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Colonizing the Womb: Women, Midwifery, and the State in Colonial Ghana

Committee:

Toyin Falola, Supervisor
Juliet E. Walker
Ruramisai Charumbira
Omi Osun Joni L. Jones
Cecilia S. Obeng
James R. Denbow

Colonizing the Womb: Women, Midwifery, and the State in Colonial Ghana

by

Nana Akua Amponsah, B.A.; M.A

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Dedication

To my mother, Agatha Christie Nyarko

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Abstract

Colonizing the Womb: Women, Midwifery, and the State in Colonial Ghana

Nana Akua Amponsah, Ph.D.

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Supervisor: Toyin Falola

This dissertation explores the British colonial government's attempt to reconstruct women's reproductive behaviors in colonial Ghana through the sites of maternal and infant welfare services and western midwifery education. In the early 1920s, the fear that the high maternal and infant mortality rates in the Gold Coast would have repercussive effects on economic productivity caused the colonial government to increasingly subject women's reproduction to medical scrutiny and institutional care. I argue that female reproduction was selected as a site of intervention because the British colonial government conceived of it as a path of least resistance to social reconstruction, economic security, and political dominance. The five chapters have been designed to analyze colonial reproductive intervention as a socio-economic and political

exigency of colonial rule. This dissertation speaks to the fact that cross-culturally, the female body has been politicized through narratives of power, culture, tradition, modernity, race, disempowerment, and empowerment.

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INTRODUCTION

This dissertation explores the medicalization and politicization of women's reproduction from the early 1920s to the early 1950s in colonial Ghana. In a period marked by significant high infant and maternal mortalities and demographic concerns, the British colonial administration became anxious about population growth, and by extension, labor supply, and increasingly subjected female reproductive functions to medical and political controls. In this dissertation, I investigate the ways in which the 'colonization of women's womb' reconstructed the feminine experience of pregnancy, childbirth, and childcare. The study examines the British colonial government's pejorative notions about African motherhood and "traditional" midwifery practice and their efforts at remaking Ghanaian motherhood through the mediums of maternal and infant welfare services, hospital infrastructure, and western midwifery education.

I argue that maternal and infant welfare and western midwifery education were selected as specific sites of reproductive intervention because the British colonial government conceived of them as paths of least resistance

to social control, economic exploitation, and political domination. I contend that while the colonial government's efforts at reconstructing motherhood disrupted the social management of pregnancy and childbirth in colonial Ghana, it did not necessarily result in a complete colonization of women's womb. Rather, Ghanaian women initiated their own counter-strategy to the medicalization and politicization of their reproductive functions.

Utilizing the concept of "Colonizing the Womb," I demonstrate that during the colonial period in Ghana, pregnancy and childbirth were no longer private experiences; rather, they were transformed into social, economic, and political issues. Thus, I investigate the ways in which pregnancy and childbirth were removed from the home environment to the hospital environment and the introduction of western midwifery practice in the late 1920s. Among the many reproductive issues discussed, I concentrate on the opening of maternity hospitals and infant welfare centers, mothercraft lectures, midwifery education, and the rules and regulations that defined the boundaries of midwifery practice in the country. Undoubtedly, midwifery is an important aspect of every society. It ensures the continuity of a society and healthy

survival of its populace as well as a source of power for women who have traditionally been in control of the process and management of childbirth.

Therefore, the British colonial government's overconcentration on the reproductive capacity of women through midwifery and maternal and infant welfare policies provide an avenue through which to assess state power because it untangles the connections between socio-economic and political management and the gender politics of colonial rule and how the female body served as a link between these sites. In focusing on the transformation of midwifery practice in the country and the medicalization and hospitalization of pregnancy and childbirth, I gender the dialogue around colonial social, economic, and political policies. In addition, by bringing attention to colonial government's importunate attempt at remaking African motherhood, and in so doing, controlling women's reproduction, this study contributes to African historiography in number of ways. It highlights how contemporary gender dynamics in many African societies bears its roots to colonially constructed ideologies on the roles of women and men, and how such ideologies have structured socio-economic and political relations grounded

in gender difference. In addition, by offering and discussing the different ways in which women, specifically mothers in colonial Ghana participated in a historical event and affirmed their agency, this dissertation incorporates women's perspectives into historical narratives, and opens an opportunity to historicize women's experiences. It joins a number of scholarships that have shown that African women actively participated in the making of history and not the passive onlookers of historical events that have generally been portrayed.

In analyzing the colonial government's attempt at colonizing the womb as a historical process of negotiations and contestations, this dissertation differs from other scholarly works that have tended to view colonial reproductive and gender impositions only in terms of "colonizers were wrong, Africans were right" or in terms of colonial oppression verses anti-colonial resistance. These interpretations fail to unearth the complexities involving the combination of the two medical systems and the in ways in which Africans and Europeans contested and negotiated to get what they wanted out the colonial reproductive measures. Moreover, many of the existing literature have ignored the broader context of African women's history as

essential in explaining women's reproduction and the colonial encounter and the reasons that made women the target group for the colonial intervention. Thus, one of the purposes of this dissertation is to attempt to address some of these concerns. The study also asks a number of questions. For instance, what motivated the British colonial government to attempt to remake Ghanaian motherhood and control reproduction? Why did some Ghanaian women readily participate in this intervention while others simply ignored it? How did the introduction of infant and maternal welfare and western midwifery education affect motherhood? How did the control of women's reproduction help the British colonial government to entrench its political domination?

Lastly, I have situated this dissertation in the period of the early 1920s, when maternal and infant mortality rates were viewed as extremely high and the early 1950s, when the British colonial machinery had been well established. I have limited myself to this timeframe because it embodied the highest period when women's reproduction received the most attention from the colonial government as well as the timeframe in which colonial health and medical officials intensely expressed their

anxieties about Ghanaian mothers and children. In emphasizing the social, economic, and political underpinning of the introduction of western midwifery practice in colonial Ghana, this study joins a limited but significant number of studies on health and medicine in Ghana that examine the complexities in the history of colonialism and the struggles over wealth, health, and power as well as struggles over modernity and tradition. This dissertation also connects, in a broader sense, to the economic significance of enslaved women's reproduction in African American history, particularly during the period after the abolition of the slave trade when women became the main source of replenishing and sustaining the workforce of the enslaved population. In the same way, it connects with the negative implications of European sexualization of the female body in African Diaspora studies.

Contextual Perspectives

The parameters of this dissertation are set within the context of twentieth century colonized Africa in which the bodies of African women became sites of appropriation for western biomedical practices and experimentation—

particularly in terms of pregnancy and childbirth. Colonial governments' efforts at maternal and child welfare in Africa resided in nineteenth century western attempts at medicalizing pregnancy and controlling of women's reproductive life, and as argued by Barbara N. Ramusack, Britain readily transported its "maternal imperialists" policies into its colonies. The transfer was possible because such policies did not entail any critique of the economic or environmental effects of colonialism on maternal and child welfare. Besides, colonial officials utilized an array of social problems, such as poverty, population decline, sexually transmitted diseases, prostitution, and adultery to guard against any questions or concerns on economic and environmental exploitation. In the Gold Coast, a 1932 report by the Deputy Director of Health Services, Dr. P. S. Selwyn-Clarke, regarding aspects of maternal welfare in England and in the Colony, indeed gives credence to Ramusack's argument.

According to the report, when maternal and child welfare began in England in 1906, it was soon discovered

¹ Barbara N. Ramusack, "Cultural Missionaries, Maternal Imperialists and Feminist Allies: British Women Activists in India, 1865-1945" in Chaudhuri, Nupur and Strobel, Margaret (eds.) Western Women and Imperialism: Complicity and Resistance (Bloomington, IN: Indiana University Press, 1992), 119-36; Anna Davin, "Imperialism and Motherhood," History Workshop, Vol. 5, (1978): 25-28.

that health advice given at schools and at health centers was invariably ineffective. To meet this challenge, a follow-up system was introduced by attaching salaried and voluntary health visitors to centers and schools to visit expectant mothers, newborn babies, and toddlers in the home environment to inspect, advise, and educate mothers about proper health practices. To implement England's maternal and child welfare aims, which included the prevention of diseases in pregnancy and childbirth-related problems, educational programs in mothercraft were imposed on women of all social backgrounds. Women were educated in infant feeding, washing and clothing of infants, exercise, sleep, fresh air, proper hygiene, balanced diet, care of teeth, eyes, mouth, care of the house, protection of drinking water, milk, and foodstuffs from dust and insects, and the proper disposal of human and household waste. 2 These components formed the quiding principles of maternal and infant welfare implemented in the Gold Coast. As our discussions will show, maternal and child welfare in the Gold Coast mirrored that of England down to its ideological principles of socio-gender control.

² Colonial Secretary's Office (CSO) 11/1/296. P. S. Selwyn-Clarke, "Memorandum: Infant Welfare Centers, General Principles," March 21, 1932. National Archives, Ghana.

Indeed, trends in British maternal imperialism commenced and complemented countless international conferences on maternal and infant welfare held in London and other European countries throughout the 1920s and 1930s. Most notable among them included the 1931 Save the Children International Union Conference held in Geneva, the Annual English-Speaking Conference on Maternity and Child Welfare, the Association of Maternity and Child Welfare Centers, Child Guidance Council, Mothercraft Training Society, and the National Baby Week Council-perhaps one of the few organizations whose activities were directly copied in the Gold Coast. As one of the major conferences, the Annual English-Speaking Conference on Maternity and Child Welfare organized by the National Association for the Prevention of Infant Mortality on behalf of the National Council for Maternity and Child Welfare main aim was educating parents in caring for their children and in training mothers in particular. Interestingly, the organization found it necessary to distinguish the category of "mothers" from the category of "parents," presumably to

 $^{^3}$ CSO 11/1/330, "English Speaking Conference on Maternity and Child Welfare." National Archives, Ghana.

emphasize their focus on the role of mothers in the care and welfare of children.

Equally focusing on mothers and children, the 1931 Save the Children International Union Conference in Geneva was organized to discuss the welfare of African children. The objective of the conference was to discuss the effective ways to implement the provisions of the 1924 Declaration of Geneva of the United Nations for the protection of children in colonized Africa. Among the many problems identified as affecting African children were the high prevalence of tropical diseases, poverty, "traditional" midwives' unhygienic practices, and the careless and unsanitary behaviors of African mothers and their irrational feeding of infants. In addition, they identified superstitious beliefs, malnutrition of pregnant mothers, and the absence of adequate medical and health services in many colonial territories. 5 Indeed, the Conference depiction of the wastage of infant life as dependent on the ignorance of African mothers and their superstitious beliefs was quite bleak.

⁴ Public Records Office, (PRO) CO 323/1066: "International Congress on African Children of Non-European Origin, 1931" and CO 323/1148: "Congress on African Children, Geneva, 1931."

⁵ Ibid., Also see Evelyn Sharp, The African Child: An Account of the International Conference on African Children, Geneva (Negro University Press, 1970), 37-38, 53, 112-115.

According to the understanding of the participants, 6 in many African societies there existed customary practices that subjected the African baby to severe scrutiny and rituals so that very few survived the first few hours of life. Examples of such customs included those that required mothers to give their newborn babies plenty of water to drink to stretch their stomachs and those that prevented mothers from feeding their newborn babies in their first few days of life. Others required mother and infant to be secluded in a dark hut for seven days and newborn babies to be given powdered dog's bone and a lizard to be put in their drinking water so that they could absorb the strength of a dog and the agility of a lizard. The conference participants also concurred that the early marital age of girls and the belief that sperm could nourish the growing fetus caused pregnant women to overindulge in sexual intercourse, which contributed to the premature labor and infant deaths.

In formulating the necessary solutions to alleviate the high infant mortality, participants, while

⁷ Sharp, 38-39.

 $^{^6}$ The conference participants consisted of colonial medical officers, government representatives, clergymen, nursing sisters, health visitors, etc., who came from both England and the African colonies.

acknowledging the effects of other factors, focused almost exclusively on educating African mothers. Dr. Agnes Fraser, a representative for the Church of Scotland Missionary Society based in Nyasaland (Malawi), summed up the conference solution as follows: "education... [in mothercraft is] the first requirement in the attack upon infant mortality." Interestingly, the solutions went without any mention of resolving the negative effects of cash-cropping, migrant labor, and taxation even though an aspect of the conference dealt with colonial economies. As one African delegate bluntly argued, "If you want to help the African women, stop this over taxation; then they need not work so hard and neglect their children."

In fact, the conference reliance on social and educational tools that targeted women to address the welfare of African children, confirms its blatant avoidance of issues relating to economic exploitation and political expediency and its resultant effects on maternal and child welfare. Essentially, the conference proceedings motivated a colonial ideal intended to construct appropriate mothering skills for African women, regardless of the

⁸ Ibid., 48.

⁹ Ibid., 31.

socio-cultural, economic, and political contexts within which these women lived. There is therefore every reason to believe that colonial rulers opted to remake African motherhood not only to legitimize their "civilizing" mission and to increase their sense of benevolence, but also to hide their economic, social, and political exploitation and imposition behind this supposed benevolence to African mothers. Of notable importance is the fact that European nurses, missionaries, teachers, and medical officials assigned the task of implementing British maternal imperialism in its colonial territories believed in the presumed superiority of Britain's maternal and infant-welfare services at home as opposed to the inferior and barbaric practices of the Other. 10 Consequently, education in the European ideals of mothercraft and the biomedical management of pregnancy and childbirth came to represent a counter-weight to the 'failed' African motherhood.

Theoretical Perspectives

¹⁰ Jane Lewis, The Politics of Motherhood: Child and Maternal Welfare in England 1900-1939 (London: Croom Helm, 1980), 13-16.

In attempting to answer some of the questions raised in this dissertation, I have employed the analytical concept of biomedical power and subjectivity in reference to Michel Foucault's "bio-power" theory and European precolonial notions about Africans. Foucault distinguished between two forms of power; one in which authoritative control is exerted directly over others-in the case of Ghana, Britain's exertion of its dominance-and a second, more subtle type, that "proliferated outside the realm of institutional politics [and]... built from bodily representation, medical knowledge, and mundane usage."11 I focus on both forms of power, for the European presence on the African continent eventually translated into their paternalistic tendencies and exertive authoritative control over Africans as well as their presumed knowledge and introduction of biomedicine which shaped the practice of medicine and the medicalization of women's reproductive life.

Foucault's idea of bio-power interprets the body as a pure physical entity that is methodically marked for

¹¹ Michael Foucault, *History of Sexuality*. Vol. 1, "An Introduction," trans. by Robert Hurley (New York: Vintage Books, 1980). Cited in Jean Comaroff and John Comaroff, *Ethnography and the Historical Imagination* (Boulder, CO: Westview Press, 1991), 22.

corrective and penal measures executed by a variety of experts. Foucault argued that bio-power had two distinct extremities. The first extremity, "anatomo-politics" centers on manipulating individual bodies, whilst the second extremity focuses on manipulating and controlling entire populations. The combination of the two poles or extremities allowed dominant powers to regulate both the private and public lives of those they controlled. Expanding on this theory, Foucault insisted that bio-power, in constructing a realm of knowledge and skill, selfcomposed what issues qualified for observation and investigation, and responded to them. In other words, "experts" categorized or labeled certain natural bodily occurrences such as pregnancy, childbirth, menopause, baldness, etc. as needing medical mediation and some human behaviors as abnormal, deviant, unnatural, and immoral; opening up an avenue for legitimized and systematic attempts at medicalization of the human body and behavior. 12 Nowhere was this more apparent than in the lives of African mothers whose reproductive knowledge, practices, and behaviors did not fit the normative practices of Europeans.

¹² Ibid.

Of course, European pejorative connotations about Africans and their anxieties over African reproduction predates the nineteenth and twentieth centuries when there was an increased contact between the two, or even the twentieth century when Europeans established their dominance on the African continent. Dating back to the sixteenth century, Europeans constructed a historical progression of representations in which the image of the African man was that of a sexual predator. The African woman, on the other hand, was the possessor of certain inherent traits that made her inhuman, shameless, reckless, overly fertile, sex-driven, immoral, animalistic, and above all, exemplified the degradation, deprivation, and "barbarity" manifested in African societies. 13 Among the many horrifying experiences the Atlantic Slave Trade visited on African women, sexual abuse-both physical and emotional-was one that not only dehumanized them, but also defined women even after the end of the slave trade. 14

Many abolitionists raised objections to the sexual exploitation and dehumanization of enslaved African women,

¹³ Jennifer L. Morgan, "Women in Slavery and the Transatlantic Slave Trade," in Anthony Tibbles (ed.), *Transatlantic Slavery: Against Human Dignity* (London: HMSO, 1994), 60-69.

Winthrop Jordan, White Over Black: American Attitudes Towards the Negro, 1550-1812 (New York: Norton, 1968); Angela Y. Davis, Women, Race and Class (New York: Random House, 1981); Morgan, 60-69.

yet their protests failed to undermine European labels and representations of African women. Indeed, Lynn Thomas has argued that, if anything, abolitionists' efforts "contributed to the construction of an alternative image of African women as victims of African men." ¹⁵ European colonizers justified their imperialistic activities in Africa as necessary for both the spread of Christianity and "civilization," and to eliminate practices that restrict African women to subservient statuses. In the eighteenth century, European travelers to the West African coast revived the old sexualized imagery that earlier Europeans had constructed about African women. Dahomey warrior women, for example, received a non-flattering depiction as being masculine, a feature Europeans found inappropriate for feminine sexuality. These early writers such as Sir John Mandeville utilized European sexual notions to point out the 'savagery' in African societies-exemplified in its women-and hence, the difference of Africans from Europeans.

Mandeville wrote that in many societies in Africa and particularly in Ethiopia, women had no sense of embarrassment either of their men or of their sexual

¹⁵ Moira Ferguson, Subject to Others: British Women Writers and Colonial Slavery, 1670-1834 (New York: Routledge, 1992).

encounters with them for whenever they had a child, they gave it to whatever man happened to be with them. 16 Another example was by John Lok in his accounts of his 1554 voyage to Guinea. According to Lok, Africans were a "people of beastly living." He established this 'beastly living' of all Africans in the lives of one group of African women, the Garamente, whom he described as "common: for they contract no matrimonie[sic], neither [do they] have respect or chastitie[sic]."17 Jennifer Morgan has argued that Europeans used this strategy of gender and sexuality "to convey an emergent notion of racialized difference and so defined themselves as 'religiously, culturally, and phenotypically superior' to the peoples they confronted in their colonies." By constantly drawing attention to African women's sexual and reproductive behaviors, they inadvertently revealed the gendered ways of exploiting the productive and reproductive labor of African supposed 'savagery.'

¹⁶ The Travels of Sir John Mandeville: The Version of the Cotton Manuscript in Modern Spelling, A. W. Pollard (ed.) (London, 1915), 109, 119.

¹⁷ The Second Voyage [of Master John Lok] to Guinea...1554," in Hakluyt, *Principal Navigations* (1598-1600), 6:167, 168.

¹⁸ Jennifer Morgan, "Some Could Suckle Over their Shoulder": Male Travelers, Female Bodies and the Gendering of Racial Ideology, 1500-1770," The William and Mary Quarterly, Third Series, Vol. 54 (1997), 167-92.

From the late nineteenth and early twentieth centuries, when colonialism began in earnest on the African continent, European derogatory and sexualized notions about Africans informed the methods they adapted to ruling and transforming African cultures and its peoples. Ironically, this period of European imperialism also coincided with a period in Europe when male physicians were wresting the control of obstetric care from women midwives and many European countries were keen on regulating female sexuality and promoting proper reproductive health behaviors. 19 This led to increased maternal campaigns to improve women and child welfare and health in Europe and inevitably fueled Colonial anxieties about Africa women's reproductive behaviors. For instance, in 1932, the Director of the Gold Coast Medical and Sanitary Services, Dr. Duff, wrote in one of his reports to the Secretary of State that,

Great interest is now being taken in England in maternal mortality and morbidity, and a departmental committee of the Ministry of Health issued a very important report on the subject in July of the present year. The figure for total puerperal mortality for all England has for several years been about 4 per thousand, and the total maternal mortality, which includes non-puerperal causes, has been a little over 5, but even that figures are considered to be too high.

¹⁹ Foucault, History of Sexuality. Vol. 1, "An Introduction."

In comparison, it may truly be sided with Mrs. Blacklock that the figures for the Gold Coast are appalling.²⁰

The referenced Mrs. Blacklock (Mary Blacklock) was a member of the Colonial Medical Advisory Committee for Africa, who at the Imperial Social Hygiene Congress held in London in July 1931, stated,

It has often surprised me to find how easy it is to raise interest in the welfare of children while comparatively little interest is taken in the welfare of women. Yet, women's welfare should surely arouse equal interest, not only for her sake, but also because her welfare in so closely interwoven with that of the child. One can obtain figures for the infant mortality rate for most of our colonies but rarely for maternal mortality and when the latter rate is given, it is often appallingly high.²¹

Although, one can argue that economic exploitation gave the British colonial government more incentive to pay attention to women's reproductive welfare. Essentially, reproduction, and hence, "the colonization of the womb," was portrayed as an important state project and a fundamental site of intervention. African women became ready-made targets of colonial medical gaze and a gateway to controlling the wider society.

 $^{^{20}}$ CSO 11/5/1, File No. 817/32, "Maternal Mortality and Morbidity in the Gold Coast," National Archives, Ghana. 21 Ibid.

The above emphasis on Europeans sexualized stereotypes about African women is not simply to weigh down on colonial negativity, oppression, and constraint. Rather, by drawing on both European racial, gender, and sexual ideologies and on Foucault, this dissertation hopes to elucidate the fact that when gender is historically posited, it shows the nuances of women's experiences during the colonial era as well as the multiplicities and ambiguities appended to sexual differences. The colonial machinations of gender shaped and reshaped women's lives during the colonial asphyxiation of Africa. By focusing on race, gender, and sexuality, we are reminded that all these factors exerted influence on one another especially in the ways in which power, social and class hierarchies, opportunities, and discrimination were negotiated and contested.

In addition, it shows that people subjected to a different form of hegemonic control and biomedical powers are not necessarily acquiescent. On the contrary, the appropriated body—in this case, Africa women's womb—can be utilized as a key "dialectical force," which functions as both a source and target of power, regardless of whether it

is dialogued in a social, political, or juridical manner. 22
Foucault emphasized that even though subjectivity militates against the control of the direction of history writ, subjugated people, nonetheless, maintain their ability to reflect, reject, or select different variables from amongst available discourses and practices and with ingenuity and creativity, utilize them to suit their needs. This may help to explain, in part, why some Ghanaian women readily accepted western midwifery practice while others completely rejected or ignored it. It also suggests that there is the need to find new idioms of alterity that would perhaps clarify and contextualize the subtle ways in which women constituted different worlds and agency for themselves in the face of the European colonial hegemony. 23

Historiographical Perspectives

In the first few years following the declaration of the Gold Coast (now Ghana), as a British colony in 1874, the British colonial government decided to divide the territory into three administrative units: the Gold Coast

²² Martin Hewitt, "Bio-politics and Social Policy: Foucault's Account of Welfare," in Hepworth M. Featherstone and B. S. Turner (eds.), *The Body: Social Process and Cultural Theory* (London: Sage Publications, 1991), 231.

²³ Sara Suleri, *The Rhetoric of English India* (Chicago: University of Chicago Press, 1992), 1.

Colony on the coast, the Ashanti in the interior, and the Protectorate of the Northern Territories in the north. 24 As a tropical country, Ghana has had its share of diseases as has any region on the African continent, and we can assume that early Ghanaian societies, just as today, were afflicted with a host of diseases. However, the arrival of Europeans on the coast in the late fifteenth century greatly enhanced the opportunities for new disease introductions like smallpox and syphilis. 25 The socioeconomic, transportation, and political changes that accompanied the British colonial occupation transformed the human disease ecology and the local systems of healing of the people; effectively altering the epidemiological patterns with new diseases taking their toll on the population.

From the late nineteenth to the early twentieth centuries, the British colonial administration decided that to maintain an adequate supply of African labor, it was necessary to institute a health care system that would support population growth. Indeed, almost all European

²⁴ David K. Patterson, *Health in Colonial Ghana: Disease, Medicine, and Socio-economic change, 1900-1955* (Waltham, MA: Crossroads Press, 1981), 2.

²⁵ Willem Bosman, A New and Accurate Description of the Coast of Guinea: divided into the Gold, the Slave, and the Ivory Coast [1705], (London: J. Knapton, 1967).

colonial powers were anxious to maintain a healthy empire to maximize their economic fleecing of Africa. A statement by Ponty, the Governor-General of French West Africa in 1908 illustrates the above point. According to Ponty, in terms of providing for Africans, Europeans must do everything necessary "to improve his moral and physical well-being" as such a measure "will profit our prestige and culture,"26 not forgetting economic profit. Again, Richard Hakluyt's collection of travel narratives, Principall Navigations, for example, had presented an Africa that was "full of promise and full of threat" and erected an edifice that made English imperialism in the face of a 'confused' and 'uncivilized' people reasonable, profitable, and moral. 27 The European powers therefore put into place public health services, biomedicine, nursing, midwifery, etc. and claiming expertise in these areas legitimized their political and economic control.

Colonial governments' efforts at achieving a healthy population with western medicine carry a pejorative connotation that may portray Europeans as redeemers and

²⁶ Speech to Conseil de Gouvernement, February 18, 1908, cited in Auguste Terrier, Charles Mourey, and French West Africa, *L'expansion Française et la Formation Territorial* (Paris: E Larose, 1910), 519.

²⁷ Emily C. Bartels, "Imperialist Beginnings: Richard Hakluyt and the Construction of Africa," *Criticism*, Vol. 34 (1992): 519.

Africans as victims of a diseased continent. However, as many scholars have argued, European imperialism created its own health problems in terms of the enslavement of Africans, economic exploitation, transportation, migration, and the disruption of everyday living. In the Gold Coast and in many other African societies, the introduction of western medicine antedated the efforts of the colonial governments. The use of western medicine in Africa began with early European missionaries, although as indicated by Michael Crowder in Colonial West Africa, the health of the people was secondary to the missionaries' aim of conversion. 28 The missionaries added medicine to their evangelizing activities out of necessity and practicality. 29 The British colonial government stepped into the field of health care with the establishment the Gold Coast Medical Department in Accra in the 1880s to cater for the health needs of first, colonial officials, and then, the rest of the population. In response to frequent cholera outbreaks, they created the Sanitary Health Branch in 1909 and the Medical Research Institute (Laboratory) Branch in 1919.

 $^{^{28}}$ Michael Crowder, *Colonial West Africa* (Totowa, NJ: Frank Cass Publishers, 1978).

²⁹ Patrick A. Twumasi, "A Social History of the Ghanaian Pluralistic Medical System," *Social Science and Medicine*, Vol. 13 B, (1979): 349-356.

The Sanitary Health Branch was responsible for sanitation, vaccinations, and other preventive measures while the Laboratory Branch conducted scientific investigations as well as routine clinical and pathological tests and post-mortem examinations. The Gold Coast Medical Department, which became the Ministry of Health in 1953, encompassed all hospitals and clinics and also gathered meteorological data and was responsible for animal health until the creation of a separate Veterinary Department in 1920. By the time Ghana achieved its independence in 1957, the Ministry of Health was a fully-fledged institution offering a wide array of services, including laboratory work, research, training, and had generated an enormous amount of printed materials, which researchers continue to access for historical research.

A number of scholars, both Africans and their western counterparts, have used the colonial records to reconstruct Ghana's medical and health histories. For the earliest period of colonial rule, very limited studies are available on local disease conditions and on medical service

³⁰ Patterson, "The Veterinary Department and the Animal Industry in the Gold Coast 1909-1954," *IJAHS*, Vol. 13, (1980): 457-91; *Health in Colonial Ghana: Disease*, *Medicine*, *and Socio-Economic Change*, 1900-1955, 11.

availability in the country. The only historical works we have of the status of health and diseases in Ghana prior to the twentieth century were the works of Africanus Horton and that of John Farrell Easmon. In 1884, Easmon wrote about "blackwater" fever (haemoblobinuric fever) and was the first to connect the disease to falciparum malaria. 31 Like Easmon, Horton was the first African medical doctor to publish his observations on the climate and disease in West Africa. In 1866, Horton published Physical and Medical Climate and Meteorology of the West Coast of Africa, in which he described diseases associated with the harmattan or cold season as, "... the worst form of gout and rheumatism, with flying pains all over the body, swollen joints, intense local pain." 32 Horton's views and notions about malaria were directed by lack of adequate knowledge on the disease and while stationed at the Danish fort at Keta, Ghana, he concluded that something originating from the banks of the Keta lagoon caused malaria.

³¹ A. Patton, "Dr. John Farrell Easmon: Medical Professionalism and Colonial Racism in the Gold Coast, 1856-1900," The International Journal of African Historical Studies Vol. xxii (1989): 601-635.

³²James Africanus B. Horton, *Physical and Medical Climate and Meteorology of the West Coast of Africa* (London, 1866). According the Stephen Addae although Horton was unaware, what he was describing was the sickle cell disease. See Addae, *The Evolution of Modern Medicine in a Developing Country: Ghana 1880-1960* (Durham, NC: Durham Academic Press, 1997). 26-27.

Horton further viewed palm leaves as having therapeutic cure for malaria and initiated the planting of palm trees along the shoreline of the lagoon. 33 As indicated above the studies of Horton and Easmon stand alone for the period of the eighteenth century. However, by the midtwentieth century, we begin to see a few studies on health and medicine. David Scott, a specialist epidemiologist who worked for many years in the Ministry of Health and was in charge of the Medical Field Units, was probably the first to break ground in writing a scholarly work on the disease history in Ghana. Scott's study, Epidemic Diseases in Ghana 1901-1960, deals exclusively with epidemic diseases. For lack of adequate historical data, Scott was only able to chronicle details regarding seven epidemic diseases-yellow fever, plague, smallpox, sleeping sickness (trypanosomiasis), meningococcal meningitis, influenza, and relapsing fever-studied in Ghana during the first half of the twentieth century. He could not include diseases like measles and malaria, which perhaps killed more people than all the other diseases combined.

³³ Christopher Fyfe, Africanus Horton: 1835-1883, West African Scientist and Patriot (London: Oxford University Press, 1972), 44.

In 1981, David Patterson in his Health in Colonial Ghana, provided an extended analysis of the epidemiological environment in colonial Ghana. He examined the factors that affected the distribution, prevalence, and severity of diseases and the effectiveness of the British medical administration in dealing with health issues in the country. Patterson's work expanded our understanding of the colonial government's view of Ghana's disease environment, administrative policies, disease eradication campaigns, and the general growth of biomedicine in the country. Patterson's study is also indicative of the lack of interest in analyzing African women's roles and experiences in both colonial and postcolonial attitudes and in historical research. He noted that colonial government policy on the provision of health care in the late nineteenth and early twentieth century simply did not include women. This was because in the initial stages of colonial rule, only British officials, government employees, and a limited number of Ghanaians (usually males) in colonial service received medical attention from the government.

Health care during this period therefore tended to be male-biased both in terms of those who provided medical

services and in terms of those who received medical treatment. 34 While this assessment is perhaps true of colonial rule, Patterson failed to understand Ghanaian women's dependence on traditional medicine, when he concluded that Ghanaian women simply relied on "quack doctors" (traditional healers/midwives) for medical and other reproductive health care services. Anthropological studies on ethno-medical practices in many African societies have concluded that neither the way people express disease symptoms nor the way they classify syndromes are predictable reflections of bio-medical disease categories. 35 Historically, Africans, and for that matter Ghanaian women, have always relied on alternative forms of therapeutic knowledge that are gender specific and culturally defined irrespective of the presence of biomedicine.

Nonetheless, Patterson's work provided an important historical perspective of Ghana's health and medical past from 1900 to1955. In 1997, Stephen Addae in *Evolution of*

³⁴ Ibid., 19-2.

³⁵ Jean Comaroff, "Medicine and Culture: Some Anthropological Perspectives," *Social Science and Medicine*, Vol. 12b (1978): 247-54; John Ehrenreich, (ed.), *The Cultural Crisis of Modern Medicine* (New York: Monthly Review Press, 1978), 1-35; Steven Feierman and John M. Janzen, (eds.), *The Social Basis of Health and Healing* (Berkeley: University of California Press, 1992), 1-23.

Modern Medicine in a Developing Country provided a comprehensive study of the changes, challenges, and opportunities of an emerging health service in colonial Ghana. He described the racial discrimination in the medical profession from 1887, when the Sierra Leonean-born Nova Scotian, Farrel Easmon, resigned as Chief Medical Officer to the end of World War II. During this period, the policy of the West African Medical Service required all applicants to the medical sector to be of European parentage. An order contested by both the Aborigines' Rights Protection Society in 1913, and by Governor Clifford himself, who, according to Addae, openly and generously challenged the principle of African exclusion in the medical field. He added that although the northern parts of Ghana was generally ignored in much of the provision of health services that the coastal cities and Ashanti enjoyed, the colonial government managed to establish Medical Field Units to fight common infectious diseases in the North. Once Ghana gained independence in 1957, the Nkrumah government maintained the model but shifted the policy towards a health system that focused more on preventive health care instead of curative health care. 36

³⁶ Addae, The Evolution of Modern Medicine in a Developing Country,

From the 1980s, researchers began focusing on rural health care, and by the 1990s, it had become a significant theme in Ghana's health and medical historiography. Researchers such as Thomas A. Aidoo (1982) and Randolph Quaye (1996) were among the most prominent contributors to this genre of scholarship and the first to base their research on the links between Ghana's health and medical systems and its political economy. Unfortunately, besides these two scholars, and with the exception of a study by the IDS Health Group that tried to approach Ghana's health care from an interdisciplinary perspective using medical, economic, political, and sociological frameworks, not much research has been done in the form of connecting Ghana's health and medical systems with its political economy. 37 Aidoo in "Rural Health under Colonialism and Neocolonialism: a Survey of the Ghanaian Experience," examined some of the implications of colonialism and neocolonialism for rural health care in Ghana. His analysis begins with a critical review of ahistorical, atheoretical, and technocratic conceptions that others have used to approach underdevelopment of rural health in Ghana.

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³⁷ IDA Health Group, Health Needs and Health Services in Rural Ghana, Vol. 1 (Brighton, England: University of Sussex, IDA, 1978).

To Aidoo, researchers who have equated rural health problems to management issues do so because of the scarcity of resources and the inequitable utilization and distribution of resources in the country. The usual complaints include "if only there were enough money, personal, facilities, and international aid and if only these were judiciously used." ³⁸ Such an approach obstructs health problems from their political-economic context and reduces them simply to technical problems requiring technical solutions. Ray H. Elling, shedding more light on the limitations of the managerial perspective, has stated:

Generally, studies carried from the managerial perspective tend to be ahistorical and atheoretical and are innocent of serious examination of the political-economic national and world-system contexts of health systems. These studies may even ignore the structuring and functioning of the broader systems within which the particular problems or facet under study occurs. Such studies reflect a technocratic mentality and usually lead to recommendations at the level of "tinkering" or "patching." 39

The ahistoricism of this perspective results in the perception of health problems as defying time and history.

Thomas A. Aidoo, "Rural Health Under Colonialism and Neo-Colonialism: A Survey of the Ghanaian Experience," *International Journal of Health Services*, Vol. 12 (1982): 637-657.

³⁹ Ray H. Elling, Cross-National Study of Health Systems: Political Economics and Health Care (New Brunswick: Transaction Books, 1980), 234.

Thus, researchers relying on this approach make little or no effort to appreciate rural health problems in terms of the Ghanaian colonial legacy, which continues to dictate and fashion the postcolonial society.

What Ghana requires, then, is an alternative conception of the problems of rural health. This alternative will have to do the opposite of what the conventional conceptions have done. In specific terms, this means studies on rural health care will have to be historical, materialist, and holistic in framework. This is a political-economy approach, by which Ghana's rural health problems can be appreciated in the context of their historical origins, national and international linkages, and by their concrete materiality. A cursory look at Ghana's postcolonial health programs indicates that it has largely been based on an approach that makes communitybased primary health care its most significant component. The World Health Organization and UNICEF define the term "primary health care" as "essential health care made universally acceptable... at a cost that the community and

country can afford."⁴⁰ In accordance with this definition, the various health care development plans implemented in the country beginning in the 1970s have emphasized the concept of primary health care.

In 1979, Alfred K. Neumann and others studied the primary health care program initiated by the Ghana government and the World Health Organization at Kintampo and Danfa. The Kintampo and Danfa Projects, implemented as part of the overall approach towards community care, began as a research and a teaching center, but Neumann notes that its intended focus on training traditional birth attendants and traditional healers in the overall process of health care has been experimental and costly. Nonetheless, the essential orientation of the project was the recognition that the socio-cultural background of any group of people is the major determinant of health care utilization. In African Therapeutic System, Dawson Imperato and Kofi Appiah Kubi discussed the dominant African beliefs in the spiritual causation of diseases and the African method of

⁴⁰ P. R. Ulin, Good Rappaport, and Anita Spring, *Traditional Healers* and *Primary Health Care in Africa* (New York: Syracuse University, African Series 35, 1980), 1.

⁴¹ Alfred K. Neumann, "Planning Health Care Programs in a Pluralistic Medical Context: the Case of Ghana," in Stanley Yoder, Africa Health and Healing Systems: Proceedings of a Symposium (Waltham: Crossroads Press, 1982).

⁴² Ibid.

treatment, concentrating on various healing practices for both organic and psychological diseases. They also examined the interaction between African and western medicine, discussing the different uses of alternative healing systems by Africans. The central thesis of the authors was questioning why traditional medical beliefs and practices persist after western medicine and medical notions became available. Although they refrained from coming up with a concrete answer, the authors concluded that the sociocultural beliefs of a people are the major factor in their choice of a healing system, irrespective of its efficacy.

The socio-cultural importance of health care utilization has sparked a major academic contestation, beginning in the late 1970s, and it continues to remain a major theme in research on health and medicine in Ghana. The main contention developed from the view that certain socio-cultural categories are the solution to rural health development. Frequently cited are all kinds of cultural practices, customs, and traditional values. It maintains that in the absence of integration between traditional and western Medicine, rural health development will be

⁴³ Dawson Imperato and Kofi Appiah Kubi, in Z. A. Ademuwun, *African Therapeutic Systems* (Waltham: Crossroads Press, 1979).

difficult or impossible to achieve. O. F. Onoge in "Capitalism and Public Health," has termed this perspective as "socio-culturalism" and critiquing it, argued that a "serious fallacy of socio-culturalism [is that] it fails to name the concrete social formations that now exist" in contemporary Africa. 44 There is no problem with a meaningful integration of western and traditional medicine to provide adequate and appropriate health care in rural Ghana, but the achievement of such a goal requires a revolutionary transformation of the contemporary neocolonial structures of the Ghanaian society, a transformation with probable unacceptable implications for both political incumbents and westernized medical practitioners and social scientists. 45

The work of Twumasi in "Social History of the Ghanaian Pluralistic Medical System," is a good example of an exercise in "socio-culturalism." Twumasi discussed the lack of understanding between modern medical doctors and the Ghanaian rural mass noting:

It is frustration if the patient cannot understand and accept medical explanations and instructions because of the existence of

⁴⁴ O. F Onoge, "Capitalism and Public Health: a Neglected Theme in the Medical Anthropology of Africa," in S. R. Ingman, and A. E. Thomas (eds.), *Topias and Utopias in Health: Policy Studies* (Chicago: Aldine Publishing Company, 1979), 220-224.

⁴⁵ Aidoo, 637-657.

different belief systems. In modern systems disease and illness are most often seen as natural phenomena hence subject to investigation and study by scientific methods... in traditional systems, diseases are seen as manifestations of super-national powers and causal explanations take on a magico-religious viewpoint.⁴⁶

Twumasi in another study, Medical Systems of Ghana, takes the same socio-cultural approach and calls for the utilization of indigenous healers in the treatment of psychiatric illness. He condemns the fact that the history of western medicine in Ghana is almost universally the history of western cultural transmission. This perspective, conceptualized in the modernization mode of analysis, suggests that prevailing illness, persistent malnutrition, and the high rate of maternal and infant mortality are due to endogenous factors, originating solely from within the Ghanaian society, such as lack of rational resource management and institutional weakness in the Ghanaian economy. Contesting such an approach, Randolph Quaye argued for the use of an analytical tool in historical studies that consider the broader effects of politics and economics in examining the Ghanaian health care system. 47

⁴⁶ Twumasi, 352.

⁴⁷ Randolph Quaye, *Underdevelopment and Health Care in Africa: the Ghanaian Experience* (New York: Edwin Mellen Press, 1996), 22.

In Underdevelopment and Health Care in Africa, Quaye examined the colonial health care system from the perspective of a capitalist mode of production. Understanding the fundamental structures of colonial health care led to the exploration of how Europeans socially and politically organized people. He traced the changing role of European colonization and the penetration of the capitalist mode of production through an examination of colonial policies and discussed the role of scientific medicine as an important legitimating tool Europeans relied on to maintain their rule over Africans. According to Quaye, both colonial and post-colonial medical services dealt initially with existing diseases and illness, and capital growth, but the consequences of the capitalist mode of production in Ghana brought new health problems by the inculcation of Ghanaians into a cash-oriented economy, which eventually resulted in the decline of subsistence production and an increase in poverty. 48

An excellent illustration of the link between health and colonial economic exploitation is Saba Mebrantu's work in Nigeria, which shows how economic pressures forced men to migrate from their farms, obliging their wives to take

⁴⁸ Ibid., 19-25.

up subsistence farming in order to supplement the family food supply. She systematically clarifies the fluidity between socio-economic and health conditions in Africa during the colonial period. She argues: "Reluctant or unable to go into farming full time, these women planted cassava rather than the traditional yam because it was less labor intensive to do so. Since cassava contains less protein than yam, the shift in crop patterns led to poorer nutrition for women and children."49 Similar patterns have been studied in Tanzania, the Ivory Coast, and Kenya. Meredith Turshen has revealed that in Tanzania the health sector has been subjected to the same limitations because of the dependent nature of its economy. "Widespread ill health and essentially chronic malnutrition are not primarily internal problems, just as continuing poverty is not. These are the results of colonial history and changed socio-cultural relations."50

Other case histories on health and medicine in Ghana emphasize the disease eradication process, or lack thereof, as either a sign of the success of colonial imperialism or

⁴⁹ Saba Mebrantu, "Women's Work and Nutrition in Nigeria," in Meredith Turshen, (ed.), Women and Health in Africa (New Jersey: Africa World Press Inc., 1991), 89-106.

⁵⁰ Turshen, "The Impact of Colonialism on Health and Health Services in Tanzania," *International Journal of Health Services*, Vol. 7 (1977): 33.

as a gross abuse of resources by post-colonial governments. Many of these works relied on the western narrow definition of "health" and "health work and thus reinforces the theory that Africa was naturally diseased and could only be redeemed by the provision of western biomedicine. This theory assumes that treatment depended exclusively on western scientific knowledge, and that patients and healers evaluate techniques of treatment purely in terms of instrumental and scientific efficacy. Furthermore, because the western model of health care is restricted to hospitals and health centers, researchers who based their studies solely on such a model tended to also base their analysis of diseases and healing systems on activities confined within the hospital space.

In Man Cures, God Heals, Appiah-Kubi has shown that many healing activities took place outside the hospital space and were performed by "untrained" men and women who dependent largely on their local healing systems of knowledge. Many scholars and health officials have acknowledged that there is more to health and health work than colonial documents and western medicine seem to imply.

⁵¹ Kofi Appiah-Kubi, Man Cures, God Heals: Religion and Medical Practice Among the Akans of Ghana (Totowa, NJ: Allanheld, Osmun, 1981), 34.

The World Health Organization, for example, states that health encompasses not only the absence of disease, but also the social and emotional well being of a person. 52 Good health is therefore not merely a by-product of the elimination of disease-causing pathogens, but achieved through the cumulative actions on the part of those who need health care and those who provide it. Arthur Kleinman in Patients and Healers in the Context of Culture has indicated that healing is a process in which the individual's experience is interpreted in relation to an entire network of symbols. 53

Ideas and practices concerning death, illness, pregnancy, childbirth and fertility, and other health issues are embedded in peoples' cultural practices, philosophical, and moral beliefs. As Terence Ranger has pointed out "the multiplication of medical facilities and the increasing enthusiasm of African recourse to them have not been paralleled by a corresponding decline in African

⁵² World Health Organization (WHO), 1978 "The Promotion and Development of Traditional Medicine," (Technical Report Series, No. 622), 9.

⁵³ Arthur Kleinman, Patients and Healers in the Context of Culture: An Exploration of the Borderland Between Anthropology, Medicine, and Psychiatry (Berkeley: University of California Press, 1980), 15-19.

concepts of healing."⁵⁴ Instead, under the circumstances of "medical pluralism" European biomedical science has failed to "monopolized the therapeutic field,"⁵⁵ because of the fact that it was, and continues to be, individualistic and mechanical to be able to disrupt and destabilize African notions of complete physical and metaphysical healing of the body and soul.

In particular, recent scholarship is beginning to show major interest in how belief systems impact peoples' health, the role of both men and women in health care provision, and how gendered perspectives on such issues can help clarify the multiple forms of therapeutic remedies many rural Africans rely on and where women have been most instrumental. In other words, gendering the historical analysis of health is important because men and women have affected or have been affected by the health sector in both colonial and postcolonial Africa in different ways. The works of scholars such as Jean Allman, Susan Geiger, Agnes A. Odinga, and Nancy Hunts have broadened our understanding of gender repercussions of socio-economic and political changes in Africa. For instance, Odinga in "Women's

 $^{^{54}}$ Terence Ranger, "Healing and Society in Colonial Africa," (unpublished paper, 1978), 1-2, 7. 55 Ibid.

Medicine and Fertility," has shown that in the 1920s and 1930s, when a syphilis epidemic hit the province of South Nyanza in rural Kenya, officials and local leaders conceded that the disease affected more men than women. Yet, the campaign to eradicate the disease targeted women. She concluded that the reason for this tactic was due to the extreme patriarchal power Africa men had over women, which was reinforced by colonial rule.

Changes in the economy of rural Kenya, brought on by colonial introduction of cash cropping, were gradually loosening the hold men had over women. Hence, when the colonial government consulted male elders in the Luo society about measures to eradicate syphilis, these chiefs seized the opportunity to reassert their authority by establishing rigid regulations against women that had nothing to do with the spread of the disease. The Luo women's experience is illustrated in Allman's work in Ghana in Asante women's experiences with colonial government policies and missionary medical projects. Allman has contended that indirect rule introduced by the British government in the 1920s had very explicit implications for

⁵⁶ Agnes A. Odinga, "Women's Medicine and Fertility: A Social History of Reproduction in South Nyanza, Kenya, 1920-1980," (An Unpublished PhD Dissertation, University of Minnesota, 2001), 13-14.

shaping gendered boundaries and dynamics. While indirect rule apparently served the need of furnishing the colonial administration with cheap labor, obedient subjects, and justifying the colonial enterprise, it also facilitated the colonization of the domestic realm—the world of marriage, divorce, adultery, childbirth, and death.

Asante chiefs, as the arbiters of "customary law," through executive order and through native tribunals, were empowered by indirect rule to manipulate meanings and redefine relationships. Indeed, the Asante chiefs became almost obsessed with women's roles, with women's sexuality and with women's challenges to existing definitions of marriage and divorce, particularly after the formal commencement of indirect rule restored the Asante Confederacy Council in 1935. Addressing issues relating to Asante women's perception and their manipulation of maternal and infant welfare projects, Allman argued that the health education and welfare initiatives introduced by the British and missionaries to combat the high infant and maternal mortality rates in the 1920s and 1930s, must be conceptualized within the context of a broader crisis in

⁵⁷ Jean Allman, "Making Mothers: Missionaries, Medical Officers and Women's Work in Colonial Asante, 1924-1945," *History Workshop Journal*, Vol. 38 (1994): 24-47.

gender relations. The gender turmoil that shook Asante during this period resulted from the emergence and spread of cocoa as a cash crop and the growth in the trading of foodstuffs, a department controlled largely by women, and had serious ramifications on relationships between Asante men and women.

In the emerging economic changes, both men and women began to contest, challenge, and even redefine marriage, divorce, and parental responsibilities, while colonial rulers, on their part, tried to use the provision of health care and the gender turmoil to reinforce their rule in Asante. See Gendering analysis therefore can enhance our understanding of the socio-economic history of health care in Africa. Hunt's work on breast-feeding in the Belgian Congo demonstrates that the establishment of maternal and child health care services in Africa resulted from the colonial government's broader concerns about labor supplies, depopulation, and their self-apportioned mission of "civilizing" Africans. Historian Toyin Falola has challenged African scholars to have a stake in writing

⁵⁸ Ibid.

⁵⁹ Nancy Hunt, "Le Bebe en Brousse: European Women, African Birth Spacing and Colonial Intervention in Breast Feeding in the Belgian Congo," International Journal of African Studies, Vol. 21 (1988): 401-32.

about the African woman and "to demonstrate a more glorified aspects of the political [and medical] worth of women and their contributions—a justifiable reaction to male—dominated historical account." He cautions, "no one should dismiss this emergency rescue operation to construct the history of women...; [writing the contributions of women into history serves as] part of creating a balance in historiographical and correcting a generation—old lapse in methodology."⁶⁰

In this instance, researchers are yet to meet fully Falola's challenge with the persistent lack of analysis on women's roles in health and medical services in both colonial and postcolonial eras. For example, for a greater part of Ghana's history, Ghanaian women working as traditional midwives and as herbal healers have played significant roles in providing maternal and child health services in Ghana long before colonialism introduced western biomedicine. Even in contemporary Ghana, the activities of traditional midwives continue to exist sideby-side with western-trained midwives; seeing to more than

Toyin Falola, "Gender, Business, and Space Control: Yoruba Market Women and Power," in Bessie House-Midamba, and Felix K. Ekechi (eds.), African Market Women and Economic Power: the Role of Women in African Economic Development (Westport, CT: Greenwood Press, 1995, 23-40. Also see the Falola, Culture and Customs of Ghana and Culture and Customs of Nigeria (Westport, CT: Greenwood Press).

fifty-two percent of all children born in the country. 61 In spite of their significant roles, these women have not attracted the needed scholarly attention in order to counteract the negative image of women's health work colonial rulers worked hard to construct for us.

Even in places such as the United States and in Europe, where the history of midwifery and obstetrics has been studied extensively, women in this field have generally remained a silent group with little attention paid to them until quiet recently. For much of the history of midwifery, research on women midwives have negatively portrayed them as ignorant, dirty, and aged women who have probably given birth to a dozen children of which only a few survived. Recent developments in women's history and in gender studies have started to change some of these perspectives. Feminist scholars in the 1980s began writing the biographies, work, and the experiences of individual midwives, although such an approach limited the ability to gain a wider perspectives of the economic, political, social, and religious currents of their times. Most of the scholarship of this period tended to focus on the decline

⁶¹ Philomena Nyarko, Harriet Birungi, Margaret Armar-Klemesu, et al, "Acceptability and Feasibility of Introducing the WHO Focused Antenatal Care Package in Ghana." *USAID*, (June 2006): 1-37.

of women in midwifery work ensuing from the usurpation of the field by men in the obstetric field.

From the 1980s, the nostalgic focus on the history of individual midwives began to shift to that of gender relations when researchers became more and more interested in understanding the social management of childbirth and the control of women's reproduction, the medicalization of pregnancy, and the shifting formulations of femininity. Researchers working in this field have reconstituted midwifery studies by locating it within a broader framework of gender relations, women's health work, the practice of medicine, and in women's education. They utilized an array of sources including documents on the regulation and licensing of midwives, birth registration records, court records, testimonies, newspapers and the rest to provide insights into the origins of modern midwifery practices. Now, the midwife in history is no longer the ignorant old crone, but one whose status has been reconstituted to be of medical importance. Furthermore, they have removed the victimhood paradigm that defined midwives in the previous era by placing them in high social and medical statues. Besides, gender historians have established that although midwives acquired their obstetric knowledge largely through informal apprenticeship system, they were better trained than had been recognized and equally better acquainted to manage the social aspects of childbirth.

As indicated above, research interest in the work of Ghanaian midwives have yet to gain substantial academic interest. Researchers such as Dennis M. Warren and Mary A. Tregoning are among the few scholars who have researched the field of midwifery practice in the country. In their seminal work "Indigenous Healers and Primary Health Care in Ghana," the authors argued that in Ghana, traditional midwives are at the forefront of maternal and child health services and can be found in almost every village and town. 62 In their respective communities, these midwives attend the majority of births, they are affordable, and most importantly, serve as a link between their communities and area hospitals and clinics. Besides Warren and Tregoning, much of the information about the practice of traditional midwifery in Ghana comes from recent waves of scholarship that have attempted to look into the effectiveness of training programs introduced by the Ghana government and the World Health Organization, intended to

⁶² Dennis M. Warren and Mary A. Tregoning, Sr., "Indigenous Healers and Primary Health Care in Ghana," *Medical Anthropology Newsletter*, Vol. 11 (Nov. 1979): 11-13.

incorporate traditional birth attendants into the country's health care delivery system.

In 1977, with maternal and infant mortality on the rise, the World Health Organization officially recognized rural women's involvement in maternal and child health at a meeting in Geneva and recommended the integration of traditional midwives into the hospital-based health care system. 63 The Ghana government acted on the World Health Organization recommendation, and with the help of nongovernmental organizations, initiated across the country a number of training programs in the 1970s. Studies by Sue Kruske and Lesley Barclay show that the governmental efforts aimed at integrating traditional birth attendants into the health system has failed to realize its expected goal of reducing maternal and infant mortality mainly due to administrative and problems of structuring. 64

Nevertheless, Warren and Tregoning maintained that traditional midwives are essential motivators of the Ghana family planning program and remain committed to providing maternal and child health services to rural women. They

⁶³ Odinga, 16.

⁶⁴ Sue Krushe and Lesley Barclay, "Effect of Shifting Policies on Traditional Birth Attendant Training," Journal of Midwifery & Women's Health, Vol. 49 (July/August 2004): 306-310.

add, "There is little doubt that traditional midwives have a significant role when it comes to cultural competence, consolation, empathy, and psychosocial support at birth with important benefits for both the mother and for the new-born child. $^{\prime\prime}^{65}$ Relying on extensive oral interviews, Hussein Julia and others have also explored the historical interaction between traditional and modern midwifery practice. They argue that unlike western-trained midwives, the social and emotional connection traditional midwives establish with their clients keep birthing mothers from seeking professional obstetric care from western-trained midwives and hospitals even when they can afford the cost of such care. 66 Such historically grounded ethnographies permit perceptive analysis of women's responses to western medical influences and highlight the resilience of culturally constructed value systems.

For our purpose, it opens a window into a historical past in colonial Ghana where the state's interference in women reproduction imposed, and perhaps, eroded traditional systems of power in which women's lives were embedded. The

⁶⁵ Warren and Tregoning, 11-13.

⁶⁶ Julia Hussein, Vanora Hundley, Jacqueline Bell, Mercy Abbey, Gloria Quansah Asare, and Wendy Graham, "How Do Some Women Identify Health Professionals at Birth in Ghana," Journal of Midwifery, Vol. 21 (2005): 36-43.

resultant effect was that Ghanaian women had to confront, simultaneously, the difficult task of balancing conflicting desires of resisting and embracing colonial government's control of women's reproduction. The states' invasion of women's space of agency and their use of western midwifery practices to remake African motherhood subjugated women, yet, just as Foucault argued, that subjectivity may have empowered some women to appropriate western midwifery as a form of socio-economic power in a "new world order." Even if such an appropriation meant tolerating colonial negative connotations about African women, forfeiting their knowledge and control of traditional management of reproduction, and above all, accepting limitations in their autonomy.

Methodology and Sources

In analyzing the British colonial government's effort at remaking African motherhood through maternal and infant welfare and western midwifery practices, this study is archival based—both in methods and in sources. It utilizes a series of text-based researches and archival materials generated during the colonial period. The archives I relied on included those of the Ghana Ministry of Health, the

Wesleyan Methodist Missionary Society Archives at the School of Oriental and African Studies at the University of London, the Balme Library at the University of Ghana, Ghana Medical School Library, Ghana National Archives, and the Public Records Office (National Archives) in London.

At these various libraries and archives, I examined the Colonial Secretary Office Annual Medical and Sanitary Reports dating from 1900 to 1955. These Annual Medical Reports provided important information on colonial medical policies pertaining to maternal and child health care programs, official discourse on disease causation, methods of prevention, administrative difficulties, and the construction of hospitals and dispensaries. The Annual Medical Reports also contained information regarding the establishment of medical, nursing, and midwifery training schools, advances and uses of new technologies, and the colonial government's uncertainty regarding the effectiveness of medical work among the "native" population. I also reviewed the Gold Coast Annual General Reports, Blue Book of Statistics, Commission of Enquires Reports, Gold Coast Ordinances and Personal Files of Medical Officers, British Red Cross Society's Reports, and other important files in order to provide a broader

perspective of both the colonial state's narrative and counter-narratives on reproductive health care and education in the country. Correspondence on health obtained from the Wesleyan Methodist Missionary Society Archives and insights from some current officers at the Ghana Nurses and Midwifery Council provided essential information on child welfare efforts in the country, European nursing sisters and other health workers who worked in the country during the colonial era.

Overview of Chapters

To understand the colonial intervention in women's reproduction as a socio-economic and political exigency of colonial rule, it is necessary to contextualize the complexities of the medicalization of pregnancy and childbirth in relation to colonial political and economic structures and policies pertaining to its perception of African "mothercraft." Chapter One, "Imperial Politics, Gender, and the Conception of Motherhood," examines the British political tool of indirect rule and the ways it affected women's agency and space. The chapter also analyzes colonial gender ideologies, and the ways in which such ideologies are reflected in the colonial view of

African motherhood. It is established in this chapter that the colonial tool of indirect rule enabled them to gain access into the social world of Ghanaian women. Chapter Two, "Maternal and Infant Welfare and the Reconstruction of Motherhood," looks at the effects of the high maternal and infant mortality rates in Ghana in the 1920s and 1930s and the activities of the colonial government, voluntary organizations, and missionaries in maternal and infant welfare services across the country. This chapter sets the stage for events leading to the re-conceptualization and institutionalization of pregnancy and childbirth in the country.

Chapter Three, "Pregnancy and Childbirth under
Colonial Medical Gaze," examines the various structures and
strategies the colonial government put in place from the
early 1920s to medicalize and hospitalize pregnancy and
childbirth. The medicalization of reproduction is analyzed
in terms of exhibiting a coalescence of two poles of power
structures. Here, the female body offered the British
colonial government both private and public sites where
power was enacted and enforced by their control of
biomedicine. I argue that despite the appearance of the
government's goodwill in decreasing the maternal and infant

death rates, and in saving mothers and children's lives, their effort cannot be seen merely as humanitarian, rather it was a well-calculated political scheme. Chapter Four, "Transformation of Midwifery Practice," examines the introduction of western midwifery education and how it transformed the practice of midwifery in the country. I explore the colonial ordinance that established the Midwives' Board, the structure and curriculum of the education program, colonial gendered notions towards midwifery training and work, colonial policy towards native midwives, private midwifery practice, and the spread of midwifery work in the country.

This chapter also analyzes the reproductive health work of Ghanaian women who received training in western midwifery in terms of how they embraced the imposition on their indigenous reproductive health knowledge. In the concluding chapter, "Acceptance, Resistance, and Appropriation," I discuss the control and management of the birthing process and reproductive health, in terms of the ways in which Ghanaian women accepted, resisted, and appropriated western midwifery practice. First, the chapter synthesizes the previous four chapters into a coherent whole. Then, it establishes that colonial attempts at

controlling women's reproduction and remaking Ghanaian women into "good" mothers may have, in the short term, provided them with an avenue of socio-economic and political control over wealth, health, and power. Yet, in the long term, Ghanaian women managed to preserve a level of agency and space by choosing to either accept or ignore western biomedical practices, and women who entered into western midwifery education and practice managed to appropriate it from its original intent to acquire higher social and economic statuses in their communities.

Imperial Politics, Gender, and the Conception of Motherhood

Colonial imagery and concept of African socio-cultural normative practices decided many of the developments that occurred in the historic encounter between Africans and Europeans. Equally, it influenced the social, economic, and political policies of the colonizers. Indeed, long before colonial hegemony took hold of the African continent European colonial rulers had been provided a purview of Africa in the stories of early European travelers in which Africa was portrayed as nothing, but 'barbaric.' England, therefore, saw itself as needing a powerful remedy to meet the challenges of bringing 'light' to a 'dark' and a 'barbaric' continent whilst ensuring that its empire would be rich in the process. In the ensuing colonizing enterprise, they redefined both women's and men's lives, but for African women, their bodies came to symbolize a shifting parameter for the colonizing project through the restructuring of gender and reproductive norms. This chapter examines the British political tool of indirect

rule and its effects on women's agency and space; colonial officials' priori gender assumptions about women's roles in the Ghanaian colonial society; and their understanding and efforts towards restructuring motherhood. Through these measures, the British colonial government laid the foundation for exercising social control and for ensuring its political imposition would appeal to Ghanaians.

Women, Chiefs, and the Politics of Indirect Rule

The establishment of British colonial rule in the Gold Coast was both gradual and tumultuous. After trading alongside the Dutch, the Danes, and the Portuguese since the fifteenth century, the British finally took over as the major European presence in the Gold Coast when the Dutch, the last European power, departed in 1872. The departure of the Dutch enabled the British imperial expansion to extend from Cape Coast to the rest of the eastern coastal areas, Asante, and the Northern Territories. In the early stages of British control, they wrestled with idea of just continuing the trading activities on the coast and taking political control. The British government in 1874 ultimately decided to declare the coastal areas the Colony of the Gold Coast after their successful invasion of the

Asante Empire. British political control in the coast areas was gradual in the sense that the long history of interaction with Europeans on the coast gave rise to what Margaret Priestly and Kwame Daaku have described as "Afro-European" communities. 67 In other words, Africans in the coastal towns had grown accustomed to the European presence such that the British political takeover came with virtually no resistance.

Unlike the political takeover in the coastal areas, incorporating the Asante Empire into the Gold Coast Colony was anything, but peaceful. The Asante and the British in the early days of contact had positioned themselves in a hostile relationship in order to control the trade at the coast. As a result, the two often engaged in armed conflicts, which finally ended in 1901 after the Asante were defeated in their final attempt to maintain their sovereignty. The British then colonized the Asante Empire and moved immediately afterwards to declare the region north of the Asante Empire, referred to as the Northern

⁶⁷ ADM: F 1: Annual Report: On the Social and Economic Progress of the People of the Gold Coast, 1932-1933, Chapter 1: Geography, Including Climate and History. For further discussion of trade and the establishment of British colonial rule see Margaret Priestly, West African Trade and Coast Society (London: Oxford University Press, 1969); Kwame Daaku, Trade and Politics on the Gold Coast, 1600-1720 (London: Clarendon Press, 1970).

Territories, as British protectorates in 1902. This action was in response to their fear that the French were going to proclaim the region part of their territory. For purposes of administration, the Gold Coast Colony, Asante, and the Northern Territories were governed as a single political territory known simply as the Gold Coast. Once this political structure was achieved, the British government began to issue proclamations for political governance instead of signing bonds with local chiefs, as was the case in the Bond of 1844.68 According to Captain George Cumine Strahan, the governor of the Gold Coast from 1874 to 1876, the Crown's political powers consisted of the preservation of peace in the colony, administration of civil and criminal justice, enacting ordinances and laws, abolition of the slave trade, and emancipation of the existing slaves.

Thus, to implement a stable and a successful rule, the British government in the early stages concerned itself

⁶⁸ The Bond of 1844 was a short document of three paragraphs introduced by Commander Hill (Lieutenant-Governor of British Forts and Castles in the Gold Coast) in 1844 to formalize the relations between the people of the Gold Coast and the British Crown. It was initially signed by seven coastal chiefs on 6th March 1844 and subsequently by ten other chiefs. The document represented the first major imperial assault on the rights and powers of the people of the Gold Coast to administer their own affairs. It outlawed certain customary practices and provided that criminal cases were to be tried by British officials in conjunction with the chiefs.

with administrative and judicial structures. They established a Legislative Council responsible for legislating for the entire country and Judicial Assessor Courts. The civil commandants of the forts became district commissioners assigned the task of adjudicating in their various districts. In 1876, the government enacted the Supreme Court Ordinance and the Criminal Procedure Ordinance, which ended the role of the Judicial Assessor Courts and established in their place a single Supreme Court headed by a chief justice. After 1877, the Supreme Court's decisions could be appealed to the Privy Council in London. This provision essentially amplified the presence and importance of English common law in the colony. Concerning the exact status and judicial powers of the chiefs in the new political order, the government was at first uncertain as to what to do with them.

In 1878, the Legislative Council proposed the enactment of a Native Jurisdiction Ordinance intended to define the power and judicial authority of "head chiefs" and "minor chiefs," however due to opposition from some elite Africans—protesting the investment of any judicial powers in chiefs—as well as colonial officials' disagreement over the proper roles of chiefs, the ordinance

was eventually abandoned. Herbert Taylor Ussher, the lieutenant governor in 1879, argued that local chiefs were "useless, tyrannical and not to be trusted to administer justice." His preference was direct government exercised by European officials. The succeeding governor, Sir Samuel Rowe, had a complete opposite view. To him, "the proper way to administer the Gold Coast [was] by acting through the chiefs" and thus, during his term, he ensured that chiefly courts had increased powers and judicial decisions there could be directly appealed in British courts.

In spite of the conflicting attitude regarding the powers of chiefs, many colonial officials came to recognize that to carry out any policies including sanitary and other health policies in the colony they needed the cooperation of the local chiefs, and hence, the need to increase their judicial authority. In 1888, the Native Prisons Ordinance gave chiefs the power to fine and imprison. In 1895, Governor Sir William Maxwell, who had served in the Straits Settlement (Malaya) where the British were utilizing a well-developed system of indirect rule, began seeking ways

⁶⁹ ADM: F 1: Annual Report: On the Social and Economic Progress of the People of the Gold Coast, 1932-1933, Chapter 11: Government. See David Kimble, A Political History of Ghana: The Rise of Gold Coast Nationalism, 1850-1928 (London: Oxford University Press, 1963), 461.

to implement a similar policy in the Gold Coast. His policy was intended to increase the judicial powers of chiefs as well as increase their role in developing the colony's road system. Governor Maxwell was even willing to work with coastal chiefs in spite of conflicts with them and allow them to play roles in the new political order provided they reject the manipulations of native lawyers. Due to his early death, the implementation of Governor Maxwell's version of indirect rule failed to take root, nonetheless, his death ended the vague relationship that had existed with local chiefs since the Bond of 1844. From the late 1880s onward, the colony would be under a non-intervention system of indirect rule in which the colonial government would minimally interfere in local government allowing instead traditional chiefs to control local affairs.

In 1900, when Governor Mathew Nathan came to head the administration of the colony, he argued that chiefs did not have inherent powers; rather, they derived their authority from the Crown, which effectively placed the British government in a position to take, increase, or decrease chiefly powers and to determine the type of relationship

 $^{^{71}}$ CO/96/294, Governor Maxwell's dispatch to the Secretary of State, January 16, 1897. Public Record Office (PRO), London.

between the two sides. In 1902, he cemented his views on chiefs by establishing a Secretariat of Native Affairs to manage the relationship with chiefs, shifting partially from non-interventionist to interventionist indirect rule. From 1919 to 1927 when Gordon Frederick Guggisberg came to head the colonial administration, he allowed the chiefs to introduce in 1924 a new Native Administration Ordinance (NAO), which strengthened the administrative and judicial powers of the chiefs and gave them the ability to formulate legislation.

By introducing the NAO, Guggisberg effectively transformed the colonial administrative policy from partial interventionist to full-scale interventionist indirect-rule policy in which chiefs, under the guidance of the resident European political officer, administered native affairs. 72 The institution of indirect rule in Gold Coast had serious implications for women's affairs in the sense that it went beyond chiefs concerning themselves with dispute resolution and traditional affairs into incorporating them into the colonial government machinery. In addition, it gave chiefs

⁷² ADM: F 1: Annual Report: On the Social and Economic Progress of the People of the Gold Coast, 1932-1933, Chapter 11: Government. See Robert Stone, "Colonial Administration and Rural Politics in South Central Ghana, 1919-1951," (Ph. D. Diss., Cambridge University, 1975), 1-2; Crowder, Colonial West Africa, 169; West Africa under Colonial Rule (Evanston: Northwestern University Press, 1968), 168.

governing powers, even for societies where chiefs have traditionally not exercised distinct political authority from those held by religious leaders. Presumably, colonial officials based their indirect rule policy on the assumption that an example of a politically structured state in one society signified the same order and structure in every society in Africa.

Contemporary critics, predominantly the colony's western educated elite, vehemently opposed indirect rule, arguing that it was unsuitable for the Gold Coast in the sense that it brought instability into the fundamentally balanced relationship between native chiefs and their people, by granting chiefs autocratic powers that they had not exercised during the pre-colonial era. Furthermore, they were incensed at the way the British government strengthened the powers of the chiefs in comparison with other structures in the native administrations. To them, indirect rule was not only designed to eliminate the educated elite from effectively participating national politics, but it was also intended to be reactionary against modernity, which the colonizers themselves had introduced. Some colonial officials who had supported the policy of indirect rule, and had in fact, adopted it during their term in office even acknowledged that indirect rule brought inadvertent consequences and modifications to African socio-economic and political structures, although the majority of the colonial governors insisted on the benefits of the policy for political development.

For example, Geoffrey Northcote who acted as governor of Gold Coast from April to November 1932 argued that institutions that were "preserved in [a] changeless way ... tended to atrophy, decay, and disappear." Captain R. S. Rattray, the second person in British African colonies to be appointed as an anthropologist, put the dilemma neatly this way:

In introducing indirect rule into this country, we would therefore appear to be encouraging on the one hand an institution, which draws its inspiration and validity from the indigenous religious beliefs; while on the other hand, we are destroying the very foundation upon which the structure we are striving to perpetuate stands. Its shell and outward form might remain, but it would seem too much to expect that its vital energy could survive such a process.⁷⁴

As pointed out by David Kimble, in his detailed study of the rise of Ghanaian nationalism, the policy of indirect

 $^{^{73}}$ Geoffrey Northcote (Acting Governor of the Gold Coast), The Gold Coast Independent, August 6, 1932.

⁷⁴ Robert S. Rattray, *Ashanti Law and Constitution* (London: 1929), ix.

rule contributed to upsetting the relationship between the chief and subjects, whilst at the same time, it emphasized the importance of the colonial exploitation and expansion of the economy by restructuring and undermining these relationships as well.⁷⁵

The collaboration of chiefs formed the core essence of the redefinition of the social and political structures in the Gold Coast. Terence Ranger, for instance, has posited that colonial administrations across Africa would have failed to achieve their imperial objectives had it not been for the overwhelming participation of African chiefs in the colonizers' imperial politics and policies. As many scholars have acknowledged, colonial governments through African chiefs redefined and codified customs that enabled them to assert and/or increase their hegemonic control over Africans, 76 but more importantly, they utilized their relationship with African chiefs to impose their version of civilization. For example, Guggisberg's adoption of a full interventionist policy of indirect rule was based in part on his belief that the institution of chieftaincy in the

 $^{^{75}}$ Kimble, 130.

⁷⁶ Terence Ranger, "The Invention of Tradition in Colonial Africa." in Eric Hobsbawm and Terence Ranger (eds.), *The Invention of Tradition* (New York: Cambridge University Press, 1983), 252-254.

Gold Coast must be preserved, even if certain aspects required to be changed through education, biomedicine, and Christianity.

Such an endeavor clearly required a better understanding of traditional societies and their institutions, so to achieve this, Guggisberg established in 1921 an Anthropological Department. It was placed under the direction of Rattray who by this time had already published in 1916 a collection of Asante proverbs he considered to exhibit the "very soul of this people" as well as published some works on societies in the Northern Territories. The With official support, Rattray provided detailed information about the dual system of political governance in the northern hinterlands derived from the tendana (the priest kings) who conducted all "religious or magico-religious concerns," and the secular rulers, who were the descendents of the invading warriors from further north.

⁷⁷ Rattray, Ashanti Proverbs: The Primitive Ethics of a Savage People Translated from the Original with Grammatical and Anthropological Notes (1916; reprint, Oxford: Clarendon Press, 1969), 12.

⁷⁸ Ibid., "The Tribes of the Ashanti Hinterland: (Some Results of a Two-Year Anthropological Survey of the Northern Territories of the Gold Coast)," Journal of the Royal African Society, Vol. 30 (Jan. 1931): 40-57

in Asante, many of the societies in the north lacked centralized system of government.

States like Gonja and Mamprugu that had the capacity to have developed centralized system of governance had disintegrated due to slave raiding and civil wars in the nineteenth century. Rattray concluded that considerable similarities existed between the northern peoples' constitutions and those of the Akan of the south. In one instance, he wrote:

The tribes speaking Vagala and Tampolem (like the Lobi) appear to be among the last survivors in this northern area of those tribes, which still trace inheritance through the sister's son-like the Akan. Evidence, indeed, is not lacking, that in the not very remote past, and contrary to all our preconceived ideas on this subject, the whole of the Northern Territories were inhabited by peoples inheriting through the female line [as was and continues to be with the Akan people]. 79

The result was that, more consciously than in the past, interventionist indirect rule was based on the Akan model of statecraft, with the administration rectifying the situation in the north by creating paramount chiefs over particular areas even in places that lacked notions of chieftaincy.

⁷⁹ Ibid.

Like most of the anthropological work of the time, Rattray interpreted his findings based on his assumptions on what should be, than on an interpretation of sociocultural practices of the studied people. His interpretation of the cultures and customs of the societies he studied appealed to the colonial government in two major ways. First, it portrayed indigenous African political institutions such as that of the Akan people with an endless quality, which caused the colonial government to believe that a government rooted in a seemingly unchanging chieftaincy system would be something they could depend on for a long period. Second, it reemphasized their assumptions about the differences between societies in the north and those in the south, or more accurately, the superiority of societies in the south that had been influenced by western cultures to those with no influence. The colonial government therefore believed that indirect rule was the best policy for the administration of the country; yet, one cannot help but observe that it was also grounded in cultural, gender, and racial differences.

In particular, the gender differences that emerged out of the institution of indirect rule in the Gold Coast enabled the British government to re-etch its colonial

agenda as it concerned eugenics, governance, economic exploitation, and religious and educational ideologies.

While its major aim was to avail the government with cheap labor and financial resources through taxation, indirect rule also provided the government with the chance to enter the domestic realm to instigate gender reconstruction, intervene in gender conflicts, reformulate gender boundaries, and to remodel Ghanaian motherhood after their own ideals. The colonial government's ability to enter into the private world of women to regulate reproduction rested on the reciprocity of local chiefs who opened the gates of the domestic space to their colonial benefactors for their newly acquired political powers.

Throughout the country, the altering of the relationship between people and their chiefs through indirect rule had consequential effects on the relationship between women and men. In Asante in particular, chiefs became renowned in their efforts to control the productive and reproductive labor of Asante women and to regulate their social mobility, which had increased considerable with more and more women entering into trading that had been opened up by the cocoa market. The result was that Asante became entangled in gender conflicts in the 1920s.

In 1994, Allman investigated this phenomenon and suggested that wives were no longer satisfied with working on their husbands' cocoa farms; rather, many moved to exploiting the market themselves, opening up a new economic autonomy and security they had not enjoyed before. The increase in cocoa production meant an increase in the demand for manual labor, which brought into the cocoa centers migrant workers. The resultant effect was the increase in the demand for foodstuffs, which caused many women to enter into the trade in foodstuffs inadvertently increasing women's economic autonomy.

During this period, some single women opted to remain single, those married were ready to seek divorce from an unproductive and an unsupportive husband, or they insisted on an equal share of conjugal benefits and obligations, while some used the native courts to challenge the Asante inheritance arrangements. 80 With their new economic independence and the willingness to take advantage of the ambiguities and inconsistencies in the colonial legal system, women incited a conservative reaction on the part of male elders, who through indirect rule had become part of the colonial legal system. Many of the chiefs sensed

⁸⁰ Allman, 24-46

that they could not continue to hold on to their control over women's productive and reproductive capabilities and sought ways to remedy the situation. Therefore, when the colonial government began its bid to control the social structure of the Ghanaian society, the chiefs certainly made the colonial job much easier for them as the examples below indicate.

In 1924, when the Guggisberg administration passed the NAO, they also passed the Ashanti Native Jurisdiction
Ordinance, which recognized the authority of chiefs and conferred on them judicial, executive, and fiscal powers.
Between 1924 and 1935, the Native Tribunals established under this Ordinance presided frequently over cases of adultery, divorce, and spousal neglect with women generally being the accusers. In 1935, the colonial government passed the Native Courts Ordinance 2, which established four grades of Native Courts in Asante. Available documents from the proceedings in these courts provide valuable information on gender and social transformation that took place through the court system. The legal standards set in these courts contended with the supposed social crisis of

⁸¹ W. Tordoff, *Ashanti Under the Prempehs*, 1888-1935 (Oxford University Press, 1965), 248.

uncontrollable and disobedient women. for both the colonial government and the native courts, there was the need to use legal means to redirect women back to an acceptable social responsibility, which ultimately meant bringing them back to the 'kitchen' and into becoming proper wives and mothers.

Certainly, the legal reasserting of customary law to reconstruct gender relations was not unique to the Asante. While we have limited documentation that speaks to the extent of the conflict between women, chiefs, and the colonial government, there were few cases that expatiate on the dynamics that occurred during the colonial period. For instance, with passage of the NAO by the Guggisberg administration, the chiefs in Sefwi Wiawso (part of the Asante Region of present day Ghana) established a State Council in order to exercise their new legislative powers. From 1925 to 1932, the State Council enacted a number of amendments into customary law in an effort to address crisis in gender relations in line with what the colonial rulers envisioned as the proper women's role and place in society. Like the case of Asante women, the cocoa economy had given Sefwi Wiawso women a new economic security and autonomy. Accordingly, the State Council made provisions to regulate the affairs of women they considered uncontrollable as well as to manage the increasing frequency of divorce.

The State Council's first initiative in dealing with the perceived problem of 'loose' women was to seek to eradicate the "free women of Sefwi Wiawso: the traders and alleged casual and full-time prostitutes who had abandoned their husbands or who had no known male guardians."82 Consequently, in I929, they enacted the "Free Women's Marriage Proclamation Act," that instituted an order to arrest and detain in the chief's palace any unmarried woman unaccounted for by a man. Such women were to be held until they were claimed by a husband or by any other man who would take charge of them. The male petitioner was responsible for a fine of 5/- in order to release the woman and to check her moral behavior. 83 Reports by the District Commissioner for the Mampong District suggests that similar cases occurred in other places in Asante. According to one report, the ohene (chief) of Effiduasi became alarmed at

⁸² Sefwi Wiawso Native Tribunal, "Free Women's Marriage Proclamation Act," Magistrate Court, Sefwi Wiawso. National Archives, Ghana. See Penelope A. Roberts, "The State and the Regulation of Marriage: Sefwi Wiawso (Ghana), 1900-40," in Haleh Afshar, (ed.), Women, State, and Ideology: Studies from Africa and Asia (Albany, NY: State University of New York Press, 1987), 61.

⁸³ Ibid.

the level at which unmarried women were spreading venereal diseases in the town.

The District Commissioner noted that the ohene issued a proclamation ordering that all unmarried maidens should immediately find husbands or risk fines and/or arrest. While the gendered implications of this edict cannot be ignored, the report showed that young women affected by this order found it amusing to be hunting for husbands.84 Not surprisingly, other chiefs in neighboring towns equally adopted the Efiduasi chief's strategy and started regulating the behaviors of women they considered to wayward and a detriment to society. Chiefs occasionally arrested and detained such young women until they provided the name of the men they would agree to marry. Any man mentioned as a prospective husband had to confirm his desire to marry the woman and then pay a "release fee" of five shillings. Interestingly, if the chosen man refused to marry the woman, he was also fined for not helping to solve the problem of unattached women roaming the town. In general, the men paid a fine of five shillings but they

⁸⁴ Ashanti Regional Administration Files [ARA]/I286: Report on Native Affairs for the Mampong District. Quarters Report, March 31, 1933. Kumasi Regional Archives, Kumasi. Also See Allman, "Making Mothers in Colonial Asante."

were sometimes required to pay a higher amount. Once they woman was released, the man was obliged to complete the marriage requirements to formally make the woman his wife.⁸⁵

Similarly, there are limited reports of chiefs in the Volta, Central, and Northern regions of Ghana who expressed similar concerns about unruly and wayward women in their mist during the colonial period. In most cases, women were branded uncontrollable or wayward when they refused to follow their parents' choose of husbands or when they enter into conjugal ties without their parents' consent. Such fears extended to the post-colonial period and it became the basis of some chiefs in the Volta region objection to a 1961 proposed "Marriage, Divorce, and Inheritance Bill." They argued that the actions of unmarried women and women who entered into conjugal relationships without their parents' consent were against cultural values. Reportedly, some chiefs even took the "extreme measure of locking up such women until their lovers would pay a fee to release them, thus legitimizing the relationship."86 Evidently, through indirect rule, the British colonial government

⁸⁵ Ibid.

⁸⁶ Letter to the Editor: "Forced Marriage of African Girls: Prevention." Gold Coast Independent, January 15, 1930. See Dorothy Dee Vellenga, "Who is a wife?: Legal Expressions of Heterosexual Conflicts in Ghana," in Christine Oppong, (ed.), Female and Male in West Africa (London: Allen & Unwin, 1983), 150.

opened a floodgate that resulted in marriage contestations, control of women's sexuality, and gender redefinition between chiefs and women. For their part, the chiefs opened the gates to the private space of women in the name of health, which enabled the colonial government to utilize it to control the larger socio-cultural setup of the Ghanaian society.

Colonial Perception of Ghanaian Womanhood and Motherhood

Once the British colonial administration gained access to the social realm of the Ghanaian society, colonizing women's reproduction became a crucial dimension in the politics of preservation, protection, modification, and Christianization of the nation. From the early period of colonial rule to the mid-1920s, missionaries and colonial officials believed they had gathered enough evidence to understand the roles and positions of women, and hence, in a position to figure out how best to utilize them in their colonizing mission. For the most part, colonial rhetoric conceived of men as lazy and unproductive and women as over burdened with domestic duties and with little attention span for their children. For example, when Guggisberg arrived with his wife in the Gold Coast in 1919 to take up

his post as governor, he toured the colony to acquaint himself with the people, their cultures, the nature of land and its resources, and anything in-between that would help his administration.

In his descriptions, he wrote:

The women wore the cloth tied tight across the breast and fastened in a draped knot at the side, leaving both shoulders bare. And the way they carried their babies! After I saw that I ceased to be surprised at anything I saw in this strange land...A woman passed me, carrying a tiny baby on her back, just above the hips, bound securely to her by a fold of her own cloth. All that showed of the baby was a pair of chubby arms and shoulders, and a head wobbling helplessly back and forth, now hanging over sideways, its owner being usually sound asleep, then falling back at an angle at which one felt that the tiny one was bound to break his neck.87

Guggisberg added that when they reached Ahireso, a village before the River Prah (located in the Asante Region of present-day Ghana), where they camped for the night, they inquired from the headman of the village if they could buy food for their carriers. According to him, the village headman at first indicated it was impossible to send message to the women who had all left for the farms to bring in the extra food required although the village was

⁸⁷ Decima Moore Guggisberg and Major Frederick Gorden Guggisberg, We Two in West Africa (New York: Charles Scribner's Sons, 1909), 24-25.

practically littered with men who obviously could carry their message to the women.

According the Guggisberg, the men spent the whole day gossiping and pretending to manage their villages, while the women marched off, "stick in hand, and baby on back, to work the farms."88 After their day's work in the farms, they would return carrying huge loads of yams and plantains on their heads whilst still carrying their babies. Even as the day drew to a close, the work of the women was far from over. They had to contend with preparing the evening meal of pounded fufu (cassava or yam mixed with plantain or cocoyam) or kenkey (fermented corn dough made into balls) by themselves. The men, with great displeasure, pretended to look after the babies, but what they were actually doing was watching them play in the dust and filth in the street. Guggisberg was particularly struck by the way a mother fed her baby while at work. He was amazed that a mother when she needed to feed her infant, she would just swing it a few degrees towards her hip, secure it with a piece of cloth, tuck its head under her arm, and allow the baby to feed while she pounded her fufu or weeded her farm. This

⁸⁸ Ibid.

technique struck him "as extraordinary—the goodness of the babies. They never seemed to cry."89

Clearly, Guggisberg's representation of the social life of this small village of Ahireso while on the surface appears to express concern for the excessive work done by women, sympathy for infants, and perhaps, contempt for men, it also carried significant racial overtones. This was in the sense that Europeans were the ones who knew how to 'treat' women and what constituted proper womanhood and motherhood. The 'savage' societies in colonized lands, on the other hand, segregated women, subjugated them, sold them, instituted customs repressive to African womanhood, and employed women as beast of burden. Guggisberg wrote, "The women issue every morning to bring in enough food to supply and serve their lords and masters, who spend the day in dignified idleness."90 Indeed, the British colonial government's vision of what amounted to proper womanhood and motherhood not only ensured that its empire would look as justifiable as it could possibly be, but it also made other societies' social institutions seem inappropriate and

⁸⁹ Ibid., 270-271.

⁹⁰ Ibid.

even offensive, and they therefore, in need of reconfiguration.

Out of this conception emerged the idea that in pursuit of satisfying their husbands, Ghanaian mothers were neglectful of their children, were unhygienic, and more importantly, lacked the proper mothering skills to bring up a healthy generation. The behavior and the position of women, therefore, became the measure by which the colonial governments evaluated those they colonized. It was also by this same measure by which some colonial officials decided that the inherent laziness of African men, the high infant and maternal mortalities, and women's apparent lack of the capacity to raise a healthy generation had everything to do with poor health and the lack of medical care. Yet, in the early years of colonial rule, little was done to tackle health issues in the African colonies. Whatever medical services that were available in the Gold Coast were for the health of the European community and a limited number of men in the employment of the colonial government.

As Dr. Blacklock of the Liverpool School of Tropical Medicine argued in her seminal article, "Aspects of Maternal and Child Welfare in the British Colonies," historically, colonial affairs were the affairs of men and

as a result, education, health, and housing all reflected the needs of men. The British government made significant changes to its health policy, but even so, improvements in the health and welfare of women and children remained poor: infant and maternal mortality rates remained high; exploitation of women and girls continued; and few girls had access to primary education. Blacklock argued that even though the success of social change in the colonies depended on women, the government had been unwilling to devote financial resources to improve the health of women and children. She called for the education of women since among other things, it provided the opportunity to train girls in domestic sciences and mothercraft, including an understanding of the importance of sanitation, ventilation, control of mosquitoes, and other vectors, food and water storage, and dietetics, thereby providing the basis for better individual and family health.

For example, Sir Hugh C. Clifford, Governor of the Gold Coast from 1912 to 1919, explicitly stated in a dispatch to his colleague in Sierra Leone, that his "Medical Establishment [was] maintained almost exclusively

for the benefit of the European population,"⁹¹ although this medical establishment and the many other health services available to Europeans were paid for by the African taxpayer. Women received virtually no substantive attention in terms of health from the colonial government until the mid-1920s to the 1930s, by which time available data on infant and maternal mortality rates produced a frenzy to focus on women's reproduction.

It must, however, be stressed that the focus on women's reproduction was not necessarily to improve their health; rather, reconstructing women's reproductive behavior was a crucial step in changing the socio-cultural practices and health behaviors of the Ghanaian society in general. For instance, during the 1931 Geneva Conference, Rattray, attending as one of the British delegates for the Gold Coast, indicated that the colonial administration had sent to England a memorandum advocating the abolition of female circumcision from the Northern Territory of the Gold Coast. While acknowledging that the rite was in the African perspective, the greatest incentive to pre-marital chastity, and that every girl looked forward to it as

^{91 &}quot;Confidential Dispatches 1915, Mereweather to Harcourt," April 14, 1915. Sierra Leone National Archives, Sierra Leone.

proving her moral fitness for marriage before the whole group, female circumcision needed re-modification. He further admitted that in spite of the threat its abolition would present to pre-nuptial chastity, he felt it should be stopped.

Sympathetic and enlightened chiefs, Rattray reasoned could be coaxed into coming into some form of agreement with missionaries, colonial officials, and other interested people, that would make it possible for the government to officially forbid the practice of female circumcision, after which girls could depend upon the authorities to refuse to go through with it. In concurrence, the Duchess of Atholl suggested that girls should be encouraged to make a statutory declaration of their aversion to undergo the process, and they should also be granted legal protection. ⁹² In addition, the delegates deliberated on a number of customs associated with womanhood and motherhood such as pregnancy and childbirth rituals that prevented women from properly caring for their children and from taking adequate

⁹² Atholl was the Vice-Chairman of the Unofficial [British] House of Commons Committee of all Parties Studying Questions Affecting the Health of Women and Children in Africa; she was also formerly Parliamentary Secretary to the Board of Education, cited in Sharp, 43. Information is also available in CO 323/1066: "International Congress on African Children of Non-European Origin, 1931" and CO 323/1148: "Congress on African Children, Geneva, 1931." PRO, Kew, UK.

care of themselves after delivery. These customs, they argued, had contributed to the high infant and maternal mortality in the African colonies.

The majority of the participants also agreed that prudence needed to be the guiding principle in reaching out to a group of people with the suggestion of abolition a socio-cultural practice, in this case female circumcision, which the people had practiced for generations. Dr. Hungerford, another official British delegate from the Gold Coast, cautioned all to advise their governments about the negative consequences of instituting major changes too quickly. In response, the Duchess of Atholl suggested that chiefs should be made to be at the forefront of the campaign, although she admitted that the effort would be a waste of time if they failed to gain the trust and the cooperation of the women of the particular group. She explained that it was "worth while to take a little time to lay a foundation of friendship before seeking to alter things; this may be more tiresome then drastic action, but it is more effective in the long run."93

 $^{^{93}}$ CO 323/1066: "International Congress on African Children of Non-European Origin, 1931" and CO 323/1148: "Congress on African Children, Geneva, 1931."

The British delegates' contributions affirmed the British colonial government's notion of proper motherhood as well as its conceptualization of African motherhood. Thus, beginning in the 1920s, a series of reproductive programs were undertaken to provide women with the necessary skills to care for children. By extension, the general view in England during this period was that the proper place of child rearing was within the family and mothers were responsible for ensuring that the family context was properly maintained to provide a healthy environment for children. Therefore, if the survival of infants and the health of children were in question, it must be the fault of the mothers, and if the nation needed healthy future citizens, then mothers must improve. 94 It was a mother's individual ignorance and neglect, which accounted for infant deaths and sick children. Thus, a powerful ideology of motherhood emerged in the twentieth century firmly rooted in nineteenth century assumptions about women and domesticity.

How the colonial government conceptualized Ghanaian motherhood was therefore not by accident because a precedent had already been set in the colonizer's home

⁹⁴ Davin, 13.

country. Ghanaian motherhood, they reasoned, was to be given a new definition to suit the colonial agenda. To become good mothers, Ghanaian women needed to be instructed; instructions provided through maternal and child welfare clinics, baby shows, health week programs, home visits, and through midwives in the home skills that were commonly referred to as mothercraft. Colonial health workers including doctors, nurses, and health visitors were all asserting their supposed superior medical knowledge and authority; establishing moral sanctions on grounds of health and in colonial interest and demeaning indigenous Ghanaian women's childcare methods-in particular care provided other members of the family. The general assumption was that neighbors, grandmothers, siblings, and older children looking after babies were dirty, incompetent, and irresponsible. As Foucault's speculations suggest, knowledge of scientific medicine both shaped and justified the colonial project. As a tool of empire, therefore, medicine enabled the colonizers to control and regulate native populations and enhanced their own survival rates in the African environment. Colonial rulers utilized

various devices and diverse techniques to achieve the subjugation of bodies and the control of populations. 95

The ideology of motherhood introduced into the Gold Coast as part of the public health campaign was not restricted to a particular class of women. Women in both rural and urban areas were targeted. The poor and the relatively well to do, received the same instructions and directions as to how to become effective mothers. Colonial health officials presented themselves as quardians of health and responsible for the preservation of infant life. Failure to breastfeed on schedule, excessive breastfeeding, lack of proper nutrition, and taking an infant out to the farm in generally hot and humid conditions were considered signs of maternal ignorance and irresponsibility and infant sickness and death were explained in such terms. For example, the Lady Medical Officer at the Princess Marie Louise Hospital and Child Clinic in one of her reports on infant deaths attributed the death of an infant brought there to the ignorance of the grandmother. According to the report, the child's own mother had died during childbirth but the grandmother's lack of knowledge about proper

⁹⁵ Foucault, History of Sexuality, 141.

feeding routine and nutrition caused the child to develop severe malnutrition and its eventual death. 96

Once maternal and infant welfare took off in earnest in the 1920s, both missionaries and colonial officials agreed that women held a central role in achieving a healthy population as well as the country's progress toward modernity. Women essentially represented the very embodiment of not just civilization, but also of establishment a Christian moral order. The Wesleyan Methodist Missionary Society, in particular, took a leading role in terms of their activities in the coastal areas and in Asante. The mission started its activities on the coast when the Christian urban mulatto elites in Cape Coast invited them to Cape Coast in the 1930s. The dynamic leadership of Rev. T. B. Freeman ensured that the Methodist Church was able to proselytize among the Fante. At first, they restricted their activities to the British posts at Cape Coast and Anomabo; however, with a growing network of African catechists, they were able to expand their missionary work to the Fante hinterlands and along the eastern seaboard, and finally, into the Asante territory

⁹⁶ Government of the Gold Coast, Report on the Medical and Sanitary Department for the Year 1930-1931, "The Princess Marie Louise Hospital," page 12.

with the assistance of a direct sanction of the British colonial government. 97

The activities of the Methodist mission regarding maternal and infant welfare were carried out mostly during the 1930s. The mission sent its female members into villages with personal cleaning materials such as sponges, soaps, powder, basins, bandages, creams, clothes, and medicines to help teach the village women the proper way to clean their children. The sections were not only about personal hygiene. The village women were also given sermons on the links between effective motherhood and Christian values. More precisely, the lectures profoundly depended on European nuclear-family values and parental responsibility than they were about baths, basins, and bandages. For instance, one Irene Mason delivered a sermon in which she suggested to the Ghanaian women present that marriage was a contract between two people in love and who proclaim their love and willingness to build a life together in the sight of God. 98 Ignoring the fact that the Ghanaian socio-cultural setup was not based on those principles. As our discussions

⁹⁷ Cited in T. C. McCaskie, "Cultural Encounters: Britain and Africa in the Nineteenth Century," in Andrew Porter, (ed.), *The Oxford History of the British Empire* Vol. III (Oxford: Oxford University Pres, 1999), 671.

⁹⁸ Wesleyan Methodist Missionary Society, Women's Wing (WMMS, WW): 6/046, I. Mason to Miss Walton, "Mmofraturo," October 24, 1937.

in the next chapter would show, missionaries were not alone in the colonial motherhood reconstructions and reproductive takeover. Voluntary organizations as well as individuals and midwives were trained to enter the homes of Ghanaian mothers to teach women how to be effective mothers for the colony.

Colonial reports show that the reproductive intervention was precise, ideologically based, and extremely intrusive into the private world of Ghanaian women. The intervention was manifested in a series of regulations that arose not only from Rattray's work, missionary activities, and maternal and infant welfare conferences, but also from colonial commissions of inquiries into the health needs of the colony that dates as far back as the 1915. Evidently, concern over the quality of Ghanaian womanhood and motherhood, the general condition of public health, and population growth as well as the chance to gain social control spurred the colonizers into monitoring and reforming not only birthing practices, but into instituting western midwifery education. The positive value of some of these intervention measures, especially the establishment of maternal and welfare centers, maternity training schools, hospitals, and clinics cannot

be denied. Yet, these institutions significantly reordered the social life of Africans for political purposes, demonstrating clearly that the welfare of women and infants had become a matter of national concern, rather than a private issue for families. The methodical strategies through which the British colonial government implemented and achieved this social reordering is the next the area to which we turn our attention.

Maternal and Infant Welfare and the Reconstruction of Motherhood

At the beginning of the twentieth century, a significant number of colonial medical and health professionals had serious concern for the high maternal and infant mortality rates in the British colonies. In the Gold Coast, the earliest reference to the serious loss of life among mothers and babies dates to 1911 when Dr. O'Brien conducted a private investigation into the health of children and wrote that the case of young children and the education of native mothers were matters ripe for the government's consideration. 99 In 1915, Dr. F. V. Nanka-Bruce gave the question prominence by arguing that the proper training of native midwives and the construction of properly equipped maternity hospitals would go a long way towards reducing maternal and infant mortality rates. At the time, infant mortality stood at 360 in Accra alone and an estimated 292 per 1000 live births for the country. 100 In 1916, Dr. Rice, who was the Principal Medical officer for the country, advised that the government appoint a committee to investigate the causes of death among babies and mothers.

⁹⁹ CSO 730/32, Government of the Gold Coast, Report on the Medical and Sanitary Department for the Year 1911. J. M. O'Brien, "Report of the Accra Laboratory," page 12-13, 77. National Archives, Ghana.

¹⁰⁰ CSO 659/21, GGCRMSD, Annual Reports, 1915. National Archives, Ghana.

In response, Governor Sir Hugh Clifford appointed a commission of inquiry in the same year to look into the matter. The committee, chaired by Mr. Crowther sat from April to June 1917. At the end of their inquiries, they concluded that the heavy loss of infant life was largely due to the faulty conduct of deliveries and to the equally faulty treatment of the newborn infants by native midwives and their mothers. 101 From the committee's recommendations and the various calls for maternal and infant welfare services, efforts to provide and/or improve welfare services became part of a broader shift towards public health as a government responsibility towards mothers and children. Indeed, the reduction of maternal and infant mortality became a commonly used indicator for assessing the standard of health in the country. The Clifford administration considered the Committee's findings; however, due to Britain's preoccupation with the events of World War I, and the fact that it was just recovering from the Boer War, funds were not available to implement the committee's suggestions.

In fact, entries in the colonial records suggest that the government was struggling to maintain economic normalcy in the matter of balancing budgets, and therefore, any policy that threatened to increase the financial burden of the crown, was

 $^{^{101}}$ CSO 11/1/296, GGCRMSD, 1932. P. S. Selwyn-Clarke, "History of Maternal and Infant Welfare in the Gold Coast," National Archives, Ghana.

feared and extremely unpopular with the government. In spite of this, in 1918, Clifford addressed an important dispatch to the Secretary of State regarding the matter. In 1919, he again drew the attention of the Secretary of State to the issue of maternal and infant welfare outlining the benefits of such an undertaken to the crown. Lord Milner in an answering dispatch indicated that if the proposal to establish a maternity hospital and a school for midwives would not exceed the capital cost of £28,000 and a recurrent charge of not more than £5,000 per annum, the crown would accept the plan. Plans to build the maternity hospital and a school for midwives were put on hold due to a change in governorship. Nonetheless, the new governor, Sir Gordon Guggisberg, upon assuming office in 1919 worked hard to achieve what his predecessor started.

In the Guggisberg administration, measures taken to reduce mortality rates reflected the ways in which the colonial government conceptualized the problem of maternal and infant mortality by neatly compartmentalizing its solutions into a range of services including maternal education and maternity services, medicalization and hospitalization of pregnancy and childbirth, controlled feeding of infants, and childrearing practices. These initiatives in healthcare policy would result in profound changes in women's experiences in childbirth, and in the role of the state in social welfare. This chapter discusses

the statistical evidence of maternal and infant mortality rates in the Gold Coast from the early 1920s to the early 1950s. The chapter also looks at the activities of missionaries, voluntary organizations, and the colonial government towards remaking Ghanaian motherhood through maternal and infant welfare services. This chapter sets the stage for events leading to the medicalization and hospitalization of pregnancy and childbirth in the country.

The Colonial State and Maternal and Infant Welfare

Before the colonial government turned its full attention on medicalizing and hospitalizing pregnancy and childbirth, its focus was first placed on providing maternal and infant welfare services and utilizing them to re-engineer Ghanaian motherhood. As a result, beginning in the early 1920s a number of maternity and child welfare centers were opened either by the government or by the mission churches and voluntary organizations throughout the country. Infant welfare work had began in the country in 1921 when Dr. Jessie Beveridge of the Scottish Mission opened a center behind the mission school at Christiansborg (Osu), Accra and a dispensary for the treatment of minor ailments of schoolchildren and infants. At the time, the infant mortality rate for Accra was 247 for every 1000 live births. According the center's records, the success of its

operations instigated the government into assisting Dr.

Beveridge by supplying her with drugs and paying the salary of an interpreter as well as paying her a small grant-in-aid. 102

With the colonial government's financial assistance, Dr.

Beveridge was able to extend her work to Aburi and Amedzofe in the eastern province and into the mandated areas of Togoland. In the following year, the government appointed a special school medical officer, Dr. Mary Magill, to examine and treat minor ailments of schoolchildren in Accra.

During the periods of 1923 and 1924, the government approved the opening of two welfare centers under the supervision of the Health Branch in rented premises in James Town, and in Christiansborg in Accra. In 1925, another welfare clinic was opened at Sekondi in the Western Province with a subcenter at Shama.

 $^{^{102}}$ CSO 149/32, file number 436/30/S.F.5, December 1922. National Archives, Ghana.



Figure 1: Sekondi Maternity and Child Welfare Center

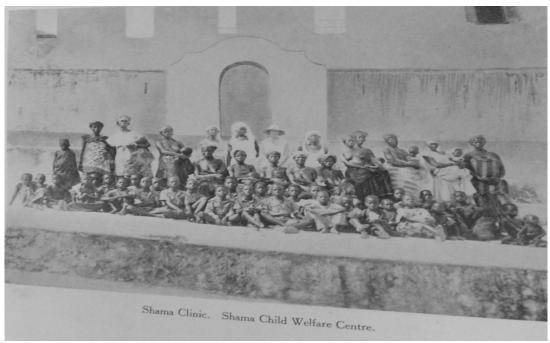


Figure 2: Shama Child Welfare Center

In 1927, a temporary welfare center was opened in Kumasi. The popularity of the center at Kumasi caused the construction of a new permanent center with twenty-four cots and beds the

following year for the city. In Cape Coast and Koforidua, welfare work began in temporary premises in 1928 and 1929 respectively, and as in the case of the Kumasi center, the centers in both towns became popular causing new permanent centers to be constructed in 1930. 103

The administration was quite pleased with the work done in infant and child welfare at these places, but worried about that of maternal welfare. The Lady Medical Officer in charge of the Cape Coast Welfare Center, Dr. F. A. Adam, wrote in her report for the center's first year of operation that the only work done under the heading of maternity was carried out by the medical officers of health and their staff, which included female sanitary inspectors. Part of their duty was to advise pregnant or puerperal women regarding their own health and the health of their babies and on domestic arrangements, but very little was achieved in this area during the reported period. 104

 $^{^{103}}$ I could not locate pictures for a number of the welfare centers including the Koforidua and the Kumasi centers in the colonial archives. 104 GGCRMSD, April 1927 to March 1928. F. A. Adam, "Maternal and Child Welfare," National Archives, Ghana.



Figure 3: Cape Coast Maternity and Child Welfare Center (Old Center)

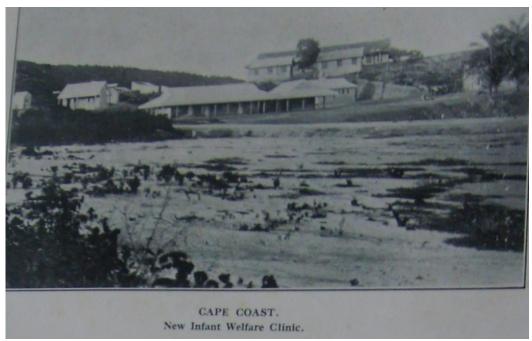


Figure 4: Cape Coast Infant Welfare Center (New Center)

The Cape Coast and Sekondi welfare centers were maintained under the aegis of the Gold Coast Branch of the British Red Cross Society. These centers represented a major aspect of the activities of the organization. The Roman Catholic Mission was

also involved in the provision of maternal and infant welfare services in many places in both the southern part of the country and in the Northern Territories. The following were a few of the centers the mission maintained: Kpandu, Djodji, Eikwe, and Jirapa. In recognition of the Catholic mission's contributions in welfare work, the government issued them with grants-in-aid and supplied them with drugs and dressings.

A maternity and child welfare center was also opened in 1929 in Accra at Christiansborg. The center was vital for welfare services in Accra and its environs.

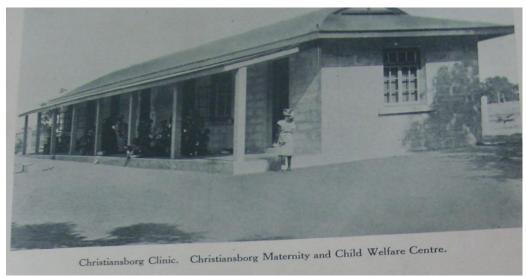


Figure 5: Christiansborg Maternity and Child Welfare Center

However, in 1931 the colonial government decided that because of the state of the economy the staff at the Christiansborg center could no longer be maintained. The center was therefore leased on a three months notice to a private medical practitioner as a

 $^{^{105}}$ CSO 18/1/135, no. 608/30, "Educational Policy in the Gold Coast," 1932 Report, page 750. National Archives, Ghana.

temporary measure during the financial depression. While valuable medical work was being done, it became obvious to the government that circumstances called for the center to be closed.

The government's reason was that as a private medical practitioner, she could hardly devote enough time to preventive healthcare campaign, public health propaganda, maintaining intimate contact with the government midwife and salaried and voluntary health visitors, and with "unqualified" midwives whilst at the same time maintaining a full preoccupation with gynecological work and other forms of general private practice. The only real solution, therefore, was to close the center. Again, in the early months of 1932, the lack of financial resources was given as the reason for the reduction in the number of Lady Medical Officers appointed to manage welfare centers. The appointments were reduced from eight to four per year, which caused a significant reorganization of welfare services in the country. 106 As our discussions will show, these early setbacks were temporary. Entries in the colonial records indicated a frenzy of activities in maternal and infant welfare in the country, especially those carried out by voluntary organizations and the various mission churches.

¹⁰⁶ CSO11/1/296, Memorandum on the Medical and Health Services. Selwyn-Clarke, "Infant Welfare Centers, General Principles," 1932, page 342.
National Archives, Ghana.

The State of Maternal and Infant Mortality in the Gold Coast

The question that confronts us is the exact nature of the maternal and infant mortality rates when colonial health and medical officials began making calls for the government to focus on the subject. However, owing to the early deficiencies in data collection, colonial medical and sanitary officers were not able to provide accurate information on birth, death, and maternal and infant mortality rates in the colony except in towns where registration was in place for a considerable number of years. Even in these towns, the figures were incomplete for death registration was not in force in many areas. On the other hand, since deaths were less easy to conceal than births, death registration was much more complete in the larger centers than birth registration. In addition to incomplete data regarding registration, the actual causes of deaths were generally inaccurately recorded. Dr. Adam, in one of her reports, noted that in the smaller areas where deputy registrars were laymen, the favorite causes of death returned included "piles," "fever," "bellyache," and "colic." 107

In one interesting scenario, Dr. Adam indicated that a young man of twenty-nine years of age was alleged to have died of whooping cough after being ill for five months. In the larger

¹⁰⁷ GGCRMSD, April 1926 to March 1927, Adam, "Birth and Death in the Gold Coast," page 188. Medical School Library, Ghana.

centers, a proportion of the deaths were registered as "cause unknown" owing to the prevailing interpretation of some of the provision of the new ordinance regulating births, deaths, and burials. We begin to see a reasonably complete data on birth and death as well as on maternal and infant mortality rates starting from 1923 onwards.

		Dea	ths		Births				
TOWNS	1000	1004	1005	1006	1000 1004 1005 1006				
	1923-	1924-	1925-	1926-	1923-	1924-	1925-	1926-	
	1924	1925	1926	1927	1924	1925	1926	1927	
Accra	1,018	986	1207	1130	1011	1000	1082	2095	
Kumasi	398	498	428	436	26	439	581	550	
Cape	314	283	341	315	218	315	219	306	
Coast									
Sekondi	382	437	309	375	178	160	150	242	
Koforidua	179	231	238	239	74	51	39	173	
Tarkwa	171	134	125	190	74	50	29	72	

Table 1: Birth and Death Record for Six Major Towns

Town	1923	1924	1925	1926	1927	1928	1929	1930
Accra	264	203	258	124	128	150	140	110
Kumasi	_	77	77	110	142	88	141	119
Cape Coast	146	82	123	124	124	99	52	73
Sekondi	123	112	173	61	68	51	123	145
Koforidua	391	647	769	196	176	181	131	267
Tarkwa	148	240	172	152	382	51	129	236

Table 2: Infant Mortality Rates for Six Major Towns

Town	1926	1927	1928	1929	1930	1931
Cape	14	13	23	15	29	12
Coast						
Sekondi	22	20	4	14	46	41
Tarkwa	38	34	0	14	46	68
kumasi	_	_	22	29	35	19
Accra	_	12	17	14	6	7
Koforidua	26	32	21	18	19	21

Table 3: Maternal Mortality Rates for Six Major Towns

In considering the above figures, it appeared that registration was extended to a large number of centers, coming into force on June 1, 1926 of the amended births, deaths, and burial Ordinance No. 26 of 1925. However, figures for maternal and infant mortality rates for the entire country only became consistently available from the late 1930s onward owing to the fact that infant births remained largely unregistered even in large centers while in smaller centers many infant and maternal deaths escaped observation. As the table below indicates, the rates for maternal and infant mortality for the entire country only became consistently recorded from 1938. These available figures unequivocally indicate why colonial health officials, who in the early twentieth century were accustomed to single digit maternal and infant mortality rates in their home country, would have reason to be alarmed. Interestingly, while selected

 $^{^{108}}$ CSO 11/5/1. no. 817/32. "Maternal Mortality and Morbidity in the Gold Coast," 1932, page 1-3. National Archives, Ghana.

areas in the country such as Accra and Kumasi managed to bring their rates to considerable levels, the overall maternal and infant mortality rates for the country did not seem to have reduced on any consistent basis as the table below indicates.

Year	1938	1939	1944	1945	1946	1947	1948	1949	1950	1951	1952	1953	1954	1955
Infant	102	110	125	119	110	117	121	125	122	117	125	120	125.8	119
Maternal	14	11.8	16	16.5	17	19	20.3	18.3	22.1	23.8	18	17	16.9	21.5

Table 4: Maternal and Infant Mortality Rates for the Gold Coast Colony

In the "Report of the Chief Medical Officer on the State of the Public Health for 1954," the Acting Chief Medical Officer,

Dr. E. W. Q. Bannerman, included two tables comparing the infant mortality rates from the 1930s with that of the 1950s for the entire country. The tables are cited below:

1930	1931	1932	1933	1934
116	114	102	100	105

Table 5: Infant Mortality Rate from 1930 to 1934

1950	1951	1952	1953	1954
122	117	125	113	119

Table 6: Infant Mortality Rate from 1950 to 1954

In his analysis, he wrote, "It will be observed that there appears to have been no real improvement in the infantile mortality rate during the past 20 years. However, under the present limitations governing registration of deaths, it is not possible to deduce an infantile mortality rate which may be said to be representative of the position throughout the Gold Coast

as a whole."¹⁰⁹ One does not have to look very far to see that the British government's maternal imperialism had not yielded the desired results.

Reconstruction of Motherhood through Maternal and Infant Welfare

The perceived deplorable state of maternal and infant mortality rates availed the colonial government with a social structure and a reason for micro managing individual lives, and through it, controlling collective life. In this regard, one cannot help but agree with Carol Summers on her argument that "social programs... were not mere sideshows to the public politics and the economic maneuvering of imperialism. They were integral to the holding of power." 110 In other words, social programs were agencies of the state, adopted and implemented for their effects on political stability and economic development. In seizing control over the realm of motherhood and reproduction, the colonial state was essentially reconstructing a society from the space of the individual to that of the entire population through a policy of social engineering. 111 In advancing a new ideology of motherhood, the colonial government sought to make women its tool to economic and political preservation. Besides, colonial

¹⁰⁹ Report on the Medical Department for the Year 1954. . E. W. Q. Bannerman, "Report of the Chief Medical Officer on the State of the Public Health for the 1954." National Archives, Ghana.

¹¹⁰ Carol Summers, "Intimate Colonialism: The Imperial Production of Reproduction in Uganda, 1907-1925," Signs, Vol. 16 (1991): 807.

¹¹¹ Ibid.

health officials figured Ghanaian mothers, with persistent persuasion, could be urged to preserve the life of their infants in spite of their unsanitary environments and their maternal ignorance of childcare. Dr. Cassie Birmingham of the Health Branch advocated strongly for a babies' hospital in connection with all large centers. She argued that there was a definite relationship between wrongful feeding of infants and childhood diseases. The African mothers' practice of carrying their babies on their backs all the time or letting them crawl about in the compound, to her, contributed to poor health in infants, and therefore, necessitated the need to reconstruct African motherhood. 112

While admitting that various factors contributed to the high maternal and infant mortality rates in the country, medical officers often blamed native midwives for their "unskilled interference" in deliveries, which caused mothers to suffer obstructed labor. Repeatedly, the most potent factors given for the high infant and infant mortality and morbidity were ineffective and faulty mothering skills, poor nutrition, bad housing, and the bad methods of native midwives. The latter was particularly blamed for umbilical hernia that frequently occurred in newborn infants. The Lady Medical Officer at the

 $^{^{112}}$ CSO 730/32, "Helen. Hendrie to Duff-Reply to Duff Letter (No. 133/31/30, Dated 20/5/32)" June 12, 1932. National Archives, Ghana. 113 Ibid.

Accra Maternity Hospital, Dr. G. M. L. Summerhayes, for instance, wrote that health officials had often pointed out that the frequency of umbilical hernia among infants was generally due to ignorant treatment by native midwives, such as leaving the cord too long—the custom was to leave it long enough to reach the baby's knee.

However, she admitted that a "certain proportion of babies born at the hospital also had umbilical hernia just as the babies delivered at home by native midwives. This showed that what was observed before was due to some racial congenital weakness." 114 Obviously, her belief in the medical expertise of health officials as well as in biomedical obstetrics, caused her to assign the blame to "racial weakness of Africans," and certainly, not to any mistake health officers may have been causing. On the other hand, native midwives had been blamed before Dr. Summerhayes settled on her racial congenital weakness theory. In many of the reports on maternal and infant welfare, colonial health officials appeared infallible for they repeatedly blamed either mothers or native midwives for reoccurring problems or for low success rates. On rare occasions when mothers and native midwives escaped blame, "racial weakness," as was the case with the umbilical hernia, bad

¹¹⁴ GGCRMSD, 1929-1930. G. H. L. Summerhayes, "Report of the Maternity Hospital, Accra." Appendix F. page 199. Medical School Library, Ghana.

economy, or the lack of financial resources were given as the reason for the lack of progress.

To purge Ghanaian mothers' maternal ignorance and to reengineer a new motherhood fashioned on the colonizers' ideals, colonial officials fell on one tool: maternal education. The reason was that out of ignorance, African mothers exposed their infants to diseases; therefore, maternal education was the most appropriate tool to rectify the situation. All mothers could be ignorant, but colonial officials believed that African women because of the excess time they spent working on the farm and in other domestic duties were particularly careless and neglectful of their children. Therefore, mothers must be educated on their responsibility for maintaining personal hygiene and controlling filth in their domestic space. In February 1924, Governor Guggisberg stated:

"Once, however, that a nation has emerged from the primitive phases of its existence, education—with all that it comprises—becomes not only the first, but the only step towards progress, and the people of this country can rest assured that government is fully aware of this fact and is making every effort towards the desired end." 115

Guggisberg's statement was not necessarily directed towards educating just women, but the entire population. However, his commitment to general education in direct sectors of the society

 $^{^{115}}$ CSO 18/1/135. "Memorandum Relating to the Educational Policy of the Gold Coast Government as Reviewed by the Joint Session of Provincial Councils at Dodowa in July, 1936. Pages 1-9. National Archives, Ghana.

emboldened voluntary societies and missionaries to step up their educational efforts including maternal education in the country.

Those involved in maternal and infant welfare conceived that education in infant management could be channeled through either the mother or the daughter. Therefore, girls' schools were designed to teach hygiene, cooking, homecraft or home economics, and mothercraft since colonial educators believed girls would eventually end up as wives and as mothers. A government report on girls' education in both government and mission schools indicated that the curriculum for girls' education in girls' schools and in 17 mixed schools involved female pupils undergoing a special course of training in domestic science (needlework, cookery, laundry, housewifery, child welfare, and hygiene). The report further stated that the practical value of this course was for the benefit of the entire population. 116 The general efforts geared towards reconstructing motherhood began in some selected areas in the country in 1925 in the name of public health. The magnitude of the pressure exerted on women to learn new mothering skills varied across the country. Urban centers tended to receive more focus as compared with the rural area since colonial health officials had limited access of the remote areas of the country, some health personnel

 $^{^{116}}$ CSO 70/37. "Director of Education to the Honorable Colonial Secretary on the Subject of Female Education in the Gold Coast." August 12, 1937.

were reluctant to serve in those areas, and some rural areas generally had limited maternal and infant welfare centers. In urban centers such as Accra, Cape Coast, and Kumasi the Sanitary Department took charge of the maternal education by introducing Health Weeks in which health workers and students cleaned up neighborhoods, and health officials inspected schoolchildren for infections and personal hygiene.

For instance, in 1925, Dr. Selwyn-Clarke, the Senior Sanitary Officer in Kumasi who later became the Deputy Director of Health Services in the Gold Coast, initiated as part of the Health Week in the city, a baby show, which became very popular with mothers in Kumasi and its environs. When the baby show first premiered, Dr. Selwyn-Clarke was expecting that about two hundred babies would be entered in the show. To his surprise, Asante mothers brought nearly five hundred babies to the baby show. Asante mothers accepted the reward of their babies being selected as winners in the show and the added benefit of publicly showing off their babies as the healthiest. The huge number of babies brought to the baby show indicated to Dr. Selwyn-Clarke that this was an avenue that could be used to change maternal behavior. Thus, in the following year, he directed that all babies whose births had not been registered in the Register of Births for the Kumasi area were not to be allowed to contest in the baby show. Although in his health

reports, Dr. Selwyn-Clarke did not directly connect his refusal to allow unregistered babies to participate in the baby show, it is easy to make the connection, as there was a substantial increase in the number of birth registration starting in 1928. From hence, the baby show became a benign tool used to regulate women's reproductive behaviors. In other words, Asante mothers were gently urged to accept colonial conception of effective motherhood and to change their maternal behaviors through a system that publicly praise mothers who had entered the colonial terrain with medals and photographs and punished those who refused the maternal reconstruction by denying them access to the baby shows. The baby shows were organized in all the urban areas with welfare centers and medical officials reported them as being very successful.



Figure 6: Kumasi Baby Show, 1929-1930



Figure 7: A Group of Prize-winning Babies, 1929-1930

With the success of the baby shows in Kumasi and in other places, colonial health officials moved to intensify the government's motherhood reconstructive programs at the various maternal and infant welfare centers in the country. When the Kumasi Welfare Center, for example, began operations in 1927, its primary objective was to provide antenatal care to expectant mothers and to offer postnatal care to infants. Its main agenda, then, was preventive treatment, and not curative treatment. In addition to its regular clinic visits, the center held weighing clinics whereby mothers were encouraged to bring their infants on a monthly basis in order to assess the child's development. Its presence meant that antenatal care could now be coordinated with postnatal care, weighing-in clinics, and instructional sessions in mothercraft. Activities at the Kumasi center were not exceptional. The Accra, Cape Coast, Koforidua, and Sekondi welfare centers took on the challenge of reducing maternal and infant mortality rates whilst at the same time focused on achieving social restructuring.

At the Princess Marie Louise Hospital and Child Clinic in Accra, about one hundred women and infants were seen every month. Advice was given individually to the mothers about nutrition and diet, infant clothing, and about the conduct of their confinements and the treatment of young babies. Women were advised to have their confinements conducted or supervised by

the government midwife and to see that the child's umbilicus was properly cared for. Minor ailments were treated and if there was a history of miscarriages or weakly children, the child was treated. Twice a week, the medical staff held a weighing or well-babies section at the hospital, and once a week at Adabraka, James Town, Labadi, and Christiansborg. Mothers who brought their children for weighing were advised on child feeding and management. In 1932, Dr. C. D. Williams, the Lady Medical Officer at the Princess Marie Louise Hospital, noted that as compared with their older siblings, infants were far better off health wise.

According to her, infants up to one year old were well cared for by the mother-nearly always breast-fed, living on the mothers back or lying on a mat in the compound. Occasionally, they had attacks of fever and chest troubles, but these were generally obvious and the mother readily sought remedy. However, as soon as the baby got a little older, it was fed on the most ill-judged diet, and inevitably the baby picked up worms as soon as it became mobile. This jeopardized the children's future health and their subsequent productivity as citizens. Evidently, Ghanaian mothers' efforts at raising their children were considered insidious and that they undermined their children's health sometimes to a fatal degree before they even realize there was something wrong. In the opinion of Dr. Williams, all

preventive work should be emphasized for the benefit of toddlers even more so than for infants. 117 At the Cape Coast Welfare Clinic, the medical staff in addition to antenatal work at the clinic, organized regular weekly clinics at Asebu, ten miles from Cape Coast, where the paramount chief provided quarters for them in the Rest House. This village was, and in fact continues to be, the headquarters for the Asebu paramount of chiefs and had a large marketing center. Therefore, it was hoped that the initiative would prove successful and improve the health of people in the "bush" villages outside the coastal area.

Attendance at the weekly clinics at Asebu, however, proved unsuccessful although Cape Coast health official remained optimistic that with perseverance it would prove popular and beneficial to the community. The problem was that Asebu mothers were reluctant to break their daily activities to sit for hours listening to lectures about mothercraft. When they attended, it was solely to seek treatment for an ailment or to find remedy for a disease. Indeed, throughout the country, women who participated in the various maternal and infant welfare activities did so on terms that they determined. Indeed, entries in the colonial health and medical reports indicate that throughout the country where maternal and infant welfare centers were located, women initiated various strategies to counter the

 $^{^{117}}$ CSO 730/32, C. D. Williams, "Memorandum to DPHS 3/9/31."

colonial imposition on their reproductive behaviors. For instance, the Kumasi welfare center, like all the other welfare centers, was intended to provide preventive services to mothers and children. However, due to Asante mothers assertion of what they wanted out of the welfare center, the health and medical officers were forced to focus on curative instead of preventive medicine. In some instances, the center was forced to attend to high-risk pregnancy and deliver babies even though they had no facility for such operations. In 1936, 84 women delivered their babies at the center and in 1937, 109 delivered there.

The Lady Medical Officer disclosed in her first annual report on the center's activities that they were focusing on curative and not preventive medicine. She wrote, "As the clinic becomes better known to the Ashantis the difficulty of confining the activities of the center to welfare work becomes greater."

The medical officer added that nearly every child brought to the center was suffering from some form of a disease. Out of the over 10,000 children mothers brought to the clinic, only 9 percent came for well-child care involving inspection and maternal advice. 119 At the Cape Coast center, Dr. Adam reported in January 1933 that the prevailing diseases mothers sought treatment against included yaws, malaria, coughs, and gastro-

¹¹⁸ Report on the Medical Department, 1936. Pages 36-37. J. M. Mackey, "(Health Branch) Maternity and Child Welfare." National Archives, Ghana.
¹¹⁹ Thid.

intestinal troubles, which seemed to be caused by mothers irregularly feeding their infants and prolonging breastfeeding them. 120 In Accra, Koforidua, and Sekondi where the colonial government maintained consistent records of welfare activities, the story was the same—Ghanaian mothers were forcing welfare centers across the country to focus more on curative health care instead of preventive health care.

By seeking curative health care rather than preventive health care, Ghanaian women reconfigured the colonial motherhood scheme into a distinctly new agenda. By this action, women successfully took advantage of an alternative medical care whilst avoiding the inconvenience of having to sit through hours of lectures on how to be an effective mother. Furthermore, they managed to indoctrinate those entrusted with the task of colonizing the womb into collaborating with them in using the welfare centers for curative medicine. However, the emphasis on curative medicine rather than preventive healthcare almost immediately triggered severe reactions from some colonial health officials who were of the opinion that preventive medicine was the only solution to the country's high maternal and infant mortality rates.

Colonial medical officials who took this position included Dr. J. Balfour Kirk, the Director of the Gold Coast Medical

 $^{^{120}}$ GGCRMSD, 1933. F. A. Adam, "Maternal and Child Welfare," page 11-14.

Services. In a 1942 annual medical report, Dr. Kirk strongly pointed out that the "so-called welfare clinics have been allowed to degenerate into treatment clinics and educative and welfare work has been completely swamped by the huge wave of suffering childhood which has inundated them." 121 According to him, welfare centers were "being used as a combined maternity and sick children's hospital." 122 He blamed this state of affairs largely on the medical officers' failure to provide direction and their desire to ensure the popularity of these clinics as far as it may be expressed in the number of attendances year by year. Dr. Kirk admitted that the absence of adequate hospital accommodation contributed to the low standard of living of those who were most in need of instruction and quidance, nonetheless, he believed that the centers given the proper management could fulfill their original purpose of preventive health care.

He used the weighing clinics in England as an example of how the core principles of maternal and infant health had been taken out of welfare measures in the Gold Coast:

In Europe the weighing center is generally the place where demonstration in the care and management of infants are conducted, cookery lessons given, dress-making classes organized, and the general welfare of children impressed upon all who attend there for these purposes. Here the weighing center appears to be merely a weighing center and the mothers have to be

 $^{^{121}}$ PRO CO 98/54: Gold Coast, Report on the Eastern and Western Provinces for 1941-1942.

122 Ibid.

continually pestered to bring their children there to be weighed. 123

Certainly, Dr. Kirk was not alone in his opinion. In 1931, Dr. H. O'Hara May, the Deputy Director of Health Services, in a memorandum had stated that the various welfare clinics in the Gold Coast were about ninety-nine percent curative and only about one percent preventive in scope. In that same year, Dr. W. M. Howells, who was a Senior Health Officer at Health Service Department noted that it was with great regret that the infant clinics throughout the Gold Coast have to a great extent, if not altogether, lost touch with the preventive side of welfare work.

Howells added that the infant clinics in short were no longer welfare centers, but "Children's Hospitals" in the truest sense of the term. This transition was inevitable, and was entirely due to the large amount of work thrown on the Lady Medical Officers. The large number of sick children mothers brought for treatment allowed little time for the question of prevention and the school health work had almost entirely disappeared. He argued that, perhaps, the time was due when the older infant clinics were frankly designated as Children's Hospital and taken over by the Medical Branch. In a similar stance, a letter dated February 20, 1932, written by a health official to the Director of Health Services, Dr. Selwyn-Clarke,

¹²³ Ibid.

 $^{^{124}}$ CSO 17/2/243. W. M. Howells, "Memorandum on Infant Clinics," April 25, 1932. National Archives, Ghana.

called welfare work in the Gold Coast, a "well-intentioned mistake." Contending this assertion, Dr. Selwyn-Clarke wrote of his pleasure in learning that the governor did not find welfare work in the colony as a "well-intentioned mistake." He added that the tens of thousands of babies, mothers, and schoolchildren who had benefited from the existence of these centers in the Gold Coast were surely an adequate reply to unfounded assertion.

In Dr. Selwyn-Clarke opinion, the reduction in infant mortality in Accra alone from 368 in 1916 to 95 in 1931 spoke volumes. To prove further his point, Dr. Selwyn-Clarke sent out a memorandum to the Lady Medical Officers in Kumasi, Koforidua, Cape Coast, Sekondi, and Accra to ascertain their opinions on curative medicine at the welfare centers. In their replies, the Lady Medical Officers all shared the view that curative medicine could not be completely separated from preventive medicine at the welfare centers. The Lady Medical Officer at Koforidua, Dr. D. E. Stewart, was more explicit in her opinion. According to Dr. Stewart, the majority of the women who attended the clinics on a regular basis came from a wide radius of about twenty to thirty miles, and certainly, they expected a bottle of medicine

 $^{^{125}}$ CSO 11/1/269. Selwyn-Clarke, "Memorandum on Infant Welfare Centers and General Principles," March 21, 1932. National Archives, Ghana. I have searched the colonial record to try and locate the writer of the letter to no avail, although it did not appear to have come from an anonymous writer, it did not bear any name either.

and a visit to the doctor when they made the trip to the center. To her, it was "unreasonable to expect these women to pay some shillings for a lorry fare to bring a perfectly well grown infant to a clinic only to be told of its weight." 126

Dr. Selwyn-Clarke could not have been happier with Dr. Stewart's position. In a lengthy lecture about preventive healthcare and welfare work, he pointed out that some medical officers in the Gold Coast had the erroneous impression that curative medicine formed no part of welfare work in England. Indeed, since 1906 when the first efforts at welfare work began in England, curative medicine existed in conjunction with preventive medicine and Ghanaian women insisting on what they needed out of government's healthcare initiatives should have been expected. 127 Even in England where the population had been accustomed from early youth to routine medical examination, lived in an atmosphere of health weeks, baby weeks, health exhibitions and displays, health societies, and listened to broadcasts on health subjects, people still demanded curative medicine in place of preventive medicine. Moreover, anyone with any experience in health propaganda in connection with welfare work would acknowledge that the only way to secure understanding and appreciation of the objects of preventive work, more

¹²⁶ CSO 11/1/296, D. E. Stewart to Selwyn-Clarke, "Memorandum on Infant Welfare Centers and General Principles," September 21, 1931.
¹²⁷ Thid.

particularly amongst a population mostly illiterate, was to show or give something tangible.

In other words, when a village was furnished with sanitary structures, a water supply, a market place, avenues of shade trees, free from flies, mosquitoes, and other nuisances of the like, they served as concrete proof of government work amongst them and a better form of propaganda than a thousand speeches and lectures on hygiene to the same community. This was because the practicality of the former case would be readily accepted because of the actual improvements brought to the village. In the same way, mothers would be more willing to listen to advice regarding their infants, and with much more chance of such advice being acted upon if their confidence was won by, for example, having seen their own, or their neighbor's child, cured with quinine. Once women's confidence had been established, it was a much less difficult matter to instill advice on mothercraft without having to gild the pill with a bottle of soap, liniment, or a few grey powders. To Dr. Selwyn-Clarke, this was precisely what had been the policy of the Health Branch from the very beginning, but unfortunately, some health officials had misunderstood this policy.

To make sure that his point was driven home, Dr. Selwyn-Clarke asked those who still had doubts about curative medicine in welfare work to ask themselves whether they would have the temerity to deny that the treatment of malaria—and twenty—three out of very hundred children seen at the welfare center in 1930–1931 received treatment for this disease—was not considered to be important method of malaria—prevention. More importantly, when children who carried the most infective stage (gametocyte) of the parasite were treated, a word or two would be imparted to the mother as to how the child may be protected by the use of a net, etc., and how the breeding of anopheles mosquitoes may be prevented within the vicinity of the home. Lessons in cleanliness of body, clothes, and household, in the leaning and protection of the sores and ulcers, in the proper disposal of human waste and refuse would be driven home at the time a mother brought her child up for an injection.

Surely, the treatment of an anemic and bloated child with anti-helminthes would be justified as a preventive measure especially when the probable cause of the infection was explained to the mother and she was made aware of the means of preventing her other children and her neighbor's children from becoming infected. Besides, if the giving of a few ounces of salts was the means to bring to the antenatal clinics an expectant mother who may be suffering from mal-presentation, placenta previa, or from tazaemia of pregnancy, who would argue that the possibility to save the life of a mother and that of a child was not a justified treatment. In computing all the

various opinions collected from the provincial medical officers, the Assistant Director of Health Services came up with the following suggestions for the colonial government:

Welfare centers in the Gold Coast fulfill a most important function in the sphere of preventive medicine. They serve as powerful means of health propaganda among the mothers and children of the Gold Coast. That there is no doubt whatever in my mind that the educational aspect of their work will attain greater proportions at the expense of the purely curative side as time goes on. That if these clinics were to function at all as preventive centers and obtain the support of the mothers and children, one must be prepared to give treatment. 128

Dr. Selwyn-Clarke himself acknowledged that preventive work had the added benefit of reducing healthcare cost, but he remained steadfast in his opinion that curative work formed an important part of welfare work, and focus on it would remain for many years. In no doubt, Dr. Selwyn-Clarke proved his point about the interconnectedness of curative and preventive work and the need to have both components in maternal and infant welfare services in the Gold Coast. Nonetheless, his arguments did not convince everybody. Dr. Kirk, for one, instructed that if Asante mothers would not "bring their babies regularly to the weighing machine, the weighing machine must be brought to the house," which thanks to the imperial politics of indirect rule, the colonial government had access to whenever they wanted. He added

¹²⁸ Ibid.

 $^{^{\}rm 129}$ PRO CO 98/54: Gold Coast, Report on the Eastern and Western Provinces for 1941-1942. Kew, UK.

when health visitors visit a household "those features of the home life of the child which may militate against its welfare should be noted and the mother's attention drawn to them." 130

To launch the new initiative of taking the weighing machine into the homes of mothers, the colonial government, voluntary organizations, and the various missionaries collaborated closely in an effort to ensure that every mother, if possible, was educated in the new mothering skills. The enthusiasm of the mission churches is clearly illustrated in the activities of the women's wing of the Methodist Mission in Accra, Asante, and the coastal areas in the 1920s. As shown by Allman, the mission's programs in Asante focused on remaking mothers through home visits and educating young girls in the science of mothercraft. The goal was that once these girls had been transformed into the colonial ideal of womanhood, they would in turn become agents of the colonial government and go back into their towns and villages where they would transform their mothers into good mothers.

The mission was so keen on cultivating new mothers through the education of girls such that in 1927 when they made plans for a girls' boarding school in Kumasi, the mission's district director in Asante, Harry Webster, indicated girls' education would be focused on "domestic and home training subjects—native

¹³⁰ Ibid.

cooking, laundry work, needle work, and gardening."¹³¹ Unlike in Accra and Cape Coast, the mission did not provide Asante girls with instructions that would allow them to sit for the general English examination in the colony. It is not particularly clear why the mission made the distinction in its educational program for girls in Asante and those in Accra and Cape Coast.

Nonetheless, we can make a reasonable assumption that the large numbers of African elites in Accra and Cape Coast who were the predominant social class able to afford western education probably influenced the type of education they wanted for their female children. In spite of the education in English, girls' education, in general, was intended to develop in them the "qualities of docility and of sweetness" and to become good mothers and good wives. The instruction was, at best, to enable some girls to work as secretaries or house servants to European families in the country.

The girls' school called Mmofraturo (children's garden), opened by the mission in 1930, therefore, emphasized women's domestic roles and the ideals of Christian motherhood. As part of its programs, the school officials in the early years ensured that students "meet in a Mothers' Council" to talk about the

 $^{^{131}}$ PRO CO 96/673/8: "Harry Webster to F. Gordon Guggisberg," February 15, 1927. Kew, UK; see Allman.

¹³² Catherine Coquery-Vidrovitch, African Women: A Modern History (Boulder, CO: Westview Press, 1997), 143.

effective ways of raising children. As has been argued, the majority of Asante girls did not get the opportunity to go to school during the colonial period, but the few who received colonial education provides the window into how the colonizers structured their motherhood reconstruction. Furthermore, both colonial health and education officials encouraged programs that allowed students and other outreach groups to enter into the homes of mothers to teach them how to properly bath their children and care for their wounds and other skin conditions. 134

The role of local chiefs was vital in this undertaking because it was through them that the colonial government was able to access the private spaces of Ghanaian women. Often, the chiefs' responsibility to the colonial government involved announcing to, as well as assembling the village women so that missionaries and other voluntary organization could carry out their mothercraft lectures and baby baths. The Methodists Women were not the only colonial agents assigned the task of reconstruction Ghanaian motherhood and womanhood. There were other groups such as the Red Cross Society, the Catholic Mission, the Basel Mission, and the Gold Coast League for Maternity and Child Welfare. For example, the activities of the League, especially in terms of providing domiciliary visits

 $^{^{133}}$ WMMS WW: 8/1048, "Official Report upon the Kumasi Mmofraturo Girls' School," June 6, 1932. 134 Allman, 23-47.

throughout the late 1920s and the 1930s, became a vital part of the colonial government's agenda of maternal reconstruction.

The League's maternal and child welfare work in the Gold Coast began in 1927. Under the leadership of Lady Slater, they managed to establish centers in Accra, Sekondi, and Kumasi from where they entered the homes of Ghanaian women to remake motherhood. At the Kumasi welfare center, the League helped to train a Cadbury health visitor in 1931. She reportedly made about ten visits into the homes of mothers every afternoon talking to four to six women in each compound. She was also responsible for visiting the infants whose births were registered at the Kumasi Public health Board. 135 In the 1930 Medical and Sanitary Report, Dr. M. C. Chappel, the Lady Medical Officer at the Kumasi Hospital, indicated that the Gold Coast League continued to do useful work in the country. They conducted numerous voluntary home visits and organized several meetings in the year during which medical officers gave lectures and demonstrations. Dr. chappel added that the organization organized a very successful baby show, even though her report did not indicate the exact place where the baby show was held. The main part of welfare instructions given by the League members to African mothers was with each individual mother.

 $^{^{135}}$ CSO 11/1/17. GGCRMSD 1931, "Maternity and Child Welfare: Training of Health Visitors." National Archives, Ghana.

The above approach was adopted because the League members and the medical officer reasoned that teaching by set lectures was not suitable for women who were mostly illiterate.

Therefore, they gave individual instructions regarding diet and home hygiene to every mother. Akin to Chappel's report, an extract from reports of local health officers referring to the work done by the Gold Coast League shows how important they became in Dr. Kirk's program:

Much good work is being done by these ladies in seeking out cases of sickness especially amongst children and in having these cases sent to hospitals for treatment, in having friendly talks with the native women and explaining to them the benefits of cleanliness, both personal and domestic, and the danger of insanitary conditions in their homes. By their knowledge of the people and districts many cases of both expectant mothers and sick children are brought to the notice of the medical officer where otherwise they might never have been seen. 137

According to many colonial medical and health officers, the propaganda spread by members of the Gold Coast League in the course of their domiciliary visits had gone a long way towards popularizing both infant and antenatal clinics. The result was that antenatal consultations had gone up and helping to reduce the terrible blemish on the colony of the high puerperal mortality rate. For example, in the 1930-1931 medical report, all the medical officers at the maternity hospitals in Accra,

 $^{^{136}}$ CSO 11/1/296. M. C Chappel, "Report on Preventive Work at the Kumasi Clinic." National Archives, Ghana.

¹³⁷ GGCRMSD, 1927-1928, "Maternity and Child Welfare."

Kumasi, Sekondi, Cape Coast, and Koforidua reported great strides in their programs. In Kumasi, there were 30,897 visits by children to the welfare clinic and 12,037 visits by expectant mothers. The Lady Medical Officer at the center commented that at times, it was difficult to cope with the number of women attending the clinic, but the charge of a small medicine fee had helped to reduce the numbers. 138

The charge of fees was also given as the reason for a 50 percent drop in the number of children women brought to the Cape Coast welfare center for treatment. In addition to the center's new system of counting new cases, which had reduced the incidence of double counting, and there was a drop in yaws cases from over 3,700 cases in 1929-1930 to fewer than 1,000 in 1930-1931. Figures for the Northern Territories were hardly available in the 1920s and 1930s. In the 1940s when they began to provide such information, it was limited to a very few places such as Tamale, Jirapa and Lawra, where welfare activities were carried out by the Red Cross Society and the Franciscan Sisters of the Roman Catholic Mission. The available figures for these areas were severely fragmented and difficult to tabulate.

What we can infer, however, from the available numbers suggests that Ghanaian women negotiated the colonial motherhood

 $^{^{138}}$ GGCRMSD, "Maternity and Child Welfare," page 45, National Archives, Ghana; PRO CO 98/58: Gold Coast, Report on Ashanti for the Year 1929-1930, Kew, UK.

reconstruction in a variety of ways. At one end, some women accepted the government's maternal reconstruction by becoming enthusiastic participants in the various programs. They attended antenatal clinics at the welfare centers, had their babies delivered by registered midwives, sought medical treatment for ailments of their older children, and took their infant children to the weighing clinics on a regular basis. At the other end were women who because of the lack of financial resources to access the government health services or by choice avoided or take no notice of the colonial reproductive intervention. They continued their lives as though no change was going on and continued to rely on the indigenous health and healing systems that had served them for generations. Colonial health and medical officials on several occasions lamented about the large numbers of women who continued to rely on the unqualified native midwife rather than the registered midwife. Many of the maternal mortality cases were reported as due to mismanaged pregnancies and labors before admission. According to some of the reports, the cases of obstructed labor seen after they have been in the hands of untrained native midwives were pitiable and often beyond assistance. In 1929, Dr. Summerhayes wrote, "the majority of cases in maternal deaths at the Accra Maternity Hospital were

preventable deaths, but caused primarily due to the ignorance and harmful practices of native midwives." 139

In-between the two poles of women were those who redefined the colonial agenda in their own terms. These women patronized the government welfare programs when it suited their needs such as when their infant child was sick in which case, they readily went to the welfare center or hospital and sought treatment but avoided the centers when their activities interfered with their daily routines and practices. In other words, these group of women took advantage of the benefits of alternative medicine in times of sickness or childbirth complications, but they collectively ignored the weighing clinics and mothercraft lectures by failing to attend them when they had no need of western medicine. On occasions when mothers had to participate in the weighing clinics and mothercraft lectures because they needed health services for their children, many paid little attention to what was been said or they turned the experience into a social occasion for themselves. In the 1947 medical report, the Director of Medical Services reported of "a growing tendency for women to regard the routine visits to the antenatal or child welfare clinic as a pleasant social event." 140 Presumably, the women appeared at the clinics more concerned

¹³⁹ GGCRMSD, 1928-1929. Appendix H, page 142. Summerhayes, "Report on the Maternity Hospital, Accra," National Archives, Ghana.

¹⁴⁰ GGCRMSD, 1948, page 10. J. G. S. Turner, "Maternal and Child Welfare," National Archives, Ghana.

about who was better dressed, had the prettiest baby, or who had got the juiciest local gossip, than they were interested in talks about environmental cleanliness, nutrition, and mothercraft.

The situation got to such an extent that the Director of the Medical Services essentially called for the abandonment of social welfare initiatives by welfare centers. For after years of trying to control women's reproductive behavior, the colonial government had not achieved its desired result. In 1941, Dr. J. G. S. Turner, Director of Medical Services had stated that dietary deficiency remained the main cause of diseases seen in both children and of anemia in mothers after repeated pregnancies. Furthermore, in spite of continued propaganda urging mothers to get the attention of a "qualified" midwife, large numbers continued to rely on the "unqualified" woman and to seek skilled help only when a case became difficult. Thus, in 1942, Dr. Kirk concluded that the colonial government had to change the field of battle. That is, besides taking the weighing machines into the homes of Ghanaian women, health officials were to increase their domiciliary visits and to add programs in mothercraft that would help to change women's maternal behavior.

In the new drive aimed at taking the battle into the homes of Ghanaian mothers, the colonial government and the mission

churches in particular, worked closely with one another to educate women in the following areas:

Personal Hygiene of Infants									
Care of Hair	Not to plaster mud on the fontanel								
Care of Skin	Not to smear henna or paste on the body to avoid prickly heat								
Care of Eyes	Not to smear charcoal around the eyes and so give the baby conjunctivitis and to prevent ophthalmic neonatorum								
Care of Umbilicus	Dressing the cord to prevent tetanus, septicemia, jaundice, and umbilical hernia								
Care of Nipples	Cleaning the nipples to prevent thrush								
	Pediatrics								
Infant Feeding	The value of regular feeding, the use of plain boiled water, the value of orange juice to promote steady growth and development, and special feeding of premature infants and orphaned children								
Habits	To teach children at a young age good habits and self-control, discourage the use of purgative medicine and enemata.								
	Personal Hygiene of School Children								
Cleanliness of Body	Cleaning of teeth, nails, hair, and toes. Cleaning of children suffering from florid yaws, and the value of wearing sandals in crab yaws								
	Expectant Mothers								
General Education	Personal cleanliness, dietetic advice, the value of regular antennal visits, prevention of avitaminosis, the use of mosquito nets to prevent malaria, and the value of quinine.								

Table 7: Maternal Education Program

Medical officers on foot, Roman Catholic sisters on bicycles, students doing voluntary work on weekends, and a combined team of trained African health visitors and European health visitors

would arrive in a village with their weighing machines and educational materials. With the help of the chief and elders of the village, they would gather the village women, weigh their children, and lecture them for hours on effective motherhood.

Through these maternal educational measures, mothers were not only being transformed, but the colonial government hoped they themselves would be agents of social change evidenced by a statement by Dr. M. M. McDowall, the Lady Medical Officer at the Koforidua welfare center. According to her, the enormous educational value to the community at large emanated through advice given to mothers about the care of their children. Every mother who went from her village to another village served as a disciple in the village about preventive medicine. 141 In the late 1940s, the new Director of Medical Services, Dr. D. Duff, revived the old debate that had taken place in the 1930s regarding whether welfare centers should be curative or preventive. He pointed out that the Red Cross Society had welfare centers at Koforidua, Cape Coast, and Sekondi, but they were operating these centers on curative medicine instead of preventive medicine. He suggested that the government employ qualified European medical women such as Dr. Chappell so it could take over the operations of the centers and operate them

¹⁴¹ CSO 11/1/296, "Memorandum on Infant Welfare Centers and General Principles." M. M. McDowall, "Infant Welfare," September 21, 1931.

as true welfare centers. He developed a scheme in which trained African women would eventually replace the European medical women employed in the districts.

To him, European women employed by the Red Cross Society to work at the Cape Coast, Koforidua, Sekondi centers lacked the necessary qualifications to carry out effective preventive work. Stated differently, these women had little conception of the scope and requirements of preventive work and the centers had at times suffered from being attached to such women who have had insufficient knowledge of welfare work. The nature of their work output even caused the Secretary of State to direct in 1934 that health officials should give preference when appointing health visitors and nursing sisters who had a health visitor's certificate. The women not only lacked the ability to make personal connections in the communities in which they worked, but they also failed to acquaint themselves with the local conditions of their communities making their work ineffective.

Dr. Duff further cited the annual medical report of the Public Health Commissioner of the government of India for 1930 in which reference was made to the unsatisfactory situation in India whereby posts in health work were out of necessity given to medical women who had no qualification in, or experience of,

 $^{^{142}}$ CSO 12/3/34. Secretary of State to Director of Medical Department (Dispatch on December 29, 1934).

preventive medicine. He continued that welfare work in the Gold Coast had suffered in exactly the same way by the employment of such women and there had been much wasted effort. Unless the government employed medical women who had the necessary training, experience, and interest in welfare work, their takeover from the Red Cross would not result in any changes and their efforts would again be wasted. 143 He further argued that the future satisfactory development of health work for the benefit of mother and child in the Gold Coast depended on the government getting together a cadre of well educated and qualified health visitors. He could not overemphasize the assistance given to the welfare movement in the Gold Coast by European nursing sisters who had special health visitor's training. These women since the beginning of welfare activities in the country had been responsible for much of the government's progress.

An extract from the 1937 medical report on welfare give credence to Dr. Duff's argument. The entry indicated that European health visitors had been appointed to work at the various welfare centers since the commencement of the welfare movement when well-educated African women were a rarity in the country. These early European health visitors did good pioneer

 $^{^{143}}$ CSO 70/37, No. 772. D. Duff, "Development of the Education of Women and their Employment in Health Work on the Gold Coast," May 10, 1937.

work, but they were not sufficiently well educated generally or professionally to advance welfare work as it should. In other words, the health visitors who were employed at the beginning of the welfare activities in the country, although keen and hardworking, were not educated or trained adequately for the important aspect of preventive work in welfare. Once appointed, these women received a comparatively short course at the Accra maternity hospital or at one of the welfare centers in house inspection, vaccination duties, and in birth registration under a medical officer and they carried out the pioneer work well in a somewhat "rough and ready" manner. The lack of skilled followup of cases by well educated health visitors rendered a good portion of the work at the various welfare centers ineffective. That is, maternal and child welfare work, unless followed up in the homes of the people by well educated visitors trained in both nursing and midwifery, tended to become useless-cases relapsed repeatedly and there would be wastage of drugs and in output of energy on the part of the staff.

The colonial government did take the advice of Dr. Duff and increased its intake of European medical women, although the majority found conditions in the Gold Coast intolerable and, therefore, returned to England. In one example, one of the newly recruited European medical women wrote to the Director of Health Services that she was not informed adequately of the living

conditions in the country and as a result, she failed to even bring the appropriate clothing. She stayed in the country for approximately six months and then left for England. The government's solution to the problem was to intensify its focus on educating African women in midwifery and health visiting so they could fill the void. As our discussions in the subsequent chapters will show, western midwifery education had been introduced into the country in the late 1920s. However, due to the colonial government's gender ideologies about providing women with higher education, they targeted men in their recruitment efforts instead of women. Ironically, in many Ghanaian societies during the colonial period, women were generally in charge of managing reproductive issues, and as such, it makes sense that they would be more welcomed into the homes of mothers for maternal and infant welfare work.

When the colonial health officials finally realized their mistake and changed tactics, they could not find a sufficient number of women to enroll in the midwifery program.

Consequently, in the early years of the program, only six women were graduated annually. The following were the reasons given for the difficulty in getting the suitable type of African girl to undertake the midwifery training:

1. The general standard of education in the girls' schools is not high enough; even those who hold the seventh standard certificates are often

- incapable of attaining the required standard in training.
- 2. The salaries offered are not sufficient to make the service attractive; there is no higher grade. A comparison with the salaries offered to women teachers as shown below demonstrates this. Under the Education department, a headmistress earned 400-600 pound as compared to 48-208 per annum for nurse midwives.
- 3. Some African mothers fear the prolonged education would interfere with the marriage of their daughters, and hence, are reluctant to let them attend the school.
- 4. African mothers, particularly those in areas outside of Accra, are unwilling to allow their teenage girls to travel to Accra for the training for the fear that they would not receive adequate supervision.

The government viewed the last reason as, perhaps, the vital, and hence, focused on providing adequate housing facilities for student midwives.

The above strategy, somewhat, alleviated the problem and by the late 1930s to the early 1940s, the enrolment of girls in the midwifery program had substantially increased. Consequently, more and more midwives were trained as health visitors. These African women worked in close connection with the various welfare centers. They followed up on cases and took part in organized home visiting. Their additional training as midwives allowed them to manage the numerous infant weighing centers throughout the country. Their work proved invaluable for the colonial government's maternal colonizing mission. For example, in 1936, health officials reported that some 42,051 and 49,351

women were registered as having attended the welfare centers in Accra and Kumasi respectively to obtain maternal advice without treatment. Health officials were, indeed, elated that Ghanaian women were readily attending the welfare centers for educational purposes for "five years ago such an occurrence would not have been believed possible." However, it must be pointed out that besides Accra and Kumasi, none of the other welfare centers reported this achievement. In fact, the majority of the centers struggled all the way to the end of colonial rule to get mothers to patronize the centers for maternal education purposes only. Moreover, the government's own action of taking mothercraft lectures into the homes of mothers suggests that they could not consistently get women to come to the welfare centers for preventive health care.

The Kumasi and Accra examples suggest that to a limited extent, the colonial government reproductive measures and campaigns did result in the colonization of the maternal although Ghanaian mothers were active in determining the outcome. The encounter was certainly not one-dimensional whereby health official with impunity directed and regulated the reproductive activities of Ghanaian women with the women having no input. Instead, Ghanaian women participated in the various

 $^{^{144}}$ CSO 11/1/413, No. 70/37. "Welfare of Women and Children in the Gold Coast, 1937-1938." National Archives, Ghana.

measures only when it suited their health and social needs and asserted their agency by directly engaging colonial health and medical officials on their own turf, and forcing a change in the focus of the welfare centers from preventive to curative medicine.

By their actions, Ghanaian women proved that they were neither the "docile bodies" acquiescent to colonial intervention nor the path of least resistance to the government's social reconstruction, economic exploitation, and political dominance, which colonial health and medical officials had conceived of them. To the government, the alternative was to try the colonization of the maternal through western midwifery education. The government concluded that by removing pregnancy and childbirth from the control of native midwives and placing it under the direction of western-trained midwives and medical professionals, they would be more effective in transforming the reproductive behaviors of Ghanaian women. Would they fare any better? To find the answer, we would now turn our attention to the introduction of western midwifery education and its resultant effects on the practice of midwifery in the country.

¹⁴⁵ Foucault, *History of Sexuality*, Vol. 1, trans. R. Hurley (New York: Pantheon, 1978), 34.

Pregnancy and Childbirth under Colonial Medical Gaze

This chapter examines the various structures and strategies the colonial government put in place from the early 1920s to medicalize and hospitalize pregnancy and childbirth. In the previous two chapters, I examined the colonial government's gendered perceptions about Ghanaian motherhood and its attempts at gaining access into the private world of Ghanaian women through the imperial politics of indirect rule. In addition, I examined the government's attempts at remaking motherhood through baby shows, baby baths, and mothercraft lectures and its efforts to reduce maternal and infant mortality through welfare services. This chapter extends the discourse into the government's attempt to subject pregnancy and childbirth to medical scrutiny in a hospital environment. Here, I contend that despite the appearance of the government's apparent benevolence geared towards reducing the maternal and infant death rates, and saving the lives of mothers and children, their efforts were not merely humanitarian. It was a strategic political strategy intended to stabilize British hegemony in the country.

Attempts at medicalizing pregnancy and childbirth began in the early 1920s when the statistical report for 1920-1921

indicated that out of every 1,000 babies born in Accra some 360 died before reaching their first birthday, and for the entire colony, 292 died per 1,000 live births. As discussed in chapter two, repeated calls for the government to look into the high maternal and infant mortality had caused the Clifford administration to set up a committee to look into finding solutions. However, the committee's recommendations for the government to make maternal and infant welfare part of its social welfare agenda was put on hold due to Britain's financial commitments in World War I. The administration of Guggisberg took over where Clifford had left off and initiated a variety of welfare programs. These welfare programs were the starting point for the medicalization and hospitalization of pregnancy and childbirth in the country. The move towards hospitalization was further prompted by researches into the clinical causes of maternal deaths that recommended that there was the need for the utilization of certain obstetric techniques that were only suitable to be used in a hospital rather than in a home environment.

Health officials argued that these obstetric techniques could not be adopted for the home environment because of the lack of proper sanitation and specifically designed spaces in the home. Therefore, the hospital was the only appropriate place for delivery. One need not dig deeper to realize that this view

was based solely on complicated labor cases and not on the numerous deliveries that had taken place in the milieu of the home. In many of the early 1920s medical reports, the following were listed as causes of maternal deaths in the country:

Ante-Partum Hemorrhage
Premature Labor
Post-Partum Hemorrhage
Obstructed Labor
Obstetrical Shock
Puerperal Fever
Puerperal Septicemia
Eclampsia
Toxemia of Pregnancy
Anemia of Pregnancy

Besides, Ghanaian women's own reconfiguration of the original intent of the welfare centers' objective of providing maternal education and well-child care further enhanced the medicalization process. That is, by seeking cure and relief from the colonizers' welfare centers with pregnancy and childbirth related complications, Ghanaian women inadvertently played into the government's efforts at colonizing the womb.

Ironically, colonial health officials failed to see the above as an opportunity to extend the government's agenda of controlling women's reproduction in the early years of healthcare services. Dr. Kirk, for example, lamented that "Welfare centers are being used as a combined maternity and sick

 $^{^{146}}$ CSO 11/5, 11/6, 11/16, 11/18. Maternal Mortality and Morbidity in the Gold Coast." The Principal Registrar of Births, Deaths, and Burials, "Memorandum," August 5, 1932. National Archives, Ghana.

children's hospital,"147 instead of focusing on preventive care. However, when the colonial government intensified its maternal health programs, health officials would repeatedly cite Ghanaian women's own enthusiastic use of the welfare centers as an indication of their willingness to have their pregnancies and deliveries subjected to western biomedical science. In other words, the government was not forcing women to have their pregnancies examined by medical officials or to have their babies delivered at the hospital; rather, Ghanaian women were seeking these services on their own even in places where such services were not provided.

Medicalization and Hospitalization of Pregnancy and Childbirth

During Guggisberg's term, his specific attempt towards ensuring that pregnancy and childbirth were brought under medical care and carried out in a hospital environment took shape when in 1922 he appointed a committee to consider the possibility of building a maternity hospital and training center for midwives in Accra from funds raised by public subscription. The committee made various recommendations, but suggested that the government bear the full financial responsibility for such

 $^{^{147}}$ Gold Coast Colony, Report of the Medical Department, 1945: Maternity and Child Welfare. National Archives, Ghana.

work, to which Guggisberg agreed. 148 The committee also suggested that as the construction of a new African hospital would take some years to complete, the government should consider the option of converting the old Cable Company's offices into a maternity hospital. Another committee investigated the possibilities of this scheme, but decided against the suggestion as the cost of the building would be £8,000 and a large sum of money would have to be spent in converting the building into the semblance of a maternity hospital, which, even then, would be difficult and uneconomical to operate. The committee, however, could not come up with a suitable alternative building and the plan for a maternity hospital was put on hold. The delay was, however, only temporary. The government's view was that skilled attention in childbirth was one of the urgent needs of the entire colony, and a great progress towards meeting this need was the completion of a maternity hospital. 149

The colonial government was also confident that once a maternity hospital was completed, it would do much to bring down the high mortality rates amongst infants and puerperal women in Accra and its environs. More importantly, the hospital was to serve as an important center for antenatal and post-natal work as well as a facility for the training of midwives, who after

 $^{^{148}}$ CSO 11/6/3. "Synopsis of the Maternity and Infant Welfare Movement in Accra." National Archives, Ghana.

¹⁴⁹ GGCRMSD, 1926-1927. "Maternal and Infant Welfare," page 36. National Archives, Ghana.

their course of training, would be well equipped to practice their profession all over the country. The government was certain that in the "war against ignorance and prejudice," this institution would be of a great and lasting worth. Moreover, if the proposed West African Medical College were eventually established in Accra, a maternity hospital would be a useful part of its teaching unit. Health officials were even contemplating the possibility of establishing, later on, a staff of African health visitors who would work with the hospital under trained European supervision. Such a system, it was reasoned, would certainly help to considerably reduce maternal and neo-natal mortality rates.

Thus, in 1924, Guggisberg directed that plans and specifications should be obtained for a new building so that funds could be provided in the 1925-26 estimates for it.

According to the plan approved for the maternity hospital, which was drawn up by Dr. G. V. Le Fanu, a medical specialist; Mr. Hedges, the chief architect; and Mr. Morley, the draughtsman, two buildings were to be constructed. One was to serve as the center for obstetrical cases and the other for gynecological cases. Mhile construction of the first major maternity hospital in the country was still underway, a combined

¹⁵⁰ Speech of his Excellency the Hon. T. S. W. Thomas, Acting Governor of the Gold Coast at the opening of the New Maternity Hospital, Accra. May 19, 1928. *Gold Coast Independent*, Vol. XII, No. 22 (June 2, 1928). National Archives, Ghana.

children's clinic and maternity hospital, named the Princes
Marie Louise Hospital and Clinic, was completed and opened in
May 1926 in Accra. The hospital was equipped with a consultation
room, dispensary, surgical room, laboratory, storeroom,
bathroom, lecture rooms and offices, and two upstairs wards with
ten children's cots and a room for three to four beds for
mothers with sick infants. The cots and beds were provided in
order that the Lady Medical Officer in charge would have the
opportunity to investigate the nature of the diseases affecting
the children brought to the hospital.

The provision of the cots and beds was considered necessary if treatment was to be on scientific bases, and not akin to the "'hit and miss' system usually associated with quacks" beds of continuing to native healers and traditional midwives. Another reason for the provision of the cots and beds was to enable an investigation into the nutritional backgrounds of infants and to institute infant feeding controls under constant supervision. Moreover, the hospitalization of pregnant women and sick infants provided constant access to mothers and infants serving as a valuable means of continuing the government's program of educating mothers in all the aspects of mothercraft. The staff at the Princess Marie Louise Hospital provided

¹⁵¹ GGCRMSD, 1926. "Maternity and Child Welfare: The Princess Marie Louise Hospital." National Archives, Ghana.

antenatal clinics every week, delivered mothers, hospitalized seriously sick children, provided vaccination to children against yaws, and did much of home visiting and follow-up with families.

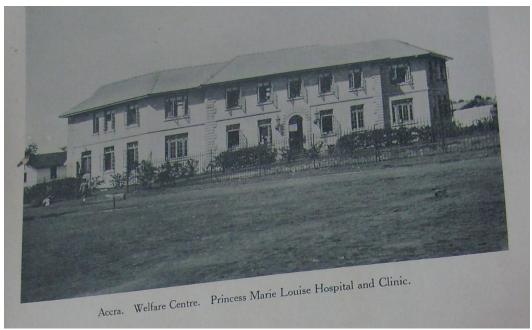


Figure 8: The Princess Marie Louise Hospital and Clinic, 1926

In the view of the colonial government, the Princess Marie Louise Hospital was a success story, although for a short time in its first year, the hospital was unpopular among mothers. For example, the Lady Medical Officer in charge of the hospital pointed out "it was against native custom for women to be delivered in an institution or other places other than her own kitchen, and only very bad and moribund cases sought admission." In addition, many mothers were unwilling to allow their babies to sleep overnight at the hospital on admission.

¹⁵² GGCRMSD, 1926. "Maternity and Child Welfare." National Archives, Ghana.

Nevertheless, in the first year alone, the total attendance at both the outpatient and inpatient clinics at the hospital reached 12,463. The outpatient clinic recorded 5,009 new cases and 2,207 old cases were transferred from the James Town Child Clinic where the hospital was located before the completion of the Princess Marie Louise Hospital and Clinic.

According to the hospital records, the commonest diseases dealt with at the outpatient clinic included malaria and unclassified fevers, which led the list at 32.9 percent, respiratory disease at 17 percent, and enteritis at 13 percent. The list of diseases presented at the hospital led the Lady Medical Officer in charge of the hospital to make the following interesting observation about the commonalities in diseases found among children in England and in the Gold Coast. According to her, diseases such as rickets and tuberculosis of the lung and gland or bone were very common in England but rare in the colony. On the other hand, severe cases of anemia were frequent in the Gold Coast but uncommon in England. However, "dirty and neglected teeth and gums, especially up to the second dentition are as common here as in England." Apparently, African mothers were not the only group of people neglectful of the personal

 $^{^{153}}$ GGCRMSD, 1926-1927. "Maternal and Infant Welfare," page 14. National Archives, Ghana.

hygiene of their children as has generally been portrayed by the colonizers.

In 1927, the Accra Maternity Hospital at the Korle Bu Hospital was finally completed, and on May 19, 1928, the Acting Governor, Mr. T. S. W. Thomas, officially opened it. As indicated above, the hospital had two main sections—an obstetrical center and a gynecological center. The hospital also had two wards with six beds each, two single wards, and an isolation ward, which brought the total number of beds to fifteen in addition to fourteen cots for babies. Later on, four extra beds were placed on the balconies to provide for the growing number of patients admitted. The hospital was also equipped with a nursing sister's quarters, quarters for a resident officer, an outpatient examination and consulting room, a lecture room, a theatre, and a clinical room. The staff at the hospital included a Lady Medical Officer, Dr. G. M. L. Summerhayes and a European nursing sister both of whom had training in midwifery; two African nurses who had considerable local experience in attending deliveries; a male nurse to give anesthesia; a clerk to keep the records; and a number of other nurses and workers.

The hospital also provided accommodation for pregnant women whom skilled assistance was necessary to produce a live child and an unharmed mother during delivery to stay for extended

periods. With the exception of one or two beds in a small private ward for those who desired separate accommodation for which they were charged, the government made all the treatment at the hospital free. The free service included advice and treatment for pregnant mothers for the period of their confinement and until the baby was a year old in the outpatient department and in the wards. All mothers who attended the antenatal clinics or who were delivered at the maternity hospital were allowed to attend regularly for one year for advice on mothercraft, weighing of infants, and for simple treatment. Two antenatal clinics and one post-natal clinic were held weekly at the hospital. Dr. Summerhayes also held extra antenatal clinic at the Christiansborg clinic before its closure in 1931 and at the Princess Marie Louise Hospital and Clinic. The Accra Maternity Hospital was also to start a one year western midwifery training program for nurses who had completed two years of general training at the Gold Coast Hospital.

In time, the government believed that the system would produce a sufficient number of trained midwives to provide what Governor Clifford referred to as "the means of saving thousands of lives wantonly destroyed through ignorance and superstition every year." During the opening ceremony, Mr. Thomas remarked

 $^{^{154}}$ Gold Coast Independent, Vol. XII, No. 2 (June 2, 1929), 690-691. National Archives, Ghana.

to all present to tell their friends and relatives about "this fine hospital and to encourage all pregnant women; rich or poor, Ga, Fanti, Hausa, Twi, or Kroo¹⁵⁵ to visit the hospital and avail themselves during their hours of travail of the skilled advice and treatment provided absolutely free of charge."¹⁵⁶ In this way, the government would be justified in the considerable expenditure it incurred, but more importantly, the people would do their share in the uphill battle against the dreaded dangers that had plagued mothers and babies for years. As should be expected, the justification was to save the lives of mothers and babies and certainly was not cast in the light that such an undertaking would make the people more amiable to the political imposition of colonial rule.

Almost immediately following the opening of the Maternity Hospital, the medical officer in charge, Dr. Summerhayes, was forced to discount the shared opinion amongst health officials that this new hospital would not succeed owing to the local prejudice against the medicalization of childbirth. She pointed out that already the hospital was beginning to experience a gradual acceptance because from June 1928 to March 1929, 104 deliveries took place in the hospital. Of the mothers delivered,

 $^{^{155}}$ I could not locate any ethnic group in Ghana called Kroo. My assumption is that Mr. Thomas was referring to the Krobo people of the Ga-Adangbe group located in the Eastern Region of Ghana.

¹⁵⁶ GGCRMSD, 1928-1929. Appendix H, Summerhayes, "Report on the Maternal Hospital, Accra," page 138. National Archives, Ghana.

82 gave birth to live infants and around 18 percent of the mothers suffered from puerperal pyrexia (maternal fever after childbirth) due to obstetrical causes. The table below represents the various submissions on the hospital's performance for a ten-year period.

	1928	1929	1930	1931	1932	1933	1934	1935	1936	1937	1938
In-Patient Admissions	183	418	678	972	1,023	1,393	1,481	1,681	1,347	1,376	1,270
Deliveries	104	260	452	553	529	772	623	662	629	642	583
Live Babies	82	208	389	485	518	698	572	532	527	638	507
Maternal Deaths	11	25	13	13	22	29	15	47	53	_	47
Infant Deaths	9	23	15	32	33	50	51	56	74	_	77
Still Births	25	52	63	68	86	99	87	98	101	_	105
Antenatal and Post- natal Attendance	3 , 599	6,224	9,968		12,722	14,394	13,907	14,132	18,696	16,295	15,980

Table 8: The Accra Maternity Hospital Performance from 1928 to 1938

During its first three years of operations, the Maternity Hospital managed to reduce its record of infant mortality rate from 9.92 percent in 1929-1930 periods to 2.87 percent in 1930-1931 periods. In addition, health officials attributed the reduction of the country's overall maternal mortality rate from 17.3 in 1934 to 11.8 in 1939 to the hospital's midwifery training program. 158

¹⁵⁷ Ibid.

 $^{^{158}}$ GGCRMSD, 1930-1931. S. Russell, "Report on Maternity and Child Welfare," page 44. National Archives, Ghana.



Figure 9: The Accra Maternity Hospital at Korle-Bu, 1928

In spite of the Maternity Hospital's apparent success story, getting to that point was not easy. In the early years of the hospital's operations, it was forced to depend on the members of the Gold Coast League for Maternity and Child Welfare to persuade mothers to patronize the hospital. The Lady Medical Officer in charge of hospital as well as many of the hospital staff had to undertake domiciliary visits to convince mothers to attend the hospital's antenatal and post-natal clinics. Indeed, the reported 3,599 antenatal and post-natal attendance and the 104 deliveries that took place at the hospital during the first year would have been less had it not for these efforts.

Approximately a year into the operations of the Maternity Hospital, Dr. Summerhayes submitted to the Director of Medical and Sanitary Service that perhaps the time was due for the

hospital to charge fees. The reason she gave was that patients often spontaneously offered money in payment for their treatment and were usually surprised when it was refused. She added that a good number of women who patronized the hospital would prefer to pay fees and all would be willing and quite beyond taking something for nothing and fully understood paying for a thing when it was good. The Director was in agreement with her, stating that the "time has now come when fees may quite fairly be demanded." When the Acting Governor decided in 1928 that there would be no fees charged for treatment at the Maternity Hospital, it was considered that if fees were not charged, women would be encouraged to avail themselves to the new facilities provided, but that if fees were charged they might stay away.

The Maternity Hospital was already regarded as a definite success, and therefore, the Director thought it was perfectly well to bring it in line with all the other hospitals in the country where the principle of charging fees was in force. He further pointed out that in maternity cases, it was very desirable that the mother should rest for a reasonable number of days after a confinement, and that in necessary cases she should be encouraged to come to the hospital some days before a confinement. Therefore, if the hospital was to charge them on a

 $^{^{159}}$ GGCRMSD, 1928-1929. Summerhayes, "The Accra Maternity Hospital: Fees." National Archives, Ghana.

daily basis, a patient might try to economize by coming in too late or going out too early. A lump sum charge for each case would obviate this, and besides, it would simplify bookkeeping for the one clerk at the hospital who already had a good deal to do. He suggested the following fees under the Hospital Fees Ordinance Cap 68, Sec. 8 (1).

1. IN-PATIENTS:

General Ward

Fees

- i. For a maternity case, which shall include three days before confinement and up to two weeks, the fees would be from 5/- to 60/- at the discretion of the Medical Officer in charge and subject to the direction of the Director of Medical and Sanitary Service
- ii. For each week or part of a week beyond two weeks, a charge of 5/- to 20/- similarly

Private Ward

Fees

- iii. For a maternity case, which shall include three days before confinement and up to two weeks after confinement of the patient, the fees would be and Sanitary Service from £3 to £8 at the discretion of the Medical Officer in charge and subject to the direction of the Director of Medical and Sanitary Service
- iv. For each week beyond two weeks, a charge of £1.10
 similarly

2. OUT-PATIENTS:

v. For a maternity case, which shall include three days before confinement and up to two weeks, the fees would be from 5/- to 20/- at the discretion of the Medical Officer in charge and subject to the direction of the Director of Medical and Sanitary Service

3. DISTRICT CASES

For attendance in childbirth on extern cases by members of the medical officer in charge and subordinate staff (midwives), a fee from 5/- to 20/- would be charge at the discretion of the subject to the direction of the Director of Medical and Sanitary Service

The governor approved the proposed fees and from 1929, the Maternity Hospital began charging service fees. There is no indication in the colonial reports that suggest that the formal introduction of fees directly caused a reduction in the number of women who attended the Maternity Hospital. However, we can infer from what happened in Kumasi and Cape Coast that women who could not afford to pay may have avoided using the services of the hospital. What is clear from the reports, however, is that by 1932, the hospital was overcrowded and calls for expansion became the new focus. In this regard, Dr. Duff, serving as the new Director of Medical and Sanitary Service, in 1932, took the first initiative towards ensuring that the Maternity Hospital was expanded to accommodate its growing patients. On September 5, 1932, he wrote to the Colonial Secretary Office that there was an urgent need to expand the Accra Maternity Hospital because the existing accommodation was insufficient to cope with the demands.

Dr. Duff requested that the government provide funds for either a 12-bed ward or a 20-bed ward, whichever it could afford, in addition to providing a septic ward. He argued that

there was the need for a septic ward, in particular, to be erected immediately since there was a real danger of a serious outbreak of puerperal fever. Such an outbreak could potentially decimate the in-patients population and thereby destroy whatever confidence women had in scientific obstetrics, which they had worked so hard to achieve. He continued that the standard laid down in England for safety was 50 to 60 maternity beds for 800 to 1000 cases per annum. With the 29 beds now available at the Maternity Hospital, it represented about 480 as the safe number of cases for the hospital. However, "the admissions in 1931/1932 were 972! Over double! The hospital could not carry on with such an appalling safety record, and at the same time, it could not turn women away!" He estimated that the cost of the project would be around £750.

A few weeks after Dr. Duff's proposal, the Public Works
Department budget estimates for 1933/1934 came out, but no
provision was made for the project. By then, Dr. P. D. Oakley
had replaced Dr. Duff as the new Director of Medical and
Sanitary Service. Dr. Oakley began to press the Acting Governor
for action on the matter. In a letter dated September 30, 1932,
the Colonial Secretary, Mr. F. V. Slaw, on behalf of the Acting
Governor responded that the issue of enlarging the Maternity

¹⁶⁰ CSO 11/4/4, No. 816/32. Duff, "Maternity Hospital, Accra," September 5,
1932. National Archives, Ghana.

Hospital had already been raised in 1929. Then, it was decided that if and when funds could be spared for additional hospital accommodation, it would be more beneficial to spend it providing maternity hospitals at the provincial centers. Besides, a new governor had been appointed for the colony who had not taken his post yet. Because of policy issues, the issue was to be suspended until the new governor arrived.

On January 25, 1933, Mr. Slaw informed Dr. Oakley that the new governor had approved the sum of £750 to be included in the 1933/1934 Public Works Extraordinary Estimates to provide a septic ward at the Maternity Hospital. 161 The expansion of the Maternity Hospital was completed in 1934. In 1935, the Red Cross Society also built an antenatal ward with a 12-bed capacity and donated it to the Maternity Hospital. However, in a few years following the expansion, the Red Cross Society had to step in again to expand another ward at the cost of £1,755 to provide for the hospital's growing need for more accommodation. Indeed, the opening of the Princess Marie Louise Hospital and the Accra Maternity Hospitals demonstrated the colonial government's growing concern towards ensuring that pregnancy and childbirth would be placed under medical supervision and that a greater percentage of women and children would survive the ordeal of

¹⁶¹ CSO 11/4/4, No. 816/32. S. Banks Keast, "Re: Head 29-P. W. E., Item 10,
1933/34 Estimates - Gold Coast Hospital. Septic Unit at Maternity Hospital £750." National Archives, Ghana.

pregnancy and parturition. However, as indicated earlier on, these two places were not the only sites of the colonial maternal encounter.

All the welfare centers, in addition to their main objective of providing maternal education and motherhood reconstruction, were involved in the medicalization of pregnancy and childbirth. By 1927, almost all the welfare centers were providing antenatal clinics and attendance of expectant mothers began to number in the thousands. For instance, at the Kumasi welfare center, the Lady Medical Officer, Dr. Chappell, reported that there were four antenatal clinics held every week for expectant mothers. There was also a government midwife, (a European), who examined all new cases of pregnant women abdominally, and referred any abnormal condition she discovered to Dr. Chappell. Old cases were re-examined during the last month of pregnancy. In addition, every pregnant woman had her urine examined at each visit.

Cases of disproportion and other abnormalities that required extensive examination and observation were referred to the medical officer at the colonial hospital since the center lacked accommodation for such cases. Occasionally, the center admitted pregnant women with albuminuria or other conditions that were viewed at dangerous to the fetal for observation or they referred them to the colonial hospital if necessary.

Pregnant women residing within the city limits of Kumasi were instructed to either come to the center to deliver their babies or to send for the midwife during their confinements. Pregnant women from outlying villages were instructed not to wait until the last minute before seeking medical help during labor and to report to the center if they deliver at home as well as to bring their infants to the weighing clinics.

As the tables below suggest, there was a consistent increase at many of centers in the number of attendance by expectant mothers and the children brought in for treatment by their mothers, except for Accra where the numbers for expectant mothers began to decrease from the early 1930s. This was probably due to the increase in private medical practices in the town. While the tables do not provide the percentage of the expectant mothers who actually gave birth at these centers, the large number of pregnant women patronizing these centers provides a clear indication of the trend towards medicalized childbirth.

Clinics	Attendances of Expectant Mothers										
	1926	1927	1928	1929	1930	1931	1932	1933	1934	1935	1936
Accra	112	230	588	946	1,600	1,689	870	920	346	163	600
Christiansborg	200	347	292	1,040	1,191	_	_	_	_	_	_
Sekondi &	340	560	802	1,638	3,050	2,978	3,012	3,910	3,325	3,463	4,779
Shama											
Koforidua	_	_	780	1,267	2,580	3,210	4,754	4,190	5,240	5,919	5,800
Kumasi			328	1,787	6,152	6,890	8,100	9,201	9,115	11,093	10,781
Cape Coast	_	_	_	21	1,257	1,970	3,245	4,001	4,115	3,893	4,677

Table 9: Attendance of Expectant Mothers at Maternal and Infant Welfare Centers

Clinics	Attendances of Children										
	1926	1927	1928	1929	1930	1931	1932	1933	1934	1935	1936
Cape Coast	_	-	3,838	21,878	11,122	12,271	4,632	10,844	11,196	10,593	10,364
Accra	12,278	15 , 752	18,938	28,902	30,637	28,441	25,655	17,189	13990	16,709	18,864
Christiansborg	3,962	7,849	13,982	18,153	18,411	_	_	_	_	_	_
Sekondi &	11,605	20,091	9,623	12,069	16,777	9,833	5,479	8,128	9,132	9,039	8,236
Shama											
Koforidua	_	_	_	_	27,901	25,616	17,008	18,177	18,330	22,757	_
Kumasi	_	15,846	24,019	28,878	30,897	30,700	21,543	19,822	18,998	17,559	13,466

Table 10: Attendance of Children at Maternal and Infant Welfare Centers

	Attendances								
Mission		Children	,	Expectant Mothers					
	1934	1935	1936	1934	1935	1936			
Djodzi (R.	6 , 560	1,903	2,659	102	90	55			
Catholic)									
Eikwe (R.	22,143	15,167	16,212	2 , 875	4,153	_			
Catholic)									
Kpandu (R.	20,710	14,930	8,734	939	1,200	_			
Catholic)									
Amedzope (Breman	_	2,363	2,210	98	90	105			
Mission)									
Total	49,413	34,383	29,815	4,014	5 , 533	160			

Table 11: Attendance of Expectant Mothers at Mission Maternal and Infant Welfare Centers

The colonial government was particularly grateful for the work done at the mission welfare centers at Djodzi, Kpandu, and Amedzope in the mandated Togoland and at Eikwe in the western province, but lamented that these missions could have achieved more except that in these "backward" areas, the mass of disease

made true welfare work very difficult. The treatment of the sick in these areas prevented medical officers from devoting enough time for preventive work. As has already been indicated, welfare work was not confined to government or mission centers.

Voluntary organizations and individuals were involved in all the various aspects of maternal education and propaganda. For example, at Savelugu in the Northern Territories, Mrs. Griffith started providing welfare services to mothers and their children in 1935. Her efforts were continued by Mrs. Jones, who was the wife of the Chief Commissioner of the Northern Territories. The amount of work these two women rendered caused the government to erect a health new building, which was opened in January 1937. From 1937 until the late 1940s, European women volunteers carried on all the work done at the center. 162

In 1932, the question of turning the infant welfare center at the Kumasi Hospital into a Maternity Hospital arose. The same issue was raised for the Sekondi welfare center. In a confidential letter to the governor, Dr. Duff argued that it was almost unforgivable that welfare work would be attended to without serious attention to maternity. Yet, the government had established an elaborate hospital at Kumasi with no maternity hospital or a center for the training of midwives attached to

Gold Coast Colony, Report on the Medical Department for the Year Ended 1936, "Maternity and Child Welfare," page 36. National Archives, Ghana.

it. There was, therefore, a crying need to turn the infant welfare center into a full maternity hospital if the government could not afford to build and staff a new maternity hospital for Kumasi. As the Director of Medical and Sanitary Service, he had considered the issue carefully and had decided to utilize the infant welfare center for a maternity hospital. He informed the governor that if he wanted infant welfare work to continue to carry on at the center, it could be done in the building formerly used as an infant welfare center located to the west of the African Hospital. 163

Dr. Duff's reason for deciding to introduce a maternity center at the Kumasi Hospital was based in part on his own belief that there was the need to increase the attention given to maternity work in the country. The other part was due to the huge number of pregnant women who had been presenting themselves at the Kumasi welfare centers for the hospital's antenatal clinics. Furthermore, Duff on several occasions referred to Dr. Blacklock's article, which had called on the British colonial government to pay more attention to maternal welfare in its colonies. Dr. Blacklock had argued that as compared with infant and child welfare, maternal welfare receive very little attention from the colonial government and health officials,

 $^{^{163}}$ CSO 5/1/320, No. 1488/30, "Legislation Relating to the Practice of Midwifery." Duff, "Extract from Confidential Letter no. 133/31/59, 20 July, 1932. National Archives, Ghana.

yet, the health and welfare of the mother is closely linked to that of the child. More importantly, if the country was to produce a healthy generation of children, its mothers must first be healthy. To Dr. Duff, the time to act on the Blacklock's call was upon them, and hence, the government must be creative in using the resources it already had in the midst of budget constraints. 164

A subtle dimension to Blacklock's article was its intimation that any neglect of women and children in any British colony negates the British presence in that colony. For colonial health officials, such as Duff, the task of medicalizing Ghanaian women's reproduction entailed more than ensuring that pregnant women were encouraged to attend antenatal clinics, had their babies delivered by trained midwives, and/or had their babies at the hospital. It meant making sure that all the necessary infrastructure had been put in place. Thus, from the mid-1930s, the government made sure that any new hospital built in the country had a maternity wing attached to it. The first hospitals to get maternity hospitals attached, besides Kumasi, were the Cape Coast and Sekondi Hospitals. The government made provisions in its 1937/38 estimates to remodel these hospitals to bring them up to new scientific standards. The maternity centers were included as part of the remodeling project. In

¹⁶⁴ Ibid.

1954, a fully equipped hospital operating exclusively as a maternity hospital was opened at Mampong (Asante). During that same year, the government built the Jirapa Hospital (Northern Territories). Although not primarily a maternity hospital, Jirapa was built to provide a center for the training of midwives for the region and to provide proper facilities for an existing large maternity clinic operated by the Catholic Mission. By the end of 1954, the number of hospitals that had maternity work as their major focus included, the Accra Maternity Hospital; the Kumasi Central Hospital Maternity Unit; the Mampong Maternity Hospital; and the St. Joseph's Hospital at Jirapa in the Northern Territories.

In some respects, the mission churches and voluntary organizations such as the Red Cross were even more aggressive in their campaigns to medicalize the maternal than the colonial government. They targeted rural areas where the majority of the population lived and where government health workers were reluctant to go. As has been indicated above, the Catholic Mission, for example, provided maternity and other welfare services in many places in the Northern Territories and in the mandated areas of Togoland. By 1944, attendance at the colonial government welfare centers and at those operated by the Red Cross and the various missionaries were almost at par, if not more, as the following table indicates:

Type of	Attendance										
Center	Expectant Mothers										
	1944 1945 1946 1947 1948 1949 1950 1951										
Government	24,830	24,750	31,290	34,120	35,820	48,122	33,037	29,685			
Centers											
Red Cross	33,784	40,324	41,231	42,370	43,110	42,262	43,667	43,177			
Centers											
Mission	4,759	4,859	5,329	5,901	6,006	5,803	6,749	6,910			
Centers											

Table 12: Attendance of Pregnant Women at Government, Red Cross, and Mission Welfare Centers

Type of	Attendance										
Center	Children 1944 1945 1946 1947 1948 1949 1950 1951										
Government	45,793	46,612	50,110	60,210	61,675	65,300	84,520	64,855			
Centers											
Red Cross	43,957	44,234	40,783	32,156	32,894	35,405	33,565	34,883			
Centers											
Mission	57,916	58,389	67 , 289	78,990	89,234	93,856	69,295	74,193			
Centers											

Table 13: Attendance of Children Government, Red Cross, and Mission Welfare Centers

Besides the increase in the number of expectant mothers who participated in the medicalization process, the government's annual medical reports showed a substantial increase in the number of births registered in the country as well as an increase in the weighted average birth rate. In the various registration centers, as should be expected, different rates were recorded. Ironically, places like Accra, Kumasi, Cape Coast, Sekondi, and the rest where much of the colonial efforts on maternal education were focused usually did not record the highest rates in the registration. For example, in the Birth and Death Report for the year 1936, Mampong, a town in the hinterlands of the Eastern Province was the one that showed the highest rate of registration at 158.9, whilst Nsawam, a few

miles from Accra, recorded the lowest at 21.7.165 No explanation was provided in the colonial reports for this trend, although it was suggested that while there was a growing appreciation of the benefits of registration amongst the literate section of the community, to the illiterate, it conveyed, but a little effect.

Even in the large towns and cities, a sizable proportion of births remained unregistered. In fact, it was pointed out that but for the sustained persuasive efforts of sanitary inspectors, health visitors, and government midwives in the course of their domiciliary visiting, none of the births that took place outside of the hospitals and welfare centers would have been registered. 166 We can therefore make a reasonable assumption based on the above entry that while the colonial government had made some gains with a portion of the population, it was not any closer to achieving its desired result of medicalizing and hospitalizing pregnancy and childbirth for all women in the entire country. Even for the portion of women who were participating in the medicalization process, a gradual trend began to unfold in the early 1950s whereby the number of expectant mothers attending both the governmental and the nongovernmental centers started to decline. Health officials, once again, had to impress on mothers to take responsibility for the

¹⁶⁵ Ibid. ¹⁶⁶ Ibid.

health of their babies by disciplining their own bodies and by acquiring the best possible care for themselves during pregnancy in order to produce live and healthy babies. Admittedly, the figures for such places as Accra and Kumasi were impressive, yet these figures were not reflective of events in the entire country. Welfare centers outside of Accra and Kumasi continued to struggle to entice mothers to come to the centers solely for educational purposes. As it was the case in the 1920s, some women readily participated in the government's maternal education programs while some completely ignored them.

Women's Roles in the Medicalization Process

To ensure that Ghanaian women shared some of the responsibility of medicalizing pregnancy and childbirth, colonial health officials began in the late 1940s to make pregnancy less and less of a social event that women controlled and shared into something pathological that needed medical attention. The public baby shows and baby baths, which Ghanaian mothers had appropriated as a social occasion for their own purposes, were no longer offered. Instead, individual women were advised through home visits and antenatal clinics on the need to manage their maternal bodies appropriately in order to give birth to healthy babies. Mothers were made the agents of the medicalization process concerning the prenatal, antenatal, and

post-natal nutrition and the amount of exercise, or more appropriately, the amount of work to exert on the maternal body during pregnancy. The latter was based on the belief that Ghanaian women overburdened their bodies with work even in pregnancy.

Health officials repeatedly advised expectant mothers to follow maternal instructions given them at the various welfare centers and during domiciliary visits because failing to do so, and hence, failing to manage their maternal bodies appropriately would put their own health and the lives of their children at risk. Mothers were told that attending antenatal and post-natal clinics and utilizing the hospital infrastructure the government had spent so much in erecting, as their fundamental birthing facility was the only way to avoid the bad influences of the native midwife and to stay on course regarding the effective ways to have a healthy pregnancy. In addition, health officials insisted that even though pregnancy was technically not a pathological issue, it was a period in which the maternal body was placed under extreme stress. Therefore, it required that trained physicians monitored and controlled it. Put differently, officials were of the view that the problem of the high maternal and infant deaths could only be alleviated, if and only if, a medical and scientific approach was applied to all stages covering before, during, and after childbirth.

Nevertheless, it would be incorrect to conclude that Ghanaian women lost all control over their bodies during the course of the government's campaign to control women's reproduction or that the government succeeded in removing pregnancy and childbirth from the home environment to the hospital environment. Besides, we cannot even conclude that the government was successful in making its political imposition less objectionable through the provision of health services to mothers and children. Undoubtedly, the female body was subjected to the machinations of the colonial health agenda; however, it was Ghanaian women who had the ultimate responsibility to order their bodies and to change their maternal behaviors. In other words, the maternal body was not a mere site of state imposition as the colonial government had envisaged, but a site where mothers contested, negotiated, and asserted their agency. This is not to suggest that colonial health officials readily gave up on making women take responsibility in the medicalization process.

Acting in the capacity as regulators of indigenous populations, colonial health officials were positioned such that they exercised direct power from the government, which allowed them to ensure that change was implemented, re-emphasizing Foucault's point that when we analyze power, we must understand

it in terms of how it was circulated. 167 Certainly in the case of colonial Ghana, it was circulated widely enough to allow health officials to carry out the government's reproductive health agenda. Furthermore, if we understand western biomedicine as one of the strategies central to the strengthening of political power in a period in which diverse medical techniques were used to subjugate bodies and control populations, 168 then we can understand why colonial health officials insisted on carrying on the government's reproductive agenda even though they were not getting the desired results. Thus, in conjunction with medicalizing and hospitalizing childbirth coupled with the various maternal and infant welfare service initiatives, health officials reasoned that western midwifery education had to be introduced. This was ultimately intended to remove childbirth from the control and management of native midwives whose practices health officials blamed for the high maternal and infant deaths in the country.

¹⁶⁷ Foucault, *Power/Knowledge: Selected Interviews and other Writings, 1972-* 77 (New York: Pantheon Books, 1980), 98.

¹⁶⁸ Foucault, History of Sexuality, 141.

Transformation of Midwifery Practice

With the reconstruction of Ghanaian motherhood through maternal and infant welfare services and the medicalization of childbirth failing to alter completely women's reproductive behaviors, the colonial government directed its attention towards colonizing the maternal through western midwifery education. The government believed Ghanaian women's persistently injurious maternal behaviors, the high levels of maternal and infant deaths during childbirth, and the other risks that occurred during and after parturition were the result of the malpractice and ignorance of native midwives. In addition, native midwives were responsible for spreading diseases and for putting the health of newborn children at risk through their unhygienic practices. To fulfill their goals, the government surmised it was essential to first replace native midwives with midwives trained by the state in western midwifery education, and then to monitor their activities. A Lady Medical Officer deftly puts the need for western midwifery education in the country in a letter to Dr. Duff dated June 12, 1932 in which she laid out the reason why midwifery was not only necessary in the Gold Coast, but it was an essential starting point for the colonial government to implement its reproductive agenda.

According to the letter, as far as West Africa was concerned, the colonial problem was "midwifery, yaws, and malaria." 169 The officer added, "I think I am right in saying that in this country midwifery comes first. In the first place, there tended to be a hiatus between the antenatal and post-natal work. If a women did not go to Korle-Bu [the government's general hospital], or employed a private doctor, she was cast back at the most critical time-the labor and neo-natal period-on the tender mercies of the local mammy." 170 She argued that the central point or person in midwifery work should be the trained midwife; and that midwifery work should be developed from this center. 171 As indicated in the previous chapter, and as the above statement suggests, the colonial government and health officials hardly withheld their severe disdain for the native midwife, and often times blamed them solely for the high maternal deaths in the country.

In the view of the government, the native midwife's only skill that entitled her to her work was her mere experience in witnessing childbirth or having given birth herself. The native midwife, it was reported, preoccupied herself with superstitious things during parturition, added to her unhygienic instruments, instead of taking the emerging fetus out immediately, and hence,

¹⁶⁹ CSO 730/32. Hendrie, "Reply to Duff: No. 133/31/30." National Archives, Ghana.

170 Ibid.

 $^{^{171}}$ Ibid.

causing the deaths of many infants. In effect, native midwives lacked the scientific knowhow to be able to manage childbirth and should be eliminated from the practice. The main way to achieve this was to replace gradually native midwives with midwives educated by the state. According to their assumption, such an institution for the training of midwives would protect women from the malpractice of native midwives, and eventually reduce maternal and infant deaths as the number of the educated midwives increased. Consequently, from the late 1920s to the end of the colonial period in the mid-1950s, the colonial state vigorously educated, licensed, regulated, and controlled midwifery practice in the country.

Although with the introduction of western midwifery education, the colonial state showed its intensions to train midwives to protect mothers and babies, its ultimate concern was to render the management and the processes of childbirth completely under its control. For this reason, I argue in this chapter that taking such a critical and traditionally female occupation under its domain was in part the colonial government's broader social regulatory goals and gender ideology. It is contended that western midwifery education offered the colonial government both private and public sites where they enacted and enforced power by their control of biomedicine. However, as opposed to utilizing male obstetricians

as a dictate of their gender ideologies, and hence, displacing women from obstetric care, developments in the field forced the government to rely on women. In the same vein, they could not displace native midwives; instead, they had to open an avenue for them to participate in their scheme despite the fact that they often blamed native midwives for the high maternal and infant mortality rates in the country. In this chapter, I focus on the introduction of midwifery education at the Accra Maternity Hospital in 1928, the Midwives Ordinance of 1931, the certification of midwives and regulation of their practice, the spread of western midwifery education, and the provision of western midwifery services in the country.

The Introduction of Western Midwifery Education

The transformation of midwifery practice in the Gold Coast began in 1928 when the first maternity hospital in the country, Accra Maternity Hospital at Korle-Bu, was opened to provide maternity services and to train midwives. In the first two years of its existence, the midwifery program lacked any specific guidelines or rules or a regulatory body responsible for ensuring its smooth operation in the country. The initial program was placed under the leadership of Dr. Summerhayes, and it was designed to link maternity work at hospitals and welfare

centers with towns and villages and to popularize the services of western-trained midwives in the country.

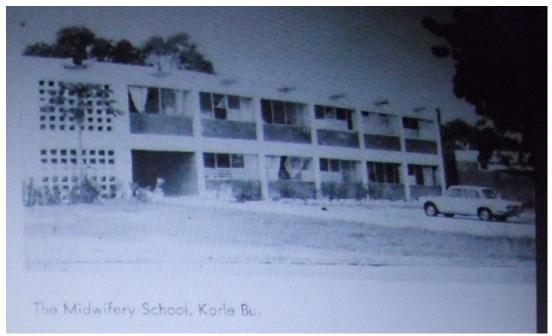


Figure 10: The Accra Maternity Hospital Midwifery School at Korle-Bu

In the 1930 legislative council's section, the Director of Medical and Sanitary Services presented a Midwives Ordinance Bill that had been drafted by the Acting Governor in consultation with various medical officers to be read a second time. The Director argued that it was generally difficult for most people who had no contact with the subject of midwifery "to realize the amount of sickness and suffering, the permanent

 $^{^{172}}$ The bill had already been read in a previous section of the legislative council, but it was not voted on because according to Dr. Nanka-Bruce "the time was inopportune and the conditions was unfavorable." See CSO 5/1/326. No, 1488/30: The Midwives Ordinance 1931 (Gold Coast Colony), National Archives, Ghana.

invaliding, and the high mortalities caused by childbirth in this country." 173

He compared the average maternal mortality rate of 15 per 1,000 in the country in 1931 to that of the United Kingdom of 4 per 1,000 for the same period. He continued that nearly all the sickness and mortality could be prevented by a skilled and efficient midwifery service and that it was no fault of mothers that their lives and the lives of the newborns were exposed to the "vast amount of ignorance and unhygienic treatment in midwifery in this country." Therefore, to bridge the gap between the present state of affairs and their ideal of a trained service, and to protect the rights of those practicing, the legislative council needed to approve and enact the proposed Midwives Ordinance Bill. The bill was approved and the governor, A. R. Slater, signed it into law in 1931 and was referred to as the Midwives Ordinance of 1931. The Council also enacted a separate Midwives Ordinance for Ashanti, and the governor signed it into law on November 9, 1931. However, in 1935, the Ashanti Midwives Ordinance of 1931 was repealed and all towns in Asante except Kumasi were covered under the Midwives Ordinance of 1931.¹⁷⁵

 $^{^{173}}$ CSO 5/1/326. No, 1488/30: The Midwives Ordinance 1931 (Gold Coast Colony) [proof]. National Archives, Ghana.

 $^{^{175}}$ CSO 5/1/331, No. 1488/30: The Midwives Ordinance, 1931 of Ashanti. National Archives, Ghana.

The Midwives Ordinance of 1931

The Midwives Ordinance of 1931 established the Midwives Board, which consisted of the Director of Medical and Sanitary Services; the Deputy Director of Health Services; the Lady Medical Officer at the Accra Maternity Hospital; and three other persons appointed by the Chairman. 176 The Board was responsible for the training, examination, regulation, licensing, and sanctioning of the behavior of midwives in the country. In addition, the Board regulated the issuing and prescribing of the type of certificate and the conditions of admission to the Roll of Midwives; prescribed the issuing of badges for midwives and the wearing of such badges; and defined the conditions under which registered midwives may be suspended or even barred from practicing again. The Board appointed examiners and fixed their remuneration as well as deciding the place and the time at which examinations were to be held. According to the records of the Legislative Council, the various provisions of the Gold Coast Midwives Ordinance of 1931 was based on the Uganda Midwives Ordinance of 1926, which was regarded by British colonial medical authorities in the Gold Coast as a suitable model.

There was, however, one fundamental difference in the scope of the two ordinances. It was considered impracticable to follow

¹⁷⁶ Information was contained in drafts signed by S. S. Abrahams, the Attorney General for the Gold Coast Colony in 1931—passed by the Legislative Council on September 25, 1931. National Archives, Ghana.

the Uganda precedent in generally restricting the practice of midwifery to properly qualified persons. This was because in spite of colonial health officials' great reservations towards native midwives, they rightly came to the conclusion that confidence in scientific methods of obstetrics was not high enough as to warrant such a course, and if there was such confidence, the country lacked the sufficient number of trained midwives to meet the public needs. The scheme in the Gold Coast was, therefore, to introduce and to extend scientific obstetric care gradually across the country. The Ordinance provided that two groups of midwives were to be allowed to practice in the country. The first group consisted of persons who though possessed of no western scientific training in midwifery satisfy health officials within a given time that they had been engaged in midwifery practice for a period of not less than two years. Once they had completed their training and the local chief had vouched for their good character, they could apply for their name to be put on the List of Unqualified Midwives maintained by the Deputy Director of Health Services and they could practice in pre-selected areas in the country.

In integrating native midwives into western midwifery practice, Allman has argued that the British colonial authority had ambiguous attitude toward native midwives and were equally not stringent on them. In my view, this assessment is to the

contrary. There was no ambiguity in colonial health officials' attitude towards native midwives. They simply saw them as unqualified and hence not worthy of being considered ready for the practice of midwifery and in many instances, they spoke plainly in their views about them. They loathed and despised the fact that the processes and management of childbirth was left in the hands of a group of people whose only contributions towards reproductive health was, perhaps, increasing maternal and infant mortality rates with their unhygienic practices. The native midwife was repeatedly blamed for anything that went wrong with childbirth, even in cases where western scientific methods could not get any different results. Through various measures, they tried to dissuade Ghanaian women from patronizing the services of native midwives. It was only when they had failed to get Ghanaian women to patronize the maternity clinics and to get them to allow their daughters to enroll in the midwifery training that they considered including native midwives and making provisions for them in the Midwives Ordinance of 1931.

The Deputy Director of Health was also granted the authority to delete from the List of Unqualified Midwives the name of any person enrolled, if he considered it in the interest of the public and for the same reason restore any name that had been deleted. Persons classified under the category of Unqualified Midwives were native midwives who presented

themselves to be trained in western obstetric practice. The government was of the view that this class of midwives was too numerous in the country and too many women depended on them for them to be displaced from their work immediately. In the 1929-1930 Medical and Sanitary Report, the Director of Health Services wrote, "Maternal welfare must be, it is feared, of rather slower growth and will be dependent largely on the rapidity with which the Gold Coast parallel of 'Sairey Gamp' can be replaced by trained midwives." 177 Moreover, health officials reasoned that the introduction of "Registered Midwives must not start with a group already tainted with bad practices; rather, they must be of a first-class material to begin with for a badly trained midwife could do more damage than one who had no training but had long practice." 178 Yet, there is no indication in the colonial records to suggest that the training given to registered midwives made them more competent than the unqualified midwives who had the advantage of experience. This was especially so when one considers the fact that registered midwives had very little independence. They were required to rely on the expertise of physicians and prohibited from using

¹⁷⁸ Ibid.

¹⁷⁷ GGCRMSD, 1929-1930. Stanley Batchelor, "Report on Maternity and Child Welfare," page 50-51. National Archives, Ghana. Siarey Gamp was a midwife/nurse character in Charles Dickens' novel *Martin Chuzzlewit* first published as a serial from 1843 to 1884. Siarey Gamp was portrayed as dissolute and drunk and became a notorious stereotype of bad secular midwife/nurse in the early Victorian era.

such obstetric tools as forceps or from performing emergency surgeries.

All the same, the Ordinance separated the two groups of midwives and placed certain restrictions on unqualified midwives to prevent their numbers from growing in the hope that with the growth of confidence in scientific methods of obstetrics, their disappearance would be accelerated and registered midwives would take their place. 179 The second category of midwives was to be known as Registered Midwives and they were to be registered on the Roll of Registered Midwives once they had completed their training. The Director of Medical and Sanitary Services was charged with the custody of the Roll of Midwives and every entry on the Roll was to indicate the qualifications by virtue of which the registration was granted. Each year, a Gazette containing the Roll of Midwives was issued under the authority of the Board. It served as the prima facie evidence that women whose names appeared on the Roll had been duly registered and certified to practice and the absence of the name of any woman from the Roll was the prima facie evidence that she was not registered.

 $^{^{179}}$ CSO 5/1/328, No. 1488/30: The Midwives Ordinance 1931 (Gold Coast Colony). Enclosure 3: Report on an Ordinance of the Gold Coast Colony Shortly Entitled "The Midwives Ordinance, 1931" (No. 10 of 1931). National Archives, Ghana.

Period of Training and Course Requirements

Before a person could apply to be placed on the Roll of Registered Midwives and allowed to practice in the country, she was required to undergo a course of training in a training school approved by the Board in nursing and midwifery for at least eighteen months. If a student entered the program without any prior training in nursing education, the midwifery training took three years. The conditions of entry were satisfactory health and the passing of a general intelligence examination. The Accra Maternity Hospital authorities reserved the right to terminate the course of training of a student at any stage in the program in the event that a student's progress was deemed unsatisfactory in respect of either her work or conduct. The course requirements for midwifery education included:

- 1. Elementary general physiology and the principles of hygiene and sanitation concerning home, food, and person.
- 2. The causes of infection and its prevention, antiseptics in midwifery and the way to prepare and use them, the disinfection of a person, clothing, and appliances.
- 3. Elementary anatomy and physiology of the female pelvis and its organs and of the breasts.
- 4. The physiology, diagnosis, and management of normal pregnancy, the hygiene and care of the pregnant woman and the unborn child, including the examination of urine.
- 5. The signs and symptoms of abnormal pregnancy.
- 6. The physiology, mechanism, and management of normal labor.
- 7. The signs of an abnormal labor.
- 8. The physiology and management of the puerperium, including the taking and recording of the pulse and temperature and the use of catheter.
- 9. Hemorrhage complications in pregnancy, labor, and the puerperium.

- 10. Complications of the puerperium including puerperal fevers, their nature, causes, and symptoms.
- 11. Obstetric emergencies and their management by the midwife until the arrival of a doctor.
- 12. The hygiene and management (including breast and artificial feeding) of infants up to one month old.
- 13. The care of the breasts under both normal and pathological conditions.
- 14. The care of children born apparently lifeless and the management of premature and weakly infants.
- 15. Signs of diseases that may develop during the first month after birth, with special reference to ophthalmia neonatorum and the responsibilities of the midwife in managing skin eruptions, especially pemphigus.
- 16. Venereal diseases (syphilis and Gonorrhea) in women and infants, their signs, symptoms, and dangers and risks of contagion.
- 17. The use of such drugs and solutions as may be required in midwifery practice, the conditions that call for their use, the mode of their administration or application and their dangers.
- 18. The duties of a midwife including the proper manner of keeping a register and records as well as filling forms and co-operating with health agencies.

In addition to the above courses, student midwives received instructions in the supervision of not fewer than twenty pregnant women; in making the necessary abdominal and vaginal examinations in the course of labor; and personally delivering a pregnant woman. They were also instructed in how to care for at least twenty lying-in women and their infants during the first seven days after delivery. In all, student midwives were required to attend a minimum of forty lectures delivered by health instructors approved by the Board. Upon the completion of these courses, student midwives took an examination for the midwives certificate, which was partly oral and practical, and

partly written. The written part embraced all the above subject areas. Prior to sitting for an examination, a student was required to send 'notice of entry' for an examination to the secretary of the Board at least four weeks before the date fixed for such examination. A certificate of character from the head of the midwifery school must accompany the notice, as well as a certificate that indicated that she had completed the required courses and a fee of £1.

The Board had the right to prevent students who failed to provide all the required certificates from sitting for an examination. However, the Board could also order the repayment of the fee if a student had already paid it, or allow a candidate to sit in the next examination without payment of an additional fee once they produce the necessary documentation. The standard for the certificate was that students must get an aggregate mark of 50 percent and not less than 40 percent on any oral or practical test. If a candidate failed an examination and was not able to pass it within six months from the date of her first failure, the Board had the right to call her to undergo further training before presenting herself again for the examination. Through the Ordinance, the government undertook further steps to make sure that midwifery practice in the country would be firmly under its control and midwives acted according to the exact prescribed dictates of their midwifery

education. Consequently, failing to follow the duties set forth in the Ordinance were grounds for suspending a midwife or for canceling her certificate and expunging her name from the Roll.



Figure 11: Student Midwives Studying the Female Anatomy

Duties of a Midwife

The provisions of the Ordinance regarding the duties of a midwife were designed to help the government not only medicalize pregnancy and childbirth, but also to help them in their mothermaking agenda. As a member of the colonial healthcare team, a midwife was responsible for a wide range of tasks—all of which availed the bodies of birthing mothers, and even her own body, to the regulatory controls of the government. In all obstetric care, a midwife had to go beyond what she knew about personal cleanliness to follow the government's regulations on how to clean her person. While such a regulation was intended to protect a birthing mother and her infant, a midwife, once she stepped into her uniform, no longer controlled certain aspects

of her personal space. Likewise, through her, the government supervised how women cleaned their homes and environment, took care of their personal hygiene and the hygiene of their children, the kinds of food they consumed when pregnant and when breastfeeding.

A midwife was held personally responsible for the instruction of mothers in personal hygiene during and after pregnancy, vaccinations, reproductive matters, nutrition, and general hygiene and sanitation (clean drinking water, clean environment, and the dangers of dirty hands). In this sense, she herself was required to be scrupulously clean in every way, including her person, clothing, appliances, and house. She was required to keep her nails cut short, and to preserve the skin of her hands as far as possible from cracks and abrasions. When attending to her patients, she must wear a clean dress of washable material that could be boiled such as linen or cotton and over it a clean washable apron or overall. The sleeves of the dress must be made so that the midwife could tuck them up well above the elbows. At all times, a midwife must ensure that she had completely disinfected her hands, forearms, instruments, and appliances before touching the generative organs of a patient.

In addition, a midwife was required to have in her possession, and to take with her when called to a confinement, a

metal case or a bag or basket kept for professional purposes only and furnished with a removable lining which could be disinfected. The bag or basket must contain an appliance for giving vaginal injections, a different appliance for giving enemata, a catheter, a pair of scissors, a clinical thermometer, a nailbrush, and an antiseptic for disinfecting hands, for douching in special cases, and for cleansing the infant's eyelids. A midwife in charge of a case of labor was obligated to stay with the patient and not to leave without giving an address by which she could be found immediately. After the commencement of the second stage she must stay with the woman until the expulsion of the placenta and membranes and as long as may be necessary. In cases where a doctor was sent for because of labor complications, the midwife in attendance was to await his arrival and faithfully carry out his instructions. It was only when a midwife had complied with the direction as to the summoning of medical assistance and remaining on duty as well as "doing her best for the patient" that she would be exonerated from incurring any legal liability.

In the event that an infant died during labor, the midwife must perform resuscitation. On the birth of a child, which appeared to be in danger of dying, the midwife was to inform one

of the parents of the child's condition. 180 She was also legally obligated to notify the Local Supervisory Authority in an array of incidents. These included when an infection occurred during delivery, every time she was engaged to deliver a patient, when she was sent for in an emergency and a doctor had not been engaged, and when she arranged with a doctor to deliver for him. Every midwife was also required to keep a book called "Register of Cases" to record details of the progress of all cases she attended outside the maternity center. She must be able to produce this book for inspection whenever it was required. The Register of Cases was to contain the following information:

- 1. Case Number
- 2. Date of Expected Confinement
- 3. Name of the Patient
- 4. Address of Patient
- 5. Date and Hour When Called to the Case
- 6. Date and Hour of Arrival
- 7. Previous History as to Labors or Miscarriage
- 8. Presentations
- 9. Condition of Fetal Heart
- 10. Stage of Labor
- 11. Date and Hour of Child's Birth
- 12. Sex of Infant
- 13. Born Living or Dead
- 14. Full Time or Premature
- 15. Name of Doctor, if Called
- 16. Present Labor, Progress, Complications, Drugs Administered, etc.
- 17. Record of Daily Visits to Check on Mother and Child (first day to seventh day)
- 18. Condition of mother
- 19. Condition of Child
- 20. Final Remarks

 $^{^{180}}$ CSO 5/1/332, No. 1488/30/S. F. 6: Midwives Ordinance of 1931. National Archives, Ghana.

The information midwives recorded in the Register of Cases book was vital because it was intended to help the Board track and regulate the activities of midwives. Another aspect of the Midwives Ordinance that is hard to overlook is the gendered nature of the language used in writing it. The feminine pronoun "her" was used throughout, suggesting colonial health authorities envisioned that all prospective midwives would be females while "his" was used for doctors indicating likewise that all doctors were to be males. Furthermore, by asking midwives to allow a doctor to make the final judgment in obstetrics suggests that the government believed a doctor's greater medical knowledge made him, rather than a midwife, a better attendant in childbirth. Ironically, at the very beginning of introducing western midwifery education into the country, the colonial policy was to target men rather than women.

This policy caused the acceptance of midwifery education to be very slow with only six female students trained annually from 1928 to 1935, with equally insignificant number of men presenting themselves for the midwifery training. In fact, by 1930, only three African girls had graduated from the midwifery school. The Gold Coast Gazatte for 1930 listed these first set of African girls to qualify as midwives in the Gold Coast as

Miss Sarah Bruce Okine, Miss Adelaide A. Mallet, and Miss Comfort G. Addo. 181 The reason the government targeted men rather than women and then, and defined the regulations that governed midwifery practice in the country in feminine terms is not explicitly stated in colonial records. Nonetheless, it is argued here that colonial authorities transferred to Africa the male physician's usurpation of obstetric care from laywomen that had occurred in Europe in the nineteenth century. The targeting of men, rather than women, also reflected colonial gender ideology that viewed women as only good for activities of domesticity and not for educational pursuits. As a result, in recruiting students, they targeted men instead of women who traditionally, have been in charge of the management of the birthing process.

Indeed, among many societies in the country, male involvement in childbirth was considered a taboo, and hence, men were restricted from the birthing process. The Chief Commissioner for Kumasi (Lady Slater) in recognition of this fact stated in a letter dated June 1, 1932 to the Colonial Secretary that when she inquired about the subject of women using maternity services in the region, one Mr. F. W. Applegate informed her of the following. According to Applegate, in "his experience, African mothers would more readily go to a women

¹⁸¹ Gold Coast Gazatte, "Examination in Midwifery of Midwife Probationers Indicated the First Set of African Girls to Qualify as Midwives in the Gold Coast," 1930. National Archives, Ghana.

medical officer than to a man. The bringing up and welfare of a child is naturally regarded as the prerogative of a woman and instinctively a woman is appealed to in times of illness." Papplegate's opinion was that an African woman, like every member of her sex in any part of the world, would naturally prefer to consult a female officer in preference to a male officer. In the Koforidua district, the Acting Commissioner of the Eastern Province reported that medical officers in the district were of the same view, that native women invariably attended to all matters connected with childbirth. The male practitioner was, in nearly all cases, only called in when something had gone wrong, and a women medical officer was not available.

The District Commissioner for Keta, L. W. Judd, and C. S. Masser, the Commissioner for Kibi, came to the same conclusion. Masser stated that although he had not been stationed in a district where maternal and infant welfare was available, however, based on his enquiries, he gathered that women preferred the services of other women because they naturally exercised more patience than men did, and were more likely to have a wider knowledge of female disorders. The District Commissioner for Kwahu, P. W. Rutherford, stated the following:

There is little doubt that women in this country prefer that the doctors in infant welfare clinics

¹⁸² CSO 11/6/4, No. 1168/344/25. "Lady Slater to the Acting Governor: Infant Welfare Work," June 1, 1932. National Archives, Ghana.

shall be Lady Doctors. Their reasons for this are easily understood. Amongst themselves it has always been the custom of the women of the community to perform all work in connection with childbirth, either the preliminary medical care or the actual midwifery work and also the subsequent treatment of the mother and child. African women have no fear of the necessary examinations preliminary or subsequent to childbirth of however intimate a nature if carried out by a women. They have a very natural dislike of this being done by a man however. 183

The District Commissioner for Sekondi and Shama submitted that although only women medical officers were operating in this province, those who worked closely with the maternal welfare movement were of the opinion that women medical officers were preferred. The Commissioner added, "one can readily understand this, when one considers, that in all native practices, as far as child bearing is concerned, only women attendants are required." The story from the Commissioner of the Northern Territories was not different from what we have heard so far. According to him, in all maternity cases native women would go more readily to a Lady Medical Officer as according to native custom, only women were allowed to be present during the latter stages of labor and at the actual time of birth. He added that "the average Dagomba woman have great objection to a man concerning himself with what they feel to be essentially

 $^{^{183}}$ CSO 11/6/4, No. 347/2/1929. "F. P. Holtsbaum to Acting Governor: Infant Welfare Work." April 25, 1932. National Archives, Ghana.

¹⁸⁴ CSO 11/6/4, No. 370/319/28. "W. R. Gosling to Acting Governor: Infant Welfare Work." April 26, 1932. National Archives, Ghana.

feminine matters, and they will not call in a doctor unless they are "in extremis." The various District Commissioners' reports clearly suggested to the colonial government that Ghanaian women were not going to submit themselves readily to male midwives/male obstetricians, and therefore, targeting men for the midwifery school was not going to be productive.

Presumably, the Director who wrote the provisions of the Midwives Ordinance Bill was already aware three years into the program that Ghanaian men were not going to be the appropriate candidates for midwifery education since the majority of them were far removed from the processes of women's reproduction, and therefore, did not bother to neutralize the language of the Ordinance. Thus, beginning in 1936, the colonial government began focusing on young women for the midwifery training. They intensified their efforts by opening a residential hostel for midwives at the Korle-Bu Hospital in 1936, which was to allow girls from all over the country to gain not only admission to the school, but also housing and supervision to eliminate the anxieties of parents far away from Accra. Moreover, officials reasoned that with a well-managed hostel, it would be much easier to induce girls from the more distant parts of the

 $^{^{185}}$ CSO 11/6/4, No. 367/39/14. "P. W. Rutherford to the Acting Governor: Infant Welfare Work." May 10, 1932. National Archives, Ghana.

country to come to Accra for training. 186 The establishment of the hostel was also to allow a greater number of girls to receive training, and to enable the trained girls return to their native towns, in due course, where it was hoped they would educate the inhabitants in the advantages of skilled midwifery and effective mothercraft.

The plans for the hostel to accommodate 28 pupil midwives received a budgetary approval in 1935 with funds drawn from a foundation established as a wedding gift to the Princess Royal (Princess Mary) from the people of Gold Coast in 1923. The hostel was opened in April 1936. Dr. Agnes Savage was appointed the Warden in addition to her duties as an Assistant Medical Officer. However, on the one-year anniversary of the building of the hostel, the Director of Medical Services, Dr. Arnold Hodson, requested that the hostel be expanded to accommodate 36 pupils instead of the original 28 pupils. His reason was that many girls left elementary school at the age of sixteen years and it was most desirable that their training should be taken in hand at once or much good material would be lost. At that age, they required a longer training then the statutory minimum period of 18 months. Dr. Hodson called on the government to extend the midwifery training over a period of 3 years and estimated that

¹⁸⁶ CSO 24/1/54, No. 7//30, Vol. 6, Sub-File 4: Annual General Report, 1934-1935, Chapter IV—Health: Maternity Hospital. National Archives, Accra.

in each year, the school would be able to pass out twelve trained midwives if the hostel was enlarged. In a dispatch on June 1937, Governor W. Ormsby Gore informed Dr. Hodson that he had approved the proposal and invited the legislative council to vote a sum of £1,485 for the construction and equipment of an extension of the hostel. In the 1937/38 estimates, the governor approved the extension of the hostel to accommodate 10 more girls.



Figure 12: The Midwives Hostel at the Korle-Bu Hospital

In addition, the government provided a tennis court completed with wired ends, posts, and net as well as cement and sand block wall to screen the student midwives washing house. 187

¹⁸⁷ CSO 1/16/9, No. 1437: Duff, "Public Works Extraordinary, Estimates for 1937/38. Item: Tennis Court and Boundary Wall, etc., at Hostel for Pupil Midwives. September 15, 1936. National Archives, Ghana.

In the early 1940s, Dr. Kirk introduced a training scheme in which the government paid student midwives an allowance of £3 a year and an additional £18 pounds a year paid by the students for their maintenance at the hostel. The £3 allowance was however, suspended in the mid-1940s by Governor Sir Alan Burns as a result of Britain's involvement in World War II. Student midwives on the completion of their training and on becoming certificated as registered midwives had two career options. In the first option, the government could appoint them as salaried midwives in government-ran welfare centers and hospitals. Such appointments allowed them government pension and the maximum salary of £208. In the second option, they may choose to enter into private practice, and be given a government subsidy of £3 per mensem and to the tune of £60 per annum to enable them to become established. At first, the subsidy was given to every midwife who went into private practice. However, to prevent midwives from crowding into the larger centers, the government started granting subsidies only to midwives willing to locate their private practice in rural areas where the government felt needed the most help and transformation. In two instances, Native Administration Authorities provided sums in their estimates for the payment of subsidies to midwives to induce well-qualified women to settle in their rural communities. 188

 $^{^{188}}$ CSO 11/1/343, No. 771/33: Subsidies to Midwives in Private Practice. W.

The measure of granting subsidies to only midwives practicing in rural areas did not affect those practicing in the urban areas and already receiving government subsidies. Even when for economic reasons some officials wanted to reduce the amount of subsidy granted to private midwives in Accra, others vehemently rejected it and the measure was eventually shelved. Another reason for rejecting the new measure was that it was necessary to attract the right type of young women to midwifery work and the knowledge that a steady income awaited her in starting her practice was a definite asset and encouragement to her. Subsidizing midwives gave the colonial government a definite hold of social and medical control over the midwives who would otherwise be independent private practitioners. For example, in 1934, Dr. Howells indicated that the places where the government wished for private midwives to practice, they could expect them to attend antenatal clinics under direct medical supervision in which case, the government could monitor their activities and direct them as what to do in the communities. In other words, subsidized midwives were required to comply strictly with the government regulations and with all the stipulated rules under the Midwives Ordinance.

M. Howells, Estimates 1934-35, Read 16, Health Branch." October 11, 1933. National Archives, Ghana.

From the early 1930s when subsidizing private midwives was introduced to the early 1950s when it was eventually discontinued, the subsidies were increased annually with estimates based on the number of women due to graduate and likely to qualify during the year. This scheme of subsidizing private practice was working well and according to colonial officers, it gave an increased incentive to individuals to build up a steady practice. Subsidized midwives in private practice had to submit some of their independence to the government, but government salaried midwives were completely under governmental control and had the most useful function concerning the colonial agenda of transforming midwifery practice and remaking motherhood. They were sent to what government officials called "backward areas" in order to educate the local inhabitants to appreciate modern scientific methods of midwifery and thereby creating a demand for such services. Once the salaried midwife had established the demand for medicalized midwifery, the subsidized midwife took over to continue the transformation.

The government's reason for this arrangement was that in many of the rural areas, a subsidized midwife would not be in a position to make a living at once. A long period of educative work was necessary, and as a result, the midwife whose income was guaranteed by the government was the best person to start the process. In the larger centers, where preventive and

educational work had been in progress for some years, the private midwife had little or no difficulty in starting a practice and the number of deliveries they recorded was a testament to their success. For example, in 1934, when the number of midwives in the country was still small, they managed to attend to some 1,100 deliveries in the various districts, and in 1935, the total was 1,352. The table below provides a breakdown of deliveries carried out by subsidized midwives in various towns from 1935 to 1936. The numbers suggested to the government that the scope of the service was steadily growing, and if they intensified their efforts, they could succeed in completely changing Ghanaian women's reproductive behaviors.

	No. of		No. of	
Station	Subs	idized	Deliveries	
	Midwives			
	1935	1936	1935	1936
Accra	9	9	585	889
Bekwei	1	2	29	41
Cape Coast	2	1	219	208
Koforidua	1	2	64	64
Kumasi	2	1	307	304
Nsawam	1	1	30	103
Oda	1	1	11	32
Odumasi	1	2	25	85
Sekondi	1	1	82	64
Anyinam		1	_	27
Saltpond	ı	1	_	57
Aburi	_	1	_	15
Hohoe		1		27
Winneba	_	1	_	14
Total	19	25	1,352	1,930

Table 14: Deliveries Carried Out by Subsidized Midwives from 1935 to 1936

Thus, from 1936 onward, the government's policy on midwifery was to extend it mainly through the agency of

subsidized midwives utilizing the salaried midwives as pioneers in areas where a subsidized private midwife could hardly be expected to make a living immediately. Where possible, both salaried and subsidized midwives were allowed to establish antenatal clinics at the local hospitals and welfare centers and the Local Supervisory Authority or the medical officer at their location supervised their work. To continue its program of inducing midwives to go into private practice and to settle in rural areas, the government increased the subsidy from £3 to £5 a month together with a bonus of 10 percent a case up to a maximum of 30 cases in month.

In 1933, the Director of Medical Services, Dr. Duff, had appealed to the governor to reduce the subsidy to £36 per annum. Dr. Duff had explained in a memorandum to the governor that the original rate approved in the Health Branch estimates for 1932/33 was £24 per annum. However, a Select Committee had increased the subsidy to £60 per annum. The reason for this increase was that during the period, the government had employed four highly qualified nurse-midwives who had spent considerable sum of money on their education and were, therefore, considered by members of the Select Committee to be worthy of a larger subsidy to assist them in starting in private practice. Shortly after their employment, one of them died, the second went to England, the third to Sierra Leone, and the fourth to Nigeria.

Moreover, the public was rapidly learning the value of the services of the trained midwives and those in private practice could easily earn good fees by their energy and ability.

Dr. Duff, therefore, considered it satisfactory to reduce the amount of the subsidy to £36 per annum. As he saw it, the amount was enough to allow a larger number to be subsidized without inflicting any real hardship on those already subsidized. Thus, instead of subsidizing only 6 midwives, it was possible to subsidized 10. As the number of midwives increased and as demand grew, he reasoned it would be possible to reduce gradually the subsidy and perhaps eventually withdraw it. The government agreed with Dr. Duff and in 1934, reduced the subsidy to £36 per annum. In spite of the reduction in the subsidy, the government increased its pressure on subsidized midwives to perform well. To prevent them from falling into what the government called "bad habits and practices" and to continue doing what was expected of them, rigid supervision came to be of cardinal importance. Refresher courses were organized for both salaried and subsidized midwives from time to time. This system was at first applied to the salaried midwives, who were usually qualified for longer periods. Later, it was applied to midwives in training so that before qualifying each midwife had a course

¹⁸⁹ CSO 11/1/343, No. 771/33: Subsidies to Midwives in Private Practice. Secretary of State to the Medical Department. National Archives, Ghana.

of instruction in general nursing and welfare work, including the hygiene of the home and other mothercraft skills.

By 1952, the training schools were admitting as many as 173 students annually, and by that same year, the number of registered midwives in the country had increased to 362. The majority of students trained both as nurses and midwives and many continued to serve in this dual capacity. The government employed 176 of the 362, and 93 of the remaining 186 went into private practice. The Red Cross Society employed the rest of the midwives with financial assistance from the government. By 1952, the training of midwives had commenced in Kumasi, which took in 40 students annually. By the end of the colonial period, midwifery schools had been established at Jirapa, Mampong (Asante), Mpraeso, and Hohoe. In all these schools, the training followed the basic principles of western scientific methods of obstetrics that had been established under the Midwives Ordinance of 1931, but the years of training was reduced from three years to two and a half years and candidates continued to be admitted without any basic training in nursing.

Challenges in Midwifery Education

In spite of the government's apparent success with transforming the maternity through midwifery education, they encountered severe challenges from multiple directions including

the midwifery training schools, native midwives, and from birthing mothers. According to reports by health and medical officials, the principal problem with the midwifery schools was the lack of a defined aim. They realized that very little was being achieved in terms of medicalizing pregnancy and childbirth. The majority of Ghanaian mothers were still reluctant to attend antenatal clinics to check the progress of their pregnancies or to give birth in a hospital environment. As with the maternal and infant welfare activities in which Dr. Kirk decided, "If the mothers would not come to the weighing machine, the weighing machine must be brought to them," he again concluded that the country had reached a point where midwives would have to take western obstetrics into the homes of Ghanaian women.

In this regard, Dr. Kirk argued that midwifery schools were responsible for producing corps of midwives who were competent to conduct delivery in the patient's home, using such materials that were likely to be obtainable there. They should be able to detect at the appropriate time the grosser signs of an ultimately difficult labor so that they could obtain a more skilled aid for the patient when the time of her labor arrived. If this was the aim, and when followed, the bulk of the practical training of midwives would be conducted in the homes of patients and not in hospital wards where many mothers felt

uncomfortable. He pointed out that the reverse was the case. The bulk of the practical aspects of midwifery training took place in hospital wards and a comparatively small proportion was done under conditions in which the midwife would spend the rest of her professional career. Dr. Kirk admitted that it was important for midwives in training to see how to conduct deliveries in the hospital environment for it would give them confidence in what they would have to deal with later in the field.

However, a vast and an important difference existed in conducting a labor aseptically in a hospital using sterilized equipment and with the means at hand to ensure asepsis with the minimum amount of trouble, and attempting the same thing in a badly lit room, using few calabashes to hold solutions. Hirk conceded that this state of affairs reflected on their own method of approach to the subject of asepsis. In other words they taught student nurses and midwives the elements of aseptic techniques in a hospital setting without referencing the field, and as a result, even the average midwife could successfully carry out asepsis in the hospital, but was hopelessly at sea when the same principles had to be applied in the field. One Dr.

¹⁹⁰ CSO 11/7/28, No. 3721 S. F. 5: Nurses and Midwives-Recruitment and Training of. Alan Burns, "Extract from File No. Conf. 3721 page 2: Proposal by Dr. Kirk, Director of medical Services, 1943. National Archives, Ghana.

G. F. T. Saunders¹⁹¹ lent his support Dr. Kirk, arguing that the technique of asepsis and other important obstetric methods in the field had to be part of the training curricula to ensure that when students entered the homes of birthing mothers, they would not expose themselves, the mother, and the infant to any danger.

Another reason for the unsatisfactory state of affairs in the training of midwives was the existing method, or lack of method, of staffing the Accra Maternity Hospital, which was the main institution for the training of midwives. Dr. Kirk pointed out that the hospital "obtained what might almost be regarded as a 'pyrrhic' victory in becoming a separate and an independent institution," because this status was attained largely at the expense of staffing arrangements. Essentially, the hospital did not make any provisions for obtaining adequate staffing. Its personnel consisted of persons who had been lent by other branches of the Health Department together with midwives who were filling more or less continual posts that were meant to be only for one year. Consequently, it was difficult for the Accra Maternity Hospital to be in a position where it could properly undertake its teaching responsibilities.

 $^{^{191}}$ Saunders was regarded by many of his colleagues, and particularly by Kirk, as an authority in the training of African women in western biomedical science.

Furthermore, the vital domiciliary teaching that student midwives were required to receive in detail was not possible because the hospital's lack of permanent staffing obliged it to depend upon senior students to carry out duties. The school administration, on their part, insisted that such employment provided students with a sense of responsibility. That might be all very well if they were designed for an institutional career, but as Dr. Kirk saw it, they were not. It was, therefore, necessary to find a way of achieving an object more in line with the students' ultimate goal in the program, which was to become efficient district midwives and ambassadors for the government's initiative to medicalize midwifery practice in the country. There is no indication that the problems outlined by Dr. Kirk regarding midwifery training were resolved by the government in any effective way. However, his suggestions regarding taking western midwifery practices into the homes of Ghanaian mothers took root when in 1946 the government directed that improved midwifery practice be introduced into the homes of birthing mothers.

The above directive was aimed at achieving two things.

First, it was aimed at destroying the practice of native midwives who had not submitted themselves to be trained under the government's program of unqualified midwives. The presence of western-trained midwives in the homes of expectant mothers

would prevent them from accessing the services of native midwives. Second, it was reasoned that it would be easier to talk about personal hygiene and effective mothercraft when conditions of filth and other bad practices were witnessed in the visited environment. It was noted in a number of medical reports that on average, each midwife practicing in the country delivered two women per month. Whether these deliveries were in the homes of patients was not clear, but in these reports, it was indicated that midwives conducted several puerperiums and carried out many house-to-house visits to help and advise women about themselves, their babies, and their homes.

Soon the government discovered it was not so simple transforming both how midwifery had been practiced in the country for generations and impressing on women to utilize the services of trained midwives. Many midwives working in the communities, particularly those in the rural areas, reported that local prejudice was common towards western midwifery practice. Not only were women suspicious of trained midwives, but also they were reluctant to pay for their services. This even caused the colonial government to institute measures that allowed trained midwives to take action against mothers who used their services but refused to pay. 192 With native midwives, a

 $^{^{192}}$ CSO 5/1/337, No.1488/30, S. F. 10: Midwives Notice of Steps to be taken against Women Retaining their Services in Childbirth but Fail to Pay their Fees. National Archives, Ghana.

family thank you, a gift of foodstuff, or even a day's work in the farm by a family member was enough to pay for their services. As a result, the government had to change once again its tactics. It allowed medical staff, including midwives, health visitors, and nurses to encourage native midwives to bring to the clinics the expectant mothers in their care for examination to ensure that conditions for an unaided birth were satisfactory and that no disorders of pregnancy were present. In addition, they began to give practical demonstrations to native midwives whenever possible. On March 24, 1932, the Lady Medical Officer at the Accra Maternity Hospital, Dr. C. D. Williams, in her report on the activities of the hospital indicated a few native midwives were gradually beginning to bring their cases to the antenatal clinic. However, they remained "deeply suspicious that all we want is to spoil their practice," 193 which, of course, was exactly what was intended.

On some level, the benefits for gaining access into the private space of women in order to control their reproductive behaviors were enormous for the colonial government. First, a healthy population from the very foundation meant a reliable source of manual labor. Second, it reduced the government's long-term health expenditure, which in all intent and purpose,

 $^{^{193}}$ GGCRMSD, April 1927-March 1928. "Maternal and Infant Welfare," page 34. National Archives, Ghana.

had to be the bare minimum in order for them to gain the most out of their economic exploitation. In addition, they entered into the private space of Ghanaian women to redefine their social normative practices and to impose on them their own social values. The colonial government through midwifery education linked the private with the public by rendering its trained midwives fully committed to promoting birthing practices in line with the colonizer's culture. Midwives supervised deliveries and infant care, promoted health education, and trained native midwives. During baby-weighing clinics, they instructed mothers about personal hygiene and sanitation and the colonial conception of effective mothercraft (regulated feeding of babies, sleeping schedules, sleeping positions, cleaning of children, and the rest).

Western-trained midwives were encouraged not only to relieve the discomforts and the dangers of childbirth, but also, to spread social values and help Ghanaian women to leave behind their "unhealthy" maternal behaviors. This way, colonial authorities indirectly changed the socio-cultural perceptions of both mothers and fathers through the utilization of women's bodies subjected to biomedical power to fuel their social imperialism and economic exploitation of African labor. Such social redefinition not only justified their rule on moral grounds, but it also provided them with political expediency. In

other words, control the areas Africans value the most—
pregnancy, childbirth, and children upbringing—and you control
the vital lifeline of the entire society. Yet, as we have seen
since the 1920s, the social, economic, and political impositions
disguised under the notion of bringing biomedical solutions to a
diseased country were not without negotiations and
contestations.

Report after report, medical and health officials were frustrated with the slow pace with which mothers were using the services of trained midwives as well as in taking full advantage of the various maternity hospitals and welfare centers. For some Ghanaian mothers, because of the lack of money to pay for such services or the lack of access to them, they ignored that any change was going on that affected their lives. Others could afford it, but chose not to participate because of deeply held beliefs about the intensions of the intruders and their medicine. Some women also participated on their own terms and effectively redefined the colonial agenda. For Ghanaian women who participated in the colonial agenda as western-trained midwives, it was an opportunity to challenge the colonial gender notion that women were only good for the responsibilities of wifehood and motherhood. In the end, they ultimately appropriated western biomedical science for their own benefit.

Acceptance, Resistance, and Appropriation

In this dissertation, I have examined the ways in which the British colonial government implemented its imperial politics of maternal reconstruction in colonial Ghana from the early 1920s to the eve of the country's independence in the 1950s. In order to present the specificities of the government's agenda on women's reproduction, I analyzed the multiple venues through which women's bodies were subjected to medical and institutional scrutiny as a vital aspect of the government's search for solutions to producing a healthy population—and by extension, a good supply of human resources, establishing social control, and augmenting political hegemony. In this regard, I looked at the imperial politics of indirect rule, maternal and infant welfare services, the medicalization and hospitalization of pregnancy and childbirth, and the transformation of midwifery practice in the country. The conceptual framework of this dissertation rests in the application of what Foucault calls "bio-power," which he defined as a "political technology that brought life and its mechanisms into the realm of explicit calculations $^{\prime\prime}$ by conceiving of political subjects as members of populations and

^{194 &}quot;Notes of T. H. R. Cashmore" cited in Lynn M. Thomas, Politics of the Womb: Women, Reproduction, and the State in Kenya (Berkeley and Los Angeles, CA: University of California Press, 2003), 67.

making their reproductive and sexual conduct matters of national interest.

For Foucault, European preoccupation with redefining populations, constructing racial hierarchies, and regulating sexualities were all essential components of bio-power. Furthermore, he pointed out that the two extremities of biopower (control of individual bodies and bodies of nations) when combined, allowed dominant powers to regulate both the private and public spaces of their subjects. In the case of the British colonial government, the control of biomedical power allowed them access into a private space where pregnancy and childbirth had been in the hands of women who managed and regulated it. Through that access, they aimed to re-order both the social and the medical aspects of pregnancy and childbirth in the public space. This conceptual position is, however, not without academic contestations. Beginning in the 1980s, some scholars examined the importance of applying Foucault's concept of biopower to understanding European colonial rule on the African continent.

To these scholars, no significant relationship exists between Foucault's bio-power and colonial power, and even if there was, it is of little value in analyzing the nuances of

colonial rule in Africa. 195 The fundamental issue these scholars confronted was the ability of colonial ruler to order individual bodies as sexual and reproductive beings, and utilizing them as gateways to accessing the large population. Moreover, they believed colonial rulers did not command the type of power comprehensive enough to be able to intervene effectively in biological behaviors and transform them into sites of regulation. In her work in colonial power and African illness, Megan Vaughan argued that colonial power and knowledge in Africa before World War II was not in a position to attain bodily subjectivities that extended from the individual to the wider society. Furthermore, in some instances when colonial rulers had the power, they remained indifferent in nurturing selfregulating subjectivity. 196 Frederick Cooper has also contested the application of Foucault's idea of circulation of power to understanding colonialism in Africa. According to Cooper, colonial power in Africa was arterial then capillary. It was spatial and its influence only covered the areas of its domain, and even than, the holders of such power, had to consistently pump momentum and vitality into it to make it effective. 197

¹⁹⁵ Ibid., 122.

¹⁹⁶ Megan Vaughan, Curing their Ills: Colonial Power and African Illness (Stanford, CA: Stanford University Press, 1991), 8-9.

¹⁹⁷ Frederick Cooper, Tensions of Empire: Colonial Cultures in a Bourgeois World (Berkeley, CA: University of California Press, 1997), 11-18.

Vaughan and Cooper's postulations suggest that there is, indeed, a possible danger in applying Foucault's bio-power to colonial reproductive interventions without qualification. Nonetheless, when one analyzes the different reproductive interventions introduced by the British colonial government, it is not hard to conclude that the colonial reproductive measures fit into Foucault's notion of bio-power. The colonial institution of measures aimed at improving the health of Africans by eliminating superstitious practices, reconstructing motherhood through mothercraft lectures, and establishing maternity hospitals and welfare centers illustrate that colonial rulers depended on medical technology to achieve political longevity. The various measures and campaigns indirectly conscripted Ghanaian women into European maternal imperialism that promised better reproductive health and threatened to displace indigenous reproductive knowledge systems. Colonial insistence on changing women's reproductive behavior relied on the ideology that the hospital environment was the proper place for childbirth, beyond the purview of female kin and the injurious practices of native midwives. Like Foucault's biopower, the colonial attempt at colonizing the womb produced sites of regulation, negotiation, and resistance, which were further exacerbated by colonial gender ideologies.

Thus, in my analysis, gender played an important role. It informed many of the colonial government's pejorative notions about Ghanaian motherhood and native midwifery practice, women's roles in society, the policy of indirect rule, and the initial recruitment policy for midwifery education. Indeed, it was through the transfer of European gender ideologies that the colonial government settled on women as the appropriate sex for the colonial enterprise of social restructuring. Thus, I argued that the British colonial government conceived of women's reproduction as an appropriate site of intervention because they conceived of it as a path of least resistance to social reconstruction, economic security, and political dominance. To achieve their aim, the government packaged and presented its maternal imperialism as a symbol of the munificence of the British Empire and a justifiable feature of their "civilizing" mission.

Beginning in the early twentieth century, pregnancy and childbirth that had been in the hands of women became increasingly subjected to medical scrutiny and political controls. In this period, the maternal behaviors of mothers in their own homes, maternal and infant mortality rates, and the management and conditions before, during, and after childbirth became the focus of the state, missionaries, and other private agencies. As women were selected as the reproductive upholders

of the Gold Coast Colony for the British Crown, their health and education gained the attention previously denied them in the early stages of the colonial encounter. Colonial health officials, missionaries, and voluntary organizations progressively intruded in the personal lives of women as they turned their medical gaze on how women managed their bodies in order to survive the ordeals of pregnancy; to give birth to healthy children; and how they managed their homes to ensure the survival of their children. Colonial health officials condemned maternal ignorance and superstitious behaviors and blamed the native midwife for the high maternal and infant mortality rates in the country.

In the ensuing reproductive campaign detailed in mothercraft lectures, baby shows, baby baths, hospital births, and forceps deliveries, colonial health officials, acting with the power vested in them by the colonial government in what Foucault has described as "capillary power," unequivocally transformed private health matters into public policy and government responsibility. At first, the state enlisted the help of local chiefs to control uncontrollable women who, it was believed, had been emboldened by the opportunities of the new market economy to seek autonomy outside the confines of

¹⁹⁸ Foucault, Power/Knowledge: Selected Interviews and other Writings, 1972-77, 96.

domesticity. Then, they gained entrance into the homes of Ghanaian mothers, once again, with the help of chiefs. Once there, colonial health officials, missionaries, the Red Cross, and the League for Maternal and Infant Welfare came together to reconstruct the maternal. As calls to focus on maternal and infant welfare intensified, domiciliary visits were combined with institutional visits at hospitals and welfare centers in a propaganda aimed at creating new colonial populations acculturated to the colonizer's biomedical methods and equally acquiescent and appreciative of the colonizer's political subjugation.

The next step of the campaign was to educate young girls in the acts of effective mothercraft so that they would become agents in the campaign to change the maternal behaviors of their mothers and to transform midwifery practice so the negative effects of native midwives would be eradicated. Once mothers were transformed, they in-turn would become agents of the state, perfectly conditioned to effect their influence on social and political stability and economic development. In other words, in attempting to seize control over women's reproduction, the colonial government was in some sense proposing to reconstruct the Ghanaian society from the micro level of a sector of the population to the macro level of the entire population. This transformation was necessary because it almost certainly

guaranteed the state a healthy supply of labor as well as an increased number of taxpaying subjects. By this process, the colonial government endeavored to make its political hegemony enduring. It is also important to note that the social reengineering through the colonization of the womb was gradual and almost mundane to a point.

As has already been pointed out, colonial governments used social welfare programs as fundamental tools in holding on to political power. Other researchers have equally argued that colonialism involved the changing of the social, economic, and political aspects of African societies in a seemingly routine manner. In effect, colonialism "entailed the reconstruction of the ordinary." 199 The British colonial government attempted the colonization of the wombs of Ghanaian mothers, through the avenues of mundane activities such as community cleanups, bathing basins, mosquito nets, powders, salts, bottles of aspirin, and baby bathes, although they had limited success with their mothercraft and hygiene lectures and weighing machines. My conclusion is that the reproductive encounter that took place between Ghanaian women and the British government occurred in three basic overlapping modes-acceptance, resistance, and appropriation.

¹⁹⁹ Comaroffs, 75.

Acceptance occurred in the sense that Ghanaian women reasonably, if not overwhelmingly, accepted the application of biomedical solutions to reproductive problems and childhood diseases by participating in maternal and infant welfare programs and in the medicalization of pregnancy and childbirth. The ability of western medicine to cure the ills of their children, to determine impending problems associated with pregnancies, and to use scientific techniques and tools in complicated childbirth encouraged mothers to avail themselves and their children at some points to the benefits of western alternative medicine. Acceptance also took place through the avenue of western midwifery education. Here, Ghanaian women not only presented themselves to be trained in the tenets of western midwifery practice, but also once they were trained, Ghanaian midwives performed many of the regulatory tasks that enabled biomedicine to function as a tool of British imperialism.

Yet, as our discussions have shown, it would be erroneous to conceive of women's acceptance of, and participation in, the colonial reproductive reconstruction agenda as a sign that the colonial government was successful in remaking Ghanaian motherhood and in transforming the processes and management of pregnancy and childbirth. Admittedly, the colonial government's reproductive agenda ultimately disrupted the social aspects of the management of pregnancy and childbirth, which had been in

the hands of women both as birthing mothers and as attendants of childbirth. However, the intervention did not necessarily result in a complete control over women's bodies and their roles in reproduction. The majority of Ghanaian women resisted, on many levels, the colonial imposition by initiating their own counterstrategy to the medicalization and politicization of their reproductive functions. From the early 1920s when the colonial government started its maternal campaign in the name of reducing maternal and infant mortality rates, it invested considerable amount of time and resources to it, yet from the very beginning of the encounter, Ghanaian women were the ones who defined the agenda. That is, it was their decision to participate or not to participate and when participating, they decided the level and details of their participation.

As some researchers have suggested, colonial rulers planted on grounds that they had very limited to no control over, and to which they only could enter intermittently. Put differently, colonial governments entered a terrain they did not own and could not make their own. Their access and control was in many ways, superficial. The resultant output was entirely different was what the colonizers had envisioned and could hardly be conceived of as a definite imperial invention. In the case of Ghana, the colonial government did manage to reasonably reduce,

²⁰⁰ Ibid., 76.

although not on a consistent basis, the maternal and infant mortality rates through it welfare programs. In addition, they established maternity hospitals with centers for training midwives; they took their mothercraft programs into the homes of women as well as sent midwives there to take control of childbirth. Yet, entries in colonial medical records indicate that as late as the end of colonial rule, health and medical officials were grim in their views regarding achieving a positive change in women's reproductive behaviors and were considering other strategies—of course they were not anticipating that Nkrumah and his colleagues would be able to end their hold on power. In essence, the colonial state had entered a space it had limited access to and could hardly control on its own terms.

Furthermore, the colonial state, mindful of the importance Africans attached to childbearing and reproductive issues anticipated that Ghanaian women—as birthing mothers, grandmothers, guardians, and as students of the midwifery schools—would overwhelmingly welcome the "superior" birthing techniques they have introduced. However, as suggested above, what emerged was a complex interplay of negotiations and contestations. Women picked and chose what they wanted out of the programs and rejected what they did not want and colonial health officials had to accept the women's terms of the

encounter. For example, with western midwifery education some women accepted the training and became registered midwives. Some native midwives even accepted the new way of obstetric practice, and joined the training program to be certified as unqualified midwives. Yet, the numbers of native midwives who entered the colonial terrain to become unqualified midwives were in the minority. The majority of women who worked as birth attendants continued their practice in the same manner, as they knew it.

For birthing mothers, although they welcomed the westerntrained midwife's ability to save mothers and infants in times of crisis, but otherwise, they did not participate in the medicalization and hospitalization of pregnancy and childbirth, at least, to the degree colonial health and medical officials had wanted-a phenomenon post-colonial governments continue to wrestle with in contemporary Ghana. Indeed, it is a paradox that in promoting western biomedical science, Ghanaian women, on the one hand, became vessels through which aspects of women's reproductive knowledge and authority in childbirth was reduced or supplanted altogether, whilst on the other hand, it provided opportunities for women's agency. Stated differently, the spread of medical hegemony through hospital-based birth technologies displaced and/or competed with indigenous practices as well as disorganized or even eliminated some indigenous knowledge systems, yet the benefits of biomedicine on African populations

are undeniable. To be specific, in return for assisting to reduce the high infant mortality rates, and hence, helping to feed the colonial exploits, women got the opportunity to participate in the new dispensation of power that had previously ignored or denied women as having any essential role to play in public affairs.

For instance, the colonial health and medical establishment established a hierarchical system in which midwives, who although were placed at its lowest levels, got the opportunity to enjoy some of the benefit of a social hierarchy. Therefore, it would be inaccurate to stipulate that midwives were only pawns in the colonial agenda; they also gained in the process. The western-trained midwife, although at the bottom of the medical hierarchy, started to enjoy some newly earned benefits such as regular income, retirement benefits, private practice, and financial aid in the form of government subsidies. Indeed, I argued that Ghanaian women who entered the colonial midwifery program consciously or unconsciously appropriated it for their own purposes. This was in the sense that the colonial government's intent on introducing western midwifery into the country was to facilitate its agenda of maternal reconstruction and not to empower women socially and economically.

Although the economic security was almost a given, considering the fact that midwives worked for remuneration,

acquiring a higher social status was not. As colonial reports indicate, midwives were earning good incomes and making a decent living. Socially, the newly emerged midwife had to negotiate her position effectively in the community in order to earn the trust and respect of the women folk in particular, and the entire public in general. In return, they gained for themselves higher social status. Appropriation did not only occur at the level of status transformation for midwives. As shown above, Ghanaian mothers appropriated western biomedical science for their own use by participating in it when it suited their needs, and ignoring it when it interfered with their daily routine or when it did not conform to their understanding of motherhood.

In conclusion, this dissertation brings to light a subject matter of historical importance by offering and investigating a topic that has remained almost completely unexamined. By seeking to unearth the experiences of Ghanaian women who conceived, gave birth, cared for children, and delivered other women, this dissertation connects with scholarship that has situated women as active participants in the making of history and not the generally perceived notion that African women were passive onlookers in historical events. By analyzing the government's attempt at colonizing the womb as a historical process of negotiations and contestations, this dissertation disrupts other scholarship that has tended to position colonial reproductive

interventions only as colonial oppression verses anti-colonial resistance. This scholarship did not consider the fact that the colonial reproductive encounter was both a contested and negotiated terrain as well as a combination of African and western medicine. As has been argued by others, colonial governments' achievements in women's reproduction took place on the heels of compromise, which indicates that the womb, after all, was not an easy site of intervention.

In using gender as a category of historical analysis, this dissertation further opens the possibilities of historicizing women's agency. By offering and discussing the different ways women in colonial Ghana participated in a historical event and asserted their own agency, and by examining the experiences of "ordinary" women, who bore children, lost children, lost their lives bearing children, and worked as midwives. This dissertation further disrupts elitist representation from the center of African historical discourses. In addition, my attempt bridges the paradigmatic frameworks of victimhood and empowerment so that the histories of "ordinary" women would not be lost in historical narratives. In the end, while the female body afforded the British colonial government a degree of access and control of the socio-cultural spaces of the Ghanaian population, women, by asserting their own agency in the colonial

encounter, became the ultimate winners of the medical and educational measures the colonizers introduced.

BIBLIOGRAPHY

Primary Sources

- Balme Library at the University of Ghana. Gold Coast Magistrate Court Reports.
- Ghana Medical School Library. Gold Coast Government Report on Medical and Sanitary Service.
- Ghana National Public Records Administration (National Archives). Colonial Secretary Office Annual Medical and Sanitary Reports from 1900 to 1955; Gold Coast Annual General Reports; Blue Book of Statistics; Commission of Enquires Reports; Gold Coast Ordinances and Personal Files of Medical Officers; British Red Cross Society's Reports.
- Gold Coast Independent. Letter to the Editor: "Forced Marriage of African Girls: Prevention." January 15, 1930.
- Guggisberg, Decima Moore and Major Frederick Gorden Guggisberg. We Two in West Africa. New York: Charles Scribner's Sons, 1909.
- Horton, James Africanus B. Physical and Medical Climate and Meteorology of the West Coast of Africa. London, 1866.
- Kumasi Regional Archives. Ashanti Regional Administration Files: Report on Native Affairs for the Mampong District.
- Lok, John. "The Second Voyage [of Master John Lok] to Guinea...1554." In Richard Hakluyt. The Principal Navigations, Voyages, Traffiques and Discoveries of the English Nation. London: Penguin Books, [1589]1972.
- Public Records Office, Kew, UK. Gold Coast Annual General Reports; Medical Reports; Gold Coast Ordinances and Personal Files of Medical Officers, International Conference Reports; Colonial Government Dispatches; Gold Coast Report on the Eastern and Western Provinces; Gold Coast, Report on Ashanti.
- Rattray, Robert S. Ashanti Proverbs: The Primitive Ethics of a Savage People Translated from the Original with Grammatical and Anthropological Notes. Oxford: Clarendon Press, [1916] 1969.

- _____." The Tribes of the Ashanti Hinterland: (Some Results of a Two-Year Anthropological Survey of the Northern Territories of the Gold Coast)." Journal of the Royal African Society.

 Vol. 30 (Jan. 1931): 40-57.
- .Ashanti Law and Constitution. London: 1929.
- Sierra Leone National Archives, Sierra Leone. Colonial Government Dispatches.
- "Speech to Conseil de Gouvernement, February 18, 1908." In Terrier, Auguste, Charles Mourey, and French West Africa. L'expansion Française et la Formation Territorial. Paris: E Larose, 1910.
- The Travels of Sir John Mandeville: The Version of the Cotton Manuscript in Modern Spelling. Pollard Alfred William, ed. London: Macmillan, 1915.
- Wesleyan Methodist Missionary Society, School of Oriental and African Studies at the University of London, UK. Report of the Women's Department; Official Report on the Kumasi Mmofraturo Girls' School; Work Among the Women of Ashanti; Report on Women's Work.

Secondary Sources

- Addae, Stephen. The Evolution of Modern Medicine in a Developing Country: Ghana 1880-1960. Durham, NC: Durham Academic Press, 1997.
- Aidoo, Thomas A. "Rural Health Under Colonialism and Neo-Colonialism: A Survey of the Ghanaian Experience."

 International Journal of Health Services. Vol. 12 (1982): 637-657.
- Allman, Jean. "Making Mothers: Missionaries, Medical Officers and Women's Work in Colonial Asante, 1924-1945." History Workshop Journal. Vol. 38 (1994): 24-47.
- Appiah-Kubi, Kofi. Man Cures, God Heals: Religion and Medical Practice Among the Akans of Ghana. Totowa, NJ: Allanheld, Osmun, 1981.

- Bartels, Emily C. "Imperialist Beginnings: Richard Hakluyt and the Construction of Africa." Criticism. Vol. 34 (1992): 519.
- Bosman, Willem. A New and Accurate Description of the Coast of Guinea: divided into the Gold, the Slave, and the Ivory Coast (1705). London: J. Knapton, 1967.
- Comaroff, John and Jean Comaroff. Ethnography and the Historical Imagination. Boulder, CO: Westview Press, 1991.
- Comaroff, Jean. "Medicine and Culture: Some Anthropological Perspectives." Social Science and Medicine. Vol. 12b (1978): 247-54.
- Cooper, Frederick. Tensions of Empire: Colonial Cultures in a Bourgeois World. Berkeley, CA: University of California Press, 1997.
- Coquery-Vidrovitch, Catherine. African Women: A Modern History. Boulder, CO: Westview Press, 1997.
- Crowder, Michael. *Colonial West Africa*. Totowa, NJ: Frank Cass Publishers, 1978.
- Daaku, Kwame. Trade and Politics on the Gold Coast, 1600-1720. London: Clarendon Press, 1970.
- Davin, Anna. "Imperialism and Motherhood." History Workshop. Vol. 5 (1978): 25-28.
- Davis, Angela Y. Women, Race and Class. New York: Random House, 1981.
- Ehrenreich, John, ed. *The Cultural Crisis of Modern Medicine*. New York: Monthly Review Press, 1978.
- Elling, Ray H. Cross-National Study of Health Systems: Political Economics and Health Care. New Brunswick: Transaction Books, 1980.
- Falola, Toyin. "Gender, Business, and Space Control: Yoruba Market Women and Power." In House-Midamba, Bessie and Ekechi, Felix K. eds. African Market Women and Economic Power: the Role of Women in African Economic Development. Westport, CT: Greenwood Press, 1995.

- _____. Culture and Customs of Ghana and Culture and Customs of Nigeria. Westport, CT: Greenwood Press.
- Feierman, Steven and John M. Janzen, eds. The Social Basis of Health and Healing. Berkeley: University of California Press.
- Ferguson, Moira. Subject to Others: British Women Writers and Colonial Slavery, 1670-1834. New York: Routledge, 1992.
- Foucault, Michel. The History of Sexuality. Vol. 1, An Introduction, translated by Robert Hurley. New York: Vintage Books, 1980.
- _____.Power/Knowledge: Selected Interviews and other Writings, 1972-77. New York: Pantheon Books, 1980.
- Hewitt, Martin. "Bio-politics and Social Policy: Foucault's Account of Welfare." In Hepworth M. Featherstone and B. S. Turner, eds. *The Body: Social Process and Cultural Theory*. London: Sage Publications, 1991.
- Hunt, Nancy. "Le Bebe en Brousse: European Women, African Birth Spacing and Colonial Intervention in Breast Feeding in the Belgian Congo." International Journal of African Studies. Vol. 21 (1988): 401-32.
- Hussein, Julia, Vanora Hundley, Jacqueline Bell, Mercy Abbey, Gloria Quansah Asare, and Wendy Graham. "How Do Some Women Identify Health Professionals at Birth in Ghana." Journal of Midwifery. Vol. 21 (2005): 36-43.
- IDA Health Group, Health Needs and Health Services in Rural Ghana. Vol. 1. Brighton, England: University of Sussex, IDA, 1978.
- Imperato, Dawson and Kofi Appiah-Kubi. In Z. A. Ademuwun, African Therapeutic Systems. Waltham: Crossroads Press, 1979.
- Kleinman, Arthur. Patients and Healers in the Context of Culture: An Exploration of the Borderland Between Anthropology, Medicine, and Psychiatry. Berkeley: University of California Press, 1980.
- Kimble, David. A Political History of Ghana: The Rise of Gold Coast Nationalism, 1850-1928. London: Oxford University Press, 1963.

- Krushe, Sue and Lesley Barclay. "Effect of Shifting Policies on Traditional Birth Attendant Training." Journal of Midwifery & Women's Health. Vol. 49 (July/August 2004): 306-310.
- Lewis, Jane. The Politics of Motherhood: Child and Maternal Welfare in England 1900-1939. London: Croom Helm, 1980.
- McCaskie, T. C. "Cultural Encounters: Britain and Africa in the Nineteenth Century." In Andrew Porter, ed. *The Oxford History of the British Empire* Vol. III. Oxford: Oxford University Pres, 1999.
- Mebrantu, Saba. "Women's Work and Nutrition in Nigeria." In Meredith Turshen, ed. Women and Health in Africa. New Jersey: Africa World Press Inc., 1991.
- Morgan, Jennifer L. "Women in Slavery and the Transatlantic Slave Trade." In Anthony Tibbles, ed. *Transatlantic Slavery:*Against Human Dignity. London: HMSO, 1994.
- _____. ``Some Could Suckle Over their Shoulder': Male
 Travelers, Female Bodies and the Gendering of Racial
 Ideology, 15000-1770." The William and Mary Quarterly, Third
 Series. Vol. 54 (1997): 167-92.
- Neumann, Alfred K. "Planning Health Care Programs in a Pluralistic Medical Context: the Case of Ghana." In Stanley Yoder, ed. Africa Health and Healing Systems: Proceedings of a Symposium. Waltham: Crossroads Press, 1982.
- Nyarko, Philomena, Harriet Birungi, Margaret Armar-Klemesu, et al. "Acceptability and Feasibility of Introducing the WHO Focused Antenatal Care Package in Ghana." USAID. (June 2006): 1-37.
- Odinga, Agnes A. "Women's Medicine and Fertility: A Social History of Reproduction in South Nyanza, Kenya, 1920-1980." An unpublished PhD Dissertation. University of Minnesota, 2001.
- Onoge, O. F. "Capitalism and Public Health: A Neglected Theme in the Medical Anthropology of Africa." In S. R. Ingman and A. E. Thomas, eds. *Topias and Utopias in Health: Policy Studies*. Chicago: Aldine Publishing Company, 1979.
- Patton, A. "Dr. John Farrell Easmon: Medical Professionalism and Colonial Racism in the Gold Coast, 1856-1900." The

- International Journal of African Historical Studies. Vol. xxii (1989): 601-635.
- Patterson, David K. "The Veterinary Department and the Animal Industry in the Gold Coast 1909-1954." *IJAHS*. Vol. 13, (1980): 457-91.
- _____. Health in Colonial Ghana: Disease, Medicine, and Socioeconomic change, 1900-1955. Waltham, MA: Crossroads Press, 1981.
- Priestly, Margaret. West African Trade and Coast Society. London: Oxford University Press, 1969.
- Quaye, Randolph. Underdevelopment and Health Care in Africa: the Ghanaian Experience. New York: Edwin Mellen Press, 1996.
- Ramusack, Barbara. "Cultural Missionaries, Maternal Imperialists and Feminist Allies: British Women Activists in India, 1865–1945." In Nupur Chaudhuri and Margaret Strobel, eds. Western Women and Imperialism: Complicity and Resistance. Indiana University Press, 1992.
- Ranger, Terence. "The Invention of Tradition in Colonial Africa." In Eric Hobsbawm and Terence Ranger, eds. *The Invention of Tradition*. New York: Cambridge University Press, 1983.
- Roberts, Penelope A. "The State and the Regulation of Marriage: Sefwi Wiawso (Ghana), I900-40." In Haleh Afshar, ed. Women, State, and Ideology: Studies from Africa and Asia. Albany: State University of New York Press, I987.
- Sharp, Evelyn. The African Child: An Account of the International Conference on African Children, Geneva. Negro University Press, 1970.
- Stone, Robert. "Colonial Administration and Rural Politics in South Central Ghana, 1919-1951." PhD. Diss., Cambridge University, 1975.
- Suleri, Sara. The Rhetoric of English India. Chicago: University of Chicago Press, 1992.
- Summers, Carol. "Intimate Colonialism: The Imperial Production of Reproduction in Uganda, 1907-1925." Signs. Vol. 16 (1991): 807.

- Thomas, Lynn M. Politics of the Womb: Women, Reproduction, and the State in Kenya. Berkeley and Los Angeles, CA: University of California Press, 2003.
- Tordoff, W. Ashanti Under the Prempehs, 1888-1935. Oxford University Press, 1965.
- Turshen, Meredith. "The Impact of Colonialism on Health and Health Services in Tanzania." International Journal of Health Services. Vol. 7 (1977): 33.
- Twumasi, Patrick A. Social Foundations of the Interplay between Traditional and Modern Medicine Systems. Accra: Ghana Universities Press, 1988.
- ____. "A Social History of the Ghanaian Pluralistic Medical System." Social Science and Medicine. Vol. 13 B (1979): 349-356.
- Ulin, P. R., Good Rappaport, and Anita Spring. *Traditional Healers and Primary Health Care in Africa*. New York: Syracuse University, African Series 35, 1980.
- Vaughan, Megan. Curing their Ills: Colonial Power and African Illness. Stanford, CA: Stanford University Press, 1991.
- Vellenga, Dorothy Dee. "Who is a wife?: Legal Expressions of Heterosexual Conflicts in Ghana." In Christine Oppong, ed. Female and Male in West Africa. London: Allen & Unwin, 1983.
- Warren, Dennis M. and Mary A. Tregoning. "Indigenous Healers and Primary Health Care in Ghana." Medical Anthropology Newsletter. Vol. 11 (Nov. 1979): 11-13.
- Willem, Bosman. A New and Accurate Description of the Coast of Guinea: divided into the Gold, the Slave, and the Ivory Coast [1705]. London: J. Knapton, 1967.
- Winthrop, Jordan. White Over Black: American Attitudes Towards the Negro, 1550-1812. New York: Norton, 1968.
- World Health Organization (WHO). "The Promotion and Development of Traditional Medicine." Technical Report Series, No. 622 (1978).