African “culture”. The second form of explanation is racist in that it binds specific (inferior) traits to people grouped together. However, even in the case of explaining problems in Tanzanian obstetric care by pointing to structural issues, German professionals generally proposed universal solutions and stuck to the aim of changing the “planning culture” so that Tanzanian hospitals and Tanzanian obstetric care would one day resemble those of the global North.

6.3.3 Summary

This analysis has revealed that during German colonial rule East Africans were not seen as able to organise matters of health and obstetric care, and German colonisers hence considered this to be their task and duty. They perceived themselves as responsible for the future of the colonised territories and people. Thus, in the realm of health care and obstetrics, German professionals did what they thought was essential to improve the organisation and quality of health care: they devised and implemented surveys, held trainings, and undertook infrastructural developments. Here, Western scientific, technical rationality and ways of organising health care were projected onto “German East Africa” (cf. Hauck 2003; Mignolo 2000). Today, Tanzania is formally an independent country and German Development cooperation sees its role as helping to instil management and planning capacities in Tanzanian health and obstetric care. Those German Development professionals interviewed tend to portray Tanzanians working in health as failing to plan, manage, and think logically. This is discernible with reference to different dimensions of the health system in which German Development aid intervenes: the national level, hospital management, and health care staff. The same deficiency in thinking ahead and systematically planning the future is at times also attributed to Tanzanians as patients. Consequently, German Development professionals try to implant a “planning culture” in Tanzanian health care. Deficiencies in planning and organisation are explained with reference to structural factors such as lack of staff and overcrowded hospitals. Yet, more strikingly, what is perceived as deficient obstetric care in Tanzania is rationalised by
German practitioners with reference to an intrinsic inability of Tanzanians to plan and think logically. The latter is racist as it binds intellectual traits to a group that is differentiated on the basis of origin (see Chapter 2). The colonial-era racist assumption of an intrinsic inability of East Africans to organise their health and take care of their future continues to be invoked by the German professionals interviewed in this research.

6.4 Mind-sets and attitudes

In addition to planning capacities, the German health care professionals I interviewed often raised the subject of attitudes of Tanzanian health professionals. Their premise was that a positive motivation, work ethic or, more generally, attitude was crucial for quality health care. In this section, I explore colonial-era discussions with regard to East Africans’ mind-sets and attitudes, and examine interviews with German professionals working on obstetric care in Tanzania today.

6.4.1 During German colonial rule

During colonisation, three issues were mentioned by German commentators when pointing to a seemingly problematic attitude of East Africans in health matters: “timidity”, “superstition”, and “carelessness”. These three aspects were continually mentioned by administrators, physicians, and missionaries to explain the supposedly poor health situation of mothers and their children in “German East Africa”.

First, there was a perception among German colonisers that East African women’s “suspicion and timidity” (Ittameier 1923, 56) caused them to fail to consult German physicians and midwives; they would only do so in the “most dire” circumstances (Ittameier 1923, 50). German hospital statistics from the colonial era confirm the reluctance of East African women to attend German health facilities. In the Medical Reports on the German Protectorates of 1903/04, 1909/10, and 1911/12, only 0.12% to 0.19% of the diagnoses issued by government physicians for African
patients were for “female disorder and obstetrics” (cit. in Colwell 2001, 89). Influence of elderly women and the persistence of “customs” of giving birth at home served as explanations for non-attendance. Thus, the Imperial Governor of German East Africa believed that more “homes for women in child bed” were not necessary because the principal reason for not delivering in hospitals was allegedly that African women did not want to leave their homes and families at the moment of birth (Gouverneur von Deutsch-Ostafrika 1909).

Historian Colwell (2001) understands the argument that East African women were too timid and too culture-bound to consult German health facilities as a strategy – “the trope of the timid tribeswoman” – to blame African women and their “culture” for their lack of attendance of European health facilities, rather than the dearth or lack of facilities to accommodate women. This allegedly allowed the German administration to legitimise its reluctance to invest in curative health services for East Africans, especially for women. According to Colwell (2001), East African women kept their distance from the colonisers’ health care because German government facilities did not cater to women in their infrastructure (lack of wards and beds) and because of stories of women who had gone to deliver in the facilities and had died or lost their babies. This argument implies that women (or their families) would actually have wanted to attend the hospitals, had they been more efficient and accommodating. Colwell’s reasoning is grounded in her assumption that East African women actually consulted mission health facilities to a larger extent than those of the colonial government because they were more accommodating to East African women. However, I find no indication in Colwell’s dissertation or elsewhere supporting the hypothesis that large numbers of women attended mission hospitals specifically for birthing. On the contrary, historian Walter’s (1992) analysis of the mission archive of the Benedictine Sisters of South-East Tanzania and historian Bruchhausen’s (2006) study of health and medicine in Tanzania point to the fact that mission facilities had significant problems attracting East African women for pregnancy-related issues and delivery. For example, a German mission annalist from Kwiro wrote in 1911 that “[o]ur young women would have none of the help of the midwifery sisters. They rather stick to the desturi
German commentators furthermore explained poor obstetric health conditions of East African women by pointing to their alleged superstition and indifference. The following quote by staff surgeon Hermann Feldmann is an example of such a position. He argued that in order to attain better quality health care, a transformation of people’s “psyche” was necessary. He saw schooling and mission work as the path to achieving this:

With the increase of purely intellectual education, as conveyed by the school, one can, of course, already achieve a considerable part of this [cultural, DB] elevation; superstitious beliefs can be pushed back through such an instruction, their effectiveness can be eliminated, and a certain degree of positive knowledge in child care and care of the sick can be conveyed through schools. [...] However, considerably more valuable are the impacts of mission work, if it leads to a heightened sense of responsibility towards children and for hygienic aspects in general. [...] Since the basis of the pagan treatment of the ill – animism, dread of ghosts and raw selfishness – relies on fear, a sensible care of the ill and of children can only be achieved by the destruction of that basis and new directions for the psyche of the natives. This task is first of all one for the mission. It is basically a bitter struggle between the darkness of the pagan being and the light of Christian insight and charity whose instrument is the mission. The institutions behind the mission work are capable of restricting and
eliminating the fatal influence of pagan mothers, grandmothers, mothers-in-law as well as sorcerers. (Feldmann 1923, 140–2)

It is evident from this quote that superstition as well as selfishness were seen as defining characteristics of East African health care. German professionals held people's belief in “spirits and magic” accountable for inadequate and irrational responses to diseases and health (Ittameier 1923, 54). The quote above evidences that it was women in particular who were seen as disseminating and perpetuating superstitious beliefs. This brings to mind the way “wise women” and their knowledge and influence were deemed dangerous in the European Middle Ages, resulting in their persecution, torture, and murder, and in the eradication of invaluable knowledge (Becker et al. 1977). That German colonisers in East Africa resorted to the dichotomies of Christian/pagan, rational/superstitious, hygienic/dirty, and (en)light(ened)/dark to understand East African maternal and child health care mirrors British colonising efforts in Africa in which Western ways of birthing were similarly represented as the epitome of “sanitary virtue and enlightenment” (Nestel 1998, 267). The means by which a change of mindsets was to be achieved was first and foremost seen in the “patient, educational work” of Christianisation and schooling (Feldmann 1923, 127). Other practices deemed to be pagan such as infanticide and abortions were prosecuted by more forceful means (see Chapter 5).

German commentators during colonisation did not only deplore “superstitious beliefs”, they also accused the colonised people of carelessness and indifference regarding health care and childbirth-related care in particular. In the quote above, this is evidenced in the reference to a low “sense of responsibility” and “selfishness”. East Africans were said to be inaccessible to advice and training (Feldmann 1923) and indifferent to proper infant care (Reichs-Kolonialamt 1913). According to a letter by Mission Superintendent Karl Axenfeld (1907), “the afflictive health conditions are [...] particularly caused by the Negro’s lethargy”. Some observers even stated that certain peoples (“tribes”) almost completely disregarded children (Van der Burgt 1914). Portraying mothers as careless was not specific to German colonisation of East Africa but common in many contexts in which
colonisers were concerned about population decline after the turn of the 20th century (Jolly 1998). Christianisation was seen as a means to instil “enlightened” rationality but also the values of “charity” and compassion. Hermann Feldmann (1923) reported that christianised Dshagga men were more fit for infant care than christianised Dshagga women because they were more motivated. The latter supposedly not only lacked knowledge but also showed less enthusiasm to acquire skills. This view might be explainable by the fact that health care was understood as requiring rational, technical skills which German physicians associated with male characteristics. Since the late 18th century, with men’s entrance in the field, obstetric care had become a profession, i.e. regarded as relevant knowledge which required the work of experts (Duden et al. 2002; Seidler 1993). Masculinisation and professionalisation had been an essentially synonymous process.

The three issues examined in this section thus far are evidence that German stakeholders were concerned about matters of mind-set and attitude in relation to health and obstetric care in “German East Africans”. Childbirth-related care in East Africa was perceived as deficient with reference to “culture-boundedness” and “timidity”, “superstitious beliefs”, and “carelessness” and “indifference”. “Education” and proselytisation were considered crucial to improving health care and midwifery.

6.4.2 During German Development cooperation in the 21st century

In contemporary German Development assistance, professionals also make reference to Tanzanians’ mind-sets and attitudes in order to assess and judge health care around pregnancy and delivery. In interviews and publications, two issues emerged as particularly important: motivation and compassion. On the one hand, the interviews and publications discussed the influence of the mind-sets and attitudes of Tanzanians working in hospitals and health administration on health care, and on the other, they discussed the attitudes of expectant mothers and their families.
The following excerpt from an interview with a German physician working in a Tanzanian hospital via CIM is a good example of how German professionals view obstetric care in Tanzania. She speaks of the way pregnant women, and patients more generally, are treated by Tanzanian nurses in the hospital in which she is deployed, and she criticises deficiencies in motivation as well as compassion:

[...] you just have the feeling that every patient who enters is perceived as a source of irritation, who interrupts the nurses drinking tea. That’s very frequent. [...] If you come from outside and, moreover, you have a European head on your shoulders, you find some things really horrible. I fetched the hospital director a week ago, because I really could not bear it any longer. They let the people give birth on a wooden board in the toilet. And next door there are two wonderful delivery beds, but these wonderful delivery beds are reserved for when somebody from the family or the staff comes. (Interview 35, June 22, 2010)

In my interviews, German Development professionals characterise nurses, but also doctors and the political elites working in the health field (such as in Tanzanian government departments) as indifferent (Interview 29, German nurse working in a hospital and training centre for midwifery in Tanzania, June 08, 2010), “apathetic” (Interview 37, physician working for DED in a Tanzanian district hospital, June 25, 2010), “unmotivated” (Interview 28, German consultant advising the Tanzanian government in a KfW-financed project, June 5, 2010), “idle” (Interview 54, retired German physician working as a volunteer in a Tanzanian mission hospital, June 22, 2010), and “not enthusiastic” (Interview 53, CIM physician working in a regional hospital in Tanzania, July 31, 2010). Many German Development staff mentioned a lack of initiative of Tanzanians working in the health sector (e.g. Interview 43, DED physician working in a district hospital, July 09, 2010). As long as everything was provided by donors, things would happen, but as soon as the flow of money stopped or a little extra effort was required, activities would stop immediately. This was regarded as running across different levels – the individual Tanzanian health worker, hospital management, and political decision-making. For example, according to a doctor working for DED in a Tanzanian district hospital, nurses did not find it problematic to be ignorant, and refused to criticise colleagues for wrong-doings
(Interview 37, June 25, 2010). During training workshops they would allegedly reproduce inert knowledge, i.e. present what they had read or heard without being aware of what they were talking about. Without showing any sign of embarrassment, nurses would engage in “PowerPoint karaoke”, by which she meant that they read out PowerPoint slides without understanding their content. None of the attending nurses would ask questions afterwards. This German Development professional explained what she perceived as indifferent and inappropriate attitudes by referring to a general lack of accountability and public scrutiny of civil servants in Tanzania, to a “culture” of not thinking independently and voicing criticism, and to an intrinsic indifference of Tanzanians.

The second aspect invoked in the quote above by the German physician deployed by CIM to work in a Tanzanian hospital is an apparent lack of compassion of Tanzanian health workers. Several interviewees complained of the absence of empathy for pregnant women and mothers. Tanzanian nurses were assumed not to care about the psychological or emotional well-being of their patients, and sometimes even to resort to verbal as well as physical violence in order to assert their authority. Here, German health professionals saw it as their task to convey compassionate midwifery, by which they referred to looking patients in the eye, massaging expectant mothers, and generally taking the needs of patients seriously (Interviews 15, 19, and 40). Compassion among Tanzanians was allegedly only reserved for their next of kin (Interview 35, German doctor working in a large Tanzanian hospital, June 22, 2010). Midwifery in Tanzania was perceived as highly “programmed”, “completely structured”, and not very “interpersonal” (Interview 15, German nurse who did a voluntary service with a German missionary organisation, April 21, 2010). This interviewee described the highly structured, impersonal approach as being comparable to practices in Germany 30 years prior and criticised it as being too “modern” in the sense of too mechanistic and not sufficiently sensitive (Interview 15, April 21, 2010). Here, “modernity” ironically equals backwardness. She contrasted this to the current state of the art in Germany, where midwives have “become a little bit more generous” and regard giving birth as something “individual” that has a lot to do with psychology and being able to open up. German
professionals reported that the supine position was favoured in Tanzania because it allowed nurses and doctors to sit or stand comfortably while exerting a maximum amount of control over the birth process and the women in labour (Interview 29, German nurse working in a hospital and training centre for midwifery in Tanzania, June 08, 2010). They claimed that Tanzanian nurses or doctors would not consider squatting down with a woman because it would question the hierarchy between patients and staff (Interview 15, April 21, 2010). This is an indication that Tanzanian hospital staff are construed as authoritarian and insensitive, and that the German professionals consider it to be professional to squat down with patients and disregard and overcome differences in status and class. For German health workers, professionalism evidently comprises more than technical skills and includes empathy and compassion. They perceive themselves not only as enhancing Tanzanian health workers’ technical skills, but also as improving the interpersonal level of health care. Figure 7 illustrates the way a DED Development worker in a Tanzanian district hospital made sure to separate delivery beds with boards and curtains so that women giving birth had more privacy (Interview 43, July 09, 2010).

Figure 7: Photograph of delivery bed in the maternity ward of a district hospital in Tanzania taken from the web blog of a DED physician working in a Tanzanian district hospital (Interview 43, July 09, 2010)
There is, however, a striking contrast between this concern for privacy and empathy and the way I was often shown around hospitals by German professionals. They commonly offered to lead me – a “white” male without a function in the hospital setting – into full maternity wards. After I mentioned that I found it disturbing to just be led into a maternity ward without the patients’ consent, several of my German interviewees stated that this was not a problem in Tanzania and that people’s bodies were generally much more public (Interview 29, German nurse working in a hospital and training centre for midwifery in Tanzania, June 08, 2010; Interview 53, physician working via CIM in a regional hospital in Tanzania, July 31, 2010). It was striking that the physician who had applauded the visual separation in the picture above invited me to put my ear to the belly of a woman and to listen to the heartbeat of her embryo. From the reaction of the delivering woman, who only just managed to cover her breasts and pubic area, it was clear that she was uncomfortable with this and that my (male) interview partner had not asked her permission. The fact that I complied and actually tried to listen to the heartbeat still troubles me today. Her body was not public because people’s bodies in Tanzania were inherently more public than in Germany, but it was made public by two “white” men who encroached upon her privacy despite the fact that one of these men had earlier on boasted of improvements initiated by German Development cooperation to increase patients’ privacy.

6.4.3 Summary

This section (6.4) indicated that during colonisation, German physicians, missionaries, and administrators related what they perceived as deficient childbirth-related practices to timidity, superstition, and indifference of East Africans. Today, German professionals relate what they consider to be inappropriate obstetric care to Tanzanian health care professionals’ lack of motivation and compassion. Thus during German colonial rule as well as in ongoing Development cooperation, matters of attitude are highlighted as problematic and linked to unsatisfactory obstetric care. By holding “superstitious beliefs” and “timidity” accountable for poor maternal and child health during the period of formal colonial rule, Germans
constructed East Africans as passive and inactive. As postcolonial theorists highlight, stasis is synonymous with traditionality in Western thinking, and vice versa (Mbembe 2001). In the characterisation of Tanzanian health practices in current German Development aid, superstition does not seem to play an important role. Instead, Tanzanian biomedical health care providers are characterised as unmotivated, rude, and lacking compassion. However, the effect has some underlying similarity to colonial-era constructs: Highlighting poor motivation or indifference makes Tanzanian health professionals appear to be passive and unaspiring, and therefore stagnant. German Development assistance in the field of population and reproductive health thus continues to establish difference with reference to problematic attitudes of East Africans. Whereas structural factors are at times invoked as explanations for problems in health care today, Tanzanians’ attitude is also related to a specific Tanzanian “culture” of indifference and carelessness. To explain behaviour with reference to “culture” serves to construct racialised difference between the global North and South (cf. White 2002). Comparing German colonial-era intervention with contemporary intervention indicates an interesting shift; today, midwifery in Tanzania is regarded as too regulated, medicalised, “modern”, and lacking in compassion; in colonial times it was perceived as not “modern” and not sufficiently medicalised. This inversion of norms is evidence that what Germans perceived as the goal of intervention in childbirth-related practices in East Africa has been transient; what is consistent is the maintenance of hierarchical difference between German Development and Tanzanian practitioners.

6.5 Conclusions
This chapter has provided empirical insight into the relationship between German Development cooperation and colonial power by identifying and interpreting patterns of similarity and divergence between colonial-era and ongoing interventions in the area of obstetric care. Resonating with Mignolo’s (2000) ideas on “colonial difference”, colonial power is primarily evident in the way German professionals continue to establish a fundamental difference between themselves
and Tanzanians. This is achieved by assessing and judging the quality of East African childbirth-related practices in general, and issues of planning and attitude in particular. Examining the manner in which obstetric care in East Africa has been characterised, and intervened into, during German colonisation and today, a sense of deficiency is omnipresent. During colonial rule, East African midwives were perceived as lacking rational knowledge and skills; today biomedical practitioners are construed as lacking knowledge, planning capacities, as well as an appropriate attitude, and Tanzanian women and families are portrayed as lacking the ability to think in a future-orientated manner. German perceptions and judgments of East African practices around pregnancy and delivery are thus an example of “the supreme receptacle of the West’s obsession with, and circular discourse about, the facts of ‘absence’, ‘lack’, and ‘non-being’, [...] of negativeness” (Mbembe 2001, 4).

Colonial difference in the area of obstetric care is mainly established with reference to biomedicine. During colonisation, East African birthing was perceived as “traditional,” as compared to “modern” German obstetrics, at the level of knowledge, skills, and attitudes. Today, Tanzanian biomedical health care is construed as having all the characteristics associated with “traditionality” and backwardness in Western thinking, as mentioned in Chapter 2 (cf. Mbembe 2001). It is presented as pervaded by irrationality (especially with regard to planning). As evident in German professionals’ testimonies on the difficulty of teaching state-of-the-art obstetrics, Tanzanian obstetric care is also portrayed as resistant to change. Taken together with the general perception of deficiency, these assessments of Tanzanian birth-related practices are in line with the way the West tends to characterise “traditional” societies (cf. Mbembe 2001). Thus, even though German Development cooperation should in principle regard Tanzanian obstetric care in health facilities as “modern” because it operates according to the biomedical paradigm, such health care is associated with “traditionality”.

By employing a dispositif-analytical approach to power, this chapter took into consideration the interconnectedness of discourses on childbirth-related issues with material practices. This mode of analysis helped me to remain sensitive to the fact
that discourses are never just linguistic expressions, but are embedded in actual practices and have institutional effects. Asserting deficiencies in obstetric care amongst East Africans went hand in hand with the construction of biomedical health facilities, the dissemination of information leaflets, and training of East Africans in biomedical healthcare. Applying and teaching concrete practices, such as the supine birth position, took place in these institutional settings and warranted particular equipment, for instance delivery beds. The dispositif-analytical methodological framework also allowed me to understand that contemporary discourses of deficient planning are intertwined with German professionals’ use and instruction of the partograph. In keeping with the conceptualisation of power as dispositif, this chapter also considered the capacity of German professionals to take different stances on childbirth-related issues, as evident in the partly positive appraisal of some East African women’s skills during colonialism as well as in the differing explanations for alleged deficits in current planning.

Seen through the perspective of German health practitioners during colonial rule as well as in ongoing Development cooperation, childbirth-related practices in East Africa have always lagged behind in comparison to what is perceived as the norm (Western obstetrics). The “development” of obstetric care is presented as leading from ignorance to rationality, and German professionals have always regarded themselves as having to lead East Africans. They have made it their task to guide East Africans towards German standards of birthing. This shows that the notion of evolutionary, linear “development” is ever-present. Yet, what is considered to be the desirable standard is transient and changes over time. Whereas, according to German colonial-era physicians, missionaries, and administrators, quality health care and obstetrics primarily required “enlightened” rationality and Christian beliefs, today compassion seems to be regarded as crucial for quality maternal health care. Crude mechanical Tanzanian midwifery is thus differentiated from caring, sensitive, post-modern German midwifery. The issue of birth positions is particularly striking and makes obstetric care standards as advocated by German interventionists seem like a mirage that disappears as soon as you come close. The supine birth position, introduced by German physicians and missionaries during the period of colonial rule
and regarded as progressive at the time, is now criticised as outdated and backward. What is more, reference to this birth position is used to characterise Tanzanian obstetric care as static and resistant to change. East African obstetric care has been constructed as in need of catching up with German childbirth-related practices ever since colonial occupation, but this seems impossible given that the norm constantly changes and fundamental difference continues to be established by German professionals on all levels of health care. Sameness is demanded, but colonial difference inhibits it. This brings us back to Escobar’s quote in the introduction that

Development “assumes that the ‘natives’ will sooner or later be reformed” and at the same “reproduces endlessly the separation between reformers and those to be reformed” (1994, 54–5).
7 Challenging contemporary German Development intervention in Tanzania

The public transcript is, to put it crudely, the self-portrait of dominant elites as they would have it themselves seen. Given the usual power of dominant elites to compel performances from others, the discourse of the public transcript is a decidedly lopsided discussion. While it is unlikely to be merely a skein of lies and misrepresentations, it is, on the other hand, a highly partisan and spatial narrative. It is designed to be impressive, to affirm and naturalize the power of dominant elites, and to conceal or euphemize the dirty linen of their rule. (Scott 1990, 18)

7.1 Introduction

The previous two chapters examined perspectives on intervention in population and reproductive health during German colonial rule and contemporary Development cooperation with a focus on the politics of population control (Chapter 5) and childbirth-related practices (Chapter 6). They concentrated on dominant narratives and practices in order to tease out the extent to which present-day German intervention was imbued with colonial power. Given the focus on continuities and divergences between colonial-era and contemporary policy and practice, German intervention appeared to be consistent and unchallenged. However, neither colonial nor recent policies were ever seamlessly applied. German intervention has always been questioned, negotiated, and subverted – by Germans as well as Tanzanians. In contrast to official and dominant versions of intervention – the “public transcript” – such challenges can usefully be described as “hidden transcripts” (Scott 1990), as mentioned in Chapter 2. An examination of colonial power in German Development intervention today would be biased and incomplete if these hidden transcripts of intervention were not taken into account. Accordingly, this chapter focuses on expressions of uncertainty and doubts, on explicit criticism of German intervention by German Development practitioners, and on German accounts of non-cooperation by Tanzanians. What is more, it sets out to elicit the effects of contemporary challenges on the articulation of colonial power.
As mentioned in Chapter 2, a focus on Development professionals’ narratives serves to “complement and critique” official versions, bringing out the “nuances and ambiguities” in Development aid (Kothari 2006c, 133), and thus allows for a more comprehensive and multifarious picture of German intervention in Tanzania. Where Development practitioners’ accounts were included in Chapters 5 and 6 to complement official documents and reports, this chapter concentrates on those accounts that seem to run counter to the “public transcripts” of German intervention. Here, I follow Scott (1990) who proposes to differentiate between “public transcripts” and “hidden transcripts” for an analysis of power. “Public transcripts”, which constitute the dominant narratives and practices in a given context (Scott 1990), can primarily be found in official documents, reports, speeches, and more formal testimonies and interviews (Bliesemann de Guevara and Kühn 2012, 22). “Hidden transcripts” contain that which is not found in such arenas and question “public transcripts”. They are not directed at the public but rather at peers and people in similar socio-political and professional positions. While public and hidden transcripts are “produced for a different audience and under different constraints of power”, this does not imply that the former are “false and what is said offstage true” (Scott 1990, 5). Public and hidden accounts may be different from each other, but they are intimately related as “the practice of domination […] creates the hidden transcript” (Scott 1990, 27). According to Scott, the hidden transcripts of dominant actors contain “gestures, speech, practices” which are “excluded from the public transcript by the ideological limits within which domination is cast” (1990, 28). Even though private narratives and practices may contradict or mediate public ones, both may share the same discourses (see Chapter 2).

While people in subordinated positions (due to class, racialisation, gender, and so on) are not able to or have obvious reasons not to challenge dominant policy and practice, those positioned in privileged positions such as Development experts also engage in private, “hidden” narratives and practices (Eriksson Baaz 2005; Heron 2007; McKinnon 2008). German Development professionals may privately modify and contradict dominant Development policy and practice; this may be more likely if
they are not in high ranking positions within Development aid and conceive of themselves as not influential in the creation of “public transcripts”. I was able to gather material which evidenced “hidden transcripts” in interviews in which my respondents seemed to feel comfortable enough to share doubts and uncertainty regarding their work. Informal settings such as being hosted in Development professionals’ private homes, sitting around the dinner table and talking over drinks, proved conducive to expressions of doubt, criticism, and opinions challenging the “public transcripts” of aid (see Chapter 3). What is more, my positionality in the field as a “white” German with personal experience in German Development cooperation often created instant commonality between me and my interviewees and thus helped me gain access to German Development professionals’ ideas and opinions which questioned or ran counter to the “public transcript” of German aid. The first two sections of this chapter are devoted to an examination of German professionals’ doubts regarding accepted practices and assumed truths (7.2) as well as their explicit criticism of Development aid (7.3). Yet, Development policy and practice are not only questioned by donor agents but are also challenged by so-called beneficiaries (see Chapter 2). German professionals’ accounts yielded ample evidence of Tanzanian agents’ challenges to Development intervention. In 7.4, I examine German narratives for signs of Tanzanian partners’ objection, negotiation, and subversion. Such accounts are complemented by statements from Tanzanian counterparts regarding their work relationship with German Development professionals.

Although this chapter suggests that contemporary German Development intervention may often be criticised, inhabited by doubt and uncertainty, and marked by objection, it does not hold that colonial power is absent or effaced. This chapter focuses on the effect of such challenges on the persistence of colonial power. Hidden transcripts may challenge dominant narratives and practices, but do not necessarily imply destabilisation of colonial discourses. While doubts, criticism, and Tanzanian opposition harbour the potential to disrupt colonial power, they may also leave such power undisturbed or even reinforce it if they do not significantly alter existing discourses or question the political-economic inequalities in which
discourses are embedded. It is thus crucial to identify how German professionals come to terms with their doubts, how and where criticism of Development aid is voiced, which actions flow from doubts and critique, and how resistance by Tanzanian partners is dealt with in German Development cooperation.

### 7.2 Doubts regarding the value of Development work

As Chapter 6 has shown, German health professionals evaluate the quality of obstetric care in Tanzania with reference to Tanzanian professionals’ planning and management capacities. For example, some interviewees suggested that Tanzanian health professionals did not know how to use partographs and needed training. However, a number of German Development workers express doubts regarding the value of their work in improving health care in Tanzanian hospitals. Two interviews mentioned in Chapter 6 show signs of doubt and uncertainty regarding Development intervention. These are examined in detail in this section.

A German Development professional working in a Tanzanian hospital training centre found young nurses’ abilities to use the partograph to be deficient and related this to their alleged inability to think systematically (Interview 29, June 08, 2010). While generally blaming Tanzanians for what she saw as poor health care, this interviewee expressed doubts regarding the value of her work in training Tanzanian nursing students:

> I often ask myself in any case .. not only with the partograph .. why Africa, yes, in quotation marks, or Africans, .. Tanzanians in this case perhaps .. don’t try to adapt biomedicine themselves, and include it in their system. Who or what forces them .. apart from the fact that they might find the uniforms stylish .. to adopt our system? Completely? Might there be another form then, yes, or might there be another form of teaching? I also always ask myself that. So, is this us standing in front of them and telling them something, is that even the right form? Wouldn’t they have to learn completely differently? (Interview 29, June 08, 2010)

The interviewee noticed that her teaching had little effect on nurses’ performance in clinical situations in which they had to apply the knowledge acquired in class.
Furthermore, she mentioned that trained nurses generally did not use the partograph and did not understand how to use it correctly. As evident in the quote, this leads her to question whether Western biomedicine was the right health care model for Tanzania and whether the corresponding way of teaching biomedical health care was appropriate in the Tanzanian context. The explanation for problems in health care put forward in this interview differs significantly from the dominant transcript presented in Chapter 6 which primarily places the blame on the attitudes and intellectual capacities of Tanzanian nurses, while also considering socio-economic circumstances. The manner in which the Development worker made sense of her experience displays her awareness that knowledge systems may differ. According to her, this could imply that different manners of acquiring knowledge and teaching are necessary. Her statement takes the form of an inner monologue (“I often ask myself”, “I also always ask myself”). Remarkably, she does not mention conversations with her Tanzanian colleagues in which her questions could be answered. At least in this quote, it appears that she does not regard the Tanzanian health workers whose conduct seems so mysterious to her to be potential interlocutors.

Having expressed her doubts about completely adapting the biomedical health model and about her own contribution by teaching the partograph, this German Development professional continues her reflections:

And I mean, indeed .. you could also ask yourself: Why is it so bad? Then you just don’t fill in this thing, and you just let yourself be surprised with each birth. And then you just say: Oh well, now the child is coming; oh, now the child is not doing well; or: Oh, now the woman is bleeding. And then you start reeling off an emergency procedure. And if you’re good, you have it in your head quickly. And if you’re not so good, then you just don’t act as quickly. And in both cases a woman can bleed to death. (Interview 29, June 08, 2010)

She entertains the idea that one could also dispense with employing the partograph. This would mean that one just lets deliveries happen and only intervenes when things go awry. However, the manner in which she verbally places herself in the position of the nurse who lets herself be surprised by deliveries (“oh
well”, “oh”) shows that she views such a stance to be passive and indifferent to matters of life and death. She evidently considers it to be irresponsible because it would mean poor quality obstetric care. What begins as openness to re-imagining midwifery and corresponding instruction ends up as criticism and cynicism. Her statement may be read as a reaction to her frustration with the ineffectiveness and futility of her instruction of Tanzanian nurse students. She continues her deliberations by voicing what she considers to be necessary for them to understand:

I mean, I .. ehm well, there is this term postpartum haemorrhage [loss of a life-threatening amount of blood following delivery, DB] .. ehm. I mean, it is one of the main causes of death here, and I see that in our delivery room, and then I try to teach my students, there are risk factors: this and this and this and this and this and this are risk factors. They can recite all this mechanically in tests. But in the clinic I don’t see that they have it in their head. [...] And it’s the same with midwives. Well, not with all of them, I can really not speak for all of them, because there are, there are really fantastic colleagues, really, who think, act and plan exactly as I am used to .. from back home. (Interview 29, June 08, 2010)

In this quote, the German nurse again explains what she sees as wrong with Tanzanian midwifery, namely the widespread inability to transfer knowledge from theory to practice (see Chapter 6). Yet, she mentions that not all Tanzanian nurses are like this, but rather that some plan and work like German nurses. This contradicts her initial reflection: that the problems might have to do with the inappropriateness of biomedical health care and instruction. In this quote, she places the blame for lack of skills and knowledge on the nurses whom she could not teach to work well. Later on in the interview, she also mentioned that schooling in Tanzania did not encourage logical, independent thinking, which means that nursing students arrive poorly prepared for their training. This argument places responsibility on the Tanzanian educational system and diverts attention away from the German professional’s role in the ineffectiveness of her instruction. She and her knowledge and skills no longer appear to be inadequate for improving obstetric health care in Tanzania. By identifying the problem as located in Tanzanian nurses’ capacity to think logically and in Tanzanian schooling rather than in her expertise, she justifies her continued involvement in aid (cf. Crewe and Harrison 1998). It
becomes evident that she cannot really imagine quality obstetric health care or instruction which is different from but not inferior to the dominant biomedical model. Notwithstanding considerable uncertainty regarding the value of her work, the interviewee maintains the colonial-era dichotomy between portrayal of the global North as rational, technological, and progressive and the global South as being irrational and passive.

Aside from the German nurse, other interviewees raised doubts about the viability of instructing Tanzanian health workers in obstetric care. The following quote from a former DED physician, partially presented in the last chapter, raises the question of doing outreach to teach the partograph in Tanzanian health facilities:

> But I’m doubting .. we sometimes had a .. I sometimes had a chat and we were laughing about it with the regional gynaecologist, when she came for supervision. In, in medicine you have something like a partograph [...] So there’s an amount of time, a maximum amount of time which you have after protraction starts, which you have before the baby should be born. If you exceed this then something is wrong, you should do something like a caesarean section, for instance. And this rule is very old, in maternal health. [...] It’s very easy: [...] And this lady was training this partograph for five years now and still, every time when she went to the hospital, the same people did not understand the partograph. And she explained again and she said: because I think this is the best way of how to deal, and in a very simple way, of how to deal with delivery and how to detect problems. But it did not get, nobody uses it. Why is this? (Interview 08, February 14, 2010).

As in the aforementioned example, this Development worker is convinced that the partograph is the most efficient way of controlling the birth process. He and the colleague he refers to who had also worked for DED realised that even though they had spent a significant amount of time and energy teaching the use of the partograph to Tanzanian health professionals, they did not employ it. While concerned with the fact that their instructions did not yield acceptance, they also laughed about the futility of their attempts – or perhaps about the fact that the Tanzanian hospital staff did not seem to get it. However, a sense of frustration predominated: the speaker is exasperated that Tanzanian staff working in obstetrics
refuse to learn such an “easy” method. The interviewee continues his deliberations and asks himself why nobody used the partograph:

Is this because this is our system, our idea? This is Western-based medicine, this is evidence-based medicine, but it doesn’t work somehow. So we sometimes say, yeah, if it doesn’t work, why try to continue with it, why try to teach and implement this thing, if maybe after five or ten years such a simple intervention [[DB, laughing: if there is no evidence that it works]] for the effect. If there is no evidence for the, for the, for the usage, that they actually use it. Who are we, who are we as white doctors to say, this is the best one? Yeah, this is a bit, this is a bit of a philosophical discussion, I think, as well. (Interview 08, February 14, 2010).

Like the interviewee above, this doctor raises the point of possible incompatibility of the Western medical paradigm. He also considers putting an end to transferring such health knowledge to Tanzanian hospitals, but he does not entertain the idea that there might be alternative paradigms or ways of teaching health care. By talking about “our system, our idea” and positioning himself and his Development worker colleagues as “white doctors”, he demarcates a clear distinction between “them” and “us”. Again, the border between the two is not bridged through dialogue; instead the questions are circulated within the “white community” (“we”) although it could most likely only be answered by “them”. In the follow-up to the excerpt above, the same interviewee tries to deal with his doubts:

But ehm .. I don’t know, as development aid workers, as doctors, advisers, you also have to have a certain background. This is my knowledge that I want to .. to give to somebody else, and if I don’t do this, then there is nothing left. And I, and I at least, then I can go home. But you should always question in the end if something which works in Europe is as effective. We come here, of course, we are asked, but it’s, we come with a certain background and knowledge, and we apply this .. to the whole situation. Yeah, I’m not sure if this is the best for that. But at least it’s something which is based on mutual agreement, not only on the local level but also on the national level. [...] But I think, yeah, you have to, I only repeat it, you have to fall back on something which you agreed on in the beginning. I mean, if you start doubting that, then you can .. start doubting the whole .. eh idea of development aid, I would say. Which is also not bad, you
can also doubt that, and discuss this sometimes. But .. if you are in the field, 
you need something to .. (Interview 08, February 14, 2010)

Even though he perceived his educational work in Tanzania as ineffective, the DED 
physician did not see any other option but to teach Tanzanian health professionals 
what he learned in Europe and agreed to in his contract. He deals with his doubts 
regarding the value and legitimacy of his work in two ways: First, he points to the 
fact that his Western medical knowledge is the only thing he can contribute and, 
second, he invokes the agreement between German Development agencies and 
Tanzanian institutions which governs his job.25 This Development professional seems 
to brush off his uncertainty by pointing out that if he began to doubt his ability to 
bring about positive change, he would have to question the whole project of 
international Development cooperation, and quite literally “go home”. While he is 
aware of the problems, he pushes this thought away in order to be able to continue 
with his work: “in the field” there is no room for “philosophical” reflection on 
Development aid.

The Tanzanian health workers’ supposed inexplicable immunity to reform 
profundely unsettles German Development professionals’ assumption that they 
have the power to effect change, are welcome and needed, and are in control of 
their students’ minds and actions. Despite their doubts about the effectiveness of 
their work, German “developers” did not seriously question their superior 
knowledge and skills, the superiority of Western medicine and health care, and the 
need for continuing with Development intervention. In her study on former 
Canadian aid workers, Heron points out that the work of Development professionals 
is “contingent on positioning the Southern Other as available to be changed, saved, 
improved, and so on, by us, thereby ensuring our entitlement to do so” (2007, 44; 
emphasis in original). However, at the same time colonial discourse tends to operate 
on the thesis that “African culture is not susceptible to change” (Heron 2007, 45), as 
shown in Chapter 6. Thus, when intervention fails, Tanzanian society (whether in the 
form of its educational system or with reference to the “nature” of Tanzanians) can

25 As explained in the next section, other interviewees doubted the actual mutuality and 
voluntariness of German-Tanzanian Development cooperation agreements.
be held accountable for the failure to impose change. While frustration due to perceiving futility of their work and the uncertainty caused by this challenges the image of Development professionals as having “enterprise” and being able to mould the world to their desires (cf. Dyer 1997), it ultimately does not destabilise colonial-era discourse of the superiority of Western health care.

7.3 Criticism of German Development cooperation

This section explores German professionals’ explicit criticism of their country’s Development cooperation with Tanzania and questions the effect of such challenges. The interviews provided evidence of different forms of critique which may be categorised as those criticising Germany’s imposition of Development policy and practice on Tanzania and those who maintain that Development intervention has not had the intended effects.

The German government explicitly follows the aid principles of partnership, participation, and ownership mentioned in Chapters 2 and 3; according to BMZ (2012a) “[p]artnership-based cooperation among all stakeholders is the single most important principle for the successful design of German development policy” and the rules of “participation and ownership” are seen as essential for satisfying the principle of partnership. My interview partners regularly affirmed that these principles guide Germany’s practical work in reproductive health and population in Tanzania. For example, a DED manager in Tanzania underlined that DED did not just impose Development interventions, but that TGPSH, DED, the Tanzanian Ministry of Health, and Tanzanian Regional or District Medical Officers\(^{26}\) engage in negotiations and reach mutual agreements\(^{27}\) (Interview 27, June 04, 2010). However, in some interviews German Development aid was criticised for imposing Germany’s wishes on Tanzanians. When a German hospital adviser deployed in a Tanzanian regional hospital complained of lack of cooperation by his Tanzanian counterparts (see 7.4

\(^{26}\) These are the highest-ranking staff members of regional and district medical administrations.

\(^{27}\) See also the insistence on “mutual agreements” in Interview 08, February 14, 2010, mentioned above.
for a detailed discussion of this issue), I asked him who had wanted him to come to Tanzania. He replied:

Well, the German government! They have a good deal of options to dictate to the Tanzanians what they should do. Then suggestions are made which the Tanzanians, however, just simply accept. The strategic plan was forced upon the Tanzanians by Germany. The people in the hospital were not involved.  

(Interview 38, June 29, 2010)

The Development professional saw his post as not based on any mutual agreement between the Tanzanian hospital management and government on the one hand and Germany on the other.

Other respondents also held that TGPSH commonly decided on the strategies which Tanzanian-German Development cooperation in health care was supposed to embark upon:

But in fact, who pays for the music normally also decides how it’s done. And this is, of course, also the case in the Tanzanian German Programme to Support Health. That those at the top . . . that most probably the Germans are the ones to say: That’s now what’s preying on our mind. That won’t be the Tanzanian.  

(Interview 37, physician working for DED in a Tanzanian district hospital, June 25, 2010)

This statement explains German imposition of Development intervention with reference to an unequal relationship between Germany and Tanzania, in which Germany provides the funds and Tanzania assumes the role of recipient (see Chapter 4 for the dependence of Tanzania and its health sector on foreign aid). Even a former senior manager of the German health programme in Tanzania was critical of what he described as Germany’s imposition of its ideas on Tanzanians in the context of political-economic inequalities (Interview 10, April 21, 2010). He believed that Development assistance was hindered by German insensitivity towards the Tanzanian partners. In the following quote he speaks of the problems caused by the latest GTZ management tool, Capacity WORKS28:

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28 According to GTZ (now GIZ), Capacity WORKS is a model “which guides and supports users in determining how the objectives and results agreed on with the partner can be achieved” and “means focusing on the objectives and results of projects and programmes” (GTZ 2010a). GTZ had
Interview 10: Well, this Capacity WORKS really takes the biscuit. [...] To now go to Tanzania, yes, and tell these poor lads there, (I laugh) here is our new, wonderful tool, GTZ, yes. Ey, you all, you have to learn this now! They will think: They must be off their nut, these Germans.

DB: And will they nonetheless say yes?

Interview 10: Of course, they don’t have any other option [...].

DB: And why don’t they have any other option? Because funds are attached to it?

Interview 10: Of course. And within German development cooperation this has won acceptance to such an extent that one can in fact only be greatly astonished. [...] Nope, we arrive with such a crazy thing that not a soul understands.

Training in Capacity WORKS, described by the interviewee as a “raving polyp” due to its complexity and incomprehensibility, became a prerequisite for any consultant to get a job with GTZ (now GIZ), and Germany’s partners in the global South had to adapt to it as well. The interviewee saw an enormous difference in negotiating power between Germany and Tanzania, which meant that Tanzanians simply had to acquiesce to German proposals.

When I asked him whether there was any room for putting into practice the touted principles of mutuality and joint formulation of policies, his answer was unequivocal:

No, that’s impossible, absolutely impossible. What are they supposed to put forward against it? They can then only fall silent and say: “Oh my God!” All of them say that inwardly, the way they sit there in these planning seminars. Guaranteed. (Interview 10, April 21, 2010)

According to this account, dependence on foreign aid does not allow Tanzanians to voice criticism or negotiate the terms of cooperation. The Development professional quoted above presents Development aid as not demand-driven but donor-driven. Later on in the interview, the former senior staff member of TGPSH continued his criticism of German Development cooperation. He expressed his disillusionment by entered into contracts with a number of selected firms which are the only ones with the right to issue certificates for training courses on Capacity WORKS (GTZ 2011).
pointing to lack of sensitivity of the current, young generation of German Development professionals:

They have little experience with [...] how to teach things to peoples, people in all these countries, without it being imposed from outside, but rather so that it grows inside them etc. That has been our main topic for years. How does one do good development cooperation by holding back, keeping out, and nonetheless bringing in one’s influence, these issues? (Interview 10, April 21, 2010)

While direct imposition seems a no-go for him, this quote indicates that he ultimately believes in German Development cooperation with Tanzania. He sees it as necessary to bring in one’s influence. What he is concerned about is the way it is done, which he regards as lacking strategy and empathy.

The accounts thus far have highlighted German Development workers’ criticism of the tendency of German Development aid to impose intervention on Tanzanians. According to these accounts, Development cooperation does not work if it is imposed. It should rather be driven by Tanzanians and Germany should be sensitive to their needs. This criticism in fact demands what German Development aid officially proclaims, namely partnership, ownership, and participation. However, due to political-economic asymmetries and German insensitivity, it does not seem possible to put these into practice. Such criticism echoes postcolonial analyses that cast doubt on the possibility of such principles in the context of colonial discourses of Western superiority and political-economic inequalities (Cooke and Kothari 2001; Eriksson Baaz 2005; Noxolo 2006). The interviews I analysed did not indicate that German Development professionals understood inequalities as being connected to the colonial past, or that lack of sensitivity was regarded as related to colonial history and the different racialised positionalities of Germans and Tanzanians. Their criticism also does not seem to question the dominant “development” teleology according to which Tanzania should become like Germany. Furthermore, it does not challenge the assumption that Germany should engage in Development aid in Tanzania.
While German Development professionals at times disapproved of German Development aid’s tendency to insensitively impose intervention, other accounts criticised the inefficiency of Development cooperation. Development supposedly did not yield what it promised to achieve. Interviewees explained this with reference to an allegedly demobilising effect of aid and they voiced the suspicion that German Development cooperation was not really interested in changing the way Development intervention was operating in Tanzania. In the following quote, a German hospital adviser criticises aid due to its negative consequences on the recipient countries:

Development aid still has a very good reputation in Germany. [...] If they only knew what is actually going on. More money is not necessarily better. It can also just augment inefficiency, idleness, and dependency. Then Africa continues to be on the European drip. (Interview 38, June 29, 2010)

This view seems to be influenced by recent popular neoliberal critiques which suggest that Development aid merely corrupts and enriches elites and prevents people in the global South from taking matters into their own hands (e.g. Moyo 2009; Shikwati 2006). These as well as similar older German critiques of aid (e.g. Erler 1985) are well-received among German Development workers. Dambisa Moyo’s book Dead Aid is common reading for German Development professionals and was visible on bookshelves of some of my interviewees. The criticism evident in the above quote seems to be directed at the German public which supposedly is ignorant of the fact that aid is not effective. However, it also blames aid recipients for not being able to deal properly with the “assistance” given to them. They allegedly become “inefficient”, “idle”, and “dependent”. The tendency to hold recipients accountable was also evident in the follow-up to the above interview excerpt, in which the respondent asked for “more monitoring and control” in “financial cooperation” (Interview 38, June 29, 2010).

Another interviewee remarked that Development aid could continue for a hundred years and still nothing would change (Interview 37, physician working for DED in a Tanzanian district hospital, June 25, 2010). Some interviewees considered it to be an illusion that deliberate Development intervention would improve socio-economic
conditions. Rather, they were convinced that the process of “development” was just a matter of time:

Ehm .. I’m not at all pessimis.., I mean completely totally in no way pessimistic, if it concerns that I think that, for example, Tanzania will develop.[...] Yes, but rather like: with us or without us. [...] I really have no doubt that, if it is another 50 years further [...] that the Tanzanians here can then also have a nice life. But that it rather develops economically, just like the other countries did. [...] it needs economic incentives, even if it is low wages or whatever at the beginning, but the next leap will then be made. (Interview 37, physician working for DED in a Tanzanian district hospital, June 25, 2010)

Here, a teleological, linear conception of “development” as universal goal is strikingly evident. Yet, unlike arguments aligned with modernisation theory which advocates for great investment into infrastructure, “development” is perceived as a “natural” process in which “market forces” will do their job. In the quote, the image of a pre-capitalist Tanzania that would profit from greater incorporation into a global market is invoked. Such a perception implies that the interviewee does not take into account Tanzania’s colonial past. German and British colonisation had sought to render “German East Africa”/“Tanganyika” susceptible to exploitation and incorporate it into the world market, as highlighted in Chapter 4 and Chapter 5. This process has not been favourable to East Africans at all – a fact which even colonial reformists acknowledged at the time (see Chapter 5). The statement above also disregards ample evidence of the detrimental effects of the expansion of capitalist accumulation and neoliberalism in Tanzania (cf. Chachage and Mbilinyi 2003; Lugalla 1995).

Criticism of German aid was taken farther by some interviewees who accused Germany of not being interested in actually changing the way Development cooperation was taking place:

Development aid is a lot about politics. Everybody is aware of the problems, but nothing is done. Everybody just continues doing the same thing. It has become an industry. [...] You [GTZ and other aid agencies, DB] do not bite the hand that feeds you. Therefore: just continue with business as usual. (Interview 38, DED hospital advisor in Tanzanian regional hospital, June 29, 2010)
Interviewees complained that Tanzanian elites as well as German Development personnel were content with the way things went because it served the interests of both parties (Interview 37, physician working for DED in a Tanzanian district hospital, June 25, 2010; Interview 53, CIM physician working in a regional hospital in Tanzania, July 31, 2010). It was also stated that rather than actually acknowledging that its interventions were not going well, TGPSH was more interested in promoting its work as a success story:

The last TGPSH meeting was like a muppet show. They were all congratulating each other on the great work they’ve been doing and the great tools they’ve developed. You ask yourself if they actually know what’s in fact going on.

[Interview 38, June 29, 2010]

This Development professional was evidently frustrated with what he saw as a contradiction between German Development policy and practice “on the ground”. His account echoes Mosse’s (2005) argument that Development policy should be understood as a way of tidying up the messiness of practice and as a means of legitimising the need for further intervention.

As this section has shown, German Development professionals at times criticise their country’s Development aid for imposing German wishes on Tanzania and for being ineffective. Yet, this self-criticism goes together with criticism of Tanzanians as being incapable of making effective use of aid. In the interviews scrutinised above, criticism tends to not be directed towards the idea of Development aid as such. It is rather concerned with the way it is administered by the donors: Germany is criticised for abusing its position of power, and Development principles of partnership and mutual equality are unmasked as mere wishful thinking. At the same time, colonial-era discourse of Germany being more “developed” and having the duty to engage in Development aid is not radically questioned. Unequal power relations between Germany and Tanzania are also not criticised as unjust or connected to global inequalities and colonial histories. Thus, the “public transcript” of partnership, ownership, and participation in German Development cooperation with Tanzania is challenged by some informal, private accounts of Development professionals, but the inherent asymmetry of Development aid relations continues
to be taken for granted. Interestingly, while the quoted interviewees criticised German Development aid in Tanzania as insensitive, they did not extend this to their own roles as German Development experts. They rather portrayed themselves to be doing things differently (Interview 37, physician working for DED in a Tanzanian district hospital, June 25, 2010) or as just being “a small cog that doesn’t have much to say” (Interview 38, DED hospital advisor in Tanzanian regional hospital, June 29, 2010). This is reminiscent of Said’s charge of the “horrifically predictable disclaimer that ‘we’ are exceptional, not imperial” (1994, xxvi).

7.4 Challenges by Tanzanians

But those defined in development discourse as the subjects of development are also active agents who contest, resist and divert the will of the developer in greater or lesser ways. (Crush 1995a, 20)

In addition to doubting their own value and criticising German Development aid, some German Development professionals reported that Tanzanian partners obstructed their work. Such accounts ranged from being deployed differently than expected and being sidelined within hospital structures to having the feeling that Tanzanian colleagues did not want German Development professionals present. These aspects point to challenge and resistance by Tanzanian counterparts of Development cooperation. In this section, allusions to such agency of Tanzanians in Development are analysed to consider their effect on the articulation of colonial power.

Several German physicians working in Tanzanian hospitals suspected that hospital management did not want them to do what had been consented to in written work agreements. Rather, heads of hospitals supposedly took advantage of their presence and used German professionals as (cheap) replacements for clinical posts: “We are just supposed to work in the hospital and serve as replacement, yet this is not part of our job description” (Interview 40, CIM physician working in a Tanzanian regional hospital, July 05, 2010). Most German interviewees complained that they did a lot more clinical work than stipulated in their contracts. Clinical work was often only
one of several tasks mentioned in the agreements, in addition to advising the management, doing outreach, and training colleagues. Whereas several German Development workers thought they were used as replacements for Tanzanian doctors, one DED doctor who had worked in a Tanzanian district hospital mentioned that he suspected his recruitment to have been due to political considerations by the hospital management (Interview 08, February 14, 2010). Allegedly, having a “white” doctor made it more likely for the hospital to be upgraded in the national hospital hierarchy.

Some German professionals voiced their impression of being used by Tanzanian hospital management. Many also had the feeling of being sidelined within hospital structures and excluded from information and decision-making. This was reported by physicians as well as by German professionals who were exclusively deployed to assist in management tasks. It emerged from the interviews that they hardly ever gained access to the hospital management level, even though DED and CIM physicians (and of course management advisers) were supposed to spend a significant share of their working hours on improving management capacities in hospitals. According to them, they were either not notified of meetings, informed too late, or not provided with relevant information. Even though they were officially part of the hospital management team, they were not let in on day-to-day management issues, and were circumvented in the case of delicate issues or far-reaching decisions. German professionals claimed to feel neutralised and suggested that hospital leaders were not interested in changing things in management (Interviews 38, 43, and 53). Supposedly, Tanzanians prevented Development professionals from interfering in management tasks in order to pursue their private agendas in an unhampered manner (Interview 53, CIM physician working in a regional hospital in Tanzania, July 31, 2010). It was suggested that Tanzanian management staff might fear that German aid workers would denigrate and discredit their Tanzanian counterparts vis-à-vis TGPSH or other donors (Interview 38, DED hospital advisor in Tanzanian regional hospital, June 29, 2010). Germans’ general perception of their superior management, planning, and problem-solving capacities, as highlighted in Chapter 6, was thus coupled with a feeling of
powerlessness given that they were not admitted to the spaces in which they could show and employ these capacities. Whereas official versions of German Development aid in Tanzanian health care presented such aid as guided by partnership and mutual agreements, the private testimonies of German Development workers alleged that they were used contrary to agreements and generally obstructed in their work. They primarily explained this with reference to Tanzanian hospital managements’ efforts to further their private agendas and unwillingness to fundamentally change the situation.

A Tanzanian who used to work as hospital manager put forward explanations for why Tanzanian hospital managers acted contrary to German professionals’ expectations. His view sheds a slightly different light on the matter. He said that many foreign professionals were arrogant and would almost instantly begin by telling Tanzanian colleagues what was not working, what they did wrong, and what they should change; apparently, this meant that the working relationship was destroyed immediately and for good (Interview 52, July 30, 2010). If Germans came across as arrogant Development experts, their Tanzanian colleagues would not tell them straightaway but would let them feel their disapproval; they would not work with them, not assist them, and not invite them to meetings. Foreign Development professionals would often interpret this as meaning that their support was not wanted. The Tanzanian professional suggested that “development workers” needed to be explained prior to their deployment that they were neither going to the “jungle” nor to work with people that did not know anything. “Development workers” should rather learn to support existing structures and habits of working: “You cannot turn our health system into a German health system; you cannot change our management system and want a completely new one” (Interview 52, July 30, 2010). According to him, many “technical advisers” were not sensitive and “need to be cultured first and to learn”, which would take a long time.

Another Tanzanian hospital manager mentioned that he was aware that TGPSH did not like “filling gaps”, but that he and his team needed German Development professionals for the purpose of placing them in clinical posts which needed filling
Rather than letting them do outreach work in health facilities across the region, and letting them stay away from the regional hospital, he wanted to make use of German Development workers for specialised clinical work in the regional hospital. He was happy with their expertise and said he assigned Tanzanian doctors to work alongside them so that they can learn from the Germans and take over one day. Both Tanzanian professionals’ accounts suggest that German health practitioners were respected for their technical knowledge and that their assistance was desired, but that cooperation was difficult because German health workers either wanted to do tasks which the Tanzanian hospital management did not consider a priority, or came across as insensitive, arrogant, and even racist. While more sensitive and humble Development professionals might thus be more acceptable to Tanzanian partners, the above-mentioned Tanzanian hospital manager made clear that these were also not necessarily exempted from being sidelined by Tanzanian hospital staff:

If we had an agenda we don’t want to go out, I preferred not to invite [...]. You want to contain sensitive information. This foreigner might speak to development partners and government, he has other allegiances; if we spoke about sensitive issues like embezzlement of funds, or even embezzlement of donor funds, we didn’t want them to know about it. (Interview 52, July 30, 2010)

Here, it is suggested that assumptions of divergent loyalties led to sidelining German professionals. While Development professionals are officially portrayed as an integral part of the hospital structures in which they are deployed, their Tanzanian counterparts seem to place greater importance on where their salary comes from and to whom they are ultimately accountable. Judging by the German practitioners’ accounts discussed in 7.3, Tanzanians have limited influence with regard to negotiation and initiation of Development interventions; in contrast, this section has highlighted Tanzanian partners’ ability to contest, resist, and subvert the manner in which German professionals go about their practical work in hospital settings. Here, Tanzanian partners seem to have significant leverage to follow their own agendas. German as well as Tanzanian accounts of working relations in hospitals hint at fissures in the donor-recipient hierarchy.
In stark contrast to the accounts by German professionals thus far reviewed in 7.4, an interview with a KfW advisor who worked with the Tanzanian government yielded no indication of opposition by Tanzanian partners. She conceived of herself as in control of processes by working sensitively with Tanzanian counterparts:

Well, down here the mills simply grind differently, you know. Everything takes longer and you have to have greater staying power and you have to go again and again and you have to push, but you should not push too much, because otherwise they feel their toes are being trodden on. Well you have to muster a lot of empathy to see how it is done here. (Interview 18, May 20, 2010).

In accordance with what the former senior manager of the German-Tanzanian health programme considered good Development aid mentioned in 6.3 (Interview 10, April 21, 2010), she thought of herself as empathetic in her working relationship with Tanzanian partners. She did not regard their way of working as valuable, but as primarily lacking in quality. She thought that it was Development aid’s task to slowly change this. The way she described her Tanzanian government departments and her counterparts demonstrates that she felt highly superior to them:

They are quite, are just all in all very unorganised. And know .. there is no task list somehow, I think. I don’t know, I mean, I prepare a task list for myself every day, of what I have to do, or what’s on the agenda. And that, that, that is not the case there. They work differently. Well, I haven’t really found out how they work, but .. ((she laughs)) [...] Because often you don’t get the documents [for meetings, DB], there is just nothing there. Or you get something sent two hours before, and you’re supposed to comment on it. Well, it’s of course impossible to do that. And they are just, well, are often unprepared. [...] What you get then, that’s sometimes, well, you get some numbers [...] which we had already discussed before, and ok, the number is wrong ((appearing astonished)) And then you see it again! Well, it really is sometimes … where you sometimes think, well, .. yeeaaah .. sometimes you think, you can do this better with, with a 12th grade, well, in a school in Germany. Well this sounds a bit arrogant … Perhaps there are also other reasons, but sometimes it seems to you as if they just don’t get it. (Interview 18, May 20, 2010)

This characterisation of Tanzanian health professionals’ skills and planning capacities concords with the points raised in the previous chapter (see especially 6.3.2). This
advisor did not treat Tanzanian professionals as equal partners who contribute their share in the partnership, but rather infantilised them. If we are to believe the former Tanzanian hospital manager just quoted and if the German advisor had been deployed in a hospital, Tanzanian professionals likely would have reacted to such a demeanour by trying to sideline her. Yet, in contrast to the German doctors or advisers working in hospitals, she did not indicate that Tanzanians were consciously working against her and obstructing her work. As a KfW adviser to the government, she is in a position to make far-reaching decisions affecting financial disbursement. We may deduce that political-economic inequalities between Germany and Tanzania have a lot more bearing at this level of the Tanzanian health system, and that this makes German intervention less susceptible to resistance by Tanzanians. In accordance, a German physician working via CIM in a Tanzanian regional hospital mentioned that German Development policy is moving away from deployment of physicians in Tanzanian hospitals because these often merely serve as replacements (Interview 39, July 03, 2010). While such replacement seems to be what some Tanzanian hospital managers hope for, it is not in line with international Development cooperation’s proclaimed aim to reform health care systems at large. From the perspective of Germany’s interest of bringing in their influence as much as possible, it seems to make sense to restrict their work to higher levels such as the Ministry where donor agendas seem to encounter less resistance.

The impression of being obstructed and sidelined in hospitals evidently unsettled German professionals’ self-conception as being wanted and needed. In addition, the impression of not being involved in what they came to do seemingly disrupted their expectations of inducing change and their self-perception as enterprising experts (cf. Dyer 1997). Tanzanian opposition is explained by German professionals with reference to Tanzanian agents’ unwillingness to improve hospital management as well as their pursuit of personal interests. Some interviews with Tanzanian hospital managers confirm that they had agendas which diverged from those expected of them by the German donors. Moreover, they hold German attitudes of superiority accountable for problems in cooperation. In German as well as Tanzanian accounts, we find evidence of Tanzanians following their own agendas within the limited
space circumscribed by the aid context. Assumptions of Germans as “developers” and Tanzanians as grateful “recipients” are unsettled as German health workers at times find themselves at the whim of their Tanzanian counterparts. However, by analysing these interviews, we see that the donor-recipient hierarchy remains intact on higher levels such as German “cooperation” with the Ministry of Health.

7.5 Conclusions

In order to complement the picture provided in Chapters 5 and 6, which focused on the prevalence of colonial power in contemporary interventions, this chapter has added a more nuanced account of German intervention. It highlighted that present-day German intervention in reproductive health and population in Tanzania is not consistent and seamless, but full of fissures and contradictions. This was achieved by concentrating on “hidden transcripts” in the form of German professionals’ accounts of their practical work in German Development cooperation, complemented by a few Tanzanian accounts. It was shown that current German Development aid in Tanzania is marked by professionals’ doubts regarding the value of their work, by criticism of German aid practices, and also by Tanzanian opposition. However, while challenges to hegemonic ideas and practices of Development aid are evidently present, these did not necessarily destabilise colonial power. Even though doubts and uncertainty regarding their work are evidence of an unsettling of German professionals’ self-conceptions as change-inducers, the German accounts I examined tend to ultimately blame Tanzanians for failures. Moreover, they did not evidence doubts concerning the need for intervention as such and the superiority of Western medical knowledge and skills. Criticism of German Development aid was forthcoming but it hardly ever touched on the need for Germans to contribute to the “development” of Tanzania and its health care system. The “public transcript” in which Germany provides necessary assistance to “underdeveloped” Tanzanian midwifery and health care remains intact. Uncertainty and criticism harbour the potential to unsettle colonial power but, as is evident from the interviews examined here, the way they were dealt with rather reified existing colonial discourses and did not challenge political-economic inequalities. This
suggests that the hidden transcripts examined here tended to “strengthen and stabilise the existing system of domination” (Bliesemann de Guevara and Kühn 2012, 22). Colonial power did not seem to be fundamentally challenged by doubts and criticism by German professionals. Opposition to Development interventions by Tanzanians appears to be providing significant potential for challenging established power relations. German as well as Tanzanian accounts of work relations in hospitals are evidence of a destabilisation of hierarchies between donors and recipients in which Tanzanian hospital managers seem to pursue their own agendas against the will of donors. Yet, on the higher level of aid intervention in Tanzanian government departments and in the light of strong dependence on donors, this unsettling of established donor-recipient relations does not seem to occur or to be possible. Taking a dispositif-analytical framework enabled me to stay sensitive to material consequences of doubts, criticism, and opposition. As mentioned, the German professionals I interviewed continue with their Development interventions and, for example, persist in trying to teach the partograph despite uncertainty. Attention to non-discursive realities also allowed for taking into account the fact that German professionals are prevented from taking part in certain activities in hospitals by their Tanzanian colleagues. The perspective of dispositif analysis furthermore made me consider the politico-economic context in which German Development interventions are challenged discursively. The prevailing belief of German professionals in the superiority of their knowledge inhibits actual cooperation and the transformation of colonial power, because it is coupled with politico-economic asymmetries which privilege the donors’ positions.
8 Conclusion: summary, contributions, and ways forward

The aim of this study has been to explore the relationship between contemporary Development and the colonial past. This thesis has examined how and with what effects current Development intervention by actors from the global North to improve the lives of people in the global South is imbued with colonial power. It has been motivated by postcolonial approaches to Development (e.g. Kapoor 2008; Kothari 1996; McEwan 2009) and postcolonial critiques of German society (e.g. Eggers et al. 2005; Gutiérrez Rodríguez and Steyerl 2003). Both contemporary Development cooperation and German society are commonly portrayed as disconnected from and uninfluenced by colonialism. This study has therefore traced how discourses that emerged during German colonial rule are evident in present-day German Development aid, while paying attention to the manner in which they are connected to and have a bearing on practices, institutions, and the political-economic environment. Given changes in institutional setups (Development programmes and projects) and international relations (Tanzania’s formal political independence and the dominance of a neoliberal global governance framework), colonial discourses play out differently in the present as compared to colonial times. This study has provided evidence as to how present-day international Development is affected by colonial power by identifying the particular colonial legacy in German intervention in Tanzania in the field of population and reproductive health. This thesis has thus emphasised the historical and geographical specificity of colonial power in Development policy and practice by highlighting similarities as well as divergences between German intervention during colonial rule and today.

This chapter summarises this study and discusses its theoretical, empirical, and methodological contributions to Development Studies. Two contributions to theorising the connection between colonialism and contemporary Development emerge. First, this thesis suggests that the impact of the colonial past on present-day Development can be best comprehended by acknowledging the multidimensionality and complexity of colonial power (8.2). Furthermore, I contend
that one needs to acknowledge the continuity of colonial power despite
fundamental changes in policy orientation (8.3). In addition to these theoretical
contributions, this research has also empirically contributed to the field by opening
up new geographical and policy areas of research (8.4). It has historicised and
localised Development by carrying out a postcolonial analysis of German
Development interventions in Tanzania. By focusing on a specific policy field, namely
population and reproductive health, it complements postcolonial Development
Studies which analyse general policy statements or subjectivities of Development
professionals. This thesis further contributes to methodological approaches by
developing and applying genealogical dispositif analysis to the study of colonial
power in present-day Development intervention (8.5). In this context, the study has
also highlighted the need to integrate a broad range of sources including archives
and publications as well as interviews and observation.

In order to carry out research in Development Studies, it is necessary to consider
the relationship between theory and policy which characterises the discipline.
Academic Development Studies is intimately linked with practical interventions
under the name of Development aid, assistance, or cooperation. This is exemplified
by the fact that Development scholars and professionals move between performing
academic work, carrying out consultancies, and employment in Development
agencies and organisations. Following Burowoy’s categorisation of sociology and
relating this to Development Studies, we can differentiate between an “academic”
and an “extra-academic audience” (cit. in Kothari 2005a, 6). The present study aims
at creating “a dialogue about assumptions, values, premises” in Development
among academics as well as extra-academic audiences (Kothari 2005a, 12). My own
work has been shaped by the multi-faceted nature of Development Studies.
Alongside my academic research, I work as a seminar facilitator, funded by German
foreign aid, for Development organisations to provide a forum for a young, extra-
academic audience doing volunteer service in the global South to reflect upon issues
such as the connection between colonialism and Development. Given the
characteristics of Development Studies, it is essential for related research to engage
with academic as well as extra-academic audiences. This thesis engages in dialogue
with scholars of critical Development Studies who take radical historical, feminist, post-development, and postcolonial approaches to Development. The extra-academic audience comprises Development aid circles, particularly those professionals interested in reflecting upon the colonial legacy of the policy fields in which they are involved. Before presenting and discussing the contributions of this study, I will briefly recapitulate the present study chapter by chapter.

8.1 Thesis summary

Chapter 1 stated the motivation and specific research interest of this study, which intended to discern whether, how, and with what effects contemporary Development is imbued with colonial power by focusing on contemporary German Development policy and practice in population and reproductive health in Tanzania. It was motivated by questioning the widely held assumption that Development is a positive, charitable undertaking by countries of the global North to improve the lives of people in the global South; by examining the power of Development as it prescribes and forges a specific path of societal change in which “development” of the global North remains the unquestioned norm; and by investigating the possibility of transforming Development cooperation in the context of colonial discourses and the connection of these discourses to political-economic inequalities. The specific research focus was German intervention in population size as well as in childbirth-related practices. In addition, an examination of challenges to German Development intervention by German as well as Tanzanian professionals was ascertained to be of value for understanding colonial power in the present.

Chapter 2 developed a conceptual framework by reviewing current debates in Development Studies on the relationship between power, postcolonialism, and Development on population and reproductive health. It argued for conceptualising power as dispositif: as discourses intertwined with practices, institutions, and political-economic conditions. This notion of power allows for considering the multiple dimensions of power as well as actors’ agency to move within and challenge dominant discourses. Colonial power was understood to be discourses
which emerged during formal colonisation, transcended this historical period, and continue to shape the present. Development was conceptualised as a process of individuals and institutions of the global North intervening in the global South to improve people’s living conditions. Development and intervention in population and reproductive health were considered to serve the function of controlling and regulating populations in the global South and establishing hierarchies between “modernity” and “tradition”.

Based on these conceptualisations, Chapter 3 developed a methodological framework to provide empirical insight into the relationship between current Development and colonial power. It suggested genealogical dispositif analysis, which draws on interpretations of Foucault’s research methodologies of genealogy and discourse analysis, as an appropriate instrument for examining colonial power in the present. The historical approach of genealogy traces the emergence of a phenomenon – in this case, German intervention in population and reproductive health in Tanzania today – in order to shed new light on contemporary ways of dealing with this phenomenon. Discourse analysis examines politics and society as time- and place-specific knowledge configurations that structure people’s perceptions of phenomena. Dispositif analysis extends that focus to take into account the relationship of discourses to corresponding practices, institutions, and the political-economic environment. Moreover, it analyses the agency of actors to adopt or reject discourses. Chapter 3 also explained the process of data collection (archives, publications, interviews, and observations) and analysis undertaken in this study.

Chapter 4 provided an introduction to the empirical study by sketching German colonialism and the case of Germany’s colonial rule in “German East Africa”. It suggested that German Development intervention in population and reproductive health emerged in the later stages of German colonial rule of East Africa. This chapter also gave an overview of post-independence Tanzanian “development” focusing on health conditions. Finally, it outlined German Development cooperation with an emphasis on Germany’s relation to Tanzania and endeavours in the field of
reproductive health and population. The chapter highlighted the significance of German colonial-era and contemporary relations with Tanzania, particularly in the area of population and reproductive health.

Chapter 5 suggested that contemporary understandings in German Development cooperation regarding what constitutes appropriate population development in Tanzania display similarities with colonial-era discourses. Regardless of the fact that German policies during colonial rule highlighted underpopulation while contemporary German Development aid stresses population growth to be the problem, German agents in both periods have associated what they considered problematic population size and fertility rates with a general backwardness of East Africans, particularly with regard to gender relations. Such racialised, gendered discourses were in both periods accompanied by actual interventions to change East African population, fertility rates, and gender relations. While forceful measures, “schooling”, and Christianisation dominated during formal colonisation, today the promotion of “modern” contraceptives takes centre stage. German colonial intervention to increase population was explicitly legitimised with reference to economic interests, while philanthropic motivations were second in importance; contemporary German policies in the field of population and reproductive health are primarily presented as philanthropic, altruistic endeavours. Only rarely is economic or political self-interest invoked. Yet, this chapter demonstrated that German pharmaceutical companies’ have considerable stakes in providing contraceptives. Hence, whether pro-natalist as during colonial rule or anti-natalist as today, German intervention into population and reproductive health is in line with German economic interests. Colonial power in current German Development policy on population and reproductive health is thus evident in the manner in which racialised, gendered discourses interconnect with legitimising strategies and the political-economy of population control.

Chapter 6 focused on a different aspect of population and reproductive health, namely obstetric care. During colonisation, German practitioners promoted medicalisation of birthing by introducing Western-style hospitals, training staff, and
changing practices such as birth positions. Nowadays, German Development aid engages in reforms within the arena of biomedical birthing. Development professionals criticise and attempt to reform the way obstetric care is carried out in Tanzanian hospitals. Analysis of ideas and practices uncovered that during colonial rule as well as today, German agents have established hierarchical difference between Western and East African birthing practices. In colonial-era as well as contemporary discourses, East African obstetric care is construed to be deficient with regard to knowledge, planning capacities, and attitudes. Ever since colonisation, East African obstetric care has been constructed as in need of catching up with German childbirth practices. However, this seems impossible given that what German actors consider to be correct obstetric care has been constantly changing, and seemingly insurmountable difference between these German actors and their Tanzanian counterparts has continually been established by German interventionists on all levels of health care.

Chapters 5 and 6 focused on dominant discourses and practices in German Development cooperation in order to examine the legacy of colonisation in the present. These chapters demonstrated how colonial power is manifest in present-day German intervention and examined the effects of the persistence of colonial power. The task of Chapter 7 was then to provide nuances to this seamless picture of colonial power. Focusing on German professionals’ narratives, it examined to what extent colonial power is challenged in German Development intervention today. Some accounts showed evidence of doubt regarding the appropriateness of instructing Tanzanians in biomedical obstetric practices. Others criticised German Development cooperation with reference to disregard and abuse of political-economic asymmetry between Germany and Tanzania. Nonetheless, these two types of challenges were found to not fundamentally unsettle colonial power since notions of the superior knowledge and skills of German Development professionals were maintained. Thus, the study found that even though dominant discourses are doubted and German endeavours subjected to criticism, colonial power ultimately prevails. A third aspect proved more unsettling: German professionals working in Tanzanian hospitals reported being sidelined or instrumentalised by their Tanzanian
hospital managers. This was affirmed by Tanzanian interviewees’ accounts which explained such resistance to German Development aid’s expectations with reference to incompatibility of agendas and German Development professionals’ attitude of superiority. Yet, in German Development cooperation on higher institutional planes such as Tanzanian ministries, there was no indication of Tanzanian professionals’ successful resistance. Donor dominance is destabilised at lower levels but maintained on higher levels of Development cooperation. While Chapter 7 provided evidence that colonial power is not monolithic but rather heterogeneous and challenged, it also showed that challenges do not necessarily imply significant disruption of colonial power. Colonial power tends to take effect in the face of and through opposition.

8.2 Acknowledging the multidimensionality and complexity of colonial power in Development

This thesis contributes to theorising the relationship between colonialism and Development by highlighting that in order to understand the impact of the colonial past on present-day Development interventions it is necessary to take into account the multidimensionality and complexity of colonial power – the interconnectedness of colonial discourses with material realities and the agency of Development professionals. As such, it also provides a response to the incessant criticism levelled at postcolonial approaches of overemphasising discourses, disregarding materiality and overlooking the heterogeneity of colonial power (Ahmad 1995; Loomba 2005; Santos 2010).

First, this study confirms, and builds on, the insights of postcolonial, feminist (Deuser 2010; Kerner 1999; Mohanty 1991) as well as postdevelopment and postcolonial Development Studies (Crush 1995c; Escobar 1994; Kapoor 2008) into the persistence of racialised and gendered discourses of “modernity” in contemporary Development. It has demonstrated that racialised, gendered discourses are today invoked to ascertain the need for curbing population growth, whereas during colonial rule their articulation was related to interventions to
increase East African population (Chapter 5). Chapter 5 also showed how discourses that hold social conditions and backward gender relations in the global South responsible for allegedly problematic fertility rates persist in informing German policy and practice today. Moreover, the analysis of German narratives and practices related to obstetric care demonstrated that these continue to be guided by the positing of racialised difference between East Africans and Germans or Westerners with regard to knowledge, planning capacities, and attitudes (Chapter 6). This study evidenced the continuity of blaming what German agents consider oppressive gender relations and backwardness for unsuitable population developments and obstetric practices. Yet, this study has not only expanded the insights of postcolonial Development Studies via empirically informed research into discourse, but also by highlighting how colonial discourses in Development interventions are connected to the global political economy and are in line with economic and political interests of the global North.

This thesis thus points out the importance of addressing actual practices and the global political economy in which Development interventions are embedded. It contends that to understand colonial power in current interventions, discursive dimensions must be complemented by attention to actual practices and the political-economic environment. The finding that colonial-era interventions were primarily justified with reference to Germany’s economic interests inspired my inquiry into the connection of colonial discourse to economic profitability (Chapter 5). This study examined legitimising strategies in German Development cooperation which emphasised self-interest, and also concrete economic stakes of transnational companies. It thus confirms Kuumba’s suspicion that transnational companies have stakes in international population politics since these create consumer markets for contraceptives (1999, 455). Examining the origins of “modern” contraceptives in Tanzanian health facilities and in the contraceptive market in Tanzania more generally, this study found that Bayer HealthCare and other German pharmaceutical companies have significant stakes in Tanzania and profit from donors’ promotion of “modern” contraception (Chapter 5). This research thus contributes to Development Studies by pointing out that colonial power in Development can only be fully
comprehended by tracing the continuity of racialised, gendered Development policies in the global South to actual practices as well as real economic interests of the global North.

By focusing on actors in Development, this study has further contributed to understanding the impact of the colonial past on current interventions. It has highlighted the heterogeneity of stances within German Development aid through an analysis of accounts of German professionals working in reproductive health and population in Tanzania (Chapters 5, 6 and 7). This challenges studies which portray Development aid as homogeneous by restricting the analysis to dominant “forms of knowledge, practices and discourses” (Deuser 2010, 438; transl. DB). It contributes to postcolonial Development Studies by emphasising that challenges by donor actors to dominant Development policy play out differently depending on the specific context of interventions. The manner in which German Development professionals dealt with their frustrations regarding teaching the partograph to Tanzanian health professionals (Chapter 7) substantiates Eriksson Baaz’ finding that “representations in the development aid context are characterized by hesitancy and a degree of self-reappraisal over time, which co-exist [...] with the location of the problem in Africa and the solution in the West” (2005, 164). While uncertain about the value of their work and whether or not the epistemology they adhered to was suitable for the Tanzanian context, German professionals ultimately located the problem in Tanzania and could not imagine other ways of pursuing or teaching midwifery. Yet, the interviews did not yield any indication that Development professionals challenged notions of Western superiority by romanticising Tanzanians as authentic and unspoiled, as Eriksson Baaz (2005) has found. What was perceived as passivity of East Africans was never presented in the form of the “desired passive Other” (Eriksson Baaz 2005, 159), but merely judged as negative and a source of frustration for German Development professionals (Chapter 6). Development professionals might present passivity as desirable when interviewed in a general manner about living and working in a “developing” country (Eriksson Baaz 2005; Heron 2007), but this did not come to the fore in this investigation of the specific field of reproductive health and population in which “professionalism” was regarded
as crucial. In this context, German Development professionals tended to associate passivity with stagnation, indifference, and lack of compassion and blamed this for poor obstetric and health care (Chapter 6). This study contributes to existing research on heterogeneity and contradictions in Development aid (Eriksson Baaz 2005; Heron 2007) by scrutinising the accounts of actors in Development and by pointing out their particularity in the case of a specific policy field such as population and reproductive health. All in all, the thesis’ contribution to understanding the relation between the colonial past and present-day Development interventions is thus to emphasise the need to acknowledge the multidimensionality and complexity of colonial power in Development and to respond to it by taking into account colonial discourses as connected to material realities and the agency of actors.

8.3 Recognising the continuity of colonial power in the face of changes in policy orientation

This thesis has found that although intervention into population and reproductive health has clearly changed over time at the level of policy orientation, it has remained remarkably consistent with regard to colonial power. Such findings lead to viewing international Development as pervaded by colonial power and thus contribute to theorising the relationship between colonialism and Development. Here, this study amends critical Development and post-development approaches which identify international Development as a discourse and institutional set-up that emerged in and is specific to the post-WWII period (Escobar 1994; Sachs 1992; Tucker 1999).

This study has provided evidence that German colonisers began to think about and intervene in population numbers, obstetric care, and the field of population and reproductive health in general during the second half of German occupation of “German East Africa” (Chapters 4, 5, and 6). Two aspects of this research in particular have demonstrated the way policy orientations have changed while colonial power remained similar: prescriptions regarding “correct” reproduction and
those regarding high-quality obstetric care. Taking a historical perspective, colonial and current policy goals regarding population size have emerged as diametrically opposed to each other (Chapter 5). Yet, as recalled in the previous section (8.2), discourses of modernity and economic considerations have shaped German policy and practice in both periods. In German obstetric care in “German East Africa”/Tanzania, interventions, discourses, and goals have also changed considerably (Chapter 6). During colonial rule, German actors criticised birthing methods as being backward because birth did not take place in hospital settings, assisted by medical professionals. Today, by contrast, Tanzanian hospitals are portrayed as dangerous places, largely due to the perception of a lack of knowledge, planning capacities, and proper attitudes of Tanzanian health professionals. As a specific example of a change in policy orientations, German professionals advocated for the supine birth position during colonial rule, but today try to convince Tanzanian nurses to dispense with this. Whereas medicalising birthing was at stake during colonisation, today the aspect of compassion and sensitivity towards patients is emphasised by German Development professionals. This study has demonstrated that Development goals and policy preoccupations regarding population growth as well as obstetric care must be understood as reflecting colonial discourses of African backwardness and traditionality. Such findings amend existing critical studies of population politics by placing emphasis on the colonial power that underpins contemporary intervention into reproductive health and population development (DuBois 1991; Schlebusch 1994).

With its critique of discourses on overpopulation, critical Development Studies has generally overlooked the older tradition of European population and reproductive health policies. During colonial rule, inhabitants of colonised territories were not feared as potentially destabilising, superfluous people but, quite the contrary, depopulation was taken to be a problem and colonisers feared disadvantageous consequences of depopulation for economic exploitation of colonised territories (Chapters 4 and 5). Taking into account the pro-natalist approach of German intervention in “German East Africa”, Development Studies’ understanding of population and reproductive health policy should be reconsidered. The focus can no
longer be merely on curbing population growth in the global South, but rather it should address population regulation in general, whether anti- or pro-natalist. The present study concurs with scholars of colonialism and Development who have questioned the notion of a clear break between colonial and Development policy and practice by pointing out that ideas and practices of Development arose over the course of colonial occupations (Cooke 2001; Hodge 2007; Kothari 2005b). The findings of this study have consequences for existing critical conceptualisations of Development. Critiques of Development as a liberal project of governmentality have situated its emergence in the post-WWII era and, for example, regard it as a “planetary architecture” to contain poor populations of the global South to the advantage of the global North (Duffield 2005, 2006; Pupavac 2005; Schultz 2006). While this study concurs with the proposition that Development can be understood as a strategy to deal with the number of people as a function of the global North’s interests, Development-type intervention during German colonisation was not meant to curb population growth but rather to preserve and augment it. In this light, Development cannot be theorised as a strategy to fight “surplus population” in the global South, but rather as serving the regulatory interests of the North. Such a perspective might also allow scholars to be sensitive to possible future developments in population and reproductive health policy towards the global South, in which anti- (regarding marginalised people) and pronatalist (regarding privileged people) policies run concurrently, as is the case in countries of the global North such as Germany today. Development in this field should thus not be understood as part of a post-WWII Development project but rather as embedded in a longer colonial history and its current legacy. Colonial power can thus be theorised as the basis of contemporary reproductive health and population policy and practice in the global South, and, by extrapolation, as the underlying basis of Development as such.

8.4 New fields of research

The empirical contribution of this study is that it focuses on largely under-researched areas: on German Development assistance and the particular policy field
of population and reproductive health. A relative wealth of information exists on the
correlation between colonialism and Development, but postcolonial Development
Studies have to date concentrated their attention on the case of British colonial rule
and Development intervention (Biccum 2005; Hodge 2007; Kothari 2006c; Noxolo
2006; Slater and Bell 2002). Adding to individual postcolonial studies of Danish and
Swedish (Eriksson Baaz 2005), Canadian (Heron 2007), and Portuguese (Power 2006)
Development endeavours, this research focuses on Germany and its interventions in
the specific context of “German East Africa”/Tanzania. The implications are both an
affirmation of the similarities between (post-)colonial undertakings, and a further
challenge to an assumed singularity of colonialism and its legacy. This study has
provided evidence of the resemblance of German colonial intervention in
population and reproductive health with other European nations’ policies and
practices. For example, various European states began to perceive the regulation of
population size, birthing, and women’s health as essential for their colonising
endeavours after the turn of the 20th century (Grosse 2000; Hesselink 2011; Jolly
1998). More importantly, this study challenges the singularity of colonisation and its
legacy as it highlights that different colonial projects cannot be subsumed under one
understanding of colonialism. Parry and others (e.g. Lambert and Lester 2006) have
argued that colonial rule was never “monolithic” but rather characterised by a
“dispersed space of power and a disseminated apparatus, wielded by diverse agents
and effecting multiple situations and relations” (2004, 14). Thus, differences
between colonisations and their legacies must also be acknowledged and studied.
While colonialism was undoubtedly a trans-European project, one cannot assume
that Germans in “German East Africa” held the same convictions, followed the same
policies, and carried out the same practices as other European colonisers in other
territories. This also means that contemporary Development interventions by
different countries from the global North draw on different cultural experiences and
backgrounds. This research shows the specificity of one individual national case of
colonial power in international Development. For example, the simultaneity of
German Development professionals’ philanthropic arguments to legitimise
interventions and ignorance regarding German economic stakes in reproductive
health in Tanzania was highlighted. The study also ascertained how obstetric
practices such as the supine birth position were introduced by Germans during colonial rule and are now called upon as evidence of Tanzanian backwardness. German professionals are positioned within the legacy of a specific, not a generic colonial past. Because colonialism was both a European and a multi-faceted endeavour, postcolonial Development Studies must take account of similarities and divergences in colonial power in contemporary Development.

In addition to developing this geographical area of research, this study put forward an analysis of the specific policy field of population and reproductive health. Since postcolonial Development Studies has thus far largely refrained from analysing specific Development interventions and has primarily focused on general policy orientations and developers’ subjectivities (for exceptions, see Chimhowu and Woodhouse 2005; Wainwright 2008), such an endeavour substantiates the value of a postcolonial approach to Development. The focus on policy and practice in the particular field of population and reproductive health has allowed for understanding the interrelatedness of discourses with practices and political-economic conditions which cannot be achieved by examining general policy papers (Noxolo 2006; Slater and Bell 2002) or interviews alone (Heron 2007; Kothari 2006c). For example, Chapter 5 highlighted German pharmaceutical companies’ stakes in “modern” contraception in Tanzania; Chapter 6 took into account the practices following from particular perceptions of what some German professionals considered to be appropriate obstetric care. The focus on activities in a particular policy field also made it possible to trace ideas and practice from programmatic top-level policy statements to programmes and projects in Tanzania as well as German professionals’ accounts of their practical work. Such a multi-level and multi-faceted examination yields a nuanced picture and highlights heterogeneity and contradictions. This concrete scrutiny of interventions has meant that an examination of colonial power in present-day Development did not remain abstract. Instead of merely finding that policy papers construct people in the global South as backward, this study discerns colonial discourses of African inability to think rationally in concrete instances such as German Development professionals’ accounts of their attempts to teach Tanzanian nurses to use the partograph. Rather
than criticising Development for generally taking Western “modernity” as a benchmark, this study has highlighted how this plays out in aspects such as promotion of specific practices (for example, “modern” contraceptives and gender relations), manners of thinking (rational “if, then” reasoning), and work ethics in reproductive health and population. Building upon existing research on Development in population and reproductive health which focuses on discourses (Deuser 2010; Schultz 2006), this study examines the connection of discourses to concrete material practices such as dissemination of contraceptives and teaching partographs and birth positions. All in all, the present study empirically contributes to Development Studies by fleshing out policy fields as areas of research as well as by extending the postcolonial analysis of the specific policy field of population and reproductive health to new levels.

8.5 The methodology of genealogical dispositif analysis

This study also contributes methodologically by developing and applying the approach of genealogical dispositif analysis. Through its application, this thesis has also underlined the need to draw on a variety of methods. Approaching colonial power in Development through genealogical dispositif analysis means tracing the emergence of contemporary discourses on population and reproductive health in the past, while taking into account their connectedness to particular practices, concrete institutions, and respective political and economic circumstances. The genealogical approach has highlighted how topics such as population size, fertility rates, gender relations, and obstetric care emerged in German policy debates at the beginning of the 20th century, and how they continue to be discussed and intervened into in present-day German Development aid. This study refines existing approaches in postcolonial Development Studies that focus on the analysis of discourse (Biccum 2005; Kothari 2005b; Noxolo 2006) by addressing the complexity and multidimensionality of power. It thus highlights the need to expand upon discourse analysis in order to understand power: discourses were examined with regard to their connectedness to actual practices and political-economic conditions, while taking account of actors’ capacity to move within and beyond dominant
discourses (cf. Gutiérrez Rodríguez 1999b). It builds on studies that have sought to bring together an analysis of discourse and non-discursive phenomena (Brigg 2001; Wainwright 2008; Ziai 2007). Thus, this thesis could not only show how German colonial-era professionals presented East African childbirth-related practices as backward, but also that they effectively introduced Western midwifery practices, built biomedical health facilities, and trained East Africans to be nurses (Chapter 6). The sensitivity of dispositif analysis for discursive as well as non-discursive dimensions of power also allowed for identifying shifts in power: In the colonial period, Germany’s economic stakes in enhancing population growth were evident in discourse as well as in the material sense; in contemporary Development policy, economic rationales for intervention are seldom expressed, even though German pharmaceutical companies are heavily involved in the procurement of contraceptives for Tanzania (Chapter 5). Genealogical dispositif analysis has enabled this research to demonstrate that discourses which underlie the specific perceptions of issues of population and reproductive health during German colonial rule continue to shape contemporary German Development policy and practice and are connected to, and have effects, in the real world. The application of this methodology allows for a new, sensitised perspective on the present; rather than manifesting its self-image of improving the lives of people in the global South, contemporary German intervention in population and reproductive health has turned out to be “a neo-colonial [...] [endeavour] in which particular gendered and racial formations constructed through colonial processes are re-presented and re-articulated” (Kothari 1996, 3). While existing historical approaches in Development Studies tend to focus on the evolution of institutions and economic “development” (Bayly 2008; Bayly et al. 2011; van de Walle 2009), this research thus provides evidence that analysing discourses through a historical perspective, with regard to their relation to materiality, and by acknowledging the agency of Development professionals is useful to “provide critical responses to the historical effects of colonialism and the persistence of colonial forms of power and knowledge into the present” (Kothari 2011, 69).
In order to put such a genealogical dispositif analysis into practice, this study made use of a variety of sources, ranging from archives, publications, and observations to interviews with professionals. The aim was to provide broad, differentiated insights into policies and practice on population and reproduction during German colonial-era and current intervention in “German East Africa”/Tanzania. Thus far, most of the empirical work on postcolonial Development has relied on analysis of documents (Biccum 2005; Kapoor 2008; Noxolo 2006; Slater and Bell 2002). Other scholars have also employed an interview method to tease out nuances and contradictions in interviewees’ accounts of their life and work in Development (Eriksson Baaz 2005; Heron 2007; Kothari 2006c). Research that incorporates further methods of data gathering, such as historical sources (Deuser 2010) or observation (Wainwright 2008), is able to unearth the variety and complexity of narratives, practices, and political-economic conditions. As underlined by the present study, interviews and observation are necessary in order to analyse what is not expressed discursively and to understand the material aspects of Development. Had I not visited hospitals and spoken with staff at the Tanzanian Medical Stores Department, I would not have realised that German pharmaceutical companies had stakes in population and reproductive health politics. Examining original historical sources (archives and publications) also seemed crucial: While German colonial-era thought and practice on topics such as population growth, fertility, and obstetric practices are broached by historical studies (Bruchhausen 2003; Colwell 2001; Grosse 2000), the focus of this research on the connections between the period of formal colonial rule and contemporary Development made it indispensable to analyse the historical material in such a specific manner that the past could be compared with the present. By developing and applying the methodology of genealogical dispositif analysis, this study has thus emphasised the need to draw upon a variety of sources to do justice to the complexity and specificity of colonial power in distinct policy fields of Development.
8.6 Building on this research

There are several possibilities for extending this research. The theoretical and methodological framework developed here could be implemented with regard to other policy fields. This could not only help to shed light on the colonial legacy in other areas of Development intervention, but would also serve to refine the framework. Furthermore, it could be interesting to ascertain whether the findings of this research, namely that colonial power underlies contemporary Development intervention in population and reproductive health, are in line with findings of a respective transnational study. This could include British, French, Dutch, Belgian or Portuguese Development aid in this field, as well as take into account countries without a history as colonial occupiers, such as Switzerland, or the “new” aid donors, such as India, Brazil, and South Korea. Such an endeavour could also attend to the interesting question if colonial power in Development persists where former colonised countries act as donors. Further research would need to follow up on the crucial question of whether there are avenues and strategies that lead beyond colonial power in international Development policy. The efforts made in this study to expose the colonial foundations of, and effects on, Development cooperation is “essentially unfinished if we do not ask the question: what would de-colonized, de-whitened, post-colonial [Development policy, DB] look like?” (Crush 1994, 334).

While this can be approached as a theoretical question, it may be fruitful to empirically examine ruptures in dominant discourses and practices, to unearth resisting voices, and to pay attention to counter-conduct in order to imagine and construct postcolonial Development perspectives. It may well be that the increasing South-South cooperation as well as the proliferation of global social movements point to ways out of colonial power in international Development. Or, perhaps countries in the global South, such as Bolivia, are opening new paths in terms of national Development strategies which revalue non-Western knowledge systems and counter the prevalent structure of land and resource ownership based on a colonial legacy. Recent changes in global power relations, such as the new role of the BRIC countries (Brazil, Russia, India, and China) and their increasing influence on regional and global affairs need to be taken into consideration in this respect. The
“traditional” donor countries might become less and less influential in issues of global reach. Whether this means a transformation of Western techno-scientific knowledge, of the primacy of economic reasoning, and of managerial approaches to societal organisation is a different issue. However, international Development aid, which is almost negligible in terms of financial volume when compared to trade and investment flows, might become less and less important on the global scale, as we are, as Hall (2011) puts it, in the midst of the “neo-liberal revolution”: “neo-liberal ideas, policies and strategies are incrementally gaining ground globally, re-defining the political, social and economic models and the governing strategies, and setting the pace” (Hall 2011, 708). Yet, there is always room for optimism as no project ever achieves a position of permanent dominance: This thesis has emphasised the significance of the colonial past for our present, but would not have been written without the trust that “history is never closed but maintains an open horizon towards the future” (Hall 2011, 728).
## Appendix 1: Table of interviews

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<thead>
<tr>
<th>Interview number</th>
<th>Date of interview</th>
<th>Place of interview</th>
<th>Affiliation</th>
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</table>
Appendix 2: Interview guide

1. How did you come to work in Development aid and in the field of reproductive health/ population/ maternal health/ health in Tanzania? What have you been doing/are you doing with respect to this area?

2. What is your opinion on reproductive health/ population/ maternal health/ health conditions in Tanzania? What do you think of current policies and their implementation?

3. Please tell me about the projects/ programmes/ initiatives in which you are involved, how they are carried out, what your role is, and the nature of your working relations with your colleagues.

4. Some scholars argue that donor policies in Tanzania are implicitly aimed at curbing population growth, even though donors officially embrace the post-Cairo Conference principles of sexual and reproductive health and rights and freedom of choice. What is your view on this?

5. The website of the Tanzanian German Programme to Support Health refers to Germany’s activities in health during colonial times. Does this history play any role for you or in your work?
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