

Mothers, Babies, and the Colonial State

The Introduction of Maternal and Infant Welfare Services in Nigeria, 1925-1945

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At the beginning of the twentieth century the high mortality rates of both mothers and babies during childbirth became a predominant concern in Britain and its empire, provoking outcries from medical and nursing professionals as well as politicians and the wider public. Infant mortality became the new marker of the vitality of the nation and a widely used indicator of general standards of health. Efforts to improve maternal and infant welfare were part of a broader shift in Britain towards public health as a government responsibility. Measures taken to reduce mortality rates emphasized state-run initiatives in maternal education and antenatal care, the medicalization of childbirth, and scientific infant feeding and childrearing practices (Fildes, Marks and Marland 1992; Lewis 1980; Marks 1996; Davin 1997). This shift in health care policies resulted in profound changes to the experience of childbirth and to the role of the state in the area of social welfare.

Although a similar focus on the improvement of infant and maternal health existed in Britain and far off colonies in Asia and Africa, both the centre and the periphery of empire, scholars have identified significant differences in the policy and practice of maternal and infant welfare in colonized areas (Jones 2004; Bell 1999; Hunt 1988; Musisi 2002; Summers 1991; Vaughan 1991; Lasker 1977; Jennings 2006). Issues such as state intervention into the sphere of reproduction and childrearing became increasingly complex with the additional concerns of race and imperialism in the colonial setting. The encounter between European health care professionals and indigenous medicine further complicated issues concerning class and gender which dominated efforts to reduce infant and maternal mortality in Britain. A feature of public health across the British Empire, there remained considerable variety in the timeline, scope, motivations, and outcomes of the application of public health policy concerning the needs of mothers and children.

This study will explore the British preoccupation with maternal and infant welfare in the colonial setting by examining measures taken to reduce mortality rates and to improve the health of mothers and children in British Nigeria from

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the beginning of these efforts in 1925 until 1945. By the end of World War II services for maternal and infant welfare were well established in the colony, and during postwar restructuring they were incorporated into a broader emphasis by the medical profession on providing preventive medicine and public health services for the Nigerian population. Within the particular colonial context of Nigeria the promotion of infant and maternal welfare was shaped by issues such as cultural, racial, and religious differences; the pace of medical Professionalization; the general education of the African population; and the degree of financial investment into colonial health. A study of the measures taken to reduce infant and maternal mortality in Nigeria provides insight into the attitudes of both the British colonizers of Nigeria and those of the indigenous population. As a major focus of colonial medicine outside of prevailing concerns with tropical disease, obstetric and pediatric care also serves as a window into British colonial policies regarding health care and medical practice.

The sources used to inform this study are the Annual Medical Reports: summaries provided by British colonial officials documenting yearly developments in medicine and health in each colony. Providing both statistics and accounts from medical officers working in the colony, the Annual Medical Reports present the chronological development of infant and maternal welfare services in Nigeria as well as British perspectives on this work. The obvious limitation, however, is the lack of an identifiable Nigerian perspective. In addition, the Annual Medical Reports often served as propaganda pieces for the British Empire and thus present only the officially sanctioned British outlook. What is apparent even from the incomplete evidence available is the diversity and negotiation present in the campaign. Even within the limitations of the Annual Medical Reports it is clear that the campaign for maternity care and children's medicine in Nigeria was not monolithic. In both the application of welfare services by health care professionals, whether European or African, and in the reception of these services by various sectors of the Nigerian population, the abiding image of the introduction of maternal and infant welfare in Nigeria was of variability in attitude and experience on both sides of the encounter.

The development of maternal and infant health services in Nigeria

After centuries of European contact through missionary activity and trade in both slaves and agricultural products the Niger delta region formally came under the political governance of Great Britain in 1900. The boundaries of the Lagos colony and the Northern and Southern Provinces of the Protectorate were established in 1914, and Sir Frederick Lugard was installed as the first governor of British Nigeria (NAGR 1927, 3).¹ Governed according to the British imperial

¹ Further administrative changes occurred in Nigeria in 1924, with the addition of the former German colony of Cameroon, and in 1939 with a final internal reorganization of the colony (Ekundare 1973).

system of indirect rule legislative councils served an advisory role to the governor and his executive in the south, while in the north Lugard relied on the co-operation of leading chiefs and Emirs to develop local conditions. With a land area three times the size of the United Kingdom and a population nearing twenty million during the interwar period, Nigeria was one of the largest and most populous of the British tropical dependencies. Nigeria was also ethnically diverse incorporating approximately 250 different ethnic groups within its borders. The primary ones included the predominantly Muslim Hausa of the Northern Province; the Yoruba near the capital, Lagos, and its surrounding region; and the Igbo in the southeast of the colony (Ekundare 1973). Nigeria's West African climate being regarded as dangerous to European health, it was not a settlement colony and European residents remained a tiny minority.²

The earliest colonial medical services in Nigeria were the nineteenth-century efforts to reduce the impact of tropical disease on those Europeans who did reside in West Africa: the "white man's grave" (Schram 1971). Early work was carried out primarily by medical missionaries and voluntary organizations such as the Lagos Ladies League, which was formed in 1901 under the leadership of Mrs. S. Williams. In 1902, the colonial government established the West African Medical Service and added a sanitary department to it in 1909. The Medical Officers in Nigeria at the turn of the century were concentrated in Lagos and focused their attention on controlling epidemics among the European military and government officials. It was not until World War I that the attention of the colonial medical service turned to addressing the needs of the African population and providing preventive medical care.³ Central to this preventive health effort was the provision of maternal and infant welfare services.

The first calls for infant and maternal services, prompted by the alarmingly high rates of infant mortality recorded for the African population of Lagos, are seen in the Annual Medical Reports for Nigeria from the early 1920s. Efforts to promote obstetric and pediatric medical services commenced in 1922 when the first Health Week and baby competition was organized by the Lagos town council (NAMR 1922, 19). In 1925 work began on a renovation of Lagos's Massey Street Dispensary to create a facility designed "with special provision for maternity, for women's and children's diseases" (NAMR 1925, 30). Supervised by the first Lady Medical Officer (LMO) appointed to practice in Nigeria, the Massey Street clinic contained a labour ward, a theatre for gynecological cases, a consulting room, dressing rooms for out-patients, and a venereal disease clinic. In its first two months of operation, three maternity cases were admitted and

² In 1927, for example, there were 4,000 Europeans, and 18,765,790 Africans in Nigeria (NAGR 1927, 2). The British emphasis of ethnic divisions during the colonial period has had significant consequences for independent Nigeria (Davis and Kalu-Nwivu 2001).

³ Historians suggest many reasons for this shift, including the African contribution in the war effort, a new recognition of the poor health of the natives, the economic value of the health of the African population, and an emerging ideology of the British "trusteeship" of Africa, which included a responsibility towards the people of the continent (Morgan 1980; Jeffries 1943).

more than 4,000 outpatients were treated at the clinic. Medical mission work devoted to maternal and infant care began in 1926 when the Sacred Heart Hospital in Abeokuta was converted into a maternity hospital and infant welfare clinic (NAMR 1926, 37).⁴

Throughout the interwar period maternal and infant health services continued to develop in Nigeria. Clinics provided key services to the community including regular visits by nurses and trained health visitors to new mothers, maternity care, infant health clinics, nutrition and food preparation demonstrations, and hygiene education for schoolchildren. Antenatal and childrearing advice was also combined with general public health education through posters, leaflets, and traveling cinema exhibits (NAMR 1932, 31). Health Weeks and baby shows became regular events in urban centres and in 1935 and 1939 Lagos won first prize in the Imperial Baby Challenge Shield Competition (*London Times*, July 3, 1935 and July 06, 1939). Many of the clinics also provided training for African midwives and nurses, and by 1937 there were 98 Africans registered under the Midwives Ordinance (Anon. 1937). In rural areas trained African nurses and health visitors working out of local dispensaries offered medical treatment, infant vaccinations, and health advice in the surrounding community (NAMR 1935, 4; Peacock 1936). The majority of maternity and infant health efforts in Nigeria were concentrated around Lagos, located in the south of the colony. In 1929 work was expanded to the Northern Provinces where Western medicine was only beginning to be accepted by the Muslim population.

The availability of maternal and infant health services in Nigeria during the interwar period was surpassed in British Sub-Saharan Africa only by that offered in Uganda and the Gold Coast (VanTol 2006). By 1936 there were a total of seventeen infant welfare clinics in the north of the colony and twenty in the south, which, when combined with medical missions providing these services, brought the number of recognized child welfare centres in Nigeria to a total of 94. At the Massey Street Dispensary in 1937 alone 198 infant welfare clinics were held, 3,697 infants were examined, and 41,836 health visits were made (Anon. 1937). Dramatic reductions in infant mortality rates, from a recorded 238.3 per thousand in 1925 to 128 per thousand by 1945, were attributed to the success of these antenatal and child welfare clinics and, in particular, to the unwavering efforts of both nurses and local women trained as health visitors in bringing health and hygiene advice to African mothers (NAMR 1928, 39; 1925, 12; 1945, 6). According to the assessment of the Annual Medical Reports, maternal and infant welfare services were perceived as fulfilling “a long felt want in the treatment of diseases in women and children” in Nigeria (NAMR 1926, 37).

Although the Annual Medical Reports for Nigeria expressed an optimistic

⁴ Except for the references to this work made in the Annual Medical Reports, the contribution of missionary medicine to infant and maternal welfare in Nigeria is largely outside of the scope of the present study. For an example of the significance of the missionary role see Jennings 2006.

outlook concerning the accomplishments in maternal and infant welfare, there was also recognition that the extent of this work was inadequate for the size of the colony. With an estimated population of 27.4 million by 1945 maternal and infant services could reach only a fraction of the Nigerian population. Furthermore, disparity existed between the north and south of colony, with the majority of the work happening in the south where less than half of the African population resided (NAGR 1927, 2). This inadequacy was not limited to maternal and infant health services. In 1927 there was only one hospital bed for every 14,000 Africans in Nigeria and by 1936 only 220 medical officers were practicing in the colony (NAMR 1927, 38; 1936, 3). Especially in the north many hospitals were still of the “bush variety”, where conditions existed that one medical officer characterized as “the fog of red mud, the debris of white ants and the unmentionable droppings off a mat roof”(NAMR 1919-1921, 26). Although recorded rates of infant mortality dropped dramatically, reliable statistics were available only for the capital of Lagos and its suburb, Ebute Metta. Even population figures were merely estimates; colonial officials possessed accurate statistical knowledge of less than 1% of the inhabitants of Nigeria (NAMR 1936, 7).

A primary constraint on the development of infant and maternal welfare services in Nigeria, as elsewhere in the British Empire, was limited financial resources. With attention to preventive medicine only beginning after World War I it was not long until the economic depression of the interwar period curtailed spending on medical staff and services in Nigeria. During the financial cutbacks of the 1930s spending on preventive rather than curative medicine was often difficult to justify. In 1935 it was observed that:

The enforced policy of economy and retrenchment has handicapped the Medical Services enormously during the past three or four years. Expansion has been impossible, and the problem to be solved has been which is the most important: research and preventive work, or curative and hospital treatment. To put it baldly, the latter is window dressing, and the former is economically in the long run the sounder policy. But hospitals are wonderful publicity, and in them the primitive African can see with his own eyes examples of, to him, miraculous cures. (Power 1935)

This emphasis on curative medicine was criticized by some contemporaries, and later by historians, as a major shortcoming of the British provision of medical services in colonial Africa (Blacklock 1936; Welch 1941; Schram 1971; Addae 1996). Although the 1932 Annual Medical Report stated that staff cuts to preventive health services would be avoided, by 1934 economizing measures such as the retrenchment of staff and a limiting of hospital improvements were required in all branches of the medical service (NAMR 1934, 6). The vacancy

created by the resignation of the Massy Street LMO was left unfilled, her duties taken on by a nurse and the Medical Officer of Health (NAMR 1932, 5; 1930, 31). Staff shortages were filled by trained African dispensers, nurses, and sanitary inspectors. This increasing reliance on indigenous personnel was further accelerated during World War II when military obligations severely depleted the European medical staff in the colonies (NAMR 1941, 1).

In 1945 the Nigerian medical services were reorganized as part of the ten-year development plan for the colony supported by the Colonial Development and Welfare Fund. The existing dispensary system was replaced by a web of central hospitals tied to outlying rural health centres, and there was an expansion of specialized services, including those for maternal and infant welfare. African medical personnel were trained, and restructuring gave a greater role in the medical affairs of the colonies to the Native Administration. In the lead up to decolonization the colonial government took on a supervisory role while local medical and health services were coordinated and carried out by the local Native Administration. Preventive medicine, including infant and maternal welfare, was central to these efforts (NAMR 1944, 7; 1948, 3).

The services for maternal and infant welfare introduced in British Nigeria between 1925 and 1945 were part of a widespread effort aimed at the reduction of infant and maternal mortality rates across the British Empire. An understanding of this concern for the health of mothers and babies goes beyond a mere factual description of the quantity and nature of the services provided; what is also essential is insight concerning the actors in this public health campaign. What were the perspectives of the British colonial servants in Nigeria and in particular the medical personnel, both British and Nigerian, responsible for the provision of maternal and infant welfare services? And what was the reaction of those at the receiving end of these efforts? Perhaps more historically significant than the rationale of British medical and health policy was the actual application of that policy “on the ground” in the colonial setting.

Perspectives on the provision of maternal and infant health care in Nigeria

Medical policy making and its applications within the colonies was far from uniform throughout the British Empire. Indeed, Margaret Jones has described “a multiplicity of actors at both centre and periphery” as responsible for shaping colonial medicine (Jones 2004). Before the Colonial Development and Welfare Fund of 1940, limited financial links between the metropole and the colonies meant that the Colonial Office in London functioned in an advisory role only. Medical policy making was largely left to the discretion of the government of each colony. As a result, there was little control by the imperial government in policy transfers. Instead, “what was salient was the indirect transfer of policies and practices through the people who chose to work in the colonies” (Jones 2004; Deacon 2000). In Nigeria opinions concerning the value of specific

attention to the medical and educational needs of indigenous mothers and babies varied, as did individual attitudes towards the Nigerian population. It was the individual outlook of medical professionals which shaped the provision of services for infant and maternal welfare work in the colony.

Assertions of the significance of maternal and infant welfare work were common in the Annual Medical Reports during the interwar period, often in the form of criticism of traditional childbirth practices. Dr. G.M. Gray, a British medical officer practicing in Nigeria, observed that “parturition as a general rule occurs much more easily and naturally in the African negro than in Europeans, nevertheless, protracted labour does occur not infrequently” (NAMR 1926, 67). Skilled assistance was essential in this case, because when complications could not be handled adequately, “the condition of the patient lacking the amenities of civilization becomes such that she is a misery to herself and a nuisance to her relatives and becomes in fact an outcast” (NAMR 1926, 67). In 1934, graphic descriptions of childbirth emergencies “made worse by the local application of native drugs and even efforts at manipulation by the more daring medicine men” were cited (NAMR 1934, 30). Readers were assured, however, that:

with increased education and the passing of the older generation much improvement may be expected to follow. Increasing ante-natal care should do much to ameliorate the wholesale use of native drugs and thus save in this province alone hundreds of maternal lives. (NAMR 1934, 30)

There was not unanimous agreement that introducing Western obstetric and pediatric practice was the appropriate policy to pursue. When Dr. Mary Blacklock proposed a survey of education and health among women in the colonies in 1930, there was disagreement in the Colonial Office concerning the value of such an effort. Blacklock was distinctly unwelcome in the West African colonies where it was suggested that real health problems took precedence over the education of African mothers (TNA: PRO CO 323/1331/11). During her investigation of the conditions of Igbo women in the mid-1930s, Sylvia Leith-Ross, a former colonial officer, applauded the work of local medical practitioners, or *dibias*, and wrote with admiration concerning indigenous methods for the treatment and care of new mothers and children in the various communities she visited (Leith-Ross 1965).⁵ With the exception of curative medicine for children, Leith-Ross recommended caution in the introduction of Western childbirth and childrearing practices, which she perceived as both largely unnecessary and potentially disruptive.

The attitudes of welfare workers towards the indigenous population also varied. British nurses were often at the front lines of maternal and infant welfare work. Letters received by the Overseas Nursing Association (ONA) from British

⁵ Although not a medical officer, Leith-Ross was a former member of the Education Department in Northern Nigeria and spent the majority of her life devoted to work in the colony.

nurses stationed in the colonies offer some insight into their individual perspectives. In many cases imperialist attitudes were displayed in this correspondence. For example, in 1925, Mary Lucas, a British nurse stationed in Calabar, Nigeria, described her work training African nurses as:

a job more suitable to a direct descendant of Job than an ordinary individual. It requires patience and again patience and then more patience for at least eight good hours every day. (ONA 140/1/35)

Lucas also explained that: "I have acquired the view that things we don't like are very good for us! Hope so—for lots of opportunity for that here" (ONA 140/1/35). British medical personnel were not uniformly disparaging, however, rather there is also evidence of a more complex attitude towards indigenous populations. Dr. Greta Lowe-Jellicoe, who was one of the first LMOs in the colony and the pioneer of maternal and infant welfare work in northern Nigeria, remembered her time there fondly (Callaway 1987). Flexibility and co-operation were regarded by contemporaries as imperative to the successful delivery of preventive health services. When the ONA sought nursing candidates for government services in the colonies they looked for women who possessed "open hearts and the will to serve," and who would approach indigenous customs with "tact and patience" (ONA 120/1/156). For Western medical services, especially those involving the intimate spheres of reproduction and childrearing, to be received by the local community European medical personnel had to appeal to the indigenous population (Jennings 2006). Successful medical personnel were judged to be those who:

equipped themselves with a knowledge of the social organization and culture of the people among whom they work, and have endeavoured to understand the meaning of some of the ceremonies, customs, treatments, and discomforts locally associated with childbirth. (Edge 1937)

Progress made in the colonies in the area of maternal and infant welfare was attributed to "the exercise of unbelievable patience, persistence, tact, sympathy, and respect for the beliefs and prejudices of the people concerned" (Edge 1937). The reception of maternal and infant welfare services could depend on the personality of the individual in charge of the infant welfare clinic or antenatal lecture.

In Nigeria, the African response to the work of Ms. McCotter, a British nurse, continually astonished the writer of the Annual Medical Reports. Attendance figures for her infant welfare clinics in Abeokuta, begun in 1929 averaged 410 African mothers per day by 1933, for a total of 126,525 attendances that year

(NAMR 1933, 25). It is likely that her success was due to her personality and individual response to the African mothers. In Ondo Province maternal and infant welfare work was described in 1940 as “an outstanding example of what can be accomplished in a few years by an enthusiastic Medical Officer” (NAMR 1940, 10). Colonial medical staff were also willing and able to negotiate with the indigenous population in the services provided. The ongoing challenges faced in northern Nigeria where preventive medicine for mothers and children was not well-received among the primarily Muslim population prompted the LMO and British nurse active in these communities to adapt their services to local customs. Home visits brought medical services to *purdah* women who were unable to leave their houses, and beginning in 1943 “Dusk Clinics” allowed them attend infant welfare and antenatal sessions under the cover of darkness (NAMR 1943, 7). There is also evidence that elsewhere in British colonial Africa clinics accommodated the demand for curative rather than preventive health services for children. In the Gold Coast, for example, Dr. Cicely Williams was instrumental in maintaining the curative services offered at local infant clinics. Although the mandate of public health care policy for women and children remained educative, where ever possible Williams insisted on providing medical treatment together with advice for African mothers: a significant concession to indigenous preference (Addae 1996).

British medical officers and nurses were not the only personnel responsible for the provision of maternal and infant health services in the colonies. A considerable role was also played by Western-educated African midwives and nurses in this work. The education of indigenous medical staff was an integral component of infant and maternal welfare work, and in 1934 there were 484 African nurses of various levels of training in Nigeria (NAMR 1934, 4). By 1947 the total number of registered African midwives in the colony was nearing 1000 (NAMR 1947, 5). Colonial midwifery and nurse training programs have been criticized by historians for their efforts to produce Western-educated indigenous medical personnel who would then contribute to the undermining of local structures of medical authority (Holden 1991; Forbes 1994; Allen 2002). In reality, the situation of trained African nurses and midwives was more problematic.

These women receive little coverage in the Annual Medical Reports, and in the particular case of interwar Nigeria they remain inaccessible from the currently available source material. In French West Africa a suggestion of the perspective of at least one such indigenous health worker is presented by Jane Turittin in her study of *Femme d’Afrique*, the autobiography of Aoua Kéïta, a Western-trained midwife. Turittin describes the role of Western-educated Africans (*évolués*) as a challenging one:

Her life story illustrates the dilemmas experiences by évolué women who struggled to reconcile the habits imparted to them by the colonial education system with the African values to which

they were socialized as children. (Turritin 2002)

Unable to accept in entirety either African traditions or European colonialism and patriarchy Kéïta faced both resistance from the African women she worked among and discrimination within the European-dominated medical service. Her position was a contradictory one as she sought to promote a Western style of childbirth while at the same time actively resisting imperial domination. In the Belgian Congo historian Nancy Rose Hunt noted that local African midwives trained at mission centres were often far more effective childbirth attendants than British nurses. Although converts to Christianity and practitioners of Western medicine these women were not unwilling to incorporate local customs and beliefs into their birth rituals in order to legitimize their work (Hunt 1999). By merging old and new knowledge African midwives played a critical role in the acceptance of medicalized childbirth in the community. Occupying a position midway between Western and traditional medical systems, trained African nurses and midwives represent what has been described as the most basic tension of empire: the blurred distinction between the colonizer and the colonized (Cooper and Stoler 1997).

The limitations of infant and maternal welfare services in the colonial setting during the interwar period have been ascribed to the “cultural chauvinism and paternalistic attitudes” among the British welfare workers that kept them “from entering the hearts and minds of urban African women” (Hansen 1992).⁶ Certainly in Nigeria there are numerous examples of racist assumptions on the part of British medical officers, nurses, and observers. Other scholars, however, have emphasized instead that colonial employees cannot be assumed to have been mere agents of empire (Jones 2004; Cooper and Stoler 1997; Deacon 2000). Medical officers, nurses, midwives, and health visitors, whether European or indigenous, were individuals with unique perspectives and attitudes toward their work. The nature of colonial medical services, including those for maternal and infant health, whether harsh, coercive, and racist or welcoming and positive, was directly influenced by the attitudes and outlook of the colonial medical personnel delivering them.

The Nigerian reception of educative and medical services for maternal and infant health

Both the availability of maternal and infant welfare services in an area, as well as the individual personalities of the welfare workers present, played a role in the African reception of colonial medicine. Responses varied considerably across time and space as African mothers came to their own decision of how,

⁶ This is also consistent with criticisms of the campaign in the metropole, where class consciousness alienated the middle class welfare workers from the recipients of their efforts. See, for example, Lewis 1980.

when, and for what purpose they would make use of infant and maternal welfare services, if they did at all. Although the perspectives of Nigerian women and children is limited by the present lack of identified African sources the Annual Medical Reports provide something of a window into the variety which existed. British colonial officers noted that the diversity of the indigenous population of Nigeria had an impact on the reception of services for maternal and infant welfare across the colony. According to Dr. M. Cameron-Blair, Deputy Director of Sanitary Services for Nigeria between 1921 and 1924,

The indigenous Natives of Nigeria taken collectively, constitute one of the most heterogeneous communities in the world. In degrees of civilization, in stages of evolution and of devolution, in religion, manner, law and custom, in language, in everything which can separate one group from another, they differ with one another. (NAMR 1922, 46)

As a consequence of this he explained, in attempts to convince Africans of the benefits of Western medicine, “some may be led; others may be influenced by persuasion; some can be driven; and many cannot be influenced at all” (NAMR 1922, 46). In Nigeria the responses of African women to the introduction of maternal and infant welfare services included outright rejection, acceptance, and, probably the most prevalent, accommodation.

Resistance to British maternity services and infant welfare work was most apparent in the Northern Provinces. Discussion of these challenges provided a clear contrast to the generally optimistic tone of the Annual Medical Reports for Nigeria during the interwar period. British observers blamed the slow acceptance of the services on Muslim conservatism and the *purdah* restrictions of the Hausa women (NAMR 1944, 5). From the start fears were expressed that the lack of education would make development difficult and this proved to be the case. Few local women were available for training as nurses or midwives and the Hausa were unwilling to seek antenatal and childcare advice from the LMO and British nurse (NAMR 1931, 36). There is an indication, however, that this rejection was not complete. Rather, the women made use of those services that they saw as useful. The Annual Medical Reports described increasing use of hospital medical services by women and attendance at the “Dusk Clinics” for infant medical needs (NAMR 1943, 7). Hausa women did not reject all Western medicine, only that which was not perceived as valuable or which conflicted with their cultural norms: primarily the educational aspects of this work (Wall 1998).

A further complication not disclosed in the Annual Medical Reports but noted by historians was the effort of the colonial government to uphold the prevalence of Islamic religion and political authority in Northern Nigeria (Barnes 1995; Shankar 2007). Since the maintenance of Muslim authority structures was advantageous to the British system of indirect rule, colonial officers limited the activities of missionaries in bringing not only the Christian religion but also

Western education and medicine to the Northern Provinces. Thus, in cases where Western medicine was introduced its acceptance depended on the support of the local Emir. According to a recent analysis by Shobana Shankar of the 1938 leprosy campaign in Hausaland, contrary to the colonial presentation of Muslim leaders as conservative Emirs promoted Western medicine for the sake of its social and political potential in order to gain “moral authority as enlightened leaders over a diverse body of subjects” (Shankar 2007). Shankar also observed, however, that “the missionaries’ attempts to extend their power beyond medicine into child-rearing and religious education rankled” (Shankar 2007). As with Hausa women the support of local leaders for new medical and health services was by no means unconditional.

Although in reality access to and acceptance of infant and maternal welfare services varied, in Southern Nigeria and especially in the Lagos region the Annual Medical Reports declared success in convincing the population of the value of this work. On some occasions the introduction of this branch of public health was not a colonial imposition but rather an accommodation of requests for these services by indigenous leaders and local populations. As in the north, African leaders were often in favour of public health measures because of their contribution to economic development (NAMR 1927, 3; 1928, 31). In 1943 the Annual Medical Report observed that maternal and infant welfare work “is widespread through the country and is the result of pressure and appeals from the indigenous population” (NAMR 1943, 7). Demands for these services far exceeded the staff and facilities available and dealing with the flood of patients became a growing concern. In 1938 it was reported that:

The continued rapid expansion of child welfare and maternity work is one of the most satisfactory features of health activities in Nigeria. The rapidity with which it is possible in a new area to develop such services has to be observed to be believed, and it is not only in the larger centres where the people have long been aware of the benefits of western medicine that success is attained. (NAMR 1938, 21)

For some Africans Western medical and childbirth techniques offered positive health benefits, or an appealing alternative to traditional birthing rituals (Vaughan 1991). In other cases the use of British maternal and infant welfare services could have been more than a logical calculation of health benefits. Individual relationships with European medical personnel and social or class pressure may have contributed to the African acceptance of services. Meghan Vaughan has noted that welfare clinics were especially popular with Africans who had attended mission schools, and that by the 1930s baby shows, hospital deliveries, and “modern” childcare practices were part of an emerging urban,

middle-class culture in Nigeria. The utilization of maternity and infant services became a status symbol among African women and was also encouraged by husbands, who on occasion expressed frustration about their wives' stubbornness in adherence to traditional birthing practices (Vaughan 1991).

The positive response to maternal and infant welfare services in Southern Nigeria, however, does not necessarily indicate wholesale absorption of Western medical ideology on the part of Africans. Rather both healers and patients were "active and creative, altering received knowledge and practice, on a quest for original knowledge" (Fierman and Janzen 1992). It was the educative aspect of infant and maternal welfare services delivered through the work of the health visitors at antenatal clinics and public health lectures that was the least popular component of this effort. African mothers made use of infant welfare clinics for the curative services they offered for particular children's medical concerns, while they remained less interested in British attempts to provide health education emphasizing European motherhood ideals (NAMR 1938, 21; for example). It is probable that Africans made use of the Western medical services that could fill a perceived need in their own health and the health of their children.

Evidence for active participation and decision making by Africans in their own health concerns rather than mere submission to Western medical ideology is also suggested by the continuing presence of traditional childbirth practices in interwar Nigeria. Although indigenous medicine may have been disrupted by European midwifery and medical services it was certainly not eliminated. Even in the post-war era the Annual Medical Reports commented on the persistence of traditional medicine and birthing techniques. According to statistics collected by health visitors, by far the majority of births in Lagos were attended by "native medicine men" rather than Western-trained medical practitioners.⁷ Difficult labours were taken to maternity hospitals often only after traditional medicine had been unable to bring relief (NAMR 1934, 24). African nurses and midwives trained in Western techniques experienced difficulties in finding work and integrating into local communities. As Luise White has suggested, there are "tantalizing hints" that in colonial Africa "aspects of western biomedicine were unpacked, examined, accepted and reinterpreted according to local meanings" (White 1995).⁸ Although evidence for local interpretation and the varieties of patient experience in the particular context of Nigeria remains scarce, that it may be unearthed is suggested by the work of historians and anthropologists in other areas of Africa (Hunt 1999; Livingston 2005). In many cases the influence of Western services may have altered rather than replaced African medical practice and belief. In this way to even describe the variety of indigenous responses to colonial medicine is an over-simplification as Africans were also

⁷ This assertion is based on the tables provided from time to time in the Annual Medical Reports, showing various statistics for the infant welfare clinics in Lagos and Ebute Metta (NAMR 1936, 42; for example).

⁸ The pluralism of medical care in colonial Africa is also discussed in Digby 2006.

pro-active, rather than merely reactive, in dealing with the new health possibilities presented by Western medicine (Worboys 2000).

In the imperial context emphasis in reporting was given to the positive reception of the indigenous population to the benefits of Western medicine. This sentiment dominated the Annual Medical Reports, which, not only fact sheets for the colony, often became progress reports for achievements within the empire as a whole. While development was often perceived to be slow as a consequence of African conservatism or “ignorance”, in general Africans were characterized as at least gradually recognizing the inherent superiority of Western treatments and techniques. In reaction to this image postcolonial historians have emphasized African resistance to and rejection of Western medicine and their continued practice of traditional healing methods and beliefs (Engels and Marks 1994; for example). It has also been argued, however, that this focus on resistance in fact limits our appreciation of indigenous agency and “does not capture the dynamics of either side of the encounter, or how those sides were drawn” (Cooper and Stoler 1997). Margaret Jones has argued that because discussions of indigenous resistance take place within an interpretation of the oppressive nature of colonial health policy, “there is a danger that the ambiguities of its legacies will be lost in an overall critique which obscures the very different experiences of colonized peoples” (Jones 2004). The case of maternal and children’s welfare in Nigeria indeed presents a reality more multifaceted than either side of the prevailing historiography would suggest.

The design of British imperial public health services: why maternal and infant welfare?

Why was infant and maternal health such a concern in interwar Nigeria that the state needed to intervene? Historians emphasize that the campaign to reduce infant and maternal mortality was motivated by the demographic concerns of the twentieth century. In Nigeria high levels of infant mortality were first identified in the Annual Medical Reports in 1922 when a rate of 290.5 deaths per thousand live births was recorded for Lagos. These conditions were thought to extend to the rest of the colony as well in spite of the fact that no statistics were available outside of the capital region. Even within Lagos infant mortality rates were of questionable accuracy throughout the interwar period.⁹ Besides the occasional emergency or abnormal labour encountered in African hospitals in the urban centres European medical personnel had limited exposure to African experiences with childbirth (NAMR 1919-1921, 26–7).

According to some historians, the British introduction of services for maternal and infant welfare in spite of their lack of accurate knowledge about

⁹ The inaccuracy of statistics was a disclaimer provided in virtually every Annual Medical Report throughout the period. For an example of contemporary commentary on this issue and its causes see Edge 1937.

colonial demographics was part of an imperial agenda designed to improve the colonial labour supply, pacify indigenous populations, and promote modernization.¹⁰ From this perspective attention to the education of African mothers was rooted in British notions of racial and cultural superiority and a resultant desire to uproot sensitive indigenous traditions surrounding childbirth and care in order to replace them with Western norms and morality (Summers 1991; Musisi 2002). Recently, however, Margaret Jones has argued instead that the public health strategies of colonial administrators may aptly be placed within the perspective of contemporary developments in Britain. Parallels in motivations, methods, controversies, and outcomes exist between the extension of state intervention into public health in both Britain and its empire (Jones 2004).

In Britain preventive medicine, including maternal and infant welfare, became a prominent social and medical concern in the early twentieth century following the discovery of poor levels of health and fitness among young men being recruited to fight in the Boer War (Lewis 1980). This concern was publicized as a national crisis and solutions were demanded from the government within the rhetoric of nationalist concerns about the preservation of the race (Davin 1997). Following World War I imperial rhetoric focused on a dual mandate: the duty to bring the advantages of Western civilization to colonial possessions and the development these areas for the benefit of the world (Gale 1976). In determining what policies to apply in the colonies it was logical that physicians and politicians, imbued with notions of the crisis of under-population and the revolutionary significance of preventive medicine that were prevalent in Britain, would assume that these concerns were also relevant to the colonial setting (Jones 2004).

As the problem was the same so was the solution; in both Britain and Nigeria education formed the foundation of infant and maternal welfare services. Education addressed the “ignorance, neglect, and preventable disease” identified as the primary factors contributing to high rates of infant mortality (NAMR 1936, 10). Condemnation of “unskilled interference by unqualified handy-women” in the Annual Medical Reports was consistent with the emphasis on trained care, and moving labour and delivery from the home to the hospital in Britain (NAMR 1936, 11). Challenges not encountered in Britain, such as the custom of the murder of twins and unwanted infants, would also be overcome through education (NAMR 1927, 38). Welfare clinics served as training centres for African nurses and midwives and as meeting places for lectures on proper food preparation, antenatal care, management of children, and basic principles of hygiene and sanitation. For mothers and expectant women who were unwilling or unable to attend the clinics home visitors ensured that they too received this information (NAMR 1929, 34).

Prior to World War II there was a growing consciousness of another cause of

¹⁰ For this argument see Summers 1991; Lasker, 1977. An alternate interpretation of the relationship between economics, politics, and health may be found in Bell 1999.

poor nutrition and high infant mortality in Britain: poor living conditions. This too became part of the rhetoric of the Annual Medical Reports for Nigeria. The LMO at Massey Street stated in 1929 that high mortality rates could in part be attributed to the fact that 75 percent of women in Lagos were engaged in trade, making proper antenatal and infant care a challenge (NAMR 1929, 34). Besides inferior midwifery techniques and maternal ignorance, the “overcrowding and unhygienic conditions still met with in many parts of Lagos” undoubtedly contributed to high rates of mortality (NAMR 1936, 11).¹¹ In spite of this recognition, however, education was still emphasized as the primary solution. The view of policy makers remained that infant mortality in both Britain and the empire was “a failure of motherhood” (Lewis 1980). In both the centre and the periphery efforts to reduce mortality were conducted within a top-down approach to health and welfare. Although in the colonies the additional dimension of race certainly complicated historical interpretation, the approach taken to infant mortality by the British was not in the first place a consequence of racial stereotyping.

One element of the British discourse on preventive medicine and maternal and infant welfare that was not transferred Nigeria was the rhetoric of racial degeneration. This had been central to earlier colonial campaigns, such as the missionary efforts in Uganda begun in 1919. In that case the preservation of the Baganda population was cited as the key justification for the beginning of maternity work (Musisi 2002). Although this rhetoric still existed by the time attention was drawn to infant mortality in Nigeria in the mid-1920s, it was far less apparent.¹² Perhaps simply a consequence of the time delay in the transfer of policy, the limited discussion of population maintenance suggests that the British in Nigeria were concerned less with justification of their efforts and more with the manner in which they would bring about improvements to infant and maternal mortality rates in the colony.¹³

Medical policies for the empire, including maternal and infant health and welfare, were made within the contemporary understanding of medicine and health in Britain. If these policies were inherently coercive and bound to fail in the colonial setting the same could be said for the metropole. Maternal and health services in Nigeria were based on policies transferred to the colony from Britain. According to Jones, “that individuals and governments chose to implement policies which had apparently brought improvements in their own

¹¹ For additional comments regarding this issue, see NAMR 1926, 67; 1932, 109.

¹² In 1926, for example, William Ormsby-Gore, Member of Parliament and later the Secretary of State for the Colonies, described Nigeria’s wide open spaces: an emptiness caused by high mortality, and a problem requiring a solution so that colonial labour supply and economic development would be improved (Ormsby-Gore 1926).

¹³ For a discussion of variety in British responses to colonial fertility and mortality, see Fierman and Janzen, 1992.

society was understandable and by no means reprehensible" (Jones 2004). The identification of high rates of infant mortality in Nigeria required a response from the British colonial government. The services for infant and maternal welfare developed during the interwar period were those that were identified by the medical officers as the most appropriate solution to the perceived crisis, and not simply the means to reach an imperial objective.

Conclusion

The legacy of the twenty years of maternal and infant welfare services in Nigeria examined in this paper is a mixed one. It has been suggested that as a direct transfer of ideas from the centre preventive health measures in the colonial setting should ultimately be judged on the same criterion as those of the metropole: their ability to improve public health (Jones 2004). For Nigeria, while positive and substantial health benefits are plausible they are difficult to substantiate. According to the Annual Medical Reports the success of maternal and infant welfare services was clear. Infant mortality rates in the Lagos region dropped steadily from 296.3 deaths per thousand live births in 1919 to 134.1 in 1929, 127 in 1939, and 104 by 1949.¹⁴ This drop was of course attributed to the benefits of the public health services put into place (NAMR 1928, 17). The difficulty in drawing any firm conclusions from this data, however, is due to the questionable accuracy and relevance of these figures. At independence, Nigeria, with a population nearing 55 million, inherited a medical system which included 24 maternity centres in the capital of Lagos alone as well as 373 in the east, 387 in the west, and 55 in the north (Ekundare 1973). This was an allocation of services which was in no way reflective of the African population distribution of Nigeria. These clinics made new health options available to at least some of the indigenous population, however, and for those Africans able and willing to take advantage of these services it is possible that at least some of their experiences were positive ones. In addition, as a positive consequence of colonial efforts attention to issues of reproductive health and children's medicine have precedence in modern Nigeria.

The introduction of maternal and infant welfare services in Nigeria was part of a larger imperial public health initiative of the interwar period. Maternal and infant welfare provides an important window into imperial medicine beyond perpetual concerns for tropical disease. This case can thus be integrated into the broader history of colonial medicine and demography. Regarded by imperialists as a visible sign of the benevolence of empire and a legitimization of the West's civilizing project, historians have, since the 1970s, severely criticized the application of Western medicine in the colonial context. Far from a benign element of colonialism, the imposition of Western medical principles and

¹⁴ Figures for maternal mortality, on the other hand, were more complex: characterized by fluctuation rather than steady decline, and with only a slight overall decrease from 8.9 per thousand in 1934 to 7.76 by 1952. For a discussion of the challenges of collecting statistics for maternal mortality, see NAMR 1936, 11.

techniques as well as their accompanying ideology of scientific objectivity came to be viewed as something more pervasive than straightforward imperial political and economic policy making and with a, perhaps, more damaging and enduring legacy (Arnold 1988; Engels and Marks 1994; MacLeod and Lewis 1988). Within this criticism preventive health measures to reduce levels of indigenous infant and maternal mortality have, because of their reach into the intimate lives of colonial subjects, received attention as a particularly oppressive component of colonial medicine.

More recent scholarship, however, has called into question this image of the strictly hegemonic nature of colonial medical practices, including maternal and infant welfare policies, emphasizing instead its nuances (Bell 1999; Jones 2004; Deacon 2000; Worboys 2000; Jennings 2006). While the postcolonial critique has effectively demythologized perceptions of the superior and beneficial nature of Western medicine it may also have obscured important concepts concerning the limits and tensions of empire. It has been observed that the legacy of colonial medicine presents a “catch-22” for scholars: Western medicine was a negative force in the colonial setting and, at the same time, indigenous populations have been disadvantaged by their limited access to modern medical care (Deacon 2000). According to Harriet Deacon the necessary solution is to perceive the reality of a dynamic relationship between Western medicine and indigenous populations and to investigate ways in which Western medicine was both useful and at the same time politically, economically and culturally loaded within the colonial setting.

An image of variability and negotiation rather than hegemony and domination in the introduction of maternal and infant welfare in Nigeria is not intended as an apologetic for colonialism. Indeed, as Meghan Vaughan has recently argued, “it is precisely this combination of patchy violent intervention...*and* skeletal administration, shallow hegemony and economic neglect which has produced such a difficult inheritance for contemporary Africans” (Vaughan 2006).¹⁵ Although her argument concerns economic conditions it is also relevant to imperial provisions for public health. The limited and uneven nature of services and the ambiguity of their reception while undermining notions of domination may also be an indictment of the “imperial project”. In any case, identifying negotiation within the colonial encounter contributes to a picture of hybridization and the limitations of empire and, as such, offers the potential for a more complete understanding of Africa, both past and present.

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¹⁵ Emphasis original.

Abbreviations

NAGR	Nigeria Annual General Report
NAMR	Nigeria Annual Medical Report ¹⁶
ONA	Overseas Nursing Association
TNA: PRO	The National Archives: Public Record Office

Reference List

Government publications:

- Nigeria Annual General Report for 1927. (HMSO, 1928).
- Nigeria Annual Medical and Sanitary Reports for 1919-1921; 1922; 1925-1935. Lagos: Government Printer, 1922-36.
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¹⁶ The NAMR abbreviation is used throughout to refer to the series of reports concerning the state of medical and sanitary services in Nigeria which were printed annually by the British administration under various similar titles. Because publication dates are often missing from these reports, the date provided in the in-text citation refers to the title date, rather than year of publication. The published titles of the individual reports are given in References.

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