A SOCIAL HISTORY OF MIDWIFERY PRACTICES IN COLONIAL IBADAN, NIGERIA, 1893 - 1960

BY

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CONTENTS

Abstract

This thesis examines the introduction and development of western medical practices in colonial spaces with particular reference to midwifery practices in colonial Ibadan, Nigeria, from 1893 to 1960. This has become necessary because of the importance placed on childbirth and maternal healthcare in the twentieth century. The trends and changes in midwifery and midwifery practices in colonial Ibadan are seen as reflections of other transformations in British African colonies at large.

The study begins with a detailed historical analysis of the major metropolitan and local factors that informed the introduction and development of Western obstetrics in colonial Ibadan, Nigeria. It proceeds to examine the development of Western midwifery practices in colonial Ibadan; highlighting the contributions of the Ibadan people to the development of Western midwifery practices and emphasizing policies affecting development, and implementation of Western obstetrics. The thesis goes further to reveal the prejudiced nature of colonial medical policies, and the ways it shaped various responses especially from rural folks who were particularly marginalized since the 1920s when maternal healthcare policies was implemented in the urban areas till the 1950s when a reformed policy for rural medical service scheme was introduced to the rural folks. Thus, influencing the ways they imagined and appropriated ideas of western obstetrics alongside African traditional midwifery practices. The idea is to demonstrate in this thesis the extent to which the precincts in colonial medical policies, most especially the establishment of maternity hospitals, clinics and dispensaries, and the institutionalization of western obstetrics, inspired critical and ingenious responses from colonial doctors, colonial officials, the missionaries, patients, African trained midwives, traditional medical practitioners and the African population in general.

Placing all of these historical events within a wider context, this thesis borrows insights from the social history of medicine in an attempt to reconstruct the colonial medical practices in Ibadan, Nigeria, through the sites of midwifery practices and maternal welfare services from 1893 to 1960. This is in addition to its dependence on a comparatively rich, but skewed historical evidence, including a plethora of annual medical reports, official reports of the department of medical and sanitary services, official correspondences within the colonial government in Ibadan and Nigeria, and between the colonial government and the colonial office in the United Kingdom. Details of African responses to medical policies were garnered from oral testimonies, newspaper publications and correspondences between the African public and the colonial government in Ibadan. In exploring this historical evidence, the thesis reveals very interesting details of colonial perceptions about African health and their underlining motives for introducing western medical ideas, the various medical schemes and policies used in driving colonial interest and the ways Africans imagined, re-imagined, and appropriated Western medical practices.

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CHAPTER ONE

Introduction

The introduction and institutionalization of Western Midwifery practices in colonial Ibadan, Nigeria, from 1893 to 1960, can be traced to the period marked by increased maternal and infant mortalities and the need for population growth in British African colonies.[1]At this time, the British colonial government had become anxious about the health of its colonial subjects, and by extension its implication on labour supply for the development of the colonial economy.[2]Thus, as a means to ameliorating this social and economic challenge posed by the increased maternal and infant mortality in the British colonies, the colonial state sort ways at revamping and replacing the African Traditional Midwifery practices which at the time, was believed to be the major cause of maternal and infant mortality with Western Midwifery practices.[3]

This thesis therefore, seeks to investigate the ways in which the colonial pejorative notions of African Traditional Midwifery practices laid the foundation for the reinvention and the institutionalization of Western Midwifery practice, through the implementation of various maternal and infant healthcare policies and establishment of hospital based maternity services, training of Africans to become midwives, training and inducting traditional midwives into the colonial medical system, educating African women on hygiene and basic midwifery knowledge, amongst others that started officially in colonial Ibadan in the 1920s through 1960.

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[1]Roy Macleod, "Preface," in, *Disease, Medicine, and Empire: Perspectives on Western Medicine and the Experience of European Expansion*, eds. Roy MacLeod and Milton Lewis (London: 1988) p.x

[2]Ralph Schram,*A history of the Nigeria health services*, (Ibadan: Ibadan University Press, 1971) ; Meghan Vaughan.*Curing their ills: Colonial power and African illness*,(California: Stanford University Press, 1991).

[3] Anna Davin, 'Imperialism and Motherhood' ,*History Workshop Journal*5, (1978): 9-65

A crucial point this study seeks to fill in historical research and provoke more scholarship on the subject, is how maternal and infant healthcare and midwifery practices were selected as specific areas of healthcare intervention. This is because, one, the missionaries conceived of them as a much easier path to spreading the gospel without any inhibition, and two, as a least resistance way for the British colonial government to achieve full socio-economic and political control.

While this thesis focuses on the various transformative stages of midwifery practices in colonial Ibadan, it would also make a detour in its dialogue, to analyze and draw attention to the reactions of the Ibadan people to the developments in maternal and infant healthcare services and midwifery practices during the colonial period. This aspect of this study will contribute to African historiography in a number of ways. Firstly, it will show how Africans were never dormant as suggested by Eurocentric scholars[4], but actively involved in the socio-economic and political development of their societies during the colonial period, and secondly, it will reveal how such activeness gave Africans a much louder and united voice and a much greater role in the development of the colonial state. In addition, by initiating a discuss on the different ways in which Africans responded to the introduction of western medical practices, specifically the experiences of the Ibadan people to western obstetrics, this thesis incorporates Africans perspectives into historical narratives, thus, availing an opportunity in historicizing Africans experiences and responses during colonial rule. Again, the study will join a number of recent scholarly works that have shown Africans active participation in the making of their history; not

[4]African colonies were left psychologically, economically, culturally, politically, and in other ways irreparably damaged by the dialectical inter-phase that happened throughout European colonization. The idea that a group of people who had been raped and decimated could contribute to the advancement and modernization of Africa proved difficult for European colonialists and Eurocentric scholars to accept. See G.W.F. Hegel, *Philosophy of History*, (New York: Willey Books, 1964), 9; David Hume, *Essays on National Characters*, (Middlesex: Penguin books, 1969), 208.

as dormant onlookers of historical events that shaped the African continent as some Eurocentric scholars have portrayed.

Therefore, in an attempt to analyzing the colonizers attempt at colonizing midwifery practice as a historical process of negotiations and contestations, this thesis differs from other scholarly works that tend to view colonial rule only from the angle of empire or in terms of colonial hostile takeover of Africa and African violent reactionary history. These interpretations of colonial history, fail to unearth the complexities involving the combination of the two dissimilar cultures and the ways in which the colonizers and Africans contested and negotiated to get what they wanted out of each other. Moreover, many of the existing literature have ignored the broader context of Africans' history as essential in explaining colonial midwifery politics and the reasons that made Africans intervened in the colonial health policies that affected them. Thus, one of the purposes of this thesis is to attempt to address some of these concerns while it gives answers to a number of questions, for instance;

a) How did Africans encounter and contest Western midwifery practices?
b) How did such contestations precipitate a sort of hybridity of dissimilar worldviews in the colonial empire?
c) What was the imperial justification for such a hybridity?
d) What was the position of local agencies in the medicalisation of colonial Ibadan?

Lastly, I have situated this dissertation in the periods beginning from 1893, when Ibadan became a colony under the British government and 1960, when Nigeria gained her independence and marked the end of colonial rule. I have limited myself to this timeframe because it embodied the highest period of maternal and infant mortality in colonial historiography, and a time maternal and infant healthcare received the most attention from colonial government as well as the period in which the missionaries and the colonial government expressed great concern on maternal and

infant mortality. In emphasizing the social, economic, and political underpinning of the introduction of western obstetrics in colonial Ibadan, this study joins a limited but significant number of studies on health and healing in Africa that examines the complexities in the history of colonialism and the struggles over modernity and traditions, and over population growth, health and politics.

Midwifery Practices and the Colonial State: The Historiographical Debates

The parameters of this thesis are shaped and set within the context of twentieth century colonized African. In this setting, the traditional healing and health practices of Africans became an issue of contestation and appropriation of western biomedicine and biomedical practices – particularly in the areas of midwifery and midwifery practices. At the beginning of the twentieth century, increase in maternal and infant mortality rates became a major concern in Britain and its colonial territories. There were worries about the effect, which this might have on Britain and its colonies, and these were motivated by colonial discourse about the possible reduction in the quality of babies, as well as their quantity. This discourse led to provoking outcries from both the public and colonial officials.[5] With this, as argued by Barbara N. Ramusack, Britain readily transported its "maternal imperialists" policies into its colonies.[6]

The transfer of colonial maternal and infant welfare and midwifery policies in the British colonies have been justified on various grounds by scholars.[7]In 1861, Stratophe Freeman

[5]D Dwork, *War is Good for Babies and Other Yong Children: A History of the Infant and Child Welfare Movement in England 1898-1918*, (London, 1987); H. Hendrick, *Child Welfare in England, 1872 -1989*, (London, 1994).
[6]Barbaraa N. Ramusack, "Cultural Missionaries, Maternal Imperialists and Feminist Allies: British Women Activitists in India, 1865 – 1945" in *Western Women and Imperialism: Complicity and Resistance*,eds. Chaudhuri, Nupur and Strobel, Margaret, (Bloomington: Indiana University Press, 1992), 119 -36
[7] For more on the background and motives of colonial health establishment see, Ralph Schram, *A history of the Nigeria health services* (Ibadan: Ibadaan University Press ,1971). Meghan Vaughan, *Curing their ills: Colonial power and African illness, (*California: Stanford University Press , 1991)

particularly observed, that the reason colonial surgeons were requested in the Lagos colony was the need to reduce the high rate of infant mortality.[8]Just like Straphone, Hillary Marland showed in “The Midwife as Health Missionary: The Reform of Dutch Childbirth Practices in the Early Twentieth Century"; the reason western medical practice was introduced in the Dutch colonies. She specifically details how “the Dutch set about the task of reforming maternity services in their colonies in response to concerns about the high levels of both infant and maternal mortality”.[10]Davin Anna., supporting this line of position, believes colonial maternal policies were a way of the British government offering solution to a problem of public health...[11]The introduction and development of western biomedicine and biomedical practice in colonial spaces has been portrayed in these studies as a social and benevolent response to the sufferings of colonial subjects. Meredith Turshen however, believes the introduction of western biomedical practices, particularly its methods of midwifery, and Maternal and Child Welfare Services were designed to maintain the reproduction of colonial labor force.[12] She further buttresses her point by analyzing the ways in which health problems were conceptualized during the colonial era, the structure of the medical services established, and the effects of health care on the health status and size of the rural population of Songea District in Tanzania. She argues further, that the colonial medical service was determined by the economic, social and political requirements of the German and British colonizers rather than by the health needs of the African population.[13] Other studies in the transfer of colonial medicine and medical services to the British colonies

[8]NAI, CSO 1/1/4, A special list of records on the origin and development of Nigeria medical and sanitary services, 1861 – 1960, 100.

[10] Hilary Marland, "The Midwife As Health Missionary: The Reform Of Dutch Childbirth Practices In The Early Twentieth Century", in *Midwives, Society and Childbirth: Debates and Controversies in the modern period,* eds. Hilary Marland and Annie Marie Rafferty (New York & London: Routledge, 1997).

[11] Anna Davin, “Imperialism and Motherhood,”12.

[12]Meredeth Turshen,1977. “The Impact of Colonialism on Health and Health Services in Tanzania”, *International Journal of Health Services* 7(1977): 29.

[13] ibid

give credence to the position of Turshen. In "The Colonial World as Mission and Mandate: Leprosy and Empire, 1900-1940", Michael Worboys argues, that the evolution of tropical medicine in European colonies was a means for the colonial government to consolidate its imperial rule and promote its economy.[14] In the study, Worboy's analyses show the relationship between colonial rule and colonial medical practices, and how it cannot be separated from colonial conquest. Roy Macleod has also argued, that "European medicine, and its public health policy implementation, served as 'tools of Empire,' which has both symbolic and practical consequence - as images representative of European commitments, with the sole intention to conquer, occupy or settle…medicine served as an instrument of empire, as well as an imperializing cultural force in itself…"[15] William Bynum supporting this line of argument, believes tropical medicine was introduced to aid Christianizing, civilizing, commercializing, or simply dominating" the new territories that had come under European rule. According to Bynum, If medicine could tame the diseases that plagued the tropics, it had undoubted political force as a tool of empire…"[16] David Arnold in his contribution to this argument, asserted in 1988, that "medicine was a part of the ideology…of empire" and that "imperial powers were beginning (in the late 1800s) to use medicine as a way of winning support from newly subject population, of balancing out the coercive features of colonial rule, and of establishing a wider imperial hegemony than could be derived from conquest alone."[17]

[14]Michael Worboys, "The Colonial World as Mission and Mandate: Leprosy and Empire, 1900-1940", Nature and Empire: Science and the Colonial Enterprise, *Osiris*, Vol. 15, (2000): 207-218.
[15] Roy Macleod, "Preface," in *Disease, Medicine, and Empire: Perspectives on Western Medicine and the Experience of European Expansion*, eds. Roy MacLeod and Milton Lewis,(London: 1988) p.x
[16] William F. Bynum, *Science and the Practice of Medicine in the Nineteenth Century*, (Cambridge: Cambridge University Press, 1944),148
[17] David Arnold, "Introduction: Disease, Medicine, and Empire," in *Imperial Medicine and Indigenous Societies*, ed. David Arnold, (Manchester: , 1988),16

The position that colonial medicine, especially in the tropics was a tool of empire have however, been reviewed by other revisionist scholars. This new perspective to the study of colonial medicine, started in part, as an effort to highlight the experiences of the colonial peoples and their cultures. In this, regard Gwyn Prins "But What Was the Disease?"The Present State of Health and Healing in African Studies," asserts that, "in the disease environment of colonial Africa, colonial medicine was used in reconstructing the disease ecology of Africa which until the later part of the nineteenth century, "Europeans in Africa, especially west Africa, trembled ignorant and defenseless for the most part before the ghastly invisible legion of African diseases which struck them down even with greater ferocity than did the native population".[18] Roy MacLeod reviewing his earlier position of colonial medicine and empire stated, that while accepting that colonial medicine was an integral part of colonial expansionist policy and can thus be described as a "tool" of imperialism, there is need to ask some important questions like; what were the characteristics of this tool and what was its implication on the health and welfare of colonial subjects? He argues further by asking, if there were social costs of production for colonial peoples resulting from development projects such as road and railway construction, building of dams and hospitals, must one charge the colonial officials who implemented these projects with indifference to the welfare of colonial subjects. Yet indifference and callousness have been ascribed to these colonial officials.[19] Steven Feierman supporting the position of MacLeod, posits in the article, "Struggles for Control: the Social Roots of Health and Healing in Modern Africa," that "the cost of making working conditions healthy, the cost of feeding workers and their families, of maintaining retired workers, and of either controlling or suffering the environmental effects of the production process" are among the social costs of

[18]Prins Gwyn, "But What Was the Disease? The Present State of Health and Healing in African Studies," *Past and Present* 124, (1989): 159 - 179

[19] Roy MacLeod, "Critical Interpretations of Colonial Medicine", *International Journal of Health Sciences*, p.5

production.[21]Feierman argues further, that although these social costs should have been anticipated and taken into account by colonial officials, he however notes, "The potential African beneficiaries of improved health care had little influence in the home countries of the colonizers."[22] Bruce Fetter also tailored his position along this line of argument by saying, "Critiques of colonial rule and capitalism in Africa are certainly justified, but they need deny neither the germ theory of epidemic disease nor the effectiveness of investments in health facilities nor wrench materials from their historical context."[23] Fetter argues further, stating how "Since about 1905, the combined powers of medical technology, private hygiene, and public health have made it possible to reduce mortality and morbidity from infectious diseases, wherever money is spent wisely and in sufficient quantity…the tragedy of colonial medicine was that there was never enough of it."[24]Leveraging on the post-colonial and revisionist school of thoughts, Hunt Davis creates a middle ground by asserting, that the major significance of the period "was not colonialism, but the spread of a world revolution into Africa."[25]

Indeed, discussions in the British justification for the transfer of western medical ideas to her colonies have been given different interpretations based on the experiences of the colonized. However, of specific interest to this thesis, is in examining how the colonial governments' efforts at medicalizing maternal and infant healthcare in her colonies, especially in Africa, resided in attempts at replacing indigenous midwifery and midwifery practices with western obstetrics. This is based on the suggestions that indigenous medical systems are relatively ineffectual and

[21]Feierman Steven., "Struggles for Control: the Social Roots of Health and Healing in Modern Africa," *African Studies Review*, Volume 28, Issuue 2 – 3, (September 1985):73 – 147.
[22] Ibid,93

[23] Bruce Fetter, "Pitfalls in the Application of Demographic Insights to African History," *History in Africa* 19, (1992): 304
[24] Bruce Fetter, "Pease Porridge in a Pot: The Social Basis of Health and Healing in Africa," *History in Africa* 20, (1993):.49.
[25]Hunt R. Davis, "Interpreting the Colonial Period in African History," *Af. Affairs*, 72 (1973):383-400.

their medical practices further complicates the health situation of patients as expressed in Margaret J. Field's pioneering work on the Gold Coast, *Religion and Medicine of the Ga People*;[26] George W. Harley's work, *Native African Medicine: with Special Reference to its Practice in the Mano Tribe of Liberia*;[27] and Michael Gelfands study of Shona healers, *Witch Doctor: Traditional Medicine Man in Rhodesia.*[28] This position is further complemented through countless international conferences on the medicalization of maternal and infant health, held in London and other European countries from the 1920s through the 1930s. Of particular interest, is the 1931 Save the Children International Union Conference in Geneva, which was organized to discuss the welfare of African children. The main discussion conference was 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.[29] 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.[30] To meet this challenge, the colonial state rolled out initiatives in midwifery education, maternal education, antenatal and postnatal care, the medicalization of childbirth, and infant feeding. A plethora of studies has presented different perspectives to this aspect of colonial medical practice. The obvious place to start from is by engaging the work of Nancy

[26]Magaret J. Field, *Religion and Medicine of the Ga People,* (New York, 1937)
[27]George W. Harley, *Native African Medicine: with special reference to its Practice in the Mano Tribe of Liberia,* (Cambridge: Mass, 1970)
[28]Michael Gelfand, *Witch Doctor: Traditional Medicine Man in Rhodesia*, (London, 1964).
[29]Public Records Office, (PRO) CO 323/1066: ―International Congreson African Children of Non-European Origin, 1931‖ and CO 323/1148:―Congress on African Children, Geneva, 1931.
[30]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.

Rose Hunt, *Colonial Lexicon*,[31] which constitutes the major and first historical study dealing specifically with the investigation of how childbirth became medicalized. Hunt sets the tone by summarizing all aspects of colonial medical services and technological advancement by weaving together stories about autopsies and bicycles, obstetric surgery and male initiation, to reveal how concerns about strange new objects and procedures fashioned the hybrid social world of colonialism and its aftermath in the Congo.[32]Relying on archival research in England and Belgium, as well as fieldwork in the Congo, Hunt explores the roots of social reproduction in rituals of manhood, by showing how the arrival of the fast and modern ushered in novel productions of gender, seen equally in the forced labor of road construction and the medicalization of childbirth.[33] Hunt focuses on a specifically interwar modernity, where the speed of airplanes and bicycles correlated with a new, mobile medicine aimed at curbing epidemics and enumerating colonial subjects. Fascinating stories about imperial masculinities, Christmas rituals, evangelical humor, colonial terror, and European cannibalism demonstrate that everyday life in the mission, on plantations, and under a strongly Catholic colonial state…where everyone was living in translation, privileged access to new objects and technologies allowed a class of "colonial middle figures"—particularly teachers, nurses, and midwives—to mediate the evolving hybridity of the Congolese society. By successfully blurring conventional distinctions between pre-colonial, colonial, and postcolonial situations, Hunt moves on to discuss the unexpected presence of colonial fragments in the vibrant world of today's postcolonial Africa.[35]Using Hunt's summary of the colonial medical service in the Congo as a background, this thesis further examines Amablika Guha's work *Colonial Modernities: Midwifery in Bengal*

[31]Nancy Rose, Hunt, *A Colonial Lexicon: Of Birth Ritual, Medicalization, and Mobility in the Congo*. (Durham; London: Duke University Press, 1999): doi:10.2307/j.ctv11689mp. Accessed August 16, 2021
[32] ibid
[33] ibid
[35]Hunt, *A Colonial Lexicon, 10*

1860 -1947,[36] to identify the interactions between childbirth and midwifery practices and colonial modernities. Guha with hard empirical data from local government bodies, municipal corporations and district boards, narrates how the late nineteenth-century initiatives to reform birthing practices were essentially a modernist response by colonial critique of the socio-cultural codes of the indigenous people. The study provides a historical analysis of how institutionalization of midwifery was shaped by the debates on the women's question, nationalism and colonial public health policies, all of these intersecting in the interwar years. Guha further traces the beginning of the medicalization of childbirth, the professionalization of obstetrics, the agency of male doctors, and the inclusion of midwifery as an academic subject in medical colleges and their consequences on maternal care and infant welfare.[37] These arguments were further examined in other studies, which sought out to provide details of colonial medical initiatives that best serve the purpose of reducing maternal and infant mortalities. Thomas McKeown's research on the causes of declining mortality in the nineteenth century, summarized briefly in the "Medical Issues in Historical Demography"[38] shows that better nutrition, sanitation were much more important than the activities of doctors. This is supported by I Buchanan, "Infant Feeding, Sanitation, Diarrhea in Colliery Community, 1880-1911."[39] However, authors such as R. Cook, has argued that the training and role of medical personnel was much more important that nutrition.[40] N.R.E Fendall in "The Medical Assistant in Africa" makes the case for greater utilization of such persons as against nutrition.[41] I. Loudon is of the view that the colonial initiative of training midwives in the late nineteenth century and the

[36]Ambalika Guha, *Colonial Modernities: Midwifery in Bengal, 1860–1947*. (London: Routledge, 2018).
[37]Ambalika, *Colonial Modernities*
[38]Thomas McKeown, "Medical Issues in Historical Demography" in Int J Epidemiol.:34(3),(June 2005):515-20.
[39]I Buchanan, "Infant Feeding, Sanitation, Diarrhea in Colliery Community, 1880-1911." in, *Diet and Health in Modern Britain*, eds. D.J. Oddy and D.S. Miller eds, (London, 1985);148-177;
[40]R. Cook, "The General Nutritional Problems of Africa" in *Af. Affairs*, LXV (1966): 329-40
[41]N.R.E Fendall, "The Medical Assistant in Africa" in *J. Trop. Med. Hyg*., 71 (1968): 83-95

gradual move towards hospitalization of childbirth as one of the best moves towards the reduction of maternal mortality.[42] Lewis Gann and Peter Duignan has however point to falling mortality rates and a booming population during this period, and concludes that, "whatever political disadvantages colonialism might possess, from the biological standpoint its record is one of the greatest success stories of modern history."[43]

Although Harley and Gelfand in their study have been able to debunk some of the assertions that indigenous medicine and medical practice are ineffectual by showing workings of some African psychological and pharmaceutical practices which were quite effective in treating so many diseases, and a practice which the indigenous peoples have relied on for centuries before the introduction of colonial medicine and medical practices,[44] this thesis examines how the indigenous midwifery system was sustained in colonial Ibadan. Findings in this study reveal that the continuous survival of the indigenous midwifery practice was for the sake of convenience and not necessarily because the colonial government saw its effectiveness or approved of it. Put differently, I argue in this thesis that the colonial state, due to the focus and implementation of its maternal health policies in the urban areas of Ibadan, and failure to extend the Western obstetrics to the rural areas, encouraged a system of medical pluralism in colonial Ibadan.

Interestingly, the colonized - Africans in particular, were not simply passive objects for experimentation of the colonizers, especially in the implementation of midwifery and maternal and infant policies. They could accept, reject, or demand health services as they saw fit. The attitudes and actions of the colonized as regards Western medicine and medical practices were

[42] I Loudon, Medical Care and the General Practitioner, 1730-1850, (Oxford, 1986); A. Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720-1911*, (Cambridge, 1984).
[43]Lewis Gann and Peter D., *Burden of Empire: An Appraisal of Western Colonialism in Africa South of the Sahara*, (New York, 1967), p. 292
[44]George W. Harley, *Native African Medicine: with special reference to its Practice in the Mano Tribe of Liberia,* Cambridge: Mass., 1970; Michael Gelfand, *Witch Doctor: Traditional Medicine Man in Rhodesia*, London, 1964

influenced not only by their indigenous cultural values, but also by their perceptions of the motives and capabilities of the colonial government, its medicine men and medical ideas. Thuy Linh Nguyen survey of the interactions between French colonial medicine and Vietnamese childbirth traditions shows how these interactions shaped maternal and infant health care in Vietnam. Nguyen provided relevant information on the language and expertise of modern medicine, which the French physicians and administrators set out on a mission to relocate Vietnamese childbirth to a clinical setting but as the French administrators ventured into indigenous communities, they found themselves negotiating with a myriad of Vietnamese cultural practices relating to childbirth and infant care.[45] Nguyen's further demonstrates how the introduction and development of French colonial medicine, led to the emergence of a plural system of maternity services, many of which were based on local practices and beliefs,[46] which serves as a testimony to the compromises and adaptations made by both the colonizers and indigenous population. Alexandar Alland, Jr., also gave a similar account on the French encounter with the medical system of the Abron people of the Ivory Coast. Here he stated that the Abron people were not passive in their response to government and missionary efforts at medicalizing the indigenous medical system.[47]Instead, a form of cultural adaptation between both the French and Abron medical system occurred. Una Maclean's study, *Magical Medicine: a Nigerian Case Study* contributes to this position. Una's study of popular medicine in Ibadan offers a fascinating story of the adaptation of 'traditional' Yoruba medicine to modern urban conditions and competition between two very different types of health care.[48]Ryan Johnson, and

[45]Nguyen, Thuy Linh. *Childbirth, Maternity, and Medical Pluralism in French Colonial Vietnam, 1880-1945*. Rochester, NY; Woodbridge, Suffolk: Boydell& Brewer, 2016.. http://www.jstor.org/stable/10.7722/j.ctt1wx90tr. Accessed August 16, 2021
[46]ibid
[47]AlexandarAlland, *Adaptation in Cultural Evolution: An Approach to Medical Anthropology*, (New York, 1970),
[48]Una Maclean, *Magical Medicine: A Nigerian Case Study*, London, 1971

Anna Khalid, (eds.)[49] have addressed the crucial roles played by local elites (intermediaries) and local day-to-day public health workers (subordinates) in influencing and determining western public health policy and practices across the colonial empire. Clement Masakure also following this line of argument, reveals in his work "African Nurses and Everyday Work in Twentieth – Century Zimbabwe," the centrality of the nurse to an emerging hospital structure built on the racial policies of British colonial rule while making an important contribution to global healthcare history by demonstrating the porous nature of medical boundaries—professional, gender, racial and bio-medical. In this work, Masakure shows that the African nurses performed dual functions, one -- as mediators and as translators. They became de facto medical authorities, especially in rural areas, where their knowledge allowed them to control diagnosis and treatment. This expertise meant they blurred boundaries—between nursing and medicine; different races; gender norms; and modernity and tradition. They were the bridge taking European biomedicine to African patients and bringing back knowledge of community medical practices and beliefs to ensure that institutional healthcare functioned effectively. Masakure however, concludes this study by unraveling how these African nurses contributed to the nationalistic movement through their medical services and how it eventually helped the nation gain independence and secured autonomy for themselves and future generations of African women.[50]Glen Ncube in his study of health care reforms in colonial Zimbabwe has decried the colonial interest in the health of Africans especially in the rural areas, by evaluating the political leadership of the senior medical and non-medical bureaucrats, by highlighting how the colony's rural healthcare infrastructure remained tentative, sporadic and makeshift until the 1930s. In an attempt to make sense of this,

[49]Ryan Johnson, Anna Khalid, (eds.) Public Health in the British Empire: Intermediaries, Subordinates, and the Practice of Public Health, 1850-1960. New York: Routledge, 2011.
[50]Clement Masakure, "African Nurses and Everyday Work in Twentieth – Century Zimbabwe", *Social History of Medicine*, Volume 34, Issue 3, (August 2021):. 1044 – 1045.

Ncube seeks answers to the divergent visions held by the medical and non-medical policymakers and the intractable debates about African health and healthcare system. By tracing these protracted debates to the turn of the century, Ncube revises the popular depiction of colonial rural healthcare, reform as an essentially post-World War I phenomenon. Ncube in this study further argues that, the collage of reasons, including the colonists' enlightened self-interest, which has been proffered by historians to explain healthcare reforms in other colonies were in colonial Zimbabwe, neither self-evident nor uncontested.[51]

Analysis of these literatures on colonial medicine and medical practices helps this thesis to critically examine the introduction of western medical practices, particularly on midwifery and midwifery practices in Ibadan from 1893 when colonial rule started in Ibadan, to 1960 when it ended. This period was characterized by increased infant and maternal mortality, which was an avenue for the colonial government to introduce western obstetrics and implement its maternal and infant welfare policies. It therefore, offers a good basis for analysis of colonial medical practices and African experiences and responses to the western medical practices during this period.

The Ibadan Division and the Beginning of Colonial Medicine

Physical Setting

Ibadan Division (comprising Ibadan Urban and Rural areas, together with the independent Ibarapa District) is approximately 2,221 square miles in size and lies wholly within the high forest zone. Structurally, the vegetation of the forest zone consists of an upper stratum of trees (emergents) with isolated crowns, rising to 120 feet and above in height; a middle stratum

[51]Glen Ncube, "The Problem of the Health of the Native': Colonial Rule and the Rural African Healthcare Question in Zimbabwe, 1890s–1930", *South African Historical Journal*, Volume 64, Issues 4,(2012): 807 - 826

varying in height from 50 to 120 feet with crowns in lateral contact with each other; a lower stratum or understorey of trees up to go feet high with spreading crowns bound together with woody climbers. Beneath the understorey there is still another stratum consisting of small single-stemmed shrubs. Timber comes from the forest zone and is drawn wholly from the emergents. Little, if any, virgin forest remains in Ibadan Division. Everywhere in the high forest zone the prevailing system of farming, aided by bush fires, and has resulted in a regrowth of secondary bush, and, in some areas, in the degradation of the forest to derived savannah.

The high forest zone is also a region of high rainfall and humidity. There are two distinct seasons in the year: the wet season (April to October inclusive) when rainfall averages between 40 and 6o inches annually, and the dry season (November to March inclusive) during which rainfall does not usually exceed 20 inches per annum. There is a short dry spell in the rainy season in August with a mean of monthly rainfall figures below 4 inches. From 1905 to 1952 the mean annual rainfall in Ibadan was 48 4 inches. In the 15 years 1937 to 1951 the mean annual rainfall varied between 30-01 inches and 54-80 inches. The warmest months in Ibadan are from February to April, and the coolest from July to August. The harmattan, a dry, cool, north-easterly wind, occurs between November and February when temperature drops to 60°F at night. The average relative humidity in Ibadan is about 80 per cent. In the early morning hours (7 a.m.) when there is ground mist and dew, relative humidity is as high as 96 per cent. At 10 a.m. the average is about 81 per cent, while in the afternoon (4 p.m.) it falls to about 62 per cent. During the harmattan season the relative humidity may fall as low as 35 per cent.

Apart from narrow valley bottoms, the land in Ibadan is undulating, and soils ranging from sands to sandy clays are freely drained. Under forest, or under a crown of natural regrowth of forest species, there is a dark fine-grained top layer of soil about 2 inches thick, formed from broken-up

worm casts, and containing about 4 to 5 per cent of humus. The humus and the clay fraction of the soil firmly retain important plant-nutrient elements, and leaching is not normally intense in this area of moderate rainfall, so that the topsoil is normally neutral to only slightly acid. These conditions are favorable for steady microbial decomposition of humus to take place when land is cleared from forest or young forest regrowth, and there is then an abundant supply of nitrate; it has been found that nitrate will continue to be produced in fair quantities for some years by decomposition of the stored-up humus, if cultivation is continued in this area. A fairly good level of crop yields has been maintained under the system of shifting cultivation, in which the chief functions of fallow growth are, firstly to build up the humus and nitrogen contents of the topsoil, and, secondly to accumulate in readily available from nutrient elements other than nitrogen.

In the past 30 years, the land within a radius of about 5 miles from the centre of Ibadan has deteriorated seriously, through the elimination of forest species and the spread of tall savannah grass. The chief causes have been the prolonging of the period of cultivation, the cutting of firewood, and the fact that the spread of fires through any fallow land in which there is already sufficient grass to give a good burn has been permitted or even encouraged. Near to the city, attempts to cultivate some of this land have continued, but worthwhile yields have become impossible to obtain without manure, and much of the area is infested with spear grass, and some sheet erosion occurs on the exposed surface. None of the vast quantity of plant-nutrient elements contained in the city's refuse and waste materials is returned to the farmland.

The prevailing system of farming in Ibadan, as indeed in most parts of Nigeria, is shifting cultivation, which has been defined as " an economy of which the major features are rotation of fields rather than crops; clearing by fire; absence in most cases of draught animals and larger types of stock; employment of the hoe, with the plough only occasionally important; short

periods of land and long periods of fallow" The system of shifting cultivation is sometimes termed "bush fallowing in this system the farmer cultivates a plot of land for about 3 or 4 years, after which he allows it to revert to bush fallow while he clears and cultivates another plot. The duration of the fallow period depends on the pressure of population and on soil conditions. Except in the immediate vicinity of towns, the fallow period in Western Nigeria varies from 5 to I5 years. Land itself is the joint property of a group. In Ibadan Division, as in Western Nigeria generally, the land-owning group is the lineage. Individual members of the group have rights of cultivation only, and are precluded from alienating group land by sale or mortgage. The cultivation of permanent crops, particularly cocoa, has, however, modified this aspect of traditional system of tenure. In the immediate vicinity of Ibadan, land is now freely bought and sold, and throughout Ibadan Division, cocoa farmers can mortgage their cocoa trees, though, theoretically, not the land on which the trees stand.

The climatic and soil conditions described above are important factors determining the types and varieties of crops grown. The dominant food crops in Ibadan Division are maize, cassava, and yams; a variety of vegetables and pulses are also grown. Because of the long duration of the rainy season, farmers are able to grow two crops of maize in a year. Cocoa is the major export crop of the Division, although little cocoa cultivation goes on within a radius of about 1o miles from the centre of Ibadan city. Approximately 25 per cent of the land area of the Division is used for cocoa cultivation and 21 per cent for food crop cultivation; 14 per cent is in fallow, 6•6 per cent in forest, and 33 per cent in thicket, that is, uncultivated bush and waste.[49]

[49] Information on the physical setting of Ibadan, is extracted, from, H.A. Oluwasanmi, "The Agricultural Environment", in The City of Ibadan: A Symposium on its Structure and Development, eds. P.C. Lloyd, A.L.Mabogunje, B. Awe, (Cambridge: Cambridge University Press, 1967), 27-29; British West Africa Meteorological Services, Nigeria, no. 2 (1955).

Economy of Ibadan

Ibadan's economy before the colonial period, was based mostly on agriculture (yam, maize, vegetables), manufacturing (particularly the textile, ceramics, and armament industries), and trade (slaves, palm oil, yam, and kola for export), salt, horses, weaponry, and Shea butter. During the colonial period, however, following a brief period of growth in the rubber industry (1901–1913), cocoa became the primary agricultural product of the (Ibadan) area and drew European and Levantine firms, as well as traders from the south and north, including those from Lagos, Ijebu-Ode, and Kano. Their activities included the export of local agricultural products such cocoa, palm oil, palm kernels, rubber, hides and skins, as well as the import of manufactured goods.[50] Ibadan became the hub for all road travel from Lagos to the North in 1901 when the railway from the North reached it. A significant bulk trade hub developed in the city.[51]

Despite the size of Ibadan and the rapidity with which the commercial and industrial sectors of its economy have expanded, agriculture remains a significant element in its economic life. One-third of its occupied males and more than two-thirds of the occupied female population earn their living either wholly or in part from farming and related occupations.[52]

The Socio-Political Configuration of the Ibadan People and Healthcare in Pre-colonial Ibadan

Before the advent of colonial rule, the Ibadan people had developed a strong communal system of living. The importance they attached to this social configuration motivated all aspect of their society especially on health and healing. The advent of colonial rule did not upset this social system; hence, the Ibadan people were able to sustain the system even during colonial rule. The

[50] Mabogunje, A L, *Urbanization in Nigeria*, (London: University of London Press, 1968), 195
[51] Ibid, 201
[52] H.A. Oluwasanmi, "The Agricultural Environment", 29-33

Ibadan people unlike other Yoruba communities developed a socio-economic and political [54]organization, which resulted in the development of a strong communal network before the imposition of colonial rule.[55] Ibadan's population was a heterogeneous one due to the attraction of trade and the policy adopted by the people to accept all new comers. This heterogeneity did not, however, cause major frictions. The different groups interacted cordially and began widen communication networks among themselves as they intermarried and soon put their original identity behind them, fusing themselves into the foundation of what is now called the traditional Ibadan.[55] Pre-colonial Ibadan people lived in large compounds which often contained hundreds of inhabitants. The compounds were built in the form of a series of enclosed rectangular courtyards where prominent men and their wives, children, other dependants, and some domestic slaves lived in.[56] The Ibadan society did not grow on the basis of ties and kinship like other Yoruba states, but of dependency on chiefs for military protection due to the nineteenth century warfare and instability in Yoruba land.[57]

During the colonial period, not much was changed in the socio-economic and political characteristics of the Ibadan people. Annual reports of Ibadan from the 1890s when Ibadan became a colonial territory through the 1930s, gave similar socio-political characteristics of the Ibadan people.[58] In fact, these accounts described Ibadan as a hive of industry[59]different from other Yoruba towns that has an official residence for the Head of that town. Unlike those other

[54]Olufunke Asake, Adeboye, "The Ibadan Elite 1893-1966", (Unpublished Ph.D. Thesis: University of Ibadan, November, 1996), 39
[55]Ibid
[55]ibid
[56]Ibid, 40
[57]ibid
[58] NAI, File No: CSO 26/2, 12723 Oyo Province: Annual Report 1928; NAI, File No: 09723, Oyo Province: Annual Report 1922; NAI, File No: 12723 Oyo Province: Annual Report 1926; NAI, File No: 60207, Annual Report; Oyo Province 1921; NAI, File No: 12723, Annual Report: Oyo Province 1930.
[59] NAI, File No: 60207, Annual Report; Oyo Province 1921, 9

Yoruba towns, in Ibadan, the Bale of Ibadan, who was also the head of the local administration, resided in the family compound.[60]

The socio-political configuration of the Ibadan people is greatly reflected in their medical culture as they depended on one another for healing. This resulted from the fact that the original Ibadan inhabitants accommodated people of varying cultures, which developed from social, economic and political linkages through inter-marriage, trade and over-lordship from the *Bale* for centuries.[61] Such constant interaction and compact settlements because of the influx of people of different cultures into the town facilitated a diffusion of therapeutic methods and expansion of therapeutic knowledge among the Ibadan people.[62] In pre-colonial Ibadan, the history of health and healing like in other African indigenous cultures is a communal matter involving the entirety of the sick person, family and community. For instance, in pre-colonial Ibadan, the community with its group of healers known as the *AjoIsegun* worked together during the outbreak of diseases such as small pox, malaria and tuberculosis to find medical solutions and bring healing to the people. This was in order to eliminate the ravaging spread of the disease in the community. It is because of this interdependency and cooperation amongst the people that the *Ipara* (an herbal concoction) was discovered and used during the outbreak of the aforementioned diseases in the pre-colonial period.[63]The Ibadan people had a lot of confidence in the efficacy of the *Ipara* herbal concoction as a cure to malarial, small pox and other related ailments such that by the 1930's, the association of traditional healers was pushing for the analytical examination of the

[60] NAI, File No:12723, Annual Report: Oyo Province 1930,509
[61]Olufunke Asake, Adeboye, "The Ibadan Elite 1893-1966", (Ph.D. Thesis: University of Ibadan, November, 1996),
[62] Interview, Adeyemo Oladejo, Herbalist and witch doctor, Aged 65+, Ogbomoso but hails from Yemetu in Ibadan, 7 October 2018.
[63]NAI, File No:857/1, COMCOL 1, B/12, J/1, Petition From the Local Native Doctors, 1935,10

product and its introduction into the African hospital.[64]Prins Gwyn also gave a similar account of the *lemba* disease in Central Africans history during the transatlantic slave trade in the 17th century that brought Africans together in one of the greatest healing "cult".[65] According to Prins, *lemba*, was a social disease synonymous with trade and capitalism, which came with the incursion of Europeans to Africa. Africans foresaw the *lemba* disease as a fundamental threat to their society and became united in an attempt to resist what they saw as a societal sickness. The disease was met head-on by communal cooperation. This is an indication in the indigenous culture of Africans, that when faced with such social issues, the solution lay in the community, hence, supporting the ideas of communal cooperation in solving societal illness. Nancy Hunt gave a similar account of the almost "cult-like" belief in the *tokwakwa* tales, in which stories of white people acting as vampires eating black bodies.[66] This tales was used as a form of societal control, keeping communities united against the lure of the whites, who were widespread representation of modernization and colonialism.[67]Other numerous examples encompassing the realms of individual health and societal well-being, indicates that the two are intrinsically linked in Africa.

This ambivalence helps us to understand the dynamics of health and healing in various African societies - that it is not monolithic. Health and healing played out in different ways, at different times. Hence, the need for this section, which helps us to understand what, is peculiar to the Ibadan society. The social construct of the Ibadan people which was communal in nature and developed along strong networks of people due to the attraction of trade and the policy adopted

[64]Ibid, 11

[65]Prins, Gwyn. "But What Was the Disease? The Present State of Health and Healing in African Studies." *Past and Present* 124 (1989), 159-176

[66]Hunt, A *Colonial Lexicon of Birth*182

[67]ibid

by the people to accept all new comers, as earlier stated above, prepared the way for the acceptance of a more virile and organized agents of change: the Christian missionaries and the colonial government, which introduced a new medical culture. In their characteristic manner, the Ibadan people who are generally welcoming of foreigners to their society welcomed the missionaries and colonial agents, encouraged and contributed to the development of modern medicine. They however, welcomed modern medicine as a complementary medicine and not as a substitute for traditional medicine. What actually emerged from the process of the development of modern medicine amounted to medical pluralism.[68]

Colonization

The year1983 marked the beginning of colonial rule in Ibadan. In March 1893, the Governor, Sir Gilbert Carter, expressed his intention of establishing a Resident at Ibadan.[69] The Ibadan chiefs who were afraid that their powers and liberties would be much restricted did not look upon this step with favor. However, on 15 August of that year, Governor Carter affected a Treaty of Friendship and Peace on the Ibadan people on behalf of Her Majesty, Queen Victoria. In 1894, a year afterwards, Captain Bower was appointed Resident and took over Ibadan as the Headquarters of Ibadan Province.[70]

By the time the British arrived in 1893, Ibadan covered some 20,000 square miles and extended over much of northern and eastern Yorubaland. The areas Ibadan had expanded to at the dawn of colonialism were sustained during colonial rule. The movement to expand the sphere of influence of Ibadan is said to have begun with Ibikunle, the Balogun of Ibadan from I85I to I862.

[68]NAI, File No: Oyo Prof. 1, 1728, Native Herbal Medicine Dealers; practice and sale of herbal preparations 1936,15-16).
[69] NAI, File No: 09723, Oyo Province Annual Report 1922, 59
[70] ibid

To the east, this meant expansion into the Ekiti country where many of the small towns were easily subjugated. To the west, most of the Ibarapa and southwestern Oyo towns came under Ibadan. In each of the conquered towns, the Ibadan placed a resident consul or Ajele, who acted much in the manner of the later British officers. He oversaw the day-to-day administration of the town, ensured that it remained loyal and paid its annual tribute, and that in times of war it sent a troop of soldiers to augment the fighting force of Ibadan. In return, Ibadan provided some form of security and protection, especially against the external threat from the Fulani.[71]

The Ibadan district therefore, comprised the area which included formerly the Oyo Province during this period, but in its early stages the whole country was administered by the Resident in person there being no sub-stations or junior officers under him to assist him. Records of the activities of Mr. Fuller, Resident in 1898, show that his presence was required variously in such districts as Ife, Iseyin and Ikirun.[72] In 1897, Resident Fuller however appointed an Ibadan Council of chiefs for purposes of direct administration by them in native affairs; and in 1901, the Advisory Court of the Resident was set up whereby the Resident could investigate charges and complaints brought forward by the chiefs and people.[73] In August 1903, two literate members were added to the number of the Council of chiefs in order that the Council might cope better with the complicated matters, which arose from time to time. At about the same time, it was arranged that all petty cases in which Europeans were parties or in which they had an interest should be heard in the Advisory Court, while the more serious cases were to be taken before the

[71] Akin L. Mabogunje, Urbanization in Nigeria,(London: University of London Press Ltd, 1968), 192.
[72] ibid
[73] ibid

Resident and the Council. This Council was constituted during this period and it consisted of the Bale, the Otun Bale, the Osi Bale, the Balogun and eight to twelve minor chiefs.[74]

In August 1904, there occurred the Judicial Agreement, establishing the Supreme Court system and regularizing the jurisdiction of the Native Courts. In 1905. an Assistant Resident was appointed to relieve the Resident of some of the work which had become too much for one man. He was known later as District Commissioner. In 1906, a District Commissioner was appointed for Oyo, and he administered the Oyo Division independently of the Resident Ibadan. In the same year, a sub-station was opened at Shaki under an Assistant District Commissioner. Ife, Ilua and the Oshogbo areas were still being administered by Ibadan, but the Ijesa country was under a District Commissioner over-looked by the Resident. In 1908 a District Commissioner placed at Oshogbo, Ife and Ilua districts were under him.[75]

In 1912, the Assistant District Commissioner was removed from Shaki and the station was closed. In the following year Ilesa, station was closed and the District Commissioner was moved to Ado-Ekiti to form the Ekiti Division of the Ondo Province. Ilesa District was brought under the District Commissioner of Oshogbo. This organization continued until the revision in 1914.

On 1 January 1914, the Districts of Oyo, Ibadan, Oshogbo, Ilesha and Ife were formed once more into one province under the name of the Oyo Province with the Headquarters of the Province at Oyo.

Sir F. Lugard reorganized the administration of the Province, and the powers of the Native Authorities were recognized and defined by Government Ordinances. The judicial agreements of 1894 were superseded by the Judicial Agreements of 14 November 1914 that recognized the

[74] NAI,File No: 12723, Oyo Province Annual Report, 1930,.578
[75] Ibid., 579

establishment of the Provincial and Native Courts. The Treaty of Friendship and Peace dated 1893 was not abrogated.

On the outbreak of the Great War, the staff of all departments was reduced, and the development of the country was at a standstill until sometime after the armistice. The slump in Revenue in 1921-22 was a further check to all public work schemes.

In 1918, direct taxation was introduced with the consent of the chiefs and produced Revenue of £56,900 half of which is paid to Government. Under the system every male adult's name, address is registered under the name of the Ward Head, and each one receives printed receipt for the tax of a different color each year. The tax is based on an assessment of $2^{1/2}$ % on the gross income of the average farmer and varies according to the locality. Traders and wealthier people are assessed at 5% of their income.[76]

The year 1920, marked the beginning of institutional practice of western medicine in the Ibadan Province. In that year a considerable amount of medical work was been done by and on behalf of the Colonial government and the Native Administration of the Province by the Christian missionaries for the improvement of the health of the inhabitants and sanitation of the province.[78]The study terminates in 1960, the year the colonial administration that superintended all health and medical services in the colonies of Nigeria came to an official end. The study is restricted to one of the colonial Provinces - the Ibadan Province, so as make it possible to have a deeper insight into the introduction and evolution of midwifery and midwifery practices during the period of study. Developments in a province exemplified development in the country because the province represented the largest political unit, from the beginning, in which colonial policies

[76] Ibid.,180
[78]NAI, File No: CSO 26/2/ 12723, Oyo Province Annual Report, 1920. 355

were implemented. Only slight differences resulting from local conditions could exist in various provinces. Because of the political importance of Ibadan to the British consular officials, in 1939, it (Ibadan) became the administrative centre when the former Southern Provinces, with headquarters at Enugu, (was) split into Western and Eastern Provinces.[78]

Sources and Methodology

A research cannot exist without assuming the use of data collection techniques and the resulting data. According to Gupta,[79] there are two types of inquiry that can be used to gather the different sources of data: qualitative research and quantitative research. On the one hand, post-positivist research paradigms that emphasize subjective forms of data are heavily emphasized in qualitative data collection methodologies. Numerous techniques, such as interviews, observations, artefacts, textual analysis, focus groups, applied ethnography, visual approaches, and document analysis, can be used to gather data for a qualitative research mode of inquiry.[80] Comparatively, quantitative data collecting methods are those that derive primarily from the positivist paradigm and place an emphasis on objective measurements that are typically in amounts. These approaches also use descriptive and inferential statistics to analyze the data they collect. Polls, class tests, national standardized assessments, and survey questionnaires are some of the tools and/or methods used to acquire quantitative data.[81]Gupta has gone further to state, that, the

[78] P. C. Lloyd, "Reader in Social Anthropology," in *The City of Ibadan*, eds. P. C. Lloyd, etal (London: Cambridge University Press, 1967),.6
[79] Mukul Gupta and Deepa Gupta, *Research Methodology*, (New Delhi: PHI Learning Private Limited, 2011), 13
[80] Norman K. Denzin and Yvonna S. Licoln, *The landscape of qualitative research*, (Los Angeles: SAGE Publications; 2013)
[81] ibid

creation of data in a quantitative format so that it may be submitted to thorough quantitative analysis in a formal and strict manner is a key component of the quantitative approach.[82]

The focus of this thesis is to apply in its discourse selected qualitative method and/or tools of data collection and analysis in research. This is because the thesis relies primarily on archival sources in analyzing the British colonizing forces effort at reinventing African medical practices through the introduction of western obstetrics in colonial Ibadan. These sources are reposed at the Nigeria National Archives in Ibadan and the Adam Matthew's Digital Archives. These archival sources are series of text-based researches and documents derived mainly from primary sources: archival records, Newspapers, Mission papers, and oral evidence, all of which were generated during the colonial period. There are numerous historical information contained in these documents mostly Federal files comprising the Chief Secretary's office papers and the Federal Ministry of Health Papers; Oyo/Ibadan Provincial Papers; Divisional Papers of the Ibadan Division; Mission Papers of the Roman Catholic Mission, the Seventh Day Adventist Mission, and the Methodist Mission and Ethnographic studies derived from oral traditions collected by British colonial officials. As Corbin and Strauss[83] have rightly noted, the availability of a wide range of data sources is one of the benefits of grounded theory studies and qualitative research in general. So far, it is quite challenging researching these relevant documents - at the Adam Matthews Digital Archives and the Nigeria National Archives in Ibadan, which happens to be the major repository housing the records used for this thesis. While the archive holds some of the most important records on the research subject, it is poorly catalogued and rarely available for use. At times, it takes a high level of concentration, persistence, and diligence (on the part of the researcher) and some traits of ingenuity and expertise (on the part of the archivists) for such

[82]Gupta and Gupta 2011, p.13
[83] Corbin, J., and Strauss, A., *Basics of Qualitative Research*, (Thousand Oaks, CA: Sage; 2015).

materials to be unearthed and available for use. At the end of the archival fieldwork, these attributes yielded considerable results and were invaluable in the reconstruction of the key social issues around the introduction and development of midwifery practices in Ibadan.

Thus, the strength of these archival documents as sources for this study is in the fact that most of the records were compiled from the early years of colonial rule in Ibadan, that is, 1983 to 1960 when colonial rule ended in Ibadan. The information they contain were collected from people, of whom some were active participants in the events been studied. These sources also makes it easy to understand the metropolitan mindset of the colonial government and the medical missions on traditional health and healing practices through an analysis of the official correspondences among colonial medical doctors, officials of the colonial office and colonial administrators in Ibadan. These sources also provides detailed information on the diverse ideas constructed in metropolitan spaces and how they were imagined and appropriated by medical doctors, nurses and midwives and colonial officials in Ibadan.

The main weaknesses of these records are that most of the colonial officials in Ibadan during the colonial period did not fully understand the traditional health and healing practices of the people and therefore passed repressive judgments on the traditional health and healing practices of the Ibadan people and thus, totally subjected them to Western biomedicine. This level of misunderstanding had enormous impact since the colonial officers assumed the health and healing practices of the Ibadan people were not only injurious to human health, but/and was detrimental to the British economic expansion of the colony. In addition, most of the colonial officers were not trained in the art of collecting historical information, especially oral traditions. The very nature of the colonial situation of the colonizer-colonized relationship foreclosed any free exchange of medical information. Besides, even without these weaknesses the amount of

information they contain, relative to their volume, is little and. More so, the archives in Ibadan rarely provided information on the missionaries and their contributions to midwifery and midwifery practices. This was sourced from the repository of a digital archive- the Adam Matthews Digital Archive – which provided detailed information on the posture of the medical missions and their home office towards maternal and infant healthcare. In addition, the records in these repositories have major limitations because they rarely present clear perspectives on the reactions of colonial subjects to colonial medical policies, maternal and infant welfare programmes, the state of maternal clinics, dispensaries and hospitals, and so on. Aside from the records that show the ways Africans in the urban areas of Ibadan approached the issues of maternal health, Africans in the rural areas are portrayed to be usually silent, docile, and passive on the subject. Since they operated in almost different locales and agitated for different agendas, Africans in the rural and urban areas were not entirely agitating on similar sensitive policy issues. For instance, the issues of maternal healthcare policy implementations and midwifery service deliveries, Africans in the urban areas were in the colonial administrative centres and had access to relatively standard medical facilities than the folks in rural communities. It is, therefore, not appropriate to sum their experiences of colonial medicine as one, as they are predominantly represented in the records in these archives as the portrait of African reactions to colonial medical policies. As a way to analyze the true voices of the rural people, and balance the information from the archives on African voices, Newspapers were used. The Newspapers, which were used in this thesis, include the Southern Nigerian Defender, the Nigerian Standard, the Nigerian Pioneer, and the Sunday Times. These newspapers give important insight into the state of public opinion on the maternal healthcare policy and implementation of the colonial government and missionary maternal and infant welfare programmes, the state of maternity

hospitals, clinics and dispensaries, and the agitations for better maternity services in both the urban and rural areas. More importantly, they highlight the contributions of the Ibadan people towards maternal health issues and amplify their reactions to western obstetrics. The views of the newspaper editors, colonial medical officials, as well as the colonial government and other stakeholders on various health and medical issues as it relates to mothers and infants are also documented in the text. This, therefore, brings an interesting perspective to the thesis and differentiates it from existing narratives on the history of medical practices in colonial spaces.

Another way to show the revolving voices of Africans in the events between 1983 and 1960 on midwifery and midwifery practices in colonial Ibadan is by gathering ample information from trained African nurses and midwives, traditional healers and birth attendants, old mothers, religious leaders and other relevant stakeholders that featured in the colonial medical schemes. However, few of this information was gathered and used to augment and corroborate archival records especially as many of the respondents interviewed had only second-hand information of the events that took place from 1893 to 1960. This is because it is somewhat difficult to locate these potential respondents because of the timeframe of the study and people who actively participated in the colonial medical service in Ibadan are either dead or too old to access mainly because of the challenge of COVID-19. Because of this, their descendants or junior colleagues in the health profession were interviewed. This explains why persons below the age of eighty were interviewed. Conventionally, the evidence supplied by a junior colleague, descendants or relatives constitutes valid sources of oral history[84], particularly in the case of this study, were they must been told stories of happenings during the colonial period and have also gone through the same process of training and had the same career. The later is applicable to the respondents

[84] Jan Vansina, *Oral Tradition: A Study in Historical Methodology*, (London: Routledge & Kegan Paul, 1965), 118.

interviewed in this study. In fact, not everyone has the ability to provide the historical data you are looking for. According to Vansina, finding informants whose status qualifies them to possess the necessary information is necessary.[85] Experts may pass down a tradition or it may be communicated through regular means, giving the researcher two options. In the first instance, it is understood that he must learn about the tradition from the experts and from them alone, as others will only know it in bits and pieces and from hearsay, whereas the experts will have learned it in a methodical way.[86] In fact, transmission by specialists occurs far more frequently than is widely believed. Once one is aware that a tradition is transferred in this way and is aware of the social group to which it belongs, collecting accurate information is not a problem. One could even claim that most traditions are specific to a group and are based on that group's previous history, making it simple for a researcher to learn about the past of any social group by just asking the group's members questions.[87]

I employed mainly the formal technique of oral data collection. Questions that were meant to elicit all relevant information from the respondents were drawn beforehand and directed to individuals believed to be knowledgeable in the aspect of maternal and infant health and midwifery. All informants answered the same questions to make it possible to assess and crosscheck their testimonies. I recorded their responses immediately, gave the data out for transcription and I analyzed later. When analysed, some of these information presented a lucid perspective of ways African subjects and medical practitioners received, appropriated and re-imagined medical ideas.

[85] Ibid, 190
[86] ibid
[87] ibid

In addition to this study's dependence on archival materials, Newspapers and oral interviews, it borrows insights from the social history of medicine and other related concepts in the reconstruction of the social history of midwifery and midwifery practices in colonial Ibadan, Nigeria, from 1893 to 1960. The idea is to demonstrate the inter-disciplinary approach to historical enquiry and to critically examine the policies of the Missions and the Colonial Government that determined the remaking of the traditional midwifery practices, their implementation, and the acceptance of western obstetrics by the people of Ibadan.

Chapters Overview

The study is organized into six substantive chapters and a conclusion. The first chapter gives a general background and an overview of the thesis research questions, the research sources and methodology, and literature reviews. The chapter two, "Missionary Medicine and Colonial Medical Establishment in Ibadan, 1890 to 1930" provides a background history to the introduction of western medicine and healthcare system in Ibadan. The chapter also analyzes the perceptions of the missionaries and colonial medical officials on African health and healthcare. It notes the ways such perceptions became reflected in midwifery and midwifery practices in colonial Ibadan. It is established in this chapter that the involvement of the colonial government on maternal and infant welfare was a well-calculated political ploy to sustain the colonial economy as evidenced in the partnership of the colonial government with the missionaries. This relationship encouraged the colonizing forces in the transformation of traditional midwifery and the institutionalization of western obstetrics.

The third chapter, "The Christian Medical Missions, Maternal Healthcare and Midwifery Development in Colonial Ibadan, 1920 to 1950", looks at the complex and diverse agendas of the

Christian medical missions in colonial Ibadan and reveals the deliberate, systematized and organized efforts of the various Christian medical missions in the development of maternal and infant healthcare services in the whole of Ibadan. This chapter further reveals how such agendas influenced the knowledge and practice of western obstetrics in colonial Ibadan.

The fourth chapter, "Western Trained African Midwives and Maternal Health in Colonial Ibadan, 1930 to 1960", examines the training of Africans in the science and art of western obstetrics to become midwives in colonial Ibadan. The training of Africans in western obstetrics is analyzed in terms of the ideas and conditions that guided African midwives in their career and practice of midwifery. The chapter also analyzes the contributions of African midwives in the spread and development of western obstetrics.

The fifth chapter, "The Ibadan Provisional District Council, Maternal Health, and Midwifery Practices in Colonial Ibadan, 1940 t0 1960", examines the contribution of the Ibadan people through the Ibadan Provincial District Council (IPDC) to the establishment and development of maternal healthcare infrastructures in colonial Ibadan. I explored how the IPDC influenced and amplified the voices and the agitations of the Ibadan people in a call for a better maternal and infant welfare services. The chapter establishes that Africans were instrumental to the debating and implementation of colonial health policies. I argue that the influence of the IPDC on colonial medical policies gave them a greater medical responsibility for the development of maternal and infant health in colonial Ibadan.

The sixth chapter, "Marginalized Wellness: Exclusionary Maternal Healthcare and Midwifery Practice in Colonial Rural Ibadan, 1940 to 1950", I discuss the dilemma of maternal health in the margins of Ibadan. This chapter also analyzes the colonial politics of maternal healthcare

provision and services in the rural areas of Ibadan, and the ways in which colonial subjects in the margins of Ibadan reacted to such politics based on the original promises of the colonial government on maternal and infant healthcare.

Chapter Seven is the Conclusion of the thesis. It summarizes the conclusions concerning the social history of midwifery and midwifery practices in colonial Ibadan, from the 1890s to 1960. It also highlights the perceptions of the Ibadan people to western obstetrics.

CHAPTER TWO

Introducing Colonial Medicine and Medical Establishments in Ibadan, 1900 – 1920s

Introduction

This chapter focuses on the significant ideas that shaped the mindset and activities of the medical missions in colonial Ibadan from the 1900s to the late 1920s. Specifically, the chapter highlights how these ideas facilitated the missions' medical outreaches towards maternal and child healthcare and the establishment of the first medical facilities during this period. The perspectives around this is to see how such imaginations gave rise to the dominant discourse surrounding midwifery practice as an important aspect of missionary and colonial medical science. First, it is important to state that, by the end of the nineteenth century Western medicine had been introduced and has evolved to become a very popular mode of treatment in most colonial territories in Africa. Initially, Western medicine was introduced to serve the pressing health needs of European settlers – military corps, missionaries, traders and colonial administrators – in British African colonies. Western medicine was specifically introduced to control high European morbidities and mortalities from tropical diseases such as malaria, dengue fever, yellow fever and filariasis. This is because; upon the arrival of Europeans to Africa, their survival rate was at a critically low level as the average life expectancy rate of Europeans ranged from two to eight years. In some cases, it was less than three months. These high rates of European deaths earned African colonies the label, "the White Man's Grave."[88]

The loss of European lives, widespread infections and the socio-economic dilemma this posed to the British colonial government through its inability to enforce its imperial rule on colonial

[88]Philip D. Curtin, "The White Man's Grave: Image and Reality, 1780-1850". *University of London Institute of Commonwealth Studies, Issue 14 of Reprint series*.(1961).

territories as a result of the death of some colonial administrators, informed the introduction of Western medicine such as the first health establishments and western therapies like quinine in Africa.[89] It also facilitated the improvement of research in the diseases of the tropics. The mindset of the colonial government during the early period of colonial rule was to transform tropical colonies into habitable areas for Europeans.

By the twentieth century however, Africans had become included in the medical plans of the colonial government. The policy for the inclusion of Africans into the medical plans of the colonial government started in the 1890s, when Joseph Chamberlain, the Colonial Secretary of State through his presentations themed "Constructive Imperialism" pushed for the intervention of the British imperial government to develop British African colonies in what he referred to as the "imperial estates" by including the West African colonies in a system of imperial developmental preference. He believes that Britain's quest to explore the potentials of the West African territorial holdings was hinged on her ability to develop such territories for the benefit of the indigenous inhabitants. It was around this interest of empire expansion that Chamberlain (from 1895 to 1903) further pushed the Britain colonial government to make greater use of Western scientific knowledge and expertise, specifically in the field of tropical medicine.[90] Later in the century, specifically during the interwar years, medical policies began to address pressing issues related to African health problems, such as the infant and maternal healthcare that was creating a

[89] ibid

[90] ***Michael Worboys***, "The ***Colonial*** World as ***Mission and Mandate***: Leprosy and Empire, 1900-1940", *Osiris 15,* 2nd Series. (2000)

disproportionately high ratio of maternal and infant related death in comparison to general death rate.[91]

However, groundbreaking and ambitious Chamberlain's preposition was, still, healthcare provisions in British African colonial territories was limited to addressing the health of a small fraction of the colonial population - the Europeans. There however, remained enormous concern within the empire, especially as regards African health and the ways it affected economic productivity. Thus, after World War 1, the colonial office in Britain became more concerned about the health of Africans, specifically on the high rates of maternal and child mortality and emphasized to various colonial governments on the need to address these series of social impediments confronting the empire.[92]

These concerns shaped the perceptions and activities of the colonial government towards voluntary agencies like the medical missionaries in colonial territories. These concerns reflected in colonial medical discourses, influenced the relationship between the colonial government and these non-state agencies on matters of health and healing.[93] As argued by Megan Vaughan, the interest of the colonial government was to leverage on the peculiar strength of these agencies to provide for the basic health needs of the rural populace. For one, the medical missions had mastered the ability to navigate through interior terrains in their quest to fulfill evangelization missions. At this point, they were positioned at the central stage of rural health service.[94] On a number of occasions, as detailed in David Hardiman's edited work on *Medical Missionaries in*

[91]G. Ncube, "Robert A. Askins and healthcare reform in interwar colonial Zimbabwe: The influence of British and trans-territorial colonial models", *Historia*, 63,(November 2018), 62-92, http://dx.doi.org/10.17159/2309-8392/2018/v63n2a4

[92] Helen Tilley. *Africa as a Living Laboratory: Empire, Development, and the Problem of Scientific Knowledge, 1870-1950*,(Chicago: University of Chicago Press, 2011).

[93]Megan Vaughan, Curing Their Ills*: Colonial Power and African Illness*, (Stanford, California: Stanford University Press, 1991),

[94]ibid

Africa and Asia, missionaries carried out medical outreaches by relying on government's financial and logistic support.[95]

The Missionary's medical outreaches were influenced by profound interest to reach the souls of 'pagans' by curing bodily ills. At the heart of these outreaches are missionaries' interests in maternal and infant health. According to Michael Jennings, welfare of children, expectant and new mothers, fell within a particular Christian vision of protecting the innocent.[96]While the missions had their objectives centered on this, their understanding of the critical value of not only saving the vulnerable was also logical in promoting the reception of the gospel.

The story of missionary interest in African health however spans from an age-long structure of traditional ideologies of organized missionary bodies. Missionary bodies like the Church Missionary Society (the CMS), the Wesleyan Methodist Missionary Society (WMMS), the American Baptist Society and a number of Catholic missionary bodies were key players in the dispensation of healthcare to Africans. Their activities were framed as an ideology that stemmed from age-long traditions within the institutions they represented on the sub-continent. This ideology includes the opening of Africa to legitimate commerce, Christianization, colonization and the promotion of secular science. The missionaries believed these ideologies would help regenerate the African mind.

The works of early European and mission doctors in saving lives and alleviating the sufferings of Africans was based on these ideologies and thus helped attract followers to the missions and contributed to the prestige of western culture. While Western medicine was portrayed as an

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[95]Hardiman, David,"Healing bodies, saving souls : medical missions in Asia and Africa," *The Wellcome series in the history of medicine*, Clio medica (80), (Amsterdam ; New York: Rodopi. 2006).

[96] Jennings, M.,"Healing of Bodies, Salvation of Souls': Missionary Medicine in Colonial Tanganyika, 1870s-1939". *Journal of Religion in Africa, 38*(1), (2008), 27-56. Retrieved from http://www.jstor.org/stable/27594444

emblem of benevolence and civilization by Europeans, it also played important roles in the legitimization of imperial dominance in the socio-cultural, political, economic and as well as in the health and health system of the colonized. The missionaries' use of Christianity and evangelism in promoting Western medical knowledge was instrumental in claiming superiority to the understanding of the body, health and diseases of Africans. Thus portraying African traditional healing and healers in negative light, by, linking the African traditional healing practice to idolatry. Colonial physicians typically depicted African medicine as dirty and superstitious, thereby authorizing racial and cultural superiority. This imagery was important in shaping the activities and outreaches of medical missionaries in Ibadan as we would see in the succeeding sections of this chapter.

The Mindsets of Early Missionaries on African Health

By 1900, seven European missionary societies had commenced the evangelization of Ibadan - Church Missionary Society, Roman Catholic Mission, Wesleyan Missionary Society, Baptist Mission, Church of God, Salvation Army and Seventh Day Adventist Mission. The Church Missionary Society (C.M.S) was the first mission to arrive in Ibadan followed by the Protestant Churches such as the Baptist-Methodist (Wesleyans), the Salvation Army and lastly the Roman Catholic Church.[97]Like in other areas in Africa, the missions in Ibadan came primarily with an intention to convert and win souls into the Christian faith through the preaching of the gospel. In spreading the gospel however, the missions acknowledged the importance of healthcare in its evangelical pursuit. The conversion of Africans to Christianity and the role missionary doctors had to play in alleviating the health challenge in Africa was a symbolic representation of western civilization. However, missionary medical work began on a small scale, and with time, the

[97] NAI, File No:12723, Annual Report Oyo Province, 1924,51-52

missionaries became the greatest proponents of western medical science throughout the colonial period as they provided the bulk of healthcare services to indigenous Africans.[98]

African health was central to missionaries' evangelical agendas of evangelizing both 'the body and soul' of potential converts. They believed that evangelism devoid of medical outreaches was unproductive because sick converts were prone to renege on Christian commitments and convictions. By consulting with local healers, missionaries feared that early converts could return to old "pagan" lifestyles. Driven by this mindset, CMS missionaries in Ibadan wrote often to the home organization, calling for the funding of medical services. In 1896, they invited doctors and nurses to Ibadan. A missionary around the Yoruba mission wrote of the desperate need for medical work in Yoruba countries. She stated that neglecting the physical health of African converts was detrimental to the course of evangelization. She claimed that;

> When a Christian woman's child gets ill, what is she to do? The only remedy she knows of is to buy heathen charms. How can we tell her to take away the charm unless we can give her the medical help that she needs? It is as hard as if a clergyman at home forbid a mother to call in the help of an atheist doctor to attend her sick child when no other medical help was available. How many Christian mothers at home could stand such a test? By our neglect of their physical welfare, we are putting the faith of the women especially to a server trial than many a woman at home could stand. Infant welfare is one of the biggest needs of the country today.[99]

[98] Megan Vaughan, *Curing their Ills*, . 56
[99] Adams Matthew Digital Archives, Annual Report of the Church Missionary Society, 1926-27,.23

As explained by Jennings, medical outreaches were important to complement itinerant missionaries who often struggled alone to fight against diseases and superstition (represented by the figure of the traditional healers).[100]African traditional knowledge and practice of healing as performed by African traditional healers were contested, challenged and presented as "unscientific" by the missionaries. The holistic worldview and attribution of disease causation to both physical and spiritual forces by African traditional healers was seen as "illogical" in the missionaries' science of medicine.[101]Despite this stereotyping, the variety of functions commanded by African traditional healers, which includes physical and spiritual healing, made them social, economic and politically powerful in their communities.[102]

The affluence welded by an African traditional healer was not only within the confines of his immediate environment, but extended onto neighboring communities. This seemingly powerful status of African healers troubled the missionaries, as it posed major threat to the missions' evangelical activities. In this regard as explained by Kent Maynard, Christian missionaries and their agents, including catechists, priests, and pastors sort ways to destroy African traditional healing system.[103] To achieve this, the missions went on a rampage of preaching against African traditional healing practices whilst buttressing its "unscientific" methods of healing. As an alternative to supplanting African healing practices, the missionaries through its institutionalized method of healing, established medical facilities.

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[100] Jennings, "Healing of Bodies,"27-56.

[101] Stephen Hunt, "Doing the Stuff: The Vineyard Connection," in *Charismatic Christianity: Sociological Perspectives*, eds. Stephen Hunt, H. Malcolm and Tony Walter, (London: Macmillan Press Ltd, 1997), 85.

[102]Honwana A. M., "Healing for peace: Traditional healers and post-war reconstruction in Southern Mozambique,". *Peace and Conflict: Journal of Peace Psychology*.3(3) (1997),:293–305

[103]Kent Maynard, *Making Kedjom Medecine: A* History of Public Health and Well-Being in *Cameroon*. (Westport, Conn.: Praeger Publishers, 2004)

In Ibadan, the American Methodist Mission prioritized setting up of hospital systems because it availed them the opportunity of evangelization on the bedside. As explained by Tilley[104], missions medical establishments was important as it served the purpose of converting Africans into Christianity, continuous fellowshipping and easy communications with the indigenous people without any form of restrictions. In fact, the Methodist Mission in Ibadan in a memo to the Resident Medical Commissioner of the Oyo Province, clearly stated, "We look upon our medical and social work as an expression of the Gospel we preach. Our main activity is the proclamation of the Gospel."[105]

Starting from the 1890s, the first healthcare facility – a medical station (which also doubled as a dispensary) was established in Kudeti, Ibadan, by the Christian Missionary Society (CMS).[106] From the 1920s, other medical missions had established healthcare facilities in Ibadan. These missions' medical facilities were established to serve wide-range purposes. For instance, in 1921, the American Baptist Medical Mission established an ad-hoc healthcare facility in Ibadan, to meet the general healthcare needs of those in the interior areas. On the other hand, the Baptist Mission prioritized maternal and child healthcare by establishing a maternity clinic in Ibadan.[108]The maternity clinic served as an antenatal, delivery and postnatal clinic to the natives in the rural areas of Ibadan.[109]More details of the Fiditi rural maternity clinic will be given in the chapter six of this study.

Missions' medical facilities in Ibadan did not only function as a place of healing. It also served as a place for evangelizing without any form of obstruction. Africans, who patronized the

[104] Helen Tilley,. *Africa as a Living Laboratory: Empire, Development, and the Problem of Scientific Knowledge, 1870-1950*, (Chicago: University of Chicago Press, 2011).
[105] NAI, File No: Oyo Prof. 1/1589, Annual Report 1955, 77
[106] Precise Book: CMS Nigerian: Yoruba Missions, 1895, 16
[108] NAI, File No: 2180/1, Rural Health Centre Fiditi. 1949 -1950. 41
[109] Ibid

missionary health facilities in Ibadan, spoke of the prayers and teachings of the gospel they received before and after they were attended to.[109]Reports of such practices in missionary medical establishments suggest that, mission medical facilities was used also as a facility to house converts from relatives who were angry about their conversion and groom them in the "Christian way." The missions believed their works on health and healing was also a social commitment as expressed in the Gospel they preach, however, not forgetting their main activity is in the proclamation of that Gospel."[110]

Missionaries' in their extension of medical works to African colonies at different points, saw themselves doing so in the transition process of Africa for different reasons. Before the First World War, medical missions in Africa provided medical services for humanitarian purposes.[111] This started through the health care provisions made available to missionary agents in Africa. With the mission's progress in evangelism in Africa, coupled with the health realities in the tropics, the medical missions extended their medical outreach to their host communities.

As a ploy to secure the acceptance of Christianity and mission medicine, the missions contended with African healers who at the time exerted so much authority over the indigenous peoples. This they did by training African agents in Western biomedical knowledge, which was seen as vital tool in the foregrounding of Christianity and western medical culture in Africa.

Medical mission has exhibited profound interest in training African medical auxiliaries as a way to reach the medical needs of their African hosts. To them, training corps of African medical subordinates was the most practical way to influence African patronage of western medicine in rural areas. According to Walima Kalusa, training African medical subordinates was important to

[109] NAI, File No: Oyo Prof. 1/1589, Annual Reports: Missions, 1938,77
[110] Ibid.
[111] Ranger T., 'Godly Medicine',.262; Williams, 'Healing and Evangelism',.274-285; Walls, '"Heavy Artillery"' 288-290.

the missionaries for championing missionary medicine crusade against 'traditional' medical culture and praxis. Their roles were in undermining local cosmologies of disease and healing, often perceived by colonial and mission doctors, respectively, as an obstacle to their imperial crusade and as a barrier to evangelical efforts to win for Christ the hearts and souls of the subjects of empire.[112] Kalusa further argued that besides 'persuading recalcitrant patients and skeptics of the superiority of western medicine,' missionaries saw auxiliary workers as important instruments for the propagation of Euro-Christian values on the African soil.[113] It became pertinent to capacitate them with a profound understanding of medical discourses as a way to navigate and penetrate colonial/mission enclaves located on the peripheries of the colonial state. In these spaces, especially in rural communities with little or no access to medical facilities, missionaries saw them as instruments to suppress and annihilate pre-existing belief systems, to civilise the 'Dark Continent' and, above all, to convert its people to Christianity (the raison d'être of medical evangelization). In Ibadan, missions such as the Methodist Missionary Society and the Seventh - day Adventist operated the Wesley Guild Hospital and the Seventh - day Adventist missionary hospital used for training Africans. The medical missions in Ibadan believed training of Africans in western bioscience will help in solving the scarcity of health personnel, help spread the knowledge of western medicine, avail trained Africans the license to practice in the province and guarantee the continuous training of other Africans.[114]

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[112]Walima Kalusa, "Disease and the Remaking of Missionary Medicine in Colonial North Western Zambia: A Case Study of Mwinilunga District 1902-1964". PhD Thesis: John Hopkins University, 2003; Walima T. Kalusa, Missionaries, African Patients, and Negotiating Missionary Medicine at Kalene Hospital, Zambia, 1906–1935, *Journal of Southern African Studies, 40:2,* (2014), 283-294, DOI: 10.1080/03057070.2014.896717

[113] ibid

[114]NAI, File No: M.H. Fed 1/1 3431, "Sgd. H. W. Forshaw. Medical Officer Handing Over, to Sgd. W. C. Dale, Medical Officer Taking Over," 22nd July, 1943,1 -2.

The extent to which these medical auxiliaries played out these roles speaks to their agency to either accept or discard European medical discourses. Kalusa argued that they were instrumental in popularizing African cosmologies despite operating with a colonial medical bureaucracy. In the fourth chapter, I will provide a similar argument by showing how African nurses and midwives alternated roles as both viable collaborators with European nurses affiliated to the CMS and WMMS and as the major voices for African midwifery practices.

In Ibadan, the Seventh-day Adventist established hospital facilities to pursue the objective of training African nurses and midwives. Trained nurses were awarded with Grade II certification that approved of them as professional nurses to administer native administration health centres and dispensaries.[115] A major area of this training was in obstetrics. According to Hilary Marland[116], the nineteenth century marked by missionaries' interest in obstetrics was triggered by concerns over the high rates of infant and maternal mortality. Training in obstetrics was fundamental to the Seventh - day Adventist medical mission in Ibadan. This training offered solution to the impending crisis of scarcity in medical personnel's attending to maternal and infant health. It also was an opportunity for the Seventh – Day Adventist to monitor each family unit of its converts through trained African midwives.[117] This perception is deeply rooted in the ideological belief of the Seventh Day Adventist mission. This started with the grooming of Africans as evangelist to spread the gospel to fellow Africans. Virtually all the great movements towards the Christian faith in Africa by the Adventist missions have been African led.[118]It believed by the SDA missions that it is easy to convert Africans if their African brothers and

[115] NAI, File No: MH/Fed 1/15384F, Annual Medical and Sanitary Report: Mission Activities, 1944.
[116]Hilary Marland, "The midwife As Health Missionary: The Reform Of Dutch Childbirth Practices In The Early Twentieth Century",in, *Midwives, Society and Childbirth: Debates and Controversies in the modern period, eds.* Hilary Marland and Annie Marie Rafferty,(New York & London: Routledge, 1997).
[117]NAI, File No: MH/Fed 1/1 5384F, Annual Medical and Sanitary Report: Mission Activities, 1944, 7.
[118]Andrew Finlay Walls. *The Missionary Movement in Christian History: Studies in the Transmission of Faith*, (Mary knoll: Orbis Books, 1996)

sisters are the ones doing the conversion. For instance, was the conversion and training of Baale, Oyenusi, in Erunmu, Ibadan by the Adventist mission – who later became the evangelical translator for the Adventist. These activities not only helped the church to win more converts for the missionaries, it was also a step towards the subtle indoctrination of Ibadan natives into the church.[119]Hence, it will be easy to monitor African converts to keep using mission hospitals if medical attendants were Africans.[120]

Other medical missionaries in Ibadan such as the WMMS and CMS took up trainings in health visiting and sanitary inspection respectively.[121] The trainings in health visiting and sanitary inspection correlated with the evolution and introduction of western science of hygiene and cleanliness in Africa. The medical missions anticipated a favorable response of the locals to the introduction of western sanitation system and its development in Africa. The medical missionaries however got a hostile response, and as a way to ensure the sanitation program does not fail, they therefore saw the need include Africans into the sanitation program by introducing the methodology of trainings in health visiting and health inspection, in order to enable the cooperation of the locals. In Ibadan, this training was not introduced only to arouse local interest but also to lay the foundation for the introduction and development of other health measures, and also closely monitor the health activities of the indigenous people.[122]

During this period, information about African's health and progresses recorded by the medical missions was being communicated to the home offices through Christian pamphlets, magazines, and newsletters. In so doing, the missionaries and people at home had a preconceived notion about Africans. The missions' home office understanding of Africa, was of a region plagued with

[119] ibid
[120]NAI, File No: MH/Fed 1/1 5384F, Annual Medical and Sanitary Report: Mission Activities, 1944.p.7
[121]ibid
[122] ibid

critical health challenges, made complicated by health and healing practices of African indigenous healers. This understanding affected its policy advocacy in the region. One of such areas of policy advocacy was in maternal and child health and health care.[123]

Maternal and infant health care took central stage in missionaries' medical activities for three major reasons. First, was the missionary's humanitarian commitment to support the health of infants and mothers by making available its medical services. This interest stemmed from the high mortality and morbidity rates of both mother and child in nineteenth century Africa. Aside the humanitarian effect this portrayed of the missionaries in the eyes of Africans, for the missions, it was a quick and easy way to get more converts into the Christian faith. Missions' contributions in this major sector of healthcare promoted its popularity among the natives and the colonial government. It likewise presented the missions an opportunity to promote its evangelical activities in Africa.[124] Second, the missionaries in the twentieth century were informed on trends in colonial medical discourses on nutrition, public health education and maternal and infant healthcare. Medical missionaries showed interest in these ideas and thus increased their participation in this sector of medicine in colonial Africa. While the missions were not the only ones promoting this trend, they however became well known in their commitment towards public hygiene education, cleanliness, and infant and maternal healthcare provisions in Africa.[125]Third, the subsidizing of missions maternal and infant services by the colonial government gave a push to missions' continuous contribution to maternal and infant healthcare from the 1920s. The colonial government by the twentieth century had ascribed so much weight to maternal and

[123] Geoffrey Chamberlain, "British maternal mortality in the 19th and early 20th centuries", *Journal of the Royal Society of Medicine*, Vol. 99, No. 11, (2006), 559-563

[124] Michael Jennings, "A matter of vital importance: The Place of the Medical Missions in Maternal and Child Healthcare in Tanganyika, 1919-39," in *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa*, ed. David Hardiman, (Amsterdam: New York; Rodipi, 2006),229

[125] ibid., 230

infant welfare. This is because of the relevance of infant and maternal health to the colonial economy, which was in need for more healthy and strong able-bodied men and women to work colonial plantations and industries. As at the nineteenth century, missionaries had already begun works around the area of maternal and infant healthcare. To encourage the increase of the services of the missions around this sector, the colonial government made available its support to infant and maternal welfare by providing grant in aids to missionaries.[126]

Colonial Justification for Western Medicine

Until the interwar years, colonial medical services were limited to improving the health of European settlers. This changed however, when western medical practices and services was introduced in the 1920s to the people of Ibadan as a way to meet up with certain colonial expediencies. This was further intensified with the colonial government's partnership with the medical missions in providing maternal and infant healthcare services in Ibadan. First, under this partnership, it was imperative to introduce a special rural health scheme for African communities because of what it meant for British dual mandate. Secondly, it was important because prior to this time in Ibadan, the colonial government had assumed no legal jurisdiction in the administration of Ibadan, thus, making it semi-independent.[127]The Colonial officials in Ibadan up until 1920 had administered the region without any form of legal authority. As such, the colonial management of Ibadan was threatened as the Ibadan people still went about the socio-political status quo of their community. Based on the colonial officials inclination of Ibadan, the colonial administrators concluded that the resentment by the locals was due to lack of colonial welfare

[126] Ibid,.228
[127]NAI, File No: Oyo Prof. 1/1 09723, Oyo Province Annual Report, 1922, 57

packages in the region as enjoyed in other Yoruba areas like Lagos, Abeokuta and Ijebu, amongst which was the health provisions for the people.[128]

Conversations within the colonial bureaucracy in Lagos and Southern Nigeria became particular about living up to advancing both the course of empire and plights of Africans that needed health services. Supporting the need for the extension of medical services to Ibadan and its interiors, S.L.A. Manuwa (who later became the Director of Medical Services in Ibadan), stated that, "it cannot be too often emphasized that the hub around which public health administration in any tropical country must revolve - if it is to justify its existence - is a well - planned and intelligently executed rural health policy."[129]

By 1920, the senior medical officer in Ibadan had reported of a considerable amount of sickness amongst Europeans. Despite the fact that majority of Europeans had been inoculated against yellow fever and plague, the epidemic kept spreading among them. This further attracted the attention of colonial research organizations such as Rockefeller. Dr. Hanson and Mr. Dyer of the Rockefeller Yellow Fever Commission were sent to investigate the epidemic in Ibadan.[130]Their findings led to intensive campaigns, seeking the improvement of the general health conditions in the colony. The medical officers who were in close contact with the locals in Ibadan supported this. In addition, reports from other colonial medical officials also showed a close connection between public health and economic development. Attempts was therefore being made to coordinate progress in public health towards the colonial objective of a general advancement in the economic and social conditions of the indigenous people, this is with reference to nutrition and increased consumption of foodstuffs leading to an expansion of production in a the Colony.

[128] ibid
[129] NAI, File No: Oyo Prof. 1/1, 2200/2, Medical Policy – Oyo Province, 1954, 130-140
[130] NAI, File No: CSO 26/2, 12723, Vol. III, Oyo Prof. Annual Report, 1925,33

This was noted under the heading of "Trade" that economic progress on these lines depends upon cooperation with other medical and educational authorities.[131]Thus, this became a call for colonial action, provoking the expansion of colonial health and medical services to the locals, as an initiative to manage and control the epidemic. It is under this initiative that the scheme for rural health and medical services was introduced in the British colony of Ibadan.

By the late1920s, the scheme for preventive medicine and hygiene was introduced in Ibadan. This was after adequate consultations with the lieutenant governors and residents in Nigeria. The scheme proposed that dispensaries be built and put under the charge of the Native Administration; that the dispensaries be equipped and staffed by officials who would have received one year intensive and standard training at some twenty-six training centres; that they be trained in the thorough knowledge on how to use small standard set of drugs and dressings; give injections and treatments for yaws and syphilis; and diagnose common ailments in the colonies.[132]This sort of arrangement, was what Ann L. Stoler and Frederick Cooper in *Tensions of Empire* explicitly highlighted while explaining how metropole and colony provided new perspectives to the definition of modernity and how welfare were developed and how new practices were included and excluded to ensure a working system.[133]

The proposed scheme became the executive blueprint for the establishment of health facilities and training of Africans in the western knowledge of medicine in Ibadan. The Adeoyo hospital, the Agodi and Oranyan dispensaries were established respectively to flag off the scheme and to pursue the developmental needs of the locals through the preventive medicine and hygiene

[131]The Journal of the Royal African Society, April, 1936, 196 – 197.
[132]NAI, File No: CSO 26/2 15216, Vol. IV, Scheme for preventive medicine and hygiene in Nigeria, 1930,1
[133]A. L. Stoler and F. Cooper, "Between Metropole and Colony: Rethinking a Research Agenda," in *Tensions of Empire: Colonial Cultures in a Bourgeois World* eds. F. Cooper and A. L. Stoler, (Berkeley & Los Angeles: University of California Press, 1997),10

programme under the plan of the scheme. By 13 October 1927, the Adeoyo hospital facility became available to the people of Ibadan as a take-off point for the promotion of the colonial rural healthcare scheme through its health provisions and training of medical and nursing staff. The Adeoyo hospital, which contained an accommodation of twenty-three male and seven female patients in February 1928, received its first in-patients, with an average of twenty-eight patients per day. While in the same year, the Agodi (also called the Government Hill) dispensary, started functioning as a service dispensary for the Ibadan Native Administration police, employees and prisoners from the Native Administration prison. The dispensary had an average number of nineteen patients per day. While the Oranyan dispensary, which was a small health facility, stationed at the heart of Ibadan served mostly schoolchildren in the neighbourhood. All of these health institutions were patterned along the British constructive imperialism plan of preventing the spread of tropical epidemics, keeping the African labour force in good working shape and preserving the health of Europeans.

As part of the provision of the scheme, the administration of the established health facilities under the scheme was placed under the Native Administration with the appointment of a colonial medical officer. The colonial government saw this as a way to maintain order, control and easily govern the people without any form of uprising by involving the Native Administration. The colonial medical officers that were appointed were carefully approved based on the need for continuity and ability to gain the confidence of the locals. This is with the view that such CMO could attract the locals to patronise Western medicine. By 1928, the first Senior Medical Officer

and a Medical Officer were appointed and stationed at the Agodi dispensary in Ibadan. A medical officer of health was stationed in Adeoyo hospital in the latter half of the same year.[134]

With the progression of the rural healthcare scheme and the end of colonial medical "garrison service"- a service, which existed for the sole purpose of looking after the health of colonial government officials,[135] colonial medical officers previously under this service, made themselves readily available into the work of the African population. This is because there was a general desire by the locals for Western medical treatment unlike in the past. Colonial Officials became ardent believers and supporters for rural healthcare provisions specifically because of their daily interactions with the locals. In Ibadan, colonial medical officials such as Doctor Okeefe, Nelson, Newport and Miss Purvis were stationed for a long time in Ibadan because of their relationship with the people. Their stay in Ibadan helped in the administration of established healthcare facilities in Ibadan and went a long way in encouraging the locals to patronise the colonial rural medical scheme.[136]

Introducing Infant and Maternal Healthcare

At the beginning of the 1920s, maternal and infant healthcare became a crucial aspect of the British colonial politics. The colonial administration had begun to have serious concern for the high infant and maternal mortality rates in the British colonies, having recognised the importance of African health to the economic growth of empire. As such, the loss of infant lives posed a major challenge to the economic survival of the colonial economy. Therefore, was the need to reduce the impact of population loss, infertility, and low birth rates to meet the growing

[134] NAI, File No: 15216, Vol. IV/ CSO 26/2, Scheme for preventive medicine and hygiene in Nigeria,1930,7
[135] For more details on colonial medical "garrison service", see, Charles Jeffries, *The Colonial Empire and its Civil Service*, (Cambridge: Cambridge University Press, 1938).
[136] Ibid,13

industrial labor needed in various plantations and industries in Ibadan. It is important to note, that, human resources are needed to run the industries and plantations in colonial Ibadan. The infant and maternal mortality crisis during the colonial period therefore threatened and posed a major challenge to the sustainability of the colonial economy in Ibadan. Although infant and maternal mortality has been an issue of social and health discourse prior 1920, in Nigeria however, formal recognition was given to infant and maternal mortality with a recommendation that the colonial government becomes more active in finding solution to the challenge from the 1920s. This was reflected in a memorandum submitted by the Colonial Advisory Medical Committee to the Secretary of State for the Colonies, where the committee stated that: infant and maternal mortality rates were often disproportionately high in comparison with the general death rates and therefore stressed the importance of maternal and infant welfare work.[137]The commission recommended that the colonial office, actively take up duties in this sector of health care of the people.

Based on the recommendation and the submission of the committee, the colonial government proposed the development of maternal and infant a welfare scheme that includes the construction of maternity hospitals, training of Africans on Western obstetrics and educating African women on proper health hygiene.[138] The colonial government believed that, a properly constructed maternity facility, education of mothers on hygiene and training of Africans in modern midwifery practices would serve the purpose of reducing the rate of maternal and infant mortality.

[137]NAI, File No: MH(FED) 1/1, 5234/S.I, Medical Policy in Nigeria, 1948,1-6
[138]Ibid. 4

During this period in Ibadan, the exact number of infant birth and death rates were not recorded officially, not until the 1950s.This is because available statistical records before the 1950s were not a true representations of the local circumstances as there were a high number of traditional childbirth that happened at home as against hospital birth.[139] However, according to the annual report reviews of the missions and colonial hospital activities, records of adult females and infant mortality stood at an alarmingly high and drastically increasing proportion while in comparison with adult males in the region. For instance, by the 1920s the estimated figure for an adult male death rate recorded was28.8 per 1000 and 290.5 of infant and maternal mortality per 1000 respectively.[140]Based on the perception of the missionaries and colonial officials, and the reason for modern midwifery practices, the major reasons ascribed to the causes of increased maternal and infant death rates in Ibadan were traced to the poor physical condition of the environment and the "primitive" delivery system by the native midwives hence the low rate of live births. However, with more observations it became obvious to the colonial government that the growing spread of disease attributed to infant and maternal mortality rate was not entirely because of the traditional birthing practices of the indigenous people, but also due to the tropical conditions and the lack of appropriate preventive medicine. This thus led to the establishment of more maternity hospitals and clinics administered by the missionaries and supervised by the colonial government.[141]

Maternal and infant welfare services became common discussion amongst colonial officials. Measures to reduce maternal and infant mortality in the colonies were being considered. These

[139]WL ANN REP WA28 NH5 N68 1922-1925, Annual Medical and Sanitary Report for the Year 1922, 19; WL ANN REP WA28 NH5 N68 1926-1928, Annual Medical and Sanitary Report for the Year 1926, 37.
[140]NAI: *The Nigerian Pioneer*, January 25, 1924, 6
[141]NAI, Church Missionary Society, African General: Cooperation between the Government and the Mission, 1926 – 1947.

includes the establishment of maternity hospital and clinics; maternal education; controlled feeding of infants; child bearing practices; training of Africans in Western obstetrics; amongst others.

The colonial government was however faced with the challenge of funds to execute colonial maternal and infant welfare policies around this sector of health care. The British governments' preoccupation with the First World War and the fact that it had barely recovered from the South Africa war, was still struggling to resuscitate the British economy at home, and also sustain and balance the colonies economy. Therefore, starting new colonial projects in the colonies would become a financial burden on the British government.

In Ibadan however, in order not to put the project of maternal and infant welfare on hold, the colonial government initiated a plan to include voluntary agencies as an alternative to reducing financial cost, specifically because of the urgency of the situation in the region. Initially infant and maternal healthcare have been within the purview of the Christian medical missionaries. Their activities were however few due to financial constraints. With the growing awareness of the medical needs around infant and maternal healthcare, coupled with limited resources in funding the new maternal and infant welfare projects in the colonies, the colonial administration decided to intervene substantially by weaving its maternal and infant welfare policies around the medical missionaries through partnership in the 1930s and 1940s with the Native Administration and private medical practitioners respectively (all grouped as voluntary agencies) by providing grant-in-aids in exchange for their services.

Before the 1930s, the missionaries had written to the Colonial Government for financial aid. The Colonial Government who was however held up with a major challenge of meeting up with its

infant and maternal healthcare welfare policy financially saw this as an avenue to initiate its plan, by utilizing the health establishments and services of the missionaries. In a letter Ref. No, B.1.3c/57 from S.L.A. Manuwa (the Deputy Director of Medical Services, Western Provinces) to the Honourable Director Medical Services in Lagos he said;

> The difficulty, which we find at present in keeping the medical development programme up to schedule, is a strong argument in favour of making use of the resources of the voluntary agencies where these are available. I wish therefore to enquire whether Government would be willing to agree in principle to the proposal that development funds allocated to particular hospital project which we are unable to immediately undertake might be made available to a voluntary Agency for the purpose of building a combined hospital either in the area originally proposed or in an alternative area approved by the honourable Director of Medical Services in cases where the area originally proposed is already adequately served by the Mission Hospital.[142]

The Colonial Secretary of State for the colonies approved this proposal in 1929 but with some strident conditions of relationship with the voluntary organizations. Before the Colonial Office fully established its relationship with the missionaries and other voluntary agencies in regards to the implementation and development of the maternal and infant welfare policies, an outline of the conditions of agreement subject to the Sydney Phillipson's recommendations of 1920 was drafted.[143] The conditions to which the proposal would be implemented were based on the

[142] NAI, File No: Ondo Prof1/3, D8, Medical Development. 1947, 2
[143]Ibid. 7

Missions' willingness to accept grant in aids and able to undertake construction of healthcare facilities, training and staffing as follows;

1. The mission will build the hospital together with its ancillary buildings and staff quarters in accordance with Government specifications and plans.

2. Copies of all plans and specifications to be submitted to the Regional Deputy Director of Medical Services for inspection and approval.

3. The hospital will admit persons of any race or creed and impose no obligatory religious observances on the patients.

4. The Missions will undertake the management of the hospital and in particular will provide and control the necessary staff of all grades, the number of trained staff being in proportions approved by the Regional Deputy Director of Medical Services.

5. Mission Medical Officers practicing in the hospital will accept no private fee or reward for their services.

6. The Hospital will comply with the conditions prescribed in the Hospital Fees Ordinance as regards the treatment of Government and N.A officers and employees.

7. The Hospital will be recognized by the Government and the Mission as a hospital of special type established by their joint effort and will be placed under the Board of Governors on which there shall be official medical administrative and financial representation: the Board to be responsible in general for the preparation of the annual estimates of income and expenditure of the hospital. The Chairman of the Board shall be a representative of the Mission of high

standings; the mission's officials shall constitute the majority of members; and the local Native Administration shall be represented.

8. Should the Mission prove unable to manage the hospital to the satisfaction of the Board of Governors or of the Government representatives on that Board, the Mission will pass over control of the hospital to the Government.[144]

Before the approval of the proposal, the Colonial Government invited the Christian Medical Missions working around the colonies in 1928, requesting that they provide medical and nursing assistance, specifically on infant and maternal welfare services. The Colonial Government proposed to offer adequate subsidies as grant-in-aid if the missions would agree to undertake medical services. The missions accepted the suggestion. This resulted in regular grants-in-aid to the missions from the 1920s.[145]

In the Ibadan Division, infant and maternal welfare began after grants received from the Colonial Development Funds were used to facilitate the expansion of missions' maternal and infant healthcare services and the construction of new rural medical facilities. Below is a table showing the grants-in-aid provided by the colonial government from the 1930s through the 1940s in the Ibadan Medical Area under the Medical and Health Services Scheme for grant to the Medical Missions for equipments and buildings;

[144]Ibid, 2

[145] NAI, Annual Report, Nigeria 1945-46, P. 91. See also, Sydney Phillipson (Appendix D), Report on Grants-in-Aid of the Medical and Health Services Provided by Voluntary Agencies in Nigeria (Lagos: Government Printer 1949) P.55

Institution	Grant Paid 1937-38	Grant Paid 1938-39	Grant Paid 1939-40	Grant Paid 1940 -41	Remarks
Baptist Mission Hospital	£50	_	_	_	The Baptist Mission hospital serves a large population. The staff consists of 2 American Doctors, 3 American Nurses, 1 Lady Dispenser and assistant. They do great deal of maternity work and infant welfare.
American Baptist Hospital	_	£50	£15	£15	For maternity work and infant welfare.
Wesley Guild Hospital	_	£50	£15	£15	Towards purchase and installation of X-ray apparatus
Methodist Mission	_	£20	£6	£6	For maternity and welfare work.

Source: NAI, File No*: Oyo Prof. 1/1, File 47 Vol. III Extension of Medical Service by Direction, Control and Subsidy of Medical Missions, 1939, 365, 340.*

The grants-in-aid enabled the American Baptist Mission to continue their contributions to maternal and infant welfare in the rural areas of Ogbomoso; the Roman Catholic Missions building of a maternity and welfare centre in Otan and a six bed maternity centre at Fiditi; the Seven-Day Adventist establishment of a hospital with ten beds for maternity work with an estimate of a minimum of hundred deliveries per annum.[146] Aside the delivering of babies in these hospitals, part of the work carried out was the education of expectant mothers on their health, personal and environmental hygiene and the health of their babies. The sensitization on

[146] NAI, File No: CSO 12723/Vol VIII Annual Report 1925, 560

hygiene was also extended to others among the rural population.[147]The locals could easily identify with the missionaries on maternal and infant related issues as well as on hygiene education than with the colonial government. This thus made the missions the main organisation in charge of maternal and infant welfare and health education during this period.

The colonial government through its partnership with the missionaries was able to make limited progress in the area of maternal and infant welfare.[148]This was because women in Ibadan were quite skeptical about the western method of child delivery. Details about what colonial medical establishments and the western method of delivery meant to the indigenous people of Ibadan will be discussed extensively in the sixth chapter of this work. Notwithstanding, according to the colonial medical officer in charge of the supervision of maternal and infant works in Ibadan - Dr. Lawson, in a report to the colonial government, he pointed out that the women in Ibadan were quick to judge midwifery facilities available to them and were not so convinced of the value of modern methods of midwifery.[149] The perception of the indigenous people of Ibadan on western obstetrics was not only due to the poor conditions and standard of health facilities available to them (especially in the rural areas).The cultural belief of the people, amongst others contributed to this. More details of this cultural belief will be examined in the fifth chapter of this work. Colonial reports however, believed that unless the available medical facilities were of a high standard, they would not gain the confidence of the population and the facilities would not be used.[150]This report further stated that the women in Ibadan were yet, unfamiliar with the idea of a trained midwife delivering them and that it would take several years of intensive propaganda and

[147]NAI, File No: CSO, 36644/S. 2, Colonial Development and Welfare Fund Schemes Submitted By The Medical Department. 1940,14-20
[148] NAI,*The Nigerian Daily Times,* July 15, 1939,6
[149]NAI, File No: IBADIV 1/1, 3374, Health Rural Development and Social Welfare Committee, 1956,62
[150]ibid

a much higher standard of staff in Ibadan to get the people to accept the western idea of midwifery.[151]

By the end of the 1920s, Dr. Lawson who was the supervisor of the maternal and infant welfare scheme in Ibadan had suggested new methods of engagements in order to achieve immediate and the required results for the maternal and infant welfare scheme. It was suggested that alternative domiciliary maternity services be developed. This new method will include the establishment of more maternity homes for antenatal care and delivery and home delivery just like it's been practiced by the locals.[152] The latter was an emergency measure expected to cater for a larger number of pregnant women and in turn attract them to established healthcare facilities.

The alternative maternity facilities in the Ibadan Division were established. The outcome was encouraging due to the increase in maternal and infant health care facilities in the rural areas and home delivery services. The mortality rate in the provinces reduced drastically because of increased patronage and cooperation by the locals. An average of one thousand two hundred attendances by patients was recorded per month in the mission's maternity centres. The Seven-Day Adventist alone had a record of 85.5% daily bed occupancy for maternal and infant healthcare out of a 100 bed capacity for general healthcare and a total of 534 obstetrical cases.[153]

The over population and popularity of these health facilities led to the expansion and construction of new maternity centres from the 1930s as we would see in subsequent chapters.

[151] Ibid, 65
[152] NAI, File No: Oyo Prof. 1/1589/14, Annual Reports: Missions; Oyo Province 1938, 77
[153] Ibid, 15

The period posed a new challenge for the Missions and the Colonial Government, thus led to the criticism of colonial public health policies in Ibadan.[154]

Conclusion

In this chapter, I have provided the historical background to the introduction of western medicine and healthcare system in Ibadan from the 1890s to 1930s. We traced the emergency of and development of the western healthcare system in sync with infant and maternal healthcare practice in colonial Ibadan. It details the perceptions of the missionaries and colonial medical officials on African health and healthcare and notes the justification for the introduction of western healthcare practice in the British colony of Ibadan. I have argued in this chapter, that the involvement of the colonial government on maternal and infant welfare was a well calculated political ploy to sustain the colonial economy as evidenced in the partnership of the colonial government with voluntary agencies, specifically the missions, to help advance the plans of the colonial office. I explored the symbiotic relationship between missionaries and the colonial government that led to the establishment of various maternity facilities and how it resulted in the patronage of these facilities by the locals. This chapter sets the stage for events leading to the transformation and institutionalization of modern health facilities, training of Africans in western medical practices and the reactions of the indigenous peoples of colonial Ibadan to this development.

[154] NAI, *Southern Nigeria Defende,r* January 21; November 26; December 27, 1944, all page 2.

Chapter Three

The Christian Medical Missions, Maternal Healthcare and Midwifery Development in Colonial Ibadan, 1920 to 1950

Introduction

Maternal healthcare and midwifery in the nineteenth and twentieth century's was an important tool for achieving missionaries' agenda in colonial Ibadan. This was because of the high infant and maternal mortality rate during this period. Medical missionaries having seen the toll and harsh realities of poor maternal and infant healthcare on the natives, capitalized on this health crisis and sort ways to alleviate the problems of maternal and infant mortality and morbidity. This they did by pursuing diverse agendas that includes the provision of healthcare services, the institutionalization of the health system, teachings and carrying out pieces of training on maternal and infant healthcare, such that by the 1940s, the missions had begun proposing and brokering organizational funding with the colonial government for missions medical services, training of Africans in obstetrics, and establishments of more medical facilities to meet the growing needs of maternal and infant health in colonial Ibadan. This was achieved through the integration of the missionaries into the colonial maternal and infant welfare scheme, and through the provision of funding for hospital expansion and maternity clinics establishment and training of both Europeans and Africans in obstetrics.

However, the diverse agendas of missionary maternal healthcare programmes and services in colonial Ibadan reveal a complex system of missionary medicine. It suggests that missionaries' maternal healthcare services were deliberate, systematized and organized effort of the various missionary bodies that operated within and outside Ibadan. It further reveals how such agendas influenced the knowledge and practice of maternal and infant healthcare and midwifery. This

chapter uses the construction of maternity facilities, the training of Africans in midwifery and the mission's partnership with the colonial government for an extensive provision of maternal healthcare to the indigenous peoples of Ibadan to buttress the medical missions' agendas during this period.

This chapter supports existing revisionist histories of medicine, which suggest new ways to imagine and re-imagine colonial medicine beyond the pursuit of the empire and imperial agendas in nineteenth- and twentieth-century Africa. In these histories, the Medical missions as an agent of Western medical knowledge production pursued diverse and unique agendas that defined them. Some missionaries saw the provision of healthcare services as a way to mobilize financial support from their home countries. To these missions, the healthcare crisis in Africa spaces during this period was the only way to appeal to "open wallets and purses" towards missionary works.[155] Jennings argues that besides using medical works as a front to seek financial support for mission's evangelical works, the missions were also real on their commitment to promote the health of their host communities.[156] Just like Jennings, Shobana Shankar's suggests that, missions' intensification of medical works in the Northern Nigeria region was a way of breaking down restrictions on Christian evangelism to Muslims, imposed by the British colonial authorities until the 1930's.[157] Also enunciating on the agenda of the medical missions and their agendas, John Manton in his study on the post-Second World War government-mission leprosy control in the Ogoja Province of Nigeria, identified the increased bureaucratic complexities in missionary medical work. Manton highlights the agenda of the medical mission's in the

[155]Michael, "A Matter of Vital Importance"229
[156]Ibid
[157]Shobana Shankar, "The Social Dimensions of Christian Leprosy Work among Muslims: American Missionaries and Young Patients in Colonial Northern Nigeria, 1920 -40" in *Healing Bodies, Saving Souls*, ed. *David Hardiman*, (Newyork: Rodopi B. V., Amsterdam, 2006),282

development of a sophisticated epidemiological apparatus to serve information and planning needs of international public health organisations. This according to Manton, led to the missions entering into contracts with colonial governments to run medical enterprises on behalf of the state, and in accountability of missionary enterprises to local communities.[158]

The complexities in the agendas of the missions reveal that the trajectory of missionary medicine was much more complicated than the generalized "empire-roles" prescribed to them during the colonial period Postcolonial histories for instance, suggest that missions used their medical work as "part of a program of social and moral engineering through which Africa' would be saved."[159] Following this school of thought, Nancy Hunt has in her work; suggest how the missionaries imposed European midwifery and birthing practices in Africa.[160] While postcolonial histories views missionary medicine as a tool for colonialism, there is however, a paradigm shift in the ways missionary medicine can be imagined in the trajectories of colonial medicine in Africa.

Empirical evidences suggest that the medical missions pursued agendas that were different. These agendas reflected in the medical trainings given to missionaries' doctors. These trainings prepared mission doctors to be physically situated in the communities they served. This made mission is better placed to both understand and persuade local society of the benefits of Western medical services.[161] The impulses that led to the medical mission's diverse agendas were however based on the very nature of Western medicine and medical practices, which served a plethora of agenda and was not entirely a straightforwardly "tool of empire" as suggested by

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[158] John Manton, "Administering Leprosy Control in Ogoja Province, Nigeria, 1945-67: A Case Study in Government-Mission Relations" in *Healing Bodies, Saving Souls*, ed. David Hardiman, (Newyork: Rodopi B. V., Amsterdam, 2006),307

[159] Megan Vaughan, *Curing Their Ills*144

[160]Nancy R. Hunt, *A Colonial Lexicon of Birth Ritual, Medicalization and Mobility in the Congo*, (Durham: Duke
University Press, 1999).

[161]Jennings, "A Matter of Vital Importance,"237

post-colonialist. Revisionist scholars such as Mark Harrison has critiqued the substances in medicine as a "tool of empire" by bringing to fore diverse perspectives in the historiography of medicine in colonial spaces. Harrison explored the often silence networks of tropical medicine which emphasized a strong relationship between colonial medical men and their local counterparts.[162] Harrisons' argument reveals that both the colonial medical men and their local counterparts were finesse in contributing to tropical medicine. Helen Tilley's in her submission also described the developments that informed and accompanied Africa as a research ground as not altogether repressive of Africans as some colonial medical officials were also critical of pre-colonial structures and institutions. She argues further, that the criticism frequently expressed and accentuated by colonial scientists contributed to weakening the rationale for empire and therefore had enduring impacts on the political wills for colonialism.[163]Both historical trajectories show that science and medicine were influenced by often multiple and overlapping networks and interest. Missionary medicine was also diverse and complicated.

As earlier mentioned, revisionist histories suggests the need for historians of medicine to look pass the binary categories of the 'colonizer and the colonized'.[164] In its stead, historians are challenged to revaluate the relations between the colonizer and the colonized from other perspectives outside imperialism.[165] The application of this context is expected to amplify a critical thought on diversity of colonial experiences and indigenous actions, but it is also characterized by compartmentalization. Thus, accepting that missionary medicine was an integral

[162]Mark Harrison, "Tropical Medicine in Nineteenth-Century India", *The British Journal for the History of Science* 25, 3, (2005), 317
[163]Helen Tilley, *Africa as a Living Laboratory*,322.
[164]Mark Harrison, "Science and the British Empire", *Isis* 96, 1, March 2005, 63
[165]Helen Tilley, *Africa as a Living Laboratory;*. See also; David Wade Chambers and Richard Gillespie, "Locality in the History of Science: Colonial Science, Technoscience, and Indigenous Knowledge", *Osiris* 15, 2nd Series, Nature and Empire: Science and the Colonial Enterprise, (2000),221-240.

part of the colonial period, the medical missionaries' involvement in medicine can be best understood in light of the diverse agendas they pursued.

To effectively articulate this position, I have divided this chapter into four sections. In these sections, I intend to discuss the perceptions of the missionaries to maternal health in colonial Ibadan; the construction of maternity hospitals by the missionaries; the training of African midwives by the missionaries; and the missionaries' partnership with the colonial government on maternal healthcare, marked by a strong relation to mission agendas in colonial Ibadan. For instance in Ibadan, the medical missions of the Christian Missionary Society, approached maternal healthcare through an advocacy for health education of the indigenous peoples. The CMS medical mission believed teachings on cleanliness and self-hygiene to women (specifically in the rural areas) will trigger some sort of basic health practices that will reduce the spread of diseases that leads to infant and maternal mortality. This, thus, influenced and intensified the direction of maternal healthcare undertaken in Ibadan by the CMS medical mission. On the other hand, the Methodist Mission pursued a different interest in its maternal healthcare provisions. Their interest was in tandem with the plot to tackle the high incidence of maternal and infant mortalities, and to encourage pregnant women to seek antenatal and postnatal services in maternity hospitals and clinics. More so, they were concerned with keying into the colonial governments interest that were at the time, constantly emphasizing the need for hospital-based labor and delivery rather than domiciliary midwifery. This influenced the Methodist Medical Mission into the construction of clinics, dispensaries and hospitals as a way to address the maternal health needs in Ibadan. The medical missions also approached maternal healthcare through its training of Africans in Western health systems. This was in order to attract more Africans seeking maternal healthcare.

Missionaries and their Perception of Maternal Health

For well over a decade after the medical missions had extended their medical services from Lagos and Abeokuta to the hinterlands of Ibadan, the missions at the time had only rendered a general medical service in Ibadan. During this period, missions were however deliberating on ongoing efforts to promote maternal and infant healthcare services in Ibadan as well as in other areas of Yorubaland. Thus, by the 1930s, Maternal Healthcare services had started in Ibadan, making it the second specialized medical service of the Christian Medical Missions in Ibadan after the treatment of leprosy.

The introduction of Maternal Healthcare in Ibadan may be understood against the backdrop of the perception of the Medical Missionaries on the indigenous health practices in Ibadan. The indigenous health and healing practices in Ibadan, which includes and is not limited to the use of native medicine; (decoctions and extractions) of valuable properties of herbs, roots, barks and juice grouped under the term *Agbo*.[166] Through years of acquired expertise and observation, traditional health practitioners ascertain with some degree of accuracy the valuable components inherent in the *Agbo*, which is useful to heal certain ailments. To the Missions, the knowledge of the traditional health practitioners does not go beyond the brewing of decoctions (*Agbo*), and recommending its use to patients, even though they claim to rank as experts in the curing of diseases. This was seen as a grave and serious disadvantage owing from the very fact that the same requisite knowledge, the same kind of decoctions is usually used on different diseases and occasions, especially on maternal healthcare.[167] The perception stems from the high incidence of maternal and infant mortality at the time, even though there are no official statistical data to

[166] NAI, *The Nigerian Pioneer*, Friday, December 15, 1922,7
[167] ibid

show the number of maternal and infant deaths during this period in Ibadan. Conversely, according to the missionaries, the high number of maternal and infant death was particularly caused by the indigenous health practices of the people.[168] In addition, they sought to not only contend with maternal and infant mortality but also to fight against certain conditions that cause and foster maternal diseases and death.[169] In Ibadan, this was inspired by the Christian Missions' intenerate general medical works in the rural areas. Indeed, the missionaries' contact with the people in their host communities as preachers of the gospel and as healthcare providers informed certain perceptions and concerns for maternal health[170]. Detailing the issues of maternal and infant mortality, missionary accounts reveal two major aspects upon which their perceptions were based - the "unsanitary" conditions of traditional midwives in the delivery and care for pregnant women and the "unscientific dietary" placement of infants by indigenous mothers.[171] In the Annual Medical Reports during this period, a British medical officer practicing in Nigeria – Dr. G.M. Gray, in support of the assertions of the missions, spoke of the need for skilled and modern practices. In his report, he stated, "parturition as a general rule occurs much more easily and naturally in the African Negro than in Europeans, nevertheless, protracted labor does occur not infrequently.[172] 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 misery to herself and a nuisance to her relatives and becomes in fact an outcast".[173] Joining this school of thought, the Director of the Medical and Sanitary Service in Nigeria also wrote, stating:

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[168]NAI, File No: 15S9/14, Annual Reports: Missions, Oyo Province, 1938,10 See also; Church Missionary Society, African General: Co-operation between the government and the Mission, 1926 – 1947,2
[169]Ibid
[170]Precise Book: CMS Nigeria: Yoruba Mission, 1895 – 1907, 1930.
[171]NAI, File No: 12723 Oyo Province: Annual Medical Report, Volume IV, 1926, 67
[172]Ibid
[173]Ibid,67

> No idea of cleanliness exists in midwifery practice and patients usually deliver upon the floor of the hut. All kinds of methods exist for delivering the placenta and I have seen a complete inversion of the uterus caused in this way…Herbalists and Abortionists practice startling methods of inducing labor or of procuring an abortion. A common practice is to fill the vagina with decoctions of herbs and I have seen cases in which sloughing of the vaginal mucosa has been caused by these methods, leading to complete vaginal stenosis causing haematocolpos. Upon a recent tour of inspection, a mission medical officer showed me a young woman whom he had operated for a large pelvic abscess. This had been caused by an abortionist who had stuffed the vaginal full of hair that had worked its way into the abdominal cavity.[174]

As cited, the graphic descriptions of delivery cases made worse by the traditional midwife through the application of native drugs and even efforts at manipulation by the traditional midwives raised concerns.[175]Furthermore, the missionaries through its observations likewise stated that improper and irregular feeding led to much infantile illness, as does also the practice of forcible feeding of infants. This, the mission believed was a common cause of pneumonia that seldom affects infants in the Yoruba area. According to the mission, a practice in the Yoruba country is to give infants large quantities of a purgative decoction (*agbo*) with most injurious effects.[176] According to Michael Jennings in his case study of the missionaries and maternal health in Tanganyika, this was the reason expectant mothers were encouraged to patronize

[174]NAI, File No: COMCOL 1, V/12, Abolition of Customs which are Detrimental to Native Welfare and Economic Prosperity, 1930,6
[175]NAI, Annual Medical Report 1934,30
[176]NAI, File No: COMCOL 1, V/12, Abolition of Customs which are Detrimental to Native Welfare and Economic Prosperity, 1930,7

European health facilities and trained staff, rather than relying on the 'harmful' and 'unskilled' care of the traditional healers.[177]

This perception of the missionaries about African midwives and the causes of maternal and infant mortality were equally supported by colonial medical doctors who also traced the cause of maternal and infant mortality to the indigenous healthcare practices of the people.[178] Although this perception undermined the potency of the indigenous traditional medical practices of the Ibadan people, it however, was a way for the missions to galvanize support for the development of Western obstetrics, and to buttress the significance of maternal and infant welfare work in Ibadan. Information particular to this perception showed the mission's concern for the general population; birth rate and infantile mortality rate in Ibadan, such that by 1924 a whole list of laws in Nigeria reflected the concerns of the mission as regards maternal and infant healthcare.[179]

These laws includes keeping records of population statistics with date; the approximate number of children aged 15 or less; birth rate with date; infantile mortality rate with date; illegitimate birth rate with date; illegitimate infantile mortality rate with date; compulsory registration of births; and compulsory notification of births to the public health authority.[180] The implication of these laws to maternal healthcare in Ibadan was that it would be possible to know the statutes relating wholly or in part to the kind of healthcare services provided for expectant mothers and children, and of the principal voluntary societies – the missions and institutions - responsible for the care and protection of children. With these laws, the missionaries were more convinced to work towards the development of maternal healthcare in Ibadan than ever before, such that in the 1934 Nigerian Medical Report, there were evidences already showing the commitment of the

[177]Jennings, "A Matter of Vital Importance",234
[178]ibid
[179]NAI, File No: CSO 26/2, 13973, An International Year Book of Child Care and Protection (Publication), 1924,19
[180] Ibid, 19-20

missionaries to this cause - through the missions maternal and infant health education program and the introduction of Western obstetrics by encouraging ante-natal care as a way to ameliorate the wholesale use of native drugs and thus save in the Ibadan province hundreds of maternal lives.[181] The question, therefore, is why was maternal health such a major concern during this period that the missionaries needed to intervene in Ibadan?

Historical studies, has however, emphasized the campaign in Britain to its colonies to reduce infant and maternal mortality as motivated by the demographic concerns of the twentieth century. For instance, in a four-day conference summoned by the Save the Children International Union during the depths of the world-wide depression, in June 1931, government, church and business representatives from eight European countries and from several colonial territories in Africa met in Geneva to discuss the welfare of African children. The participants of this conference discussed the application of the 1924 Declaration of Geneva and its provisions for the protection of children to the children of colonized Africa. Echoing much of the broader discourse surrounding maternal and infant welfare of the late 1920s and early 1930s, the conference participants blamed social diseases, poverty, 'native midwives and their anti-hygienic practices', mothers'' carelessness' and 'irrational feeding' of infants, superstition and, finally, 'lack of sufficient medical aid' for infant mortality rates which exceeded seventy percent in some areas.[182]

Ibadan in the 1920s was estimated to be a town with a population of about a quarter of a million with very little done to meet the health needs of the native population. By the 1930s, the

[181]NAI, Annual Medical Report 1934, 30

[182]Evelyn Sharp, The African Child: An Account of the International Conference on African Children, Geneva, (Negro Universities Press, 1970, reprinted from Weardale Press, 1931),3, 26-29. See also PRO CO 323/1066: International Congress on Children of Non-European Origin, 1931 and CO 323/1148: Congress on African Children, Geneva, 1931.

population had increased with extremely unsatisfactory medical facilities on sight.[183] The encounters of the missionaries with the natives and indigenous converts seeking maternal and infant healthcare from traditional midwives, owing obviously to the lack of Western health services in the rural areas especially, prompted the medical missions in establishing maternity hospitals and clinics in Ibadan like in most parts of Africa. The realities of the locals as expressed by different missions, thus, shaped the missionaries' interest in maternal and child healthcare in Ibadan. While there are no statistical records to show in numbers the maternal and infantile mortality rates in Ibadan as at the 1920s, in Lagos Nigeria however, high levels of infant mortality were identified in the Annual Medical Reports of 1922. A rate not accurate, but estimated at about 290.5 deaths per thousand live births was recorded. This statistic was thought to extend to the rest of the colony as well.[184]

The missions in Ibadan, therefore, thought of taking up maternal healthcare service as a way to shape the indigenous existing birthing practice. This was also a contingency measure employed by the missionaries to ensure the natives do not go back to their traditional practices and in the process go back to their African religious practices. In order to see this through, and to ensure that the natives (specifically the new Christian converts) comply with the idea of Western obstetrics, some missionaries raised concerns about why going on with the idea of Western obstetrics was important but a little tacky. The importance for the introduction of Western obstetrics is tailored in the preposition of most missionaries during this period. For instance, a missionary – Mr. Brynell of the Yoruba mission clearly spoke of the overwhelming need for

[183]NAI, File No: CSO 26/2, African Hospital Ibadan, 1924 -27,127

[184]The inaccuracy of statistics was a disclaimer provided in virtually every Annual Medical Report throughout the period.

medical treatment and the urgent need for the establishment of maternal and child welfare works in the Oyo province[185]as a duty unto Christ. In Mr. Brynells' words;

> …there is no help at all for women and children, who suffer agony through ignorance and lack of proper treatment. It is no exaggeration to say that the infant and mortality alone is between 450 - 500 per thousand…our nearest Medical Officer, thirty miles away in one direction and fifty or sixty miles away from big outstations, informs me that it is the policy of the present Director of Medical Services to hand over as much as possible of the medical work to the missionaries as they can cope with…what a power for Christ it would be in our district – healing of souls through the bodies.[186]

Other missionaries shared the concern raised by Mr. Brynell on the state of the health of women and children in the province and its impact on the missionary agenda to spread Western civilization in the area. However, another missionary, while speaking of the desperate need for maternal and infant healthcare services in the Yoruba countries, also lamented the challenges and the decision women converts were left with while dealing with their personal health and those of their children. The mission stated that, if the missionaries cannot provide the necessary medical attention needed by a Christian mother for her sick child, then it would be difficult to forbid her to patronize traditional health healers, which is the only option available to her. Thus, not providing the necessary healthcare is putting the faith of the women in particular to a greater test than they could bear and putting them in a position to seek alternative help.[187]

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[185]Ibadan was a district under the Oyo province during this period. For details on this, see the NAI, Iba. Div/Oyo Prof Annual Reports of 1920 – 1940.
[186]NAI, Annual Report of the Church Missionary Society, 1933-34, 23.
[187] NAI, Annual Report of the Church Missionary Society, 1926-27, 23

Moving forward with these concerns came with some implications on the cultural practices of the people of Ibadan. This was because the functionality of Western obstetrics was in the medical mission's placing much value in its potential to bring new converts into the Christian faith, with illness creating a captive audience for the gospel. In this regard, the activities of the missionaries in Ibadan involved much more than preaching the gospel. It is the whole man that the missions aim to save. To the missions, it was like emulating the works of the Lord by giving attention to the body and soul.[188] For instance, while introducing Western obstetrics to the people in Ibadan, the mission had sort to instill discipline on its converts based on its bias against the African practice of midwifery. While insisting that new converts must patronize European obstetrics, the medical missions believed that it is in its services on midwifery that maternal and child welfare works will be greatly encouraged. This is with the hope that the resulting care of mothers and babies may be of real help in the fight against harmful practices.[189]

While other missions lend their voices to see that Missionaries take up duties in providing maternal and infant healthcare in Ibadan, others took up courses in obstetrics. For instance, Miss J. J. Kilburn, after consultation with several Yoruba Missionaries took a course of training in Obstetrics with a view of offering her services after passing her examinations in service to the indigenous people.[190] In Ibadan, however, maternal healthcare and infant welfare did not get underway until well into the 1930s. Mission's intervention in maternal health was based on their philosophy and perceptions of infant mortality as a direct result of the 'failure of motherhood'.[191]

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[188]David Hardiman (ed.), *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa*, (Rodopi B.V.: Amsterdam-Newyork, 2006).
[189]CMS Outlook, March 1934,47-49
[190]Precise Book: CMS, Nigeria: Yoruba Mission, 1895 – 1907, 152
[191]Lewis, *Motherhood*, 19 and Davin, "Imperialism",12. On the centrality of hygiene and nutrition to child welfare discourse, see Davin, "Imperialism",16-17, 52-54.

Constructing a Maternity Hospital

By the late 1930s, the medical missionaries in Ibadan began its maternal healthcare. Officially, this service began with the construction of maternity hospitals, clinics and dispensaries. Before the mission started its institutionalized maternal healthcare service, the missions first embarked on various maternal and infant healthcare programmes that incidentally helped prepare the ground for the acceptance of hospital based maternal healthcare and the spread of Western obstetrical practices in Ibadan. For instance, as at 1932, the Church Missionary Society (CMS) had initiated maternity works in the interiors of Ibadan that had no mission, government or Native Administration medical center.[192] The missions developed and carried out rural healthcare programs, rendering general medical and maternity services through constant tours of villages.[194]The Women Guild of the CMS made these health services possible. The CMS Women Guild often went out to the hinterlands of Ibadan to carry out maternal and child welfare works. There they gave lectures to pregnant women on proper dieting and general care of themselves during pregnancy. [194] These lectures helped most women in basic hygiene and care for their children and families. The success from the activities of the Women Guild often led to the conversion of natives who were attended to, and their health problems solved.[195] The activities of the women Guild motivated the CMS in Ibadan in a continuous and direct responsibility on maternal health, through its constant tour of the Ibadan area. Although the CMS did not establish any health facility to attend to the maternal and infant health issues in Ibadan during this period,

[192]NAI Oyo Province: Annual Report 1935,21
[194]Ibid, P.21
[194]NAI, CMS Outlook, June 1932,119
[195]Ayandele E.A,"The Missionary Impact of Modern Nigeria, 1842-1914: A Political and Social Analysis", *Ibadan History Series*, (the University of California: Longmans, 1966), 285

it, however, paved way for other medical missions that by the late 1930s they started an institutionalized maternity service with the construction of dispensaries and maternity homes.[196] During this period in Ibadan, other medical missions had begun working towards the establishment of a hospital-based maternity service. This decision was in tandem with the plot to reduce the high incidence of maternal and infant mortalities, and to encourage pregnant women to seek antenatal and postnatal services.[197] More so, Annual Medical Reports during this period constantly emphasized the need for hospital-based labor and delivery rather than from the home.[198] This further gingered the medical missions into establishing and opening maternity hospitals and clinics, dispensaries and motherless baby's homes in different locations of the Oyo province serving Ibadan and other districts. For instance, in 1937, the Wesley Guild (Methodist Mission) established a Maternity Welfare Centre with a certified midwife in charge and supervised by Dr. Dale - a missionary.[199] By 1938, the Methodist Missionary Society had established another Maternity Clinic and Dispensary in Oyo.[200] These Maternity Clinics and Dispensaries served people from all denominations and the native population. During the year, 878 maternity cases were treated, with 17,337 attendances.[201] In 1939, the following year, the Methodist Mission opened a modern Maternity Home with four beds, better hygienic conditions with expert help.[202] Over 32 mothers were delivered in the year, with 18,000 attendances.[203] In addition, the Seventh-day Adventist Mission during this period had established a Clinic facility, which treated 538 maternity cases.[204]

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[196]NAI, File No: MH (Fed) 1/13987F: Annual Medical and Sanitary Report, Mission Activities, 1944,7A
[197]Ibid
[198]NAI, Annual Medical Report 1936,11
[199]NAI, Annual Report of the Southern Provinces of Nigeria for the year 1937,65
[200]NAI, File No: Oyo Prof 1, 15S9/14, Annual Reports: Missions,1
[201]Ibid
[202]Ibid,11
[203]Ibid
[204]Ibid,8

These Missions continued with the construction of maternity clinics such that by the 1950s, a large number of maternity homes and clinics more or less efficiently supervised by the missions were scattered throughout the Oyo Province.[205] Existing Maternity Clinics were enlarged and new ones constructed. In the year 1955, the Methodist mission services on maternal and infant healthcare increased tremendously. The total number of attendance during the year averaged about 1200 a month, with native women coming in for delivery.[206] This was an indication that the Medical Missions continued to meet the maternal healthcare needs of the native population. The Seventh-day Adventist by 1958 alone, already had a 100-bed capacity, daily bed occupancy 85.5, Physicians 2, Nursing sisters (grade 1 midwives) 3, African graduate nurses 9, Grade 1 midwifery students 5, General nursing students 56. These staff and students jointly assisted in attending to 534 obstetrical cases during the year.[207]

While other medical missions were providing a hospital-based maternal healthcare service, the CMS also continued its tours to villages in Ibadan, visiting the homes of those in need of medical assistance in one way or the other.[208] This was in consideration for expectant women and mothers who were reluctant or unable to attend the clinics. The CMS medical home visitors on tour ensured that they too received health information and care.[209]

This era witnessed a remarkable change in women's attendance of hospitals and maternity clinics for all maternal healthcare-related services such as prenatal, delivery and postnatal. Between the 1930s and 1950s, the medical missions' recorded substantial growth in the attendance of maternity hospitals and clinics amounting to over a thousand people in attendance. In fact, in the

[205]NAI, File No: Ondo Prof 1/3, File No D8: Medical Development, 1947,138
[206]NAI, File No: Oyo Prof 1, 15S9/14, Annual Reports: Missions. 1938,77
[207]Ibid,13
[208]ibid,11
[209]NAI, Iba. Div Annual Medical Report, 1929,34.

whole of Nigeria during this period, there were a total of seventeen infant welfare clinics in the north of the colony and twenty in the south, which, when combined with those of the medical missions providing same services, brought the number of recognized child welfare centers to a total of 94. According to statistical data generated from the Massey Street hospital in Lagos, a dramatic reduction in infant mortality rates, from a recorded 238.3 per thousand as at the 1920s, shrink to 128 per thousand by the 1940s.[210] This record was also extended to other colonies of Nigeria. This progress was attributed to the antenatal and child welfare clinics and, in particular, to the unwavering efforts of the medical missions in bringing health and hygiene advice to African mothers.[211] According to the assessment of the Annual Medical Reports, maternal and infant welfare services were perceived as fulfilling "long-felt want in the treatment of diseases in women and children" in Nigeria.[212] The missionaries' concern however, was that, although the Ibadan people do not take quickly to new ways, there is evidence that they value the advantages that the Maternity Clinics offers, such as the hygienic conditions and expert helps.[213]

Missionaries and Early Training of African Midwives

The successes recorded by the medical missions in the treatment of antenatal, delivery and post – natal cases since the establishment of its maternity hospitals, clinics and dispensaries, attracted many African patients seeking medical treatment.[214] With the expansion of maternity hospitals, clinics and dispensaries by the missionaries, to meet the increasing population of the maternity centers, the missionary doctors and nurses stationed to attend to patients in the various maternity hospitals were few, overworked and sometimes had to travel a long distance to engage in

[210]NAI, Iba. Div, Annual Medical Report 1928,39; 1925,12; 1945,6
[211]Ibid,6
[212]NAI, Iba. Div, Annual Medical Report 1926, 37.
[213]NAI, File No: Oyo Prof 1, 15S9/14, Annual Reports: Missions, 1938, 11
[214]NAI, File No: D8, Ondo Prof 1/3, Medical Development, 1947,138

midwifery activities.[215] The Methodist (Wesleyan) Mission during this period had a staff that consists of only two doctors (one a lady doctor), and three European Sisters.[216] The scarcity of medical staff became a major obstacle in the missions aimed higher standard of maternal and infant healthcare. The shortage of mission doctors and nursing sisters available to take up midwifery duties where and when they were needed makes the plan almost unattainable. Moreover, if the missions contemplate extension seriously, it will be necessary to provide an increase of nurses, and of nurses in training to become Midwives. In response to shouldering the large volume of medical work by the few European mission medical staff and to serve the increasing numbers of patients, the mission is resolved on training Africans. This was after considering the cost of maintaining a European medical staff. According to the analysis of the Methodist Mission in the Ibadan district, the cost of maintaining one doctor continuously at work was £520, and if married, at least £550. The cost of maintaining a Sister is; salary £160, Outfit Allowance £30, Passage and Land transport £37.10, Relief not less than £82.10. A total cost per annum to maintaining a Sister continuously at work, is £310 per annum.[217]Money for the payment of salaries of the mission's medical staffs and the funding of missions medical services comes mostly into the Circuit from the mission's home office outside the colony, with little generous contributions to the support of mission medical work by the church parishioners.[218]It is important to note that, the funding gotten by the missions are not enough to pay missions medical staff, let alone execute major health projects. Thus, as part of the Christian Medical Mission's plans for a possible future expansion in maternal and infant healthcare, together with the need to manage

[215]Ibid,146
[216]NAI, File No: CSO 26/2, Medical Missions in Nigeria Control Grants ETC. Vol. I, 1949,82
[217]Ibid,83
[218] NAI, File No: 15S9/14, Oyo Provincial Annual Report: The Methodist Church, Oyo Circuit, 1938,77

resources, the missions resorted to training indigenous African midwives, who will not only assist in maternal and infant works, but also in evangelizing the natives in Ibadan.

In 1930s, as documented in the Annual Medical Reports, the colonial government during this period became unswerving in the emphasis for trained caregivers.[219] Interesting facts concerning medical progress are to be found in the Nigerian Medical and Sanitary Report issued by Dr. Alexander, Director of the Nigerian Medical and Sanitary Service at the time. The Report is quoted as stating:

> Advance is retarded by the fact that there is a shortage of qualified medical staff, and it is clear that the training of Africans in medical work and the creation of class of medical assistants which has proved so useful in the French and Belgian colonies, has not yet been taken in hand on a scale commensurate with the need.[220]

In compliance with government encouragement and promise of financial support to missions as we would see in the next section, the medical missionaries in Ibadan became more anxious in training Africans in the practice of midwifery.

The training of Africans in Western obstetrics by the missions was of two categories. The first category consisted of training illiterate indigenous women and the second was the training of schoolgirls who had reached Modern II or Middle IV educational standards. The first category of training can be traced to the early 1920s. During this time in Ibadan, the medical missions' had annexed and maximized the opportunity of their general medical tours to the interiors of Ibadan, gathering and educating illiterate indigenous women on the rules of hygiene and sanitation as a disease prevention measure, training them in all branches of housewifery, to prepare them to be

[219]NAI, File No: Annual Medical Report 1936, 11
[220]NAI, Church Overseas, January 1929, 79

good wives and mothers and also on taking care of infants.[221] One of such instances was the teachings received by native women in several of the tours of the Women Guild of the Christian Missionary Society in the rural communities of Ibadan.[222] Although, these women were not trained in modern professional obstetrics, they however, served as medical auxiliaries to the missions. They were instrumental in navigating the interiors of the Ibadan area with the missionaries, and they assisted in teaching other natives basic hygiene lessons learnt from the missionaries. Missionaries who took up the service of going to villages teaching the natives on hygiene and other basic health practices, encouraged most of the young women to take up professional courses as midwives, dispensers and general medical practitioners. An example of such missioners was Mrs. Ludlow F.R.C.S. of the Wesley Guild Mission and Wesley Hospital in Ilesa, who extended her services to the people of Ibadan through her teachings on midwifery to native women in the hinterland of Ibadan.[223]

From the late 1920s, the missionaries were teaching a more advanced lesson on maternal and infant healthcare to schoolchildren. Lessons on infant and maternal care were introduced to the curriculum of the girl school at Kudeti, Ibadan.[224] The teachings, for the first time, involved a more practical aspect of midwifery. In 1928, a teacher, of the Christian Missionary Society – Miss Brown, while giving a report of events of the previous year in the mission girl's school in Ibadan, spoke of the measures they took in teaching practical lessons on maternal health. She spoke of the adoption of a motherless baby, as shift from theoretical teachings, saying,

> …teaching about the care of infants is a great need in this country, and we realized how far short theory may come when we had the opportunity of doing it

[221]NAI, Annual Report of the Christian Missionary Society, 1930-31, 21
[222]Ibid,
[223]NAI, Oyo Province: Annual Reports 1936, 1937, 1938, all on page 22
[224]NAI, File No: D8, Ondo Prof 1/3, Medical Development, , 1947,139

> practically…it was not possible that 100 girls should be able to handle her, but they had the object-lesson of her upbringing before their eyes.[225]

From this, indigenous students learnt much as to the real importance of regular feeding, the right kind of feeding, and the clothing, etc.[226] Subsequently, the missions increased the value of the mother-craft lessons by adopting some motherless babies and making a "Nursery" close to the girls' bedrooms where the girls take turn in acting as "mother" to the children.[227]

Building on the lessons taught in the girl's school in Ibadan, and with a view to giving practical teachings on maternal and infant health, the various medical missions in Ibadan deliberated and agreed on establishing a professional training institution for lady nurses and midwives. Ibadan and Oyo were suggested as sites for possible locations of the training institutions. The latter was decided on as best suited for the training institute.[228] It is important to state, that, initially, each medical mission, providing staff for their local clinics and hospitals, did the training of nurses and midwives independently. This, however, changed from the 1930s.

From the late 1930s through the 40s, the missions had successfully established a specialized and permanent training school for nurses and midwives. The Seventh-day Adventist mission had its nursing and midwifery training school instituted in Ile-Ife. The school was accredited for General Nursing and Grade 1 Midwifery.[229] The Methodist Mission established its training school in Ilesha. The school had an accommodation facility for seventy nurses and students, and residences for three doctors, a matron, and four nursing sisters.[230] The training school comprised

[225]NAI, Annual Report of the Christian Missionary Society, 1930-31, 17-18
[226]Ibid,18
[227]Ibid,22
[228]Precise Book: CMS, Nigeria: Yoruba Mission1895,3
[229]NAI, File No: Oyo Prof 1, 15S9/14, Annual Reports: Missions, 1938,13
[230]Ibid,14

also of a lecture room, a demonstration room, a study room and a lecture room.[231]Girls from all of the Yoruba area including Ibadan attended the Missions' Nursing and Midwifery school. Girls with Modern II or Middle IV educational standards were admitted to the Nursing school. This is because they were believed to be mature enough to understand the school curriculum.[232] Aside the specialized training school for nurses and midwives, missionary clinics also served as training centers for African midwives and nurses and as meeting places for lectures on proper food preparation, antenatal care, management of children, and basic principles of hygiene and sanitation, that by 1937 there were 98 certified African midwives, registered under the Midwives Ordinance.[233]

The various missions mostly sponsored Africans that were trained on General Nursing and Midwifery. It was not until the 1940s when the colonial government fully started its Grant in Aid Scheme, supporting Voluntary Agencies involved in maternal healthcare that the missions started receiving allocations for the training of African midwives.[234] However, upon graduation from the Nursing and Midwifery training schools, trained African midwives were assigned to mission maternity clinics, hospitals and dispensaries.[235] Under the supervision of European missionary doctors and nursing sister in-charge of the maternity centers, African midwives attended to infant and maternal cases.[236] In rural areas, trained African midwives went on working tours aside their assigned local dispensaries to offer medical treatment, infant vaccinations, and health advice in their surrounding community.[237] Worthy of mention is an African nurse, trained at the Seventh-day Adventist training school in Ilesha on General nursing and Midwifery. In 1953, she delivered

[231]NAI, File No: CSO 26/2, Medical Missions in Nigeria Control Grants ETC. Vol. I, 1949, 82
[232]NAI, File No: Oyo Prof 1, 15S9/14, Annual Reports: Missions, 1938,51
[233]NAI, Annual Medical Report, 1937.
[234] NAI, File No: MH (Fed)1/1: Welfare and Development Committee Ibadan,25
[235]NAI, File No: Oyo Prof 1, 15S9/14, Annual Reports: Missions, 1938, 11
[236]Ibid
[237]NAI, Annual Medical Report 1935,4.

32 mothers and made 285 visits to the homes of people needing medical assistance in one way or the other.[238]

From the late 1940s through the 1960s, Missionaries medical officers and nurses were not the sole providers of maternal and infant health services in the colonies. The Missionary-educated African midwives and nurses in the maternal and infant work shouldered a considerable amount of responsibility and role. This was because their works became indispensable in maintaining the standard of the missionary is maternal and infant healthcare programs. They became popular and made Western obstetrics renowned in the colonial medical circles. With their new knowledge, trained African midwives played a critical role in the acceptance of hospital-based childbirth in their community. As Hunt noted in the Belgian Congo, local African midwives trained at mission centers were often far more effective childbirth attendants than British nurses.[239]In Ibadan, their expertise grew with their experience within their years of service, such that, the Missionaries trusted them enough to run Maternity Homes, and also take senior girls in the Kudeti Girls School on practical lessons in Mother-craft.[240]

The education of African midwives by the missions was an integral component of the missions' maternal healthcare service. By the late 1940s, there were a total of 201 African trained Grade I Midwives and 203 Grade II Midwives in Nigeria.[241] By the 1950s, the total number of registered African midwives in the colony was nearing 1000.[242]However, because of the poor financial standing of the missionaries, the training of African midwives by the missions was in a comparatively small portion and still did not meet the increasing population of the people of

[238]NAI, File No: Oyo Prof 1: Annual Report Missions, 1938,11
[239]Hunt, *A Colonial Lexicon*,8
[240]NAI, Annual Report of the Church Missionary Society, 1937 – 1938,14
[241]NAI, Fie No: MH(Fed)1/2: MH 17/S.4, Medical Services Annual Report 1942, Vol. III, 1942,227
[242]NAI, Annual Medical Report 1947,5.

Ibadan who needed maternal healthcare. This, among other reason made the mission go into partnership with the colonial government. With an annual medical grant-in-aid provided by the colonial government, the medical missions were able to continue the training of more Africans in midwifery.

Maternal Health and Missionaries' Engagement with the Colonial Government

Beginning from the early 1930s through the 1950s, the missionaries had gradually and effectively extended maternal and infant healthcare services to areas where no government or Native administration medical center had reached in Ibadan. Thereby, filling the vacuum and complementing the health services of the colonial government and Native administration in the rural areas. However, a primary constraint on the mission's development of the infant and maternal welfare services in Ibadan as elsewhere in the British Empire was limited financial resources. The medical missions grappled with a lack of fund and health personnel with which to promote the maternal healthcare agenda of the mission. Therefore, for the growth of the medical missions and the need to extend maternal and infant welfare, it demanded that there be a basis of cooperation between the Missionaries and the Government as regards financing medical activities. As pointed out by Michael Jennings, 'colonial medicine' in Africa can never, and could never be provided solely by a single actor.[243] In the case of Tanganyika as posited by Jennings, attempting to meet the health needs of the territory could only really be justified by the colonial government (to the extent that it could) by recognition of the roles voluntary organizations such as the missionaries were playing in the health sector.[244] Accordingly, the

[243]Jennings, "A Matter of Vital Importance",153
[244]Ibid

colonial government in Ibadan thought to encourage the medical missionaries in order to expand and upgrade their services for maternal and infant healthcare in the rural areas.

By the mid-1940s, the missionaries in Ibadan had become official partners with the colonial government. This partnership, however, was been suggested from the early 1940s. At the time, the Archdeacon of the Christian Missionary Society on behalf of other medical missions in Ibadan, had written in a letter to remind the office of the Director of Medical and Sanitary Services, Southern Province, on the need for cooperation between the Missions and the Colonial government. In the letter, he stated, that;

> Dr. Adams, Director of Medical and Sanitary Services, whose recent retirement is a loss to the whole of this Southern Province, submitted to Government a scheme for bringing the medical mission efforts of the different societies under the direction and subsidy of the Government, the object being to extend as widely as possible medical relief to the community by cooperation with the Missions. Dr. Adam's proposal is that aid should be given towards buildings, laboratory and other equipment, organized Infant Welfare work, leprosy treatment, also for expensive drugs, and if necessary by grants for staff. It will be interesting to see if the scheme gets the necessary booking now that Dr. Adam has retired. A practical outcome of this new attitude has been the acceptance by the government of financial responsibility for an eighteen months' tour by Miss Elms (formerly of the Niger Mission) in the interest of Child Welfare and Maternity work.[245]

[245]NAI, Annual Report of the Christian Missionary Society, 1928 – 1929,25-26

The Colonial Government welcomed the above proposal by the CMS on behalf of other missions in Ibadan with intense deliberation such that by 1945, an outline of general policy the Government intends to apply in its relations with the missionaries in respect of medical services was defined in Circular No. 93.[246] Details of the Circular reveals the Government's concerns towards instituting its own medical services, which was believed, will absorb all the money likely to be available from the Colonial Development and Welfare Vote and from the revenue of Nigeria.[247] These concerns were based on the financial considerations of the Government. The Government believed if it were to confine its expenditures strictly to services under its direct control, the effective development of medical services in Nigeria, which is, of course, the essential aim of the Government's policy might be unnecessarily retarded. For this reason, the Colonial Government decided, that closer integration of the efforts of the Government and the Missionaries as envisaged in the earlier proposal by the missionaries was now required. More particularly, since it tallies with the Government's Ten-Year Plan for education and medical service.[248]

Prior to this time, the missionaries had worked independently and most times, informally in providing maternal and infant healthcare in Ibadan. The decade that followed, the Missions became formal partners with the Colonial Government in the delivery of a more encompassing maternal healthcare to the natives. As Jennings noted in his work, in return for accepting greater government oversight of mission facilities and a requirement to meet state-set standards and targets, missionary medicine was to be financially supported by the colonial state and granted

[246]NAI, File No. D8: Ondo Prof 1/3, Medical Development, 1947, 48
[247]ibid
[248]Ibid,81

privileged access to policy-making and policy-setting structures.[249] In Ibadan, foregrounding the deliberations by the Colonial Government on Mission's partnership, the Acting Director of Medical Service - Sgd R.L. Cheverton on 17 June 1949, wrote of the outcome of the discussion of the proposal with the Development Secretary and its approval to the CMS. He, however, stated that, until the Phillipson's' Report on Grant-in-Aid of Medical and Health Services provided by Voluntary Agencies is approved by the Government nothing can be done.[250] Therefore, to make certain that the proposal becomes effective, the Medical Missions were to consider the following;

a) Government inspection of all Hospitals, Dispensaries, Maternity and Child welfare centers, Venereal clinics, which are carried out by the Missions.
b) Calling upon the Missions to supply necessary equipment and staff for the performance of the activities with due efficiency and according to modern standards.
c) Giving grants to such Missions according to the fulfillment of demands made under upon them under (b).
d) The development of such hospitals as is suitable for the purpose of training subordinate staff.
e) The extension of more particularly of infant welfare, maternity service (in hospitals and also among the people and of treatment centers of leprosy, yaws, and so on, with specific grants for specific work.
f) Return of cases and diseases treated.[251]

Upon the final agreement and the approval of the Phillipson's Report, the Colonial Government through the Secretary of State gave permission for the allocation of funds to encourage the

[249]Jennings, "A Matter of Vital Importance",153
[250]Ibid
[251]NAI, File No: CSO 26/2/19963, Medical Missions in Nigeria Control Grants to Special Buildings, Vol. I, 1949, 8 - 10

medical activities of the various medical missions in Ibadan through its grant-in-aid scheme.[252]Although, while there are no specifics on the amount allocated to each medical mission to finance maternal healthcare initiatives and services, allocations ranging from £200 to £5000 were allocated to medical missions for infant and maternal services, training of African nurses and midwives, and for the establishment of maternity hospitals, clinics and dispensaries. This period marked a new era in the partnership between the colonial government and the missions. It was a period of increased hospital facilities in Ibadan and in the provision of maternal and infant healthcare services.[253] A missionary wrote of the attitude of the colonial government towards the missions despite its strategic interest in the partnership, stating;

> The government is very sympathetic and eager to help the missions if they will help themselves. This last condition must not be lost sight of.[254]

Although both the missions and the colonial government had their personal interest in its partnership and provision of medical service, both were; however, ready to serve the native population. In the application for the approval of the Government - Mission medical service cooperation, in Ibadan, Fourteen Rural Health Centre's were established by the mid-1940. These rural health centers consist of a welfare clinic with examination and treatment rooms and rooms for the carrying out of infant welfare work and demonstration, a sanitary inspectors section, detached waiting shelter and residence for representatives of the sanitary inspectorate and the Nursing and Midwifery and other staffs of the center.[255]

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[252]Ibid, 174
[253]NAI, Oyo Prof 1 : Extension of Medical Service, Directing Control and Subsidy for Medical Mission, 1946,149
[254]NAI, Annual Report of the Christian Missionary Society, 1927 – 1928,10
[255]NAI, File No D8: Ondo Prof 1/3, Medical Development, 1947, 52; see NAI, P.W.D. Information Book Hospitals and Dispensaries, 1946.

With the grant-in-aid made available by the colonial government, missions' medical services standards were raised. The Christian medical missions went fully into maternal and infant medical services in Ibadan such that by the 1940s, there was spectacular development of maternity and child welfare works in Ibadan. One of the notable areas of progress in this direction was the increasing speed and confidence with which maternal and infant health cases were brought into mission hospitals for early treatment.[256] A combined Statistics of activities of medical institutions in this regards for 1948 are as follows;

Item	Figure
Normal Labor	2,580
Difficult Labor	?
Antenatal Cases	8,609
Antenatal Attendances	?
Child Welfare Cases	2,880
Child Welfare Attendances	?

Source: NAI, File No D8: Ondo Prof 1/3, Medical Development, 1948, 15

A great deal of maternity and infant welfare work was undertaken in the numerous hospitals, clinics, and homes of the various missions during this period. Although the period does not give a clear data of the maternity clinics and hospitals established by the missionaries, however, by the 1950s, there were about a total of 27 maternity clinics and hospitals established with the cooperation of the missions and the government. The sore need at this time was trained midwives and medical staff. Despite the medical progress, the concern was for adequate and well-trained

[256]NAI, File No D8: Ondo Prof 1/3, Medical Development, 1948,15

staffs. In the "Nigerian Medical and Sanitary Report" issued during this period by Dr. Alexander, director of the Nigerian Medical and Sanitary service, the report is quoted as stating;

> Advance is retarded by the fact that there is a shortage of qualified medical staff, and it is clear that the training of Africans in medical work and the creation of the class of medical assistance which has proved so useful in the French and Belgian colonies, has not yet been taken in hand on a scale commensurate with the need.[257]

Considering the training of African staffs in Ibadan, as well as in other parts of Nigeria, the colonial government referenced the issue with a probability that some financial help will be given to medical missions, and some scheme of grants suggested for assistant-training, such as is already in existence for teacher-training, which might go far towards the early solution of the difficulty.[258] In 1945, in the governments Medical Development Plan-Western Provinces, it was decided that each Province should have a midwives' training school. The government promised to pay for trainings in the maternity centers in Ibadan.[259] Moreover, as a general rule, by means of capitation fee for the training of nurses and midwives at recognized training centers, that grants shall be given to Missions for their recurrent expenditure in connection with their medical and health activities.[260] It is however true that the government could not meet the needs of all the missions' medical facilities, but did, by enlargement and increased training of African medical staff. On the later, the American Baptist Mission Hospital amongst other medical missions, wrote in expression of gratitude for the governments' grant-in-aid, saying, "Your recent gifts made it possible for us to make larger plans, taking more boys and girls for training as nurses and

[257]NAI, Annual Report of the Christian Missionary Society, 1927 – 1928, 36-37
[258]Ibid,37
[259]NAI, File No: MH (Fed)1/1: Welfare and Development Committee Ibadan, 1940 – 1956,25
[260]NAI, File No: Oyo Prof 1 : Extension of Medical Service, Directing Control and Subsidy for Medical Mission, 1946, 438

assistants, looking forward to early extension, through other branches."[261] The government's grant-in-aid scheme for the training of the natives by the missions encouraged schoolchildren to take up training in nursing and midwifery.[262]

The cooperation between the colonial government and the medical missions has a very important influence and control over the activities of the medical missions in Ibadan. By implication, and to estimate the extent to which this new relationship operates, all new mission medical establishments must go through the approval of the government. Missions hospitals are now to be opened to the inspection of government officers, plans and buildings are to be sent to the government for record purposes. Mission hospitals are to keep certain records and medical directors and staff are to be approved by the government. This gives the colonial government a very tight hold on all missions' medical activities. If any mission faults any of these agreements, a penalty of withdrawal of support and closure of such mission's facility will be melted on such mission.

The mission medical director in Ibadan speaks of the great changes that have taken place in medical development. These are not only due to the new attitude of government but to the new demand for health services on the part of the people, especially those used to traditional birthing systems. They are determined to patronize mission hospitals but are often content with a minimum if it gives them value for their needs. Although the Annual Medical Reports for Nigeria expressed an optimistic 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

[261]Ibid,.133
[262]Ibid,146

colony. With an estimated population of 27.4 million by 1945, maternal and infant services could reach only a fraction of the Nigerian population.

Conclusion

This chapter has attempted to examine the contribution of medical missionaries to maternal health in colonial Ibadan from the 1920s through the 1950s. It has highlighted the mission's perceptions of the indigenous practices of midwifery and how it influenced their roles and functions in the provision of infant and maternal healthcare. This chapter has shown that, although the missionaries in Ibadan as in elsewhere in Africa were faced with financial challenges and human resources, they nonetheless overcame these challenges through their partnership with the colonial government and the training of Africans in Western obstetrics. The missions did not only ensure that maternal and infant morbidity and mortality were drastically reduced, but also helped in promoting Western medical practice, encouraged hospital based healthcare system and African patriotism of western medicine.

From the early 1930s, the medical missionaries had begun the of practice Western midwifery in Ibadan which became the second specialized medical profession in the area. This was influenced by their perception of African indigenous birthing practices and their general medical works in the interiors of Ibadan. During this period, the missionaries went on medical tours to the interiors of Ibadan, and in the construction of maternity facilities providing prenatal, delivery and postnatal services. This period witnessed a remarkable change in the attendance of hospitals, clinics and dispensaries by the natives. By the mid 1930s, the medical missions began the training of African nurses and midwives. At the completion of their training, they were assigned to missions' maternity clinics and dispensaries where their task included attending to infant and

maternal cases, proper food preparation, and teachings on basic principles of hygiene and sanitation. The trained African midwives performed these task so effectively that by the 1940s, they became so popular amongst their people, helped promote Western obstetrics and indispensable in maintaining missions' standard on maternal and infant welfare. It was among these trained African midwives that emerged and became popular in Ibadan. By the mid 1940s, the partnership of the missionaries with the colonial government further promoted the activities of the missions in its roles and provision of maternal healthcare through the colonial government's grant-in-aid schemes made available for infant and maternal welfare.

This chapter also highlighted the diverse agendas of medical missions and how these agendas has influenced and affected the historical trajectories of missionary medicine in Africa. The chapter has demonstrated that western biomedicine was integral to the cause of the missionaries in Africa; the medical missions nonetheless had a self-conscious objective of eradicating the high mortality and morbidity rate that predated the 1920s in Africa and influenced how medicine came to be practiced. They ensured that mission-based medicine was understood through a deliberate, systematized and organized effort in influencing the knowledge and practice of maternal and infant healthcare. The highlight of the medical missions was that through the functionality of the services offered, the medical missions became successful in the field of maternal healthcare. Arguably, the concerns of the medical missions on maternal health that shaped their diverse agendas made it an unusually good fit in their achievements on improving maternal healthcare.

Chapter Four

Trained African Midwives and Maternal Health in Colonial Ibadan, 1930 to 1960

Introduction

The year 1930, marked the beginning of the training of Africans as professional midwives in Ibadan. Between 1930 and 1960, significant developments were recorded in midwifery practices and maternal and infant healthcare services in colonial Ibadan due to the contributions of these trained Africans in western obstetrics. First, the period was characterized by a drastic change in language and attitude of the government towards the expediency of institutionalizing health institutions to address African health challenges. The change of tone of colonial administration concerning African health grew from concerns raised in colonial discourses regarding disease and reproduction.[263] In these discourses, emphasis was laid particularly on maternal and infant welfare. According to Hillary Marland, policy changes on African health were fostered by the rise of infant and maternal mortality and what this meant for the colonial state.[264]It was important to grow the African population in order to increase laborers for the colonial economy, by increasing the market and income to be earned by exploiting the natural resources (such as agricultural lands) through indigenous labor.[265]Thus, the Dutch colonial government in Hillary's

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[263]David Arnold, *Imperial Medicine and Indigenous Societies* (Manchester: Manchester University Press, 1988); Sheldon Watts, *Epidemics and History: Disease, Power and Imperialism* (New Haven: Yale University Press, 1998); Gerald W. Hartwig and David K. Patterson, eds., *Disease in African History: An Introductory Survey and Case Studies* (Durham: Duke University Press, 1978); David Patterson and Gerald F. Pyle, "The Diffusion of Influenza in Sub-Saharan Africa During the 1918–1919 Pandemic," *Social Science and Medicine*, 17, no.17 (1983): 1299–1307; Daniel R. Headrick, *The Tools of Empire: Technology and European Imperialism in the Nineteenth* Century (New York: Oxford University Press, 1981); Daniel R. Headrick, ed., *Colonialism, Health and Illness in French Equatorial Africa, 1885–1935 (*Atlanta: African Studies Association Press, 1994); Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Stanford: Stanford University Press, 1991).

[264]Hillary Marland, "Midwives, missions and reform Colonizing Dutch childbirth services at home and abroad *ca*. 1900", in *Medicine and Colonial Identity*, eds. Mary P. Sutphen and Bridie Andrews, (New York: Routledge, 2003),62

[265] John Iliffe, "The Origins of African Population Growth", *Journal of African History*, 30 (1989),165 – 169; Herschel L. Grossman and Murat F. Iyigun, "Population Increase and End of Colonialism", *Economica New Series*, Vol. 64, No. 255 (Aug, 1997), 483 – 493.

study set about the task of reforming the Dutch maternity services. In an effort to improve the standard of maternal healthcare in the Dutch colony, the midwife was turned upon as an instrument in the hands of the colonial government. These trainees were 'native agents' drawn largely from the districts where they would later return to practice.[266]To this end, ideas turned into policies. The crux of this chapter is to examine how Africans were trained in the science and art of Western obstetrics to become midwives in colonial Ibadan. The training of African midwives, which started in the 1930s in Ibadan as highlighted in the previous chapter, accentuates some form of complexities. The period witnessed how the government and missionaries' interest clashed and merged at various points from the 1930s through to the 1960s. The interest of the government and the missionaries became fully expressed through the activities of African midwives as modern practitioners of Western obstetrics, as well as instructors of Western biomedical practices and hygiene and infant care to indigenous women and traditional birth attendants known as the *Iya-Abiye's* through the colonial government's activation of a scheme for the education and constant training of traditional birth attendants. This scheme brings to play and seems to capture the idea of medical pluralism particularly in the development of maternal health care at a time when health and healing is supposed to be in its "modern" and Westernized stage, and when reference to African traditional healers and healing practices is been questioned. The concept of modernity and tradition helps examine the historical position of this scheme.[267].

[266]ibid

[267] Waltraud Ernst, "Plural medicine, tradition and modernity: Historical and contemporary perspectives: views from below and from above"in, *Plural Medicine, Tradition and Modernity, 1800 – 2000*, ed. Waltraud Ernst, (London and New York: Routledge, 2002), 1-19.

This chapter, therefore, takes a closer look at the ideas and conditions that guided the African midwives in their practice of midwifery. This chapter further explores the contestations between the missionaries and the colonial government and how it shaped the training and activities of African midwives. This is particularly salient in understanding the maternal and infant healthcare protocols by African midwives during the last three decades of colonial rule in Ibadan. These revisions provide an array of discussions of how the ideas of the missionaries shaped the practice of midwifery and how African midwives read such discourses in their approach towards maternal health in rural communities. This chapter, is therefore projected towards examining the career and conditions of service of African midwives who received training in Western obstetrics in colonial Ibadan from 1940 to 1960; the roles of these trained African midwives in applying Western ideas of childbirth and infant care to the development of maternal health in their communities; it looks beyond the training of African midwives in modern midwifery to reveal how the careers and conditions of service of educated African midwives shaped the context in which midwifery was practiced in Ibadan.

This study further reveal that, not only did the midwives maintain the standard of their trainings, they were also responsible for the increased patronage of missions and colonial maternity centers and succeeded in popularizing Western obstetrics in their indigenous communities. The African trained midwives who acted as teachers and instructors to pregnant women, mothers and traditional birth attendants known as the *Iya-Abiye*, were instrumental to the development of maternal and infant healthcare in colonial Ibadan. The chapter concludes that although African midwives were instrumental in the development of maternal and infant healthcare and in popularizing western healthcare practices, they however incorporated and reinvented some

indigenous birthing knowledge in the course of their practice and service to African communities by function of their relationship with members of the *Iya-Abiye* institution. This is not only because majority of these midwives were a product of the cultural practices of the communities they were reassigned to at the completion of their training, but by virtue of their status, understanding and cooperation between both practitioners.

Evidence of similar development took place in several territories in the British Empire. Africans were trained in the science of Western hygiene and obstetrics to become midwives, to alleviate the disastrous maternal and infant death rates in the colonies. For instance in Kenya, the colonial administration in suggesting a panacea to the ongoing debate of maternal and infant mortality, encouraged colonial governors to provide training for "native women in maternity work" and to promote "infant and child welfare work". The colonial state in Kenya reasoned that through the agency of state-trained African nurses, midwives and welfare workers, reproductive crises could be abated and degrading customs curbed.[268]

Scholars from various disciplines have traced this kind of development and initiatives such as the midwifery reform in African colonies to ideas and models within and across empires and colonies that were circulated through official and non-official circuits and conduits.[269] Helen Tilley, has argued, that, the roles of the League of Nations' Health Organization and the Rockefeller Foundation and its International Health Board had considerable bearing on medical

[268]Lynn M. Thomas, *Politics of the Womb: Women, Reproduction and the State of Kenya*, (University of California Press; Berkeley Los Angeles London, 2003),53

[269]A.L. Stoler and F. Cooper, "Between Metropole and Colony: Rethinking a Research Agenda", in *Tensions of Empire: Colonial Cultures in a Bourgeoisie World*, eds, F. Cooper and A.L. Stoler, (University of California Press, Berkeley and Los Angeles, 1997); D. Ghosh and D. Kennedy, "Introduction", in), *Decentring Empire: Britain, India and the Transcolonial World*, eds. D. Ghosh and D. Kennedy, (Orient Longman, New Delhi, 2006); K. Trumpener, *Bardic Nationalism: The Romantic Novel and the British Empire* (Princeton University Press, Princeton: NJ, 1997).

developments in colonial Africa during the interwar period. Tilley states that both the intergovernmental organization and the private philanthropy stressed cooperation and collaboration that moved beyond national boundaries.[270] According to Glen Ncube, the call for cooperation and collaboration across transnational boundaries during this period influenced the rural healthcare reform in interwar colonial Zimbabwe.[271] He illustrates the ways in which local colonial healthcare policies evolved in the contexts of transfer of ideas within and across colonies and empires.[272] According to David Arnold, colonial policies, which were based on happenings in colonies, were mirrored around the ideological and administrative processes that went into the building of modern states.[273] In this context, as suggested by Marland, the ideological and administrative processes of making professional midwives out of Africans through training, the identity of Africans as model and modern midwives was forged.[274] In colonial Ibadan however, what this proves is that local health initiatives were influenced by diverse and complex agendas. Colonial locales were therefore melting points for international and local ideas and initiatives that played-out in policy implementation quite glaringly during this period.

[270]Helen, *Africa as a Living Laboratory:*7

[271]G. Ncube, "Robert A. Askins and healthcare reform in interwar colonial Zimbabwe: The influence of British and trans-territorial colonial models", *Historia*, 63, 2, (November 2018),62-92

[272]ibid

[273]D. Arnold, *Imperial Medicine and Indigenous Societies* (Manchester: Manchester University Press, 1988), and *State Medicine and Epidemic Disease in Nineteenth-Century India* (Berkeley, Los Angeles and London: University of California Press, 1993),9

[274]Hillary Marland, Midwives, missions and reform Colonizing Dutch childbirth services at home and abroad *ca*. 1900, in *Medicine and Colonial Identity*, eds. Mary P. Sutphen and Bridie Andrews, (New York: Routledge, 2003),62

African Midwives: Careers and Conditions of Service in Ibadan

The careers of African midwives in colonial Ibadan began from the period of their training. The colonizing government in Ibadan initiated its maternal welfare scheme first, through the education of African midwives in Western obstetrics in colonial Ibadan. The medical administration realized that they could gain more strength over the indigenous people and their birthing practice not only through its services but also through mental control. This mental control was carried out through the training of Africans in midwifery[275]. The intention of the colonial medical administration was to expose Africans to Western medical practices. The Colonial Office believed training Africans in Western biomedicine would bring them to a higher level of civilization. Also, the need for African midwives to aid the development of maternal healthcare and population growth entrenched in the Ten-year Medical and Health Services Development Plan (1945 -56) necessitated the colonial government to use education and the training of Africans as a tool to achieve social control over the African people.[276]

This systemic control conforms to Foucault's position in his work, *The Subject and Power*.[277] Michel Foucault in his argument on the human subject and manner in which it is determined by power structures, described power as turning the subject into an object, an object of knowledge; of language and of the power which is mediated through them and that create subjects.[278] He further describes three manners of objectification, which turn individuals into subjects. The first way is modes of inquiry and aspiring to the status of science, which produce "objective" knowledge about the subject, thus objectifying life itself. The second practice of objectification

[275]NAI, File No: MH/Fed. 1/1.3987F, Rebuilding of Hospitals and Colonial Development Welfare Fund, 1940,1-8
[276]NAI, File No: Iba. Div 43693/S.3, J/1/C, Q/1/C, Q/2/A, Development of Health Services (Revision 10 Year plan) (C.D.W.A. Scheme), 1949, 2
[277]Foucault, M., "The Subject and Power", In: *Critical Inquiry*, Vol. 8, No. 4, (the University of Chicago Press, Chicago: 1982),777-795,
[278]ibid

he portrays as having to do with separation and distinction such as those drawn between mad and sane, criminals and law-abiding citizens (notions offered in his "Discipline and Punish" or "Madness and Civilization"). The third mode of objectification has to do with the manner in which individuals turn themselves into subjects by identifying themselves in relations to larger structures.[279] According to Foucault, these processes are related to specific forms of political rationality, a form of thinking described by Max Weber, which is concerned with appropriating means to ends.[280] According to Weber, this instrumental rationality, takes over modernity, which seeks control over society.[281] 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.[282]

Therefore, as a means to an end, the harsh reality of infant and maternal mortality necessitated the colonial government in Nigeria to initiate a scheme to make all mothers 'welfare conscious'.[283] This was coupled with concerns on the shortage of staff, which was unable to meet the maternal healthcare needs in the colony, thus leading to the training of Africans in Western obstetrics. The missionaries and the colonial government respectively sponsored most of these trainings. The missionaries and the colonial government offered generous incentives including free tuition, accommodation and monthly stipends, with a guaranteed career after graduation.[284] During this period, the criteria demanded before enrolling and commencing training in

[279]ibid

[280]Max Weber, *Rationalism and Modern Society: New Translation on Politics, Bureaucracy, and Social Stratification*, (Palgrave: Macmillan, 2015), 73-128

[281]ibid

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

[283]ibid

[284]NAI, File No: D8, Ondo Prof 1/3, Medical Development, 1947,139

midwifery was a standard VI pass.[285] At the completion of a three-year full course training in midwifery they would absorb the trained African midwives into missions and government established hospitals, clinics, maternity centers and dispensaries where they were trained or other branches, as its continuous existence depended upon the availability of trained and certified midwives to staff it.[286] This is as opposed to the case of student at midwifery schools in the French West African colonies where students had to pay tuition or secure funding from their local communities or hospitals.[287] This was because, the recruitment after the training of the first sets of student midwives languished for years. Graduate midwives were not available to take up duties in maternity centers and this apparently upset the French administrator's interest in funding Africans in midwifery trainings.

The training of African midwives which dates back to the 1930s in colonial Ibadan, include teachings to aid prospective midwives lecture and advise young mothers on every phase of infant welfare, care, attention and diet on the most modern lines of children from birth to the age at which they come under school clinics.[288] The midwives in training also learned to diagnose serious ailments, whereby the infant can be passed on for expert medical care.[289] In 1945 however, it was suggested by L.J. Hoskyns-Abrahall of the European hospital in Lagos to the Director of Medical Services in Ibadan, that, midwives in training should be given teachings in scope and constructive work that includes how;

a) To run a home for motherless babies at Ibadan.

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[285]NAI, File No: 47, Oyo Prof. 1, Volume II: Extension of Medical Service Directing Controls and Subsidy Medical Mission, 1946,135

[286]Ibid

[287]Thuy Linh Nguyen, "French-Educated Midwives and the Medicalization of Childbirth in Colonial Vietnam", *Journal of Vietnamese Studies*, Vol. 5, Issue 2, (2010),133–182.

[288]NAI, File No: Oyo Prof. 1, 4155, Prospective Mothers: Training of., 1944, 5

[289]ibid

b) To carry out research into the artificial feeding of African infants.

c) To carry out research in native diets.

d) To run courses in the care of infants and young children.

e) To run courses in dietetics for health workers, nurses, teachers etc. and above all for European workers, Government and Mission.[290]

Majority of the trained African midwives in Ibadan got their trainings from the Seventh Day Adventist Missions, the Methodist Missions and the Our Lady of the Apostles Catholic Missions in the Ibadan district of the Oyo province.[291] However, while some of the African midwives begun their careers as students in training in Ibadan, others were sent to Massey Street Hospital (midwifery school) in Lagos, and Abeokuta[292] respectively. During this period, males and females from Higher Schools took up the calling of becoming Nurses and prospective Midwives. With Mission Sisters and Doctors as tutors, they expounded the Government Scheme of Nursing and the Midwives curriculum both for the two and half-years training for the Midwives Board Certificate (Nigeria) and the shorter training of tribal or village midwives for another six months.[293] In 1949, the midwifery course of training was made equivalent in standard to the English S.R.N. (State Registered Nurse) and upon qualification, formed the nucleus of the nursing staff for the University College Hospital in Ibadan, and for the senior nursing staff in Government service.[294]

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[290]NAI, File No: Oyo Prof 1 4172,. (i) Maternity Centres (ii) Domestic Centre Oyo Province, 1945,38

[291]Interviews conducted traces the training institutions to the aforementioned mission's midwifery institutions.

[292]NAI, File No: COMCOL 1044, Midwifery and Infant Welfare: A Bill Entitled "Midwives Ordinance", 1930 -31,3

[293]NAI, File No: 47, Oyo Prof. 1, Volume II: Extension of Medical Service Directing Controls and Subsidy Medical Mission.1946,146

[294]NAI, Ondo Prof 1/3. File No. D8, Medical Development, 1947, P.139

As students, African midwives were already being assigned to orphanage homes within the premises of the midwifery school, to learn and practice the care of infants, under the supervision of European nursing sisters.[295] This was to prepare them for future engagements after graduation. Upon graduation, the midwives were assigned to work in maternity clinics or hospitals under the direct supervision of European medical personnel.[296] In rural communities where supervisory medical personnel was not present, the midwives were left in complete charge of the maternity centre as they were deemed capable as a result of their training and experience to run the maternity centre without supervision. Hannah Agboola recounting her days as a student, reports;

> As a student, I was trained to head wards between afternoon and night shifts with only one or two nurses to supervise me. And as a semi-final year student, we were expected to be able to carry out duty alone. And in your final year they are sure you can work anywhere without difficulty.[297]

The respondent like so many others who commented on the age long training of midwives since the 1930s, provided quite critical reflections on the subject based on her experience and as passed to them by retired African midwives who trained during this period. Another midwife corroborating Hannah Agboola's report with her training under the missionary as a midwife, states that;

> During training, one will be posted to the (missionary) annex hospital to have practical experience and at times recruit those willing to work. If anyone wants to join the government, he/she can only be employed as midwife and nothing more. Such person

[295]NAI, File No: COMCOL 1044, Midwifery and Infant Welfare: A Bill Entitled "Midwives Ordinance" 1930 -31,4-5
[296]ibid
[297]Hannah Agboola, Retired Midwife, 62 Years, (Phone interview) June, 2020.

> will be posted to maternal ward where such person will put into practices all that has been taught in school which is to monitor pregnant women, ensure safe delivery without complication, child care etc.[298]

The medical administrative bureaucracy focused on incorporating the trained midwives into the colonial health sector as part of the colonial healthcare policy during this period. However, preferences were placed on trained midwives who had no family ties.[299] This is because they believed they could go on far posting to interior villages without any commitment or distraction to their service, as they were particular about the considerable wastage of midwives through marriage. This is similar to what was attainable in other African colonies. For instance in Nairobi, metropolitan reformers and medical officers preferred single and school-educated girls or young women, between the ages of 16 and 25 years, because they made the best midwives This, partly, was due to midwives being free of family ties that could distract them from their careers.[300] In colonial Ibadan, this assumption was different as it was considered in a more advance place to train a number of older women as midwives who might be expected to remain in the profession practically for the rest of their lives. This is because of their literacy and assimilation level, as it was believed that older women could learn faster given the urgency of the training and that with their work, female education will spread and may give an opening for educated women of a younger generation.[301] This consideration was also in fear of an impending difficulty that might

[298]Olukemi Omotunde Komolafe, Retired Chief Nursing Officer, 63 years, June 2020.
[299]NAI, File No: COMCOL 1044, Midwifery and Infant Welfare: A Bill Entitled "Midwives Ordinance", 1930-31,3
[300]Lady Grigg, Welfare League, African Maternity and Child Welfare Hospital and Training Centre, Nairobi, "Rules for Candidates for Acceptance as Probationers," forwarded by D. M. Blomfield, Medical Officer, Native Civil Hospital, Meru, to the Superintendent, Methodist Missionary Society, Meru, 2 July 1946, MOM, 16.
[301] NAI, File No: 994, COMCOL 1, Abolition of Customs Which are Detrimental to Natives Welfare and Economic Prosperity, 1930,12

arise from the fact that nearly all girls within a year or two of completing their training as midwives will get married and resign their appointments.[302]

Among the trained African midwives, some were posted to urban and rural mission health facilities, while others were posted to the Native Administrative hospitals, clinics, maternity centers and dispensaries.[303] This arrangement was part of the Infant Welfare Scheme extended from Lagos to other parts of Nigeria in 1944. The scheme made provision that after training, midwives will be posted to the districts where their knowledge is most needed.[304]

At first, professional African midwives started their careers officially as assistants to European missionary and colonial nursing sisters. Starting from the late 1940s, professional African midwives in Ibadan gradually began practicing independently, but under the supervision of missionary and colonial government doctors and nursing sisters. In rural areas without the presence of European medical personnel, the trained midwives were left in charge of the entire maternity home, with junior grade level of midwives assisting them.[305] This was not however, until they were certified as Midwife II, after undertaking courses that were a prerequisite to attain the level of Midwife II.[306] One of such trained African midwives in Ibadan who attained the level of Midwife II, includes one named Mrs. Durojaiye, a state certified midwife who possessed a certificate issued by the Central Midwives Board London, dated 27th of June 1952. She had undergone two years training in England, and returned to Nigeria to gain experience. She was left in charge of the Maternity Section at the Wesley Guild Hospital. She was ranked among the

[302]NAI, File No: 1044, COMCOL 1, Midwifery and Infant Welfare: A Bill Entitled "Midwives Ordinance", 1930-3125
[303]NAI, File No: 4172, Oyo Prof 1, (i) Maternity Centres (ii) Domestic Science Centre Oyo Province,1945,7
[304]NAI, File No: 4155, Oyo Prof. 1, Prospective Mothers: Training of. 1944,5
[305]NAI, File No: 1044, COMCOL 1, Midwifery and Infant Welfare; A Bill Entitled "Midwives Ordinance",1930 – 31, 4
[306]ibid

top trained and practicing midwives in Ibadan and Nigeria[307] during this period. As shown in the annual statistical report during this period, African midwives such as Mrs. Durojaye, were able to increase output in maternal and infant healthcare service, thereby, increasing the indigenous patronage of Western obstetrics.[308]

The scope in the career of trained African midwives in Ibadan, was however, within the confines of voluntary activities; that is, assisting the missionaries and European registered nurses in the domiciliary sphere. This they did in their capacity as health and welfare visiting and domiciliary midwives.[309] The reason behind this arrangement is that it was very easy for African midwives to navigate the interior areas due to their familiarity of the terrains. For instance, in 1945, one Miss Alice Cowper who was employed by the Salford Borough Council based on the recommendation of the Assistant Chairman of the government clinic in Ibadan,[310] whilst carrying out her duties requested and utilized the services of trained African midwives to assist her in the infant and maternal health works around Ibadan with the condition of serving as a domiciliary midwife combing the interiors of Ibadan.[311] Although, one of the conditions of her employment was to train women in Ibadan on clinic matters,[312] she however needed midwives that could travel long distances with her to rural areas and were familiar with the people and their culture. This, also was because the services of African midwives were needed to popularize child welfare: thus making the people appreciates the service.[313]

In light of the above, advisability and experience on midwifery in the careers of African midwives from the 1950s were facilitated towards running major government hospitals in Ibadan.

[307]NAI, File No: 4172/Oyo Prof, 8/1/45, (i) Maternity Centres (ii) Domestic Science Centre, 1945,104
[308]ibid
[309]Ibid,50
[310]Ibid,42
[311]ibid
[312]ibid
[313]Ibid,82

With regards to this, Miss Harriett Pratt, a Grade I Midwife and a Yoruba, was put in charge of the Adeoyo Native Administration Hospital.[314] Miss Pratt who commenced training at Massey Street in 1934, qualified as a midwife in 1937…she was recommended by the Medical Officer Massey Street, who suggests that the midwife…proceed to Ibadan doing not only midwifery works but also be allowed to perform some district infant welfare duties.[315]

While the colonial maternal reality defined the rationale for the training and careers of Africans in Western obstetrics, the conditions of service guiding African midwives and their functionalities, reflected the colonial medical bureaucratic ideas of how midwifery should be taught, licensed and practiced. In colonial Ibadan, as elsewhere in Africa and in the world, trained midwives, having gained the recognition of the colonial government through their education and certification in midwifery, their careers and duties, however, were primarily subject to medical administrative reforms.[316] The reform in Ibadan began in 1953, when the Resident, Oyo Province, suggested that it would be useful to have a conference of those concerned with medical work in the Ibadan division, to discuss the problems of medical organization and supervision, and the general future of medical work in the division.[317] The conference which held in November the same year, outlined a number of policies to be considered for the future development of medical services in the Ibadan Division. In respect to the licensing and the conditions of practice of trained African midwives towards improving the service of midwifery and infant welfare, the following reforms were made;

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[314]NAI, File No: 470/405/24, Oyo Prof 1, , Adeoyo Hospital, 1933 - 1945,103

[315]ibid

[316]Phyllis Stock Morton, "Control and Limitation of Midwives in Modern France: The Example of Marseille," *Journal of Women's History* 8, no. 1 (Spring 1996): 60–94. See also, M. J. van Lieburg and H. Marland, 'Midwife regulation, education, and practice in the Netherlands during the nineteenth century', *Medical History*, 33 (1989), 296–317.

[317]NAI, File No: 2200/2, Medical Policy – Oyo Province, 1954,12

Firstly, a sanction was made towards grouping midwives separately as - Midwives, First Class Midwives; Second Class; and Pupil Midwives.[318] From the decision reached at conference, this grouping was necessary, in order to identify African midwives that had become highly trained and in order for the colonial medical administration to identify African midwives with the capable of managing maternity centers in the division with or without the supervision of a European Nursing Sister. Through this grouping, an increased number of welfare centers can be opened with the guarantee of capable work force to run them at a comparatively low cost, without any need to source for European medical personnel who were more cost intensive.[319]

The second condition for service as an African midwife was to qualify for registration. The conditions to qualify for registration, was that a midwife must apply for registration in a prescribed manner that satisfies the Midwives Board of Nigeria. To ascertain she is of good character and shall be entitled to be registered if –

a. She holds a certificate issued by the Board under the Midwives Ordinance of 1930; or
b. She produces satisfactory evidence that she has been certified or registered as a midwife in any other country in which there is for the time being any law in force for the certification or registration of midwives; provided that the standard of training and examination required in that country is in the opinion of the Director of Medical and Sanitary Service, whose decision thereon shall be final, equal to the standard adopted by the Board for registration in respect of the whole of Nigeria; or
c. She holds a certificate of competence in midwifery issued by the Director of Medical and Sanitary Service in Nigeria before the commencement of this Ordinance;

[318]NAI, File No: COMCOL 1044, Midwifery and Infant Welfare: A Bill Entitled "Midwives Ordinance", 1930-31,7
[319]ibid

Provided that where in case (a) the certificate is expressed to qualify the holder for registration only in respect of a specified part of Nigeria, the holder shall be so registered, and shall when in any other part of Nigeria be deemed to be unregistered.[320]

Thirdly, to keep the African midwives activities in check, a system of supervision was integrated into their practice. The reform states, that for the Supervision of Midwives;

1. The Board may appoint any person or body of persons to be a Supervisory Authority over any registered midwife or class of registered midwives wherever practicing. It shall be the duty of every Supervisory Authority in respect of any midwife over whom it has supervision –

a) To exercise general supervision in accordance with the rules made under the Ordinance;
b) To investigate charges of malpractice, negligence or misconduct or contravention of a rule, and should a prima facie case be established to make a report to the Board;
c) To report at once to the Board the name of any midwife who is convicted of any offence.[321]

Therefore, a system of inspection was approved and set up to keep the midwives' practices under control. For example, a Travelling Medical Officer (later named an Inspecting Medical Officer) was assigned to a midwife or group of midwives. The assigned travelling medical officers had to conduct investigation tours at least every month in all maternity centers, hospitals, clinics and dispensaries with posted African midwives in the Ibadan district and the entire Oyo province.[322] During these tours, the travelling medical officers needed to report the activities of the midwives; the number of infants they had delivered, the number of attendances, verifies their use of

[320]Ibid,10-11
[321]NAI ,File No: COMCOL 1044, Midwifery and Infant Welfare: A Bill Entitled "Midwives Ordinance", 1930 – 31,11
[322]NAI, File No: CSO 26/2, 15216 Vol IV, Scheme for Preventive Medicine and Hygiene in Nigeria, (ii) Travelling Medical Officers, 1930, P. 5

medicines and instruments, including umbilical bandage and serve as advisor to the midwives and the colonial medical government. The midwives were only allowed to give prescribed dosages of drugs with easy instructions. The administration also required all midwives to occasionally go on courses to renew their training.[323] The refresher course was designed to ensure the constant application of Western knowledge and practices. In addition, the midwives needed to keep a notebook recording of their conducted births, which will be used to check the veracity of annual birth and mortality figure.[324]

Fourthly, the penalty for improperly claiming to be or practicing as a registered midwife, states that , any woman who not being a registered midwife takes or uses any name, title or description implying that she is registered or that she is recognized by the law as a midwife, shall be liable to a fine of five pounds.[325] Therefore, every registered midwife shall, before commencing to practice or holding herself out to practice, give notice of her intention to do so to the Secretary of the Board. The clause in this section goes further to state, that, whereby any registered midwife who has been practicing in any place transfers herself to any other place for the purpose of practice, there she shall within seven days after such transfer give notice thereof through the Secretary to the Board. Every notice shall contain such particulars as may be prescribed by the Board. Any midwife who fails to comply with any of the provisions of this section shall be liable to a fine of two pounds.[326] Any registered midwife who employs an unregistered person as her substitute shall be liable to a fine of ten pounds.[327] Registration under this Ordinance shall not confer upon any woman any right to assume any name, title or designation implying that she is

[323]Agboola ModinaIbijoke, Retired Chief Nursing Officer, 62 Years, (Phone interview) June 2020.
[324]ibid
[325]NAI, File No: COMCOL 1044, Midwifery and Infant Welfare: A Bill Entitled “Midwives Ordinance”, 1930 – 31,10-11
[326]Ibid, 16
[327]ibid

by law authorized to practice medicine and surgery or to grant any medical certificate, or any certificate of death or stillbirth, or to undertake the charge of cases of abnormality or disease in connection with parturition.[328]

Apparently, African midwives were subject to these reforms and professional constraints for a couple of reasons. The colonial medical bureaucratic administration believed that African midwives should be under constant surveillance to ensure both their professional performance and their moral conduct. The objective and reason for these conditions, was not only to improve maternal and infant healthcare, but it was also to improve the training and the statue of midwives, by providing for the registration of midwives who satisfy certain conditions and to regulate the practice of registered midwives.[329] Hannah Agboola, while working at the missionary and state maternity clinics at the Our Ladies of the Apostle Catholic Missionary hospital and Adeoyo government hospitals in Ibadan respectively, states that, the conditions of service given to them during and after training made their practice clinical, standard and more professional, unlike what became of the service after the colonial period. She reports:

> As a student who later graduated to become a midwife, we were trained and given conditions to help us stand on our own. Sometimes we work with less supervision, but the conditions of service given to us as midwives gave us discipline outside the school. This made us work to complete our daily target regardless of time.[330]

[328]ibid
[329] ibid
[330]Hannah Agboola, Retired Midwife, 62 Years, (Phone interview) June, 2020.

African Midwives and the Development of Maternal Healthcare in Ibadan

Between 1949 and 1950, a "simple scheme" was proposed for improving maternity and infant welfare services in Ibadan.[331] It was believed that too many people were ignorant of the value of the clinics at their disposal and that the distance was possibly too great for them. The colonial government through the Native Administration therefore offered to bring the clinics to the people, to safeguard them against the dangers of childbirth, and infant diseases. According to the Senior Medical Officer, A.H.C. Walker;

> Far too many cases come into Hospital too late, or die in their own homes. This is a situation, which is detrimental to the progress of Ibadan and the Western Provinces. This situation, he said once existed in the United Kingdom, but now, because we applied the same scheme we offer to Ibadan the maternal and infant mortality is at a record low figure.[332]

Part of the requirement proposed and offered by the scheme was for maternity hospitals, clinics and dispensaries to be staffed by trained African midwives, who will be responsible for running the clinics under the direction of the Senior Medical Officer, and for sending difficult cases or sending for aid in emergency.[333] Although the careers and recruitment of African midwives languished for some years due to mostly, the marital commitments of some of the graduates, and the conditions of service imposed by the colonial medical administration, which begun to upset the colonial healthcare plans. Nonetheless, the achievement of the few available to service cannot be overemphasized. Their supporting duties such as in ante-natal and postpartum consultations to mothers, teachings on infant care and the danger of arbitrary diet and premature artificial feedings were indispensable to the overall provision and development of maternal and

[331]NAI, File No: 1221 Iba. Div Vol. VI, Ibadan District Hospital Council Adeoyo, 1949,52A
[332]ibid
[333]ibid

infant healthcare,[334] such that, by the end of the 1960s, their work ensured that modern midwifery practices got to the rural communities.

Thus, the development and expansion of medical services during this period offered less difficulty. At this time, there was a surplus of trained midwives eager to obtain jobs. This surplus source of midwives was tapped into to fill gaps in the shortage of staff from the 1940s through the 1960s.[335]As part of the colonial governments' Ten-Year Medical and Health Services Development Plan (1946 - 1955, it was proposed that African staff undertakes the direction of a circle of improved Native Authorities' dispensaries, and the supervision of practicing midwives, maternity homes, home visiting and nursing, and the development of health consciousness through education and propaganda.[336] Provision was also made in the plan for an extension of training midwives in conjunction with maternity hospitals and wards in order that the field maternity service may ultimately be extended to desirable proportions.[337] This marked a new direction in the development of maternal health in colonial Ibadan. As suggested by Anne Hugon in her research into the history of colonial maternity in Ghana, and the medicalisation and hospitalization of pregnancy and childbirth, she revealed how colonial midwives trained at the Korle-Bu Hospital from the late 1930s to the early 1950s assisted in the development of maternal healthcare.[338]Hugon's ethnographic study with Ghanaian midwives indicates that the colonial government managed to recreate a microcosm of the colonial world through western midwifery education and biomedical practices. In the case of colonial Ibadan, as soon as more midwives

[334]ibid
[335]NAI, File No: Oyo Prof. 1/1 22002 Medical Policy – Oyo Province, 1953 – 1954,10
[336]NAI, Fie No: Iba. Div 43693/S.3, J/1/C, Q/1/C, Q/2/A, Development of Health Services (Revision 10 Year Plan): C.D.W.A. Scheme, 1949,2
[337]ibid
[338]Anne Hugon, "Korle Bu and the Midwives Hostel as a Site of Memory for Ghanaian Pupil Midwives, 1930s-1950s," *Ghana Studies* Volume 7, (, 2004),43-58

became trained, certified and registered, it was considered that welfare centers in connection to large African Hospitals be opened. These welfare centers would be managed by certified and registered African midwives, under the supervision of European Nursing Sisters holding a C.M.B. (Certificate of the Midwifery Board). African midwives yet to attain certain professional grade levels were to undertake district maternity work as well, but as assistants at the welfare centre.[339]

Given the above arrangement, in the Annual Report of the Ibadan Division in 1955, the Resident of the Oyo Province reported of locally recruited nursing and midwifery staff with an encouraging statistical fact of large numbers of babies and children attended to – evidence that people of the Oyo Province are conscious of the need for prompt medical attention to their children.[340] Hereunder, are details of attendances at the Native Administration Clinics, Maternity Centre's and Dispensaries run by professional African midwives during this period.

Native Administration Dispensaries	**No. of Cases**	**Total Attendances**
Oyo N.A. Disp.	1647	11355
Fiditi	1165	7843
Awe	1374	6516
Ilora	522	4360
Iseyin	2423	12712
Otu	1081	3247
Shaki	2426	15691
Ago Are	1780	7764
Okeho	2844	5443
Iganna	2160	9086
Kishi	2646	12476
Igbetti	1314	9113

Source: NAI, Annual Report Medical and Health Departments, 1958, P.303

[339]NAI, File No: 1044 COMCOL, Midwifery and Infant Welfare: A Bill Entitled "Midwives Ordinance", 1930-31,5
[340]NAI, Annual Report Medical and Health Departments, 1958,303

The African midwives in colonial Ibadan were able to achieve great strides in the number of attendances and the number of maternal healthcare services rendered within in a year of their service in Ibadan. This was due to their familiarized activities with the natives, alongside, employing the Western system of obstetrics to alleviate maternal and infant mortality rate in Ibadan.[341] As medical intermediary between the Europeans and the natives, the African midwives took advantage of their cultural roots and social relations to relate with Africans and created awareness that would convince the indigenous patronage of Western obstetrics. This was important as it contributed towards making plain the intentions of the missions and colonial government, and thus, encouraged African patronage of hospital based birthing practice. As reported by a midwife;

> Rural dwellers were majorly our patients. Our relationship with the people and consistency towards promoting our practice made it possible for them to absorb the new idea of maternal and infant health.[342]

In fact, professional African midwives in Ibadan, did not only work as collaborators to the missions and colonial government, but also operated independently. Due to the increasing popularity of African midwives in their communities, majority of them took up private practices. The medical bureaucracy gave enormous support to them, as a way of campaign against maternal and infant mortality. By the 1950s, a good number of these midwives sent applications to the colonial government for approval and the registration of their private practices. Worthy of mention for instance, was in 1952, when one Mrs. I. Durojaiye, a Grade 1 Midwife, proposed her "Tika-Tere Maternity Homes" to the Deputy Director of Medical Services, Ibadan, for

[341]Ibid
[342]Modupeoluwa Omotosho, 64 Years, Retired Midwife, (Phone interview) June2020.

approval.[343] According to the Rural Medical Officer, "Mrs. Durojaiye is a state certified midwife and possesses a certificate issued by the Central Midwives Board London, dated 27th of June, 1952. She had undergone two years training in England, and returned to Nigeria to gain experience – had been in charge of the Maternity Section at the Wesley Guild Hospital. Her reputation is good and her financial stability appears to be sound."[344] In view of the Rural Medical Officer's letter, the application of Mrs. I. Durojaiye was recommended to the Resident, Oyo Province, Oyo, to grant a private practiced Maternity Home.[345] Mrs. Durojaye exemplifies a pioneering set of African midwives who ventured into the profession for the sake of alleviating maternal and infant mortality in Africa.

Evaluating the impact of African midwives in the development of maternal healthcare in Ibadan, shows that these midwives may have being responsible for the positive outcome on the increased birth rate, early detection of complications before, during and after child birth, and in referral of maternal and infant health related issues to mission and government health facilities[346]. This is because they were able to effectively deliver the various nutritional, hygiene and healthcare plans to their people without any form of discrimination or hindrance, unlike occasional hostilities from the indigenous people towards European healthcare givers.[347] Because of maternal and infant healthcare, in the late 1950s, emphasis was made on services rendered to many hundreds of natives from all parts of the Ibadan district, under the Oyo province, and many sections of adjoining provinces.[348] This made the colonial government promised releasing funds for more

[343]NAI, File No: 4172/Oyo Prof, 8/1/45, (i) Maternity Centres (ii) Domestic Science Centre, 1945,102
[344]ibid,104
[345]Ibid,106
[346]NAI, File No: 47, Oyo Prof. 1, , Volume II: Extension of Medical Service Directing Controls and Subsidy Medical Mission. 1946,133.
[347] ibid
[348]ibid

training of native boys and girls as nurses, midwives and assistants, with the aim of looking forward to extensions in other areas.[349]

During this period, however, there was not enough funding coming from the missions' home countries and government funding of maternal and infant healthcare became irregular.[350] The voluntary agencies such as the missions were mainly hit by this challenge, as they had low income to finance their health facilities from home or the colonial government. They were left with four choices:

1. Reduce staff and work to that of small branch dispensary, without regular surgery such as it was 5 years ago.
2. Receive a considerable income from some unexpected source.
3. Receive aid from government (N.A. or general).
4. Turn the hospital over to government.[351]

The implication of this, if none of the choices outlined above were met, was that there would be a considerable increase in maternal and infant mortality rate and an increased unrelieved suffering amongst the African population. However, it was recognized that a small fraction of the sufferings can be managed, but it is urgent that healthcare services in the colonies be as widely extended as possible. As such, every effort must be made to reach the people and to this end cooperation be sought.

Ibadan at the time was a town with an estimated population of about a quarter of a million, little had been done to meet the medical needs of such a large community,[352] especially in the interior

[349]ibid
[350]Ibid,135
[351]NAI, File No: 47, Oyo Prof. 1, Volume II: Extension of Medical Service Directing Controls and Subsidy Medical Mission, 1946,136
[352]NAI, File No: 17220/ CSO 26/2, African Hospital Ibadan, 1926,127

villages. This therefore called for a new initiative to manage the maternal welfare needs in colonial Ibadan. This initiative, which was proposed by the colonial medical administration, involved the services of professional African midwives trained in Western medical ideas and the traditional birth attendants, popularly known as the *Iya-Abiye* in colonial Ibadan.

Necessary Compromises: the Colonial Government and Traditional Birth Attendants (*Iya-Abiye*) in Ibadan

The relationship between trained African midwives and the *Iya-Abiye* in Ibadan developed alongside the missions' and states' efforts to medicalize childbirth and modernize maternity services in the whole of Ibadan. The reliance on African midwives for maternity services, however, required that they play a more demanding and varied roles in their communities. The activities and practices of professional African midwives did not only offer an opportunity for their integration into the colonial medical sector, it also, facilitated the activation of a scheme for the education and constant training of Traditional Birth Attendants known as the *Iya-Abiye* in Ibadan.[353] This particular scheme was also initiated elsewhere in colonial Africa such as in Tanzania. According to Stacey Langwick, the Tanzania government ostensibly made great efforts to incorporate traditional practitioners into the 'bio-medically' designed national healthcare system. Landwick explained that the incorporation of the TBA's into the national development plans required that the Tanzanian state discern differences among "indigenous practitioners." The nebulous distinction between the biomedical practitioners and all other healers (whether "charlatans" or persons with "good intentions"), who had served as a foil for biomedicine since the beginning of the twentieth century, came to be slightly more refined through the separation of traditional midwives and traditional healers. Traditional midwives were

[353]Olukemi Omotunde Komolafe, 63 Years, Retired Chief Nursing Officer, June 2020; NAI, File No: COMCOL 1, 994, V/12, Abolition of Customs which are Detrimental to Native Welfare and Economic Prosperity. 1923 – 1946, P.10

to be outreach workers, helping in the fight to reduce the maternal and infant mortality figures that contributed to Tanzania's ranking as one of the least developed counties in the world.[354] While the scheme was a post-colonial initiative in Tanzania, the colonial government had pushed for this initiative in Ibadan.

Also, the attempt to train Iya Abiye's to appeal to local patients was ultimately driven aground by the lack of appeal of the medical profession for the average Ibadan people, especially, those in the rural areas. Years of arduous medical training of African midwives led to an increased patronage of missions and colonial maternal health facilities, a progress that in contrast required little efforts from traditional birth attendants. As patients, the Ibadan people, were not simply refusing "new medicine;" they were weighing their options and going for healthcare that best meets their needs. The colonial health services quickly realized that other techniques would be required to appeal to local populations and increase the scope of the medical services within the Western midwifery operational limitations. Since the local population did not prove as open to Western medicine as originally envisioned, the colonial service had to display some flexibility on its part. The reason for the British colonial government's attempts to accommodate the Iya Abiye's within its operating system, can be divided into three categories: limiting local competition through the elimination or regulation of indigenous healers; incorporating indigenous customs and medicines within Western medical practices and establishments; and popularizing Western medicine at the grassroots level with education and medical outreach.

[354]Stacey Ann Langwick, Medicine, "Mobility, and Power in Global Africa: Transnational Health and Healing", in *the Choreography of Global Subjection*, eds. Hansjörg Dilger, Abdoulaye Kane, (Indiana: Indiana University Press), 37

The scheme started in the 1940s, when the medical bureaucratic government strove to educate and train the *Iya-Abiye,* using the services of African midwives.[355] Development theorist such as Charles Good, supporting such colonial policies, believes that African health needs would be better served by strengthening the interface between modern and traditional practices…, which he considers as an "outstanding colonial health program."[356] The scheme in Ibadan was a deliberate attempt by the colonial government to remedy the dearth of trained African midwives in rural areas, and as a bid to extending the provision of modern healthcare services to interior villages. This was after deeply evaluating the services the Mission's provides with all their expenses, and putting into consideration the works of African midwives, thus, resolving that not even the colonial government during this period could carry on the work for even twice the amount of annual grant given for voluntary services to enable the Missions to go on in a good way.[357] Therefore, from an economical standpoint, and in order to ensure the maternity work already done does not go to waste a different measure had to be implemented. That is, educating traditional midwives and bringing them into the healthcare system where their activities can be controlled and closely monitored.

The *Iya-Abiye* before the advent of colonial biomedicine, operated in the villages and towns of Ibadan. They had complete influence over the social, economic and the political organization of their communities. In Ibadan as well as elsewhere in Africa, the TBA has posed a major challenge to the development of Western obstetrics. The missionaries and the state healthcare providers were in the early period of the introduction of Western medicine forced to compete

[355]NAI, File No: 43831/S7, Colonial Development and Welfare Schemes: (i) Estimates 1948-49), 20; NAI, File No: COMCOL 1, 994, V/12, Abolition of Customs which are Detrimental to Native Welfare and Economic Prosperity.1946,10

[356]Charles M. Good, *Ethnomedical Systems in Africa: Patterns of Traditional Medicine in Rural and Urban Kenya* (New York: The Guilford Press, 1987), 38.

[357]NAI, File No: 47, Oyo Prof. 1, Volume II: Extension of Medical Service Directing Controls and Subsidy Medical Mission.1946,136

with the traditional healthcare providers by building levels of trust and acceptance in their comparative skill and success,[358] until Western medicine gained more ground specifically in urban areas in colonial spaces. It was therefore important to recognize the services of the TBA's not only because of the dearth in educated midwives to serve the increasing population seeking maternal healthcare, especially in the rural areas, but because the TBAs already had an already existing birthing institution which was well recognized by the people and despite the missionaries and colonial governments propaganda against the institution, it still survived. More so, during this period, there were records of continuous patronage of Traditional Birth Attendants - *Iya-Abiye* by the indigenous peoples in Ibadan. This was attributed partly to the under staffed maternity health facilities, closed healthcare facilities, financial constraints, the inaccessibility to interior areas by healthcare providers, the difficulties of getting a pregnant woman in labor to urban medical facilities, and most especially healthcare fees being too high for the average patient, though they do not pay the expenses.[359]Additionally, many of the indigenous Ibadan people acknowledged the efficacy of the traditional health and healing practices of the indigenous midwife. This belief continued to affect their patronage of the traditional midwives even after the introduction of western obstetrics.[360]Quoting the words of a colonial medical officer during this period where he stated; "it is surprising and not a little disappointing to find that in this area of so much education and enlightenment, there still exist a desire among Africans to take their sickness to the local fetish or herbalist while right in his town there exist a fine modern hospital. It is notably so with maternity cases who receive the most extraordinary,

[358]Michael Jennings, "A Matter of Vital Importance",246
[359]NAI, File No: 47, Oyo Prof. 1, Volume II: Extension of Medical Service Directing Controls and Subsidy Medical Mission. 1931,136
[360] Interview with, Abiloye Titilope. Traditional Midwife and Herbalist Aged 70+. Interview conducted at resident in Agbowo, Ibadan, 10/7/21

cruel and primitive treatment before being brought to hospital in extremes."[361]More so, the services of the trained African midwives had no widespread effect on the general population who needed maternal and infant healthcare. To fill this vacuum, it was however debated and concluded by the colonial medical bureaucracy that an education and training of the *Iya-Abiye* in hygienic methods of birthing would be necessary to prevent a total decline in the achievements in maternal and infant mortality rate; help increase the patronage of hospital based healthcare service by the natives through referrals from the TBA's during difficult labor cases; promote the spread of western medical ideas; and also keep in check the activities of the traditional midwife.[362]

The above decision of educating and training of the *Iya-Abiye* according to the colonial medical director[363] was needed as an effective strategy not only to prevent maternal and infant health complications, but as a means to ensure the spread of western biomedicine.[364] This decision was reached after the colonial government considered the fact that the missions were the major providers of the doctors, nursing sisters and trained African midwives, and was responsible for all their expenses with little subsidies from the government. This also includes the request of government sponsorship to run the missions' maternity hospitals and clinics to capacity and reduce the medical fees being paid at mission hospitals or risk reducing the capacity of patients attended to.[365]The government after weighing the situation and studying the works of the trained midwives and taking into careful consideration the serious financial situation of the Province,

[361]NAI, File No: MH/Fed, The Nigerian Medical Report, 1945,17
[362]NAI, File No: 47, Oyo Prof. 1,Volume II: Extension of Medical Service Directing Controls and Subsidy Medical Mission. 1931,136
[363]ibid
[364]ibid
[365] ibid

concluded that it was economically best to create a scheme, whereby the African trained midwives would train the *IyaAbiye's* who were already in the craft of birthing, to save cost of training more midwives and also cover the areas in dire need of professional midwives without crippling the work of efficiency already done on maternal and infant healthcare.[366]

Trained African midwives were used as facilitators of the scheme and instructors in the education and training of the *Iya-Abiye*. The trained African midwives were directed to engage, educate and instruct them regularly on proper hygiene, dietary needs of infants and mothers, and were mandated to refer complicated cases to professional and trained mission and government midwives.[367]Landwick suggests also, that in Tanzania, the nurse-trainers gave elaborate messages for a healthy, safe and hygienic birth.[368] She states further that instructions were given to the TBA's to always refer pregnant women to the hospital to get safe, clean medicine and not use the medicine of traditional midwives.[369]

In Ibadan, to ensure that the *Iya-Abiye* comply with the terms of their training, they were placed at mission houses were they continued their practices, were monitored and regularly educated on new maternal and infant health practices.[370] In so doing, the missions attracted more TBAs in the 1950s through the 1960s.[371] The impact of this arrangement reflected in the reduction of maternal and infant mortality, especially in rural areas, and increased referral to formal health services.[372]

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[366] ibid
[367]NAI, File No: 43831/S7, C/1/G, Colonial Development of Welfare Schemes: (i) Estimates 1948-49,18
[368]Stacey Ann Langwick, *Medicine, Mobility, and Power in Global Africa* 37
[369]ibid
[370]NAI, File No: 43831/S7, C/1/G, Colonial Development of Welfare Schemes: (i) Estimates 1948-49,19
[371]ibid
[372] ibid

Jane Turritin for instance, supports this account.[373] In her argument, the education and training of TBA's were required to increase awareness about the benefits of Western obstetrics. This awareness was needed, especially with the traditional healthcare practitioner's integration into the modern health care system, particularly in the rural areas where most mothers are not open to or have access to professional care in childbirth. If we examine the personal communications and daily records of administrators in Ibadan, we do find that some British colonial officials showed remarkable sensitivity to the indigenous worldview of medicine. Colonial administrators accepted a combination of medical pluralism, hybridity of medical ideas and accommodation. An instance of this is in the granting of African trained midwives and the Iya-Abiye's an avenue to form a medical relationship. From the late 1940s to the 1950s, the Iya-Abiye's, with the aid of the trained African midwives, were able to attend to patients and referred those with critical cases to the mission and state hospitals.[374] This act itself was vital to the development of maternal healthcare in Ibadan, as a means to preventing maternal and infant mortality. The scheme for the training of the TBA has assisted professional African midwives to reach more pregnant women and children in their infancy and provide health services to them.[375] African midwives were in fact the first health professionals pregnant women contacted in and outside the health facilities in Ibadan.[376] In other words, before and after delivery, they interacted with the midwives, who were sometimes on domiciliary duties.[377] These midwives put them through the various stages of their pregnancy, explained to them the complications of not engaging trained professions and not utilizing hospitals and eventually delivery them. By implication, the trained African midwives in

[373]Jane Turritin, "Colonial Midwives and Modernizing Childbirth in French West Africa," in *Women in African Colonial Histories*, eds. Jean Allman, Susan Geiger, and Nakanyike Musisi (Bloomington: Indiana University Press, 2002), 73–83.
[374] NAI, File No: 43831/S7, C/1/G, Colonial Development of Welfare Schemes: (i) Estimates 1948-49,18
[375]Ibid, 20
[376]ibid
[377]ibid

Ibadan, helped shaped the experiences of their indigenous patients. Consequently, they influenced how Western obstetrics was seen and embraced by Africans, and the processes served as a counterweight to the indigenous birthing practice and as a way of shaping the relationship between the traditional and western practice of childbirth.

Trained African midwives threatened the livelihood of indigenous traditional birth attendants and pre-existing African traditional birthing system. This is because the indigenous people became interested in hospital-based delivery due to the presence and services of the trained African midwives and because they were part of the indigenous community. The African midwives being products and part of the local community, were well acquainted with the traditional practices of the *Iya-Abiye*, with whom they shared certain healing and cultural ideas about how to prepare for and perform birthing. As a result, it was easy for them to know the areas to educate, instruct and guide them through the modern processes of pregnancy, childbirth, and the postpartum period and providing them with advice regarding diet, fitness, and even infertility treatment. As one midwife who was trained by the missionary, and practiced as a midwife in the missionary and government hospital in Ibadan retold:

> Before I went to midwifery school, my mother used to be one of the traditional birth attendants, and I loved seeing what she was doing. When I got to school, I saw that her local practice was not the best because of the way she managed and controlled birthing complications. This is why in most communities there was high mortality rate after delivery due to post-maternal complication. The traditional system was so horrible. However, while in school I was taught on how to monitor pregnancy from day one to the period of delivery. With my experience, I was able to convince my

> mother to stop her unprofessional midwifery service. However, midwifery services rested on the shoulder of the oldest woman in any family compound in Ibadan.[378]

The formation of the scheme and the facilitation of the scheme through professional African midwives were therefore aimed at replacing most of the traditional birthing practices presumed to be injurious to maternal and infant healthcare, with the new Western model of childbirth. Aside the fact that the scheme helped in controlling the activities of the TBA's, it also helped in reducing the mortality rates of infants and mothers, and increased patronage of Western obstetrics.

The service of trained African midwives to the Ibadan community was particularly essential given that child-birthing practices remained the most enigmatic field in the social construct of the people of Ibadan. The education, instruction and guidelines to the *Iya-Abiye* who were more familiar with the indigenous people, while possessing new knowledge in western obstetrics achieved a number of advantages over the missionaries and government approach to maternal and infant healthcare. The implication of this is that the *Iya-Abiye* was more trusting and comfortable with the trained African midwives than they would have been with European medical personnel. On this note, it is imperative to reflect on the colonial policy of 1928, during which a tentative proposals for a scheme put forward by Dr. Stanton to the colonial Governor in Lagos, for the abolition of Private Practice in the West African Medical Service – a scheme in which traditional medical practice took the core discussion.[379] This caused a friction between traditional health care practitioners and the colonial government. However, by the 1940s, the scheme was reviewed. The colonial medical bureaucracy decided that instead of a complete

[378]Olukemi Omotunde Komolafe, 63 Years, Retired Chief Nursing Officer, June 2020.

[379]NAI, File No: MH/Fed) 1/1,5234 /31, Proposed Abolition of Private Practice in the West African Medical Staff, 1944, 4

eradication of the Private Practice within the context of maternal healthcare, the *Iya-Abiye* would be placed under the control of trained African midwives. The provision of the scheme was that trained African midwives would actively serve as instructors of modern midwifery practices to members of the *Iya-Abiye* Institution under the directives of the colonial medical bureaucracy.[380] Despite the African midwives roles in educating, instructing and monitoring the *Iya-Abiye* given their privileged status of exercising their duties in Western obstetrics, their relationship was however, one born out of understanding and concerns shared of something pathological that needed medical attention as maternal and infant health than one of a "supervision, control and liability" relationship as was the case with the French-educated midwives and the local *ba mu* in colonial Vietnam.[381] The success of the scheme completely reduced the suspicion of the indigenous people of Western biomedicine in colonial Ibadan. For instance, majority of the *Iya-Abiye* during this period started attending training, especially on the need for them to become better birth attendants so as for them to know their capacity and when to refer those beyond their ability. This reflected in the increased number of patients that patronized maternity hospitals and clinics.[382]

African midwives entrusted with the duty of educating, instructing and supervising indigenous midwives were determined to pursue their responsibility to the later. However, with this new power and status, saw some of these African midwives pursuing their own agenda and getting into direct conflict with members of the Iya-Abiye institution, as they wanted a complete eradication of the institution. As Tilley rightly posits, aside the fact that the livelihoods of African midwives usually depended on remaining in the good graces of their employers, but that, that did not stop them from expressing their own criticisms or from simply ignoring

[380]ibid
[381]Thuy Linh Nguyen, "French-Educated Midwives". 133–182.
[382]Olukemi Omotunde Komolafe, 63 Years, retired Chief Nursing Officer, June 2020.

epistemological perspectives with which they disagreed. Nor did it stop them from forming opinions about their colleagues, both senior and junior, African and European, and taking issue with their points of view.[383] Although the scheme for integrating the traditional midwives into the health care system was to ensure that modern midwifery practices gets to the rural areas, African midwives however doubted the possibility of totally achieving that through the network of the Iya-Abiye institution. They believe traditional midwives do not have sufficient training in the complex aspects of child delivery, hence, had nothing to contribute to ameliorate the maternal health problems.[384]

In the colonial context, the gap between the professional African midwives and the members of the Iya-Abiye institution became socially and professionally close. However, the professional African midwives saw this as a bridge to their relationship with their patients who were more culturally bound to the traditional midwives and that their activities were in defiance to the midwifery profession. Agboola Modina Ibijoke, a professional midwife detailed the conflict the professional African midwives had with the colonial arrangement of integrating traditional midwives into the midwifery profession. She reports;

> Our people fight for their profession by asking why we have to bring our profession that low level with the traditional health worker. However, many of us do not like going to rural areas and as a result, sometimes we liaise with the traditional health workers to relieve us of workload. In fact, we trained them (the Iya-Abiye). However, I cannot grade them as a professional midwife. Many of them go beyond their capacity. In fact, midwives know their capacity, which proves professionalism. The Iya-

[383]Tilley, *Africa as a Living Laboratory*,.15
[384]Agboola Modina Ibijoke, 62 Years, retired Chief Nursing Officer, June 2020.

> Abiye sees us as their enemy. They rival with us and forget that we understand our limit, which has been helpful in saving lives.[385]

This report offer a rare insight into the complex and difficult arrangement of the colonial scheme in integrating the Iya-Abiye institution into the maternal and infant welfare programme. Oral testimonies reveal that;

> Most times when the traditionalist brings their patient to the hospital and there was complains such as, "a patient delivered yesterday but the placenta is yet to come out," if we try to interrogate them further on negligence on maternal service, the traditionalists would reply "are we not the ones that gave birth to you people?" If we recommend drugs such as oxytocin or drip to them, they will reject and reply that it is better for them to go and manage their patient. Aside that, they block their patient from such health care, and sometimes inject oxytocin injection in the cervix of their patient directly and bring such patients to the hospital after complications and it becomes so difficult for the baby to come out. When you then tell them such patient will have to be operated, it generates real conflicts.[386]

According to the above report, this incident seldom occurs between the professional midwife and the Iya-Abiye. However, in a case this happens, there are assigned centre's to report such an incident where both parties will be called upon to give account of the incident and made to undergo some further training. In spite of this, the incident continues to occur and same process of training the Iya-Abiye is applied. However, since there were few registered midwives, the traditional birth attendants were still allowed to practices but with stringent instructions such as

[385]Agboola Modina Ibijoke, 62 Years, retired Chief Nursing Officer, June 2020.
[386]Olukemi Omotunde Komolafe, 63 Years, Retired Chief Nursing Officer,(Phone interview) June 2020.

not conducting any delivery beyond normal virginal delivery, and they are monitored closely to make sure cases do not get complicated before its been referred to the hospital.[387]

Conclusion

Narratives in the history of trained African midwives from the 1940s to the 1960s showed a valuable uptrend increase in their careers, services and practice of western obstetrics. Beginning from the 1940s, African midwives had replaced European nurses and midwives, and had become the main providers of maternal and infant healthcare services amongst the African population in colonial Ibadan. Due to the emergence of the trained African midwives, missions and colonial midwives gradually retreated to the position of supervisors rather than healthcare providers.

A central goal in the careers and practice of midwifery by African midwives during this period was in the education of African women to give birth easily and to provide women with maternal and infant knowledge when they wanted help. It was within this context, trained African midwives in Ibadan became the face and modern practitioners of childbirth as well as instructors of Western hygiene and infant care to pregnant women, mothers and traditional birth attendants - *Iya-Abiye's*. The colonial government's collaboration with the Iya-Abiye shows their understanding of the value the traditional birth attendants holds in their society. The training of these midwives was also away the colonial government gave their consent to the birthing activities of the TBAs in Ibadan. The implication of this however, was that the indigenous knowledge and practice of the TBAs were to be replaced (although not completely) with the knowledge of trained missionary midwives through constant trainings in western obstetrics and monitored to ensure their activities are not detrimental to infant and maternal health. In a way, the position of the trained Iya-Abiyes have been transition into one of middlemen between the

[387]ibid

indigenous people and the colonial health workers by encouraging the patronage of available medical facilities for antenatal and postnatal services, and referring critical cases to the hospitals.

However, the condition of service of African midwives reflected the colonial medical bureaucratic attitude towards maternal healthcare. The efforts put in by the African midwives despite the shortage of medical staff defined the essential role of the midwives in the fight against infant and maternal mortality. The medical bureaucratic control of the activities of the midwives was quite effective in regulating the medical service and practice, and in upholding the standard of the midwifery profession.

In addition, it is undeniable that the successful development and acceptability of Western obstetrics in Ibadan depended upon the relationship of the African trained midwives and the *Iya-Abiye's*. Through the colonial governments' community based initiatives, trained African midwives helped in reducing maternal and infant mortality, which fostered population growth, and encouraged indigenous patronage of western medicine. This reorientation programme brought a certain level of understanding and cooperation between the two partners on maternal healthcare. With the programme an initiation of referral though one directional - from the *Iya-Abiye's* to hospitals were implemented.

Chapter Five

The Ibadan Provisional District Council (IPDC), Maternal Health, and Midwifery Practices in Colonial Ibadan, 1940 - 1960

Introduction

In this chapter, I examine how the Ibadan Provisional District Council (IPDC) influenced the developments in maternal healthcare services in the township of Ibadan from 1940 to 1960. The IPDC–an elitist body of traditionally high-ranking officials in the council of the Olubadan, who are influential among the Ibadan people, selected and rotated by the Olubadan and Chiefs in council as representatives of the people of Ibadan on maternal health related issues for a period of two years.[388] This corps of representatives, includes, the Iyalode (the head of market women), the Balogun (the chief security officer), the Osi (the chief to the left of the Olubadan), amongst others. The constitution of the IPDC was an offshoot of/and a way to attend to various maternal health related complaints brought by the Ibadan people to the Olubadan and Chiefs in Council. The duties of the IPDC include and were not limited to the advocacy for better maternal and infant welfare services. Thus, the main objective of this chapter is to examine the activities of the IPDC in its advocacy for better maternal healthcare service delivery for Africans in urban Ibadan. This chapter also critically examines the responses of the Ibadan people to the IPDC, specifically in their interactions and negotiations on maternal healthcare and welfare policies with the colonial medical government. The chapter further explores the ways and extent to which the interest and complaints of the patients addressed by the colonial medical administration and medical officers through the representation and intervention of the IPDC.

[388] NAI, File No: Iba. Div 1/1, 1221 Ibadan District Council Hospital Adeoyo Vol. VII, 1949, 194

To appreciate this synergetic approach to maternal healthcare management during this period of study, it is necessary to state that, in Ibadan, the Ibadan Provisional District Council (IPDC) did not only function as an intermediary between the natives and the colonial government, but also in a way took over the medical administration of the people. Thus, becoming the voice of patients on maternal health related matters in urban Ibadan from the 1940s.The IPDC as it were, was a committee founded by choice and the decision of the Olubadan and Chiefs in Council out of concern for the health of the Ibadan people. The IPDC is therefore, a structural representative of the traditional political class in Ibadan on the questions of Maternal Health and Maternity Services delivery, for Ibadan women, with particular reference to Hospital Based Midwifery and Domiciliary Midwifery.[389]

However, while the IPDC's primary assignment was to advocate for better maternal healthcare services for the people and serve as an intermediary between the natives and the government on medical and maternal health related issues, it also doubled as a colonial legitimizing agency for western obstetrics. In fact, the colonial medical administration saw the IPDC as a means for sensitizing and convincing women in Ibadan who were quick to judge midwifery facilities available to them and were not so convinced of the value of modern methods of midwifery.[391]Notwithstanding, the IPDC was able to play both roles in the advocacy for better healthcare services, especially maternal health service during this period. In the context of this chapter, I see the IPDC as a constituted traditional council, which was created out of a particular need – maternal health – by the traditional Ibadan political class. The IPDC is an elitist body that is "people centered," based on the nature of its emergence and its responsibility of representing

[389]ibid

[391]NAI, File No: Iba. Div, Ibadan (Provincial) District Council: Antenatal Clinics, and Domiciliary Midwifery, 1956, 23

and serving as intermediaries between the patients and health workers; and the people and colonial government on obstetrical matters.

The chapter also makes bold of patients voices through a collective and organized front – the IPDC. It likewise indicates not only the IPDC influence in the establishment and development of maternal healthcare infrastructures from the 1940s, but also reveals indirectly that the patients influences based on their health experiences were not limited. The patients (through the interventions of the IPDC) was instrumental to colonial health policy implementation as more evidenced from the late 1940s through 1960 when decisions on health infrastructures, recruitments and training of health workers were to be made. Although, at first, the activities of the natives were on the basis of consultation on locations to erect colonial healthcare infrastructure, this however transitioned into influencing the maternal welfare and healthcare provisions of the Ibadan people through policy making. The Ibadan peoples influence on the IPDC on colonial medical policies gave them a greater medical responsibility on the collective health of Africans in urban Ibadan.

Overall, the chapter intends to show, that the influence of agencies such as the IPDC in their quest for the provision and development of better maternal health care services is much louder and easily identified with than the individual/patients in most colonial spaces. From the 1940s, the relationship between the patient, doctors, midwives and nurses was determined largely by the IPDC in Ibadan. The role assumed by the IPDC, and the manner with which they informed and influenced the Colonial Medical Service as we would see in the subsequent sections of this chapter, shaped colonial medical practice and the medical experience of the people in urban Ibadan till the end of colonial rule.

Colonial Healthcare and the Ibadan Provisional District Council The period between the 1900s and 1930s in the trajectory of colonial biomedicine represented crucial decades in health and healing in Ibadan. During this time, missionaries and colonial government intensified their medical works in Ibadan to lay a strong hold in the health and healing sector of the Ibadan people. In the cause of carrying out various medical works in Ibadan by the colonizers – the missionaries in particular -the Ibadan people played important health related roles in conjunction with the Christian missionaries and colonial medical government. The Ibadan people did not however carry out these roles as an organized institution, but as individuals (mostly Christian converts) supporting the missionary and colonial movement in the spread of western medical ideas and practices.[391]

The Christian missionary's intenerate medical work in the interior areas especially on maternal healthcare was of interest to the Ibadan people, hence, created an avenue for them to also contribute to the development of the missions intenerate medical work. For instance, in 1932, the Church Missionary Society (CMS) in Ibadan initiated maternity works in the interiors of Ibadan that had no mission, government or Native Administration hospitals.[392] In rendering these general medical and maternity services, it was members of the community (converted native leaders of the missions) that assisted the missions navigate interior villages.[393]Besides assisting the missionaries on logistics, the educated elites amongst the indigenous people also did well by interpreting the words of the missionaries from the English language to the local dialect (Yoruba)

[391]NAI, Annual Report of the Church Missionary Society, 1926 – 1928.
[392]NAI, File No: CSO, Oyo Province: Annual Report 1935,21
[393]CMS Outlook, June 1932,.119

to the local during medical evangelism.[394] This removed the challenge of language barrier and gave the medical works of the missions some solid footing in Ibadan.

By the late 1930's, other missions such as the Methodist and Seventh Day Adventist Missions had started an institutionalized medical service with the construction of maternity homes, dispensaries and clinics.[395]It was the services of the members of the Ibadan community that was employed as construction laborers for the building projects.[396] More so, by the late 1930s, according to the Annual Medical Reports, maternal and infant welfare services were perceived to be fulfilling the agenda for the treatment of diseases in women and children in other colonial areas like Lagos and Abeokuta in Nigeria. The missionaries were however, concerned about the Ibadan people not embracing western obstetrics completely and seeing the advantages of the maternity infrastructure and services. This was because of the less value given to the maternity facilities and the expert helps available to them.[397]This is because, during this period, Ibadan women who were familiar with Western biomedicine patronized colonial maternity clinics and hospitals based on the fun of it by just attending antenatal and postnatal services, but when it was time to give birth, request the services of the traditional birth attendants. This is because the Ibadan people did not see Western biomedicine as a more viable form of medicine when compared to traditional medicine.[398] This as earlier mentioned in the chapter three of this thesis, made the missionaries went on series of medical evangelical outreach in order to convince the people of the importance and effectiveness of western obstetrics.[399]To cause a change in the minds of the Ibadan people as regards western biomedicine, the medical missions gathered and

[394]E.B. Idowu, "Traditional Religion and Christianity" in *The City of Ibadan*, eds. P.C. Lloyd et. Al., (Cambridge: Cambridge University Press, 1976),.239
[395]ibid
[396] ibid
[397]NAI, File No: Oyo Prof 1, 15S9/14, Annual Reports: Missions, 1938, 11
[398]ibid
[399]ibid

educated illiterate African women in Ibadan on the basics of maternal and infant healthcare and the need for the people to patronize hospital based health services.[400]These women in return, served as propagandist for the missions, rallying patronage to mission maternity centers. As they were instrumental in the navigating of interior Ibadan, they were also assisting in teaching other natives of the basic hygiene lessons they learnt from the missionaries, thus, canvassing more patronage for mission maternity facilities and services.[401]

With the education of African women in Ibadan on western obstetrics, some of them later became professional midwives in mission's hospitals. Ibadan women, who initially disliked the modern treatment during pregnancy and more especially during delivery, began patronizing mission maternity clinics and hospitals.[402]This is because of the presence of African midwives who were able to canvass for more attendances in the hospitals to their neighbors and relatives.[403] Because of this, the patronage of mission maternity facilities increased tremendously from the late 1930s and early 1940s.[404]This increased patronage resulted in shortage of staff, increased charges of bed space for delivery and offering of substandard medical services.[405] This led to a soaring population of disgruntled patients who complained of bullying by nurses and midwives; others who sought antenatal treatment but could not afford hospital bills; as well as those who could not procure compulsory delivery and baby materials required from them before hand.[406]

[400]NAI, Annual Report of the Christian Missionary Society, 1930-31, 21
[401]ibid
[402]NAI, File No:4155, Oyo Prof. 1, Prospective Mothers: Training of. 1930,.5
[403]NAI, File No:15S9/14, Oyo Provincial Annual Report: The Methodist Church, Oyo Circuit, 1938, 77
[404]NAI, File No:43693/S.3, J/1/C, Q/1/C, Q/2/A, Development of Health Services (Revision 10 Year Plan): C.D.W.A Scheme, 1949,2
[405]NAI, P.W.D. Information Book: Hospitals and Dispensaries, 1943.
[406]ibid

It is also important, to note that, the political atmosphere in Africa during this period caused by the nationalist movement that emerged after World War I and intensified after World War II,[407] had already brewed a consciousness amongst the people. They began seeking social, economic and political change and exerting more pressure on the colonial administration to provide more social and economic services for Africans.[408] Largely, the rising African nationalist consciousness of this period led to the increased cries for better and standard medical service delivery in Ibadan.[409]

Given the aforementioned trend of this period, specifically, the awakened nationalist consciousness amongst the people, coupled with several complaints presented to the Olubadan and Chiefs in council by aggrieved Ibadan women who patronizes colonial maternity facilities, the traditional political class in Ibadan, sought to take a forward step by directly intervening in the development of maternal healthcare.[410] The IPDC became a nationalistic movement of some sort. Their activities marked a transitioning in the individualistic roles played by some members of the Ibadan community – elites- towards the development of maternal healthcare services, to a more ardent and united involvement of the entire Ibadan people on maternal and infant welfare. It also marked the formal formation of the Ibadan (Provisional) District Council as an indigenous maternal health advocacy organization.

In 1945, the Ibadan Provisional District Council (IPDC) was constituted and inaugurated.[411] The emergence of the IPDC coincided with the growing nationalistic movement in Africa during this

[407] Olusola Olasupo, Isaac Olayide, E.O.C. Ijeoma, "Nationalism and nationalist agitation in Africa: The Nigerian trajectory", *The Review of Black Political Economy* 44 (3-4), (2017), 261-283.
[408]Fredrick Cooper, *Africa Since 1940: The Past of the Present*. (Cambridge: Cambridge University Press,2002), 44-48
[409] ibid
[410] NAI, *Southern Nigerian Defender*, 1944.
[411]NAI, File No: Iba. Prof. 1/1, File 382/22/11, Ibadan (Provincial) District Council: Health, Rural Development and S. Welfare Minutes of. 1945,7

period. The aggravated concerns amongst the people of Ibadan on the ill treatment they receive at maternity clinics and hospitals; the standard of maternity facilities; and the growing need and urgency of institutional maternity facilities due to the soaring population of people patronizing the only available ones was a major trigger and cause for concern. Consequently, in order to achieve immediate results on the growing population and to get pregnant women who could not be accommodated by the available maternity facilities, it was suggested by the *Olubadan* and the *Ijoye's* in council that the IPDC help facilitate the establishment of Maternity homes for ante-natal care and delivery. In addition, was tasked to development a domiciliary service from which Maternity homes could follow later after confidence had been established in the women of Ibadan.[412] This idea was raised, deliberated and agreed on by members of the IPDC after making due consultations with the Medical Officers in-charge of the Ibadan division.[413]

The high point of the IPDC was in its function in managing maternal health related crisis. From the mid 1940s, the influence and contributions of the IPDC was felt in the revamping of the maternal healthcare system in Ibadan. An important feature of the services of the council was that it was instrumental to the establishment and expansion of maternal healthcare infrastructures during this period. The IPDC as representatives of the Ibadan people called for the expansion and consolidation of all existing maternal hospitals in Ibadan. The Council did not only call, but also provided their expertise through consultations and recommendations to the colonial medical administration and in provision of suitable land locations befitting of such projects.

Reflecting on the history of the services of the Ibadan (Provisional) District Council on the establishment of maternal healthcare infrastructure in Ibadan, in 1956, the council initiated

[412]ibid
[413]Ibid, 12

recommendations for additional maternity centers in Ibadan. Before this period, the Senior Divisional Adviser, Dr. Williams in a request to the Council which as at this period, includes, Chief S.A. Aminu (the Balogun of Ibadan) as chairman, E.A. Akinwale (Osi Olubadan) Abimbola (Iyalode), Mr. S.A Ogunkeye, Y.A. Salami, Alhaji Audu Zungeru, Mrs. H.T. Soares, and others, had proposed to discuss the important question of the only serving maternity hospital in Ibadan at the time - Adeoyo Hospital. He informed the committee that Adeoyo Hospital, with particular reference to Maternity Clinics, needed urgent attention. He recounted that about three years ago the number of births at Adeoyo Hospital was about 2000 a year, but now the number had trebled. The hospital could no longer cope with the demand for maternity services and the building of one or two more maternity centers was therefore a critical resource. He said that Dr. Lawson, the Head of the Department of Obstetrics of the University College Hospital, Ibadan, being an expert, was present at the meeting to give details of the whole plan.[414] In the meeting, Dr. Lawson confirmed what Dr. Williams had said and added that of the number of 5000 pregnant women needing attention, the hospital could only deal with 2,500, that apart from the Hospital, he know that there were three other maternity centers, one mission and two private. However, between these three, they could probably deal with about 1000 cases. The rest might have to be sent away.[415] Dr. Lawson went on to say, that, there was no possibility of Adeoyo Hospital being expanded because the area had all been hemmed in, and as such the only way was to provide maternity centers elsewhere. True indeed, Dr. Lawson said, the University with certain maternity cases, particularly the abnormal ones; with the years, the birthrate would increase at the rate of say normal cases leaving the abnormal ones to both the Adeoyo Hospital and the University

[414]ibid
[415]ibid

College Teaching Hospital.[416] Dr. Lawson said, as regards the locality of the centers, was a question for the committee to decide.[417] Mr. S.A. Ogunkeye, a member of the IPDC, in response said, they could not give their consent on the spot especially as the proposal involved expenditure. Now that details of the plan had been outlined, they would arrive at a decision.[418] The Chairman himself said that the scheme was laudable but they needed time to consider it.[419]

Stemming in part from the above conversation, born out of the needs of the patients, the IPDC in its representation of the Ibadan people influenced the ideas of the establishment of maternal healthcare infrastructures.[420] Thus, resulting to the frequent consultation of the IPDC by senior medical officials on not just the establishment of maternity hospitals, but also on other maternal health related matters.[421]Thus, the colonial medical government seeking the advice of the IPDC demonstrates the power the people willed within the colonial medical administrative circle and gave the people advantage in seeking better medical services. Contrary to Foucault's position on the politics of biomedicine, [422]this goes to prove also, the fluid relationship between the colonial subjects and the colonial government, especially in the provision and expansion of western obstetrics in colonial territories.

It is important to state here that, the IPDC is quite different from many "elitist" organizations. Due to the nature of its formation, unlike other elitist organizations such as the Lagos Ladies League and African Doctors (LLLAD) who in their formation are limited to the elite group whose relatively high level of education and distinguished lifestyle set them apart from the rest

[416]NAI, File No: 3374, Ibadan 1/1, Ibadan (Provincial) District Council, 1956,3; See also, NAI, File No:382/22/11, Ibadan (Provisional) District Council: Health, Rural Development and S. Welfare Minutes of. 1953, 5
[417]Ibid, 4
[418]ibid
[419]ibid
[420]Ibid, 7
[421]ibid
[422]Foucault,"The Subject and Power". 777 - 795

of the people, and even though they claimed to represent the people, their interest comes first. In fact, most of these organizations were not mass movements; they nevertheless sowed the seeds from which the nationalist movement of the 20th century in Africa would grow. In urban Ibadan especially, the IPDC became a "people centered agency." This is due to the circumstances that made the Olubadan and Chiefs in Council inaugurated the IPDC as a representative of the people on maternal health issues.[423] This in a way marked a transitioning in the individualistic roles played by some members of the Ibadan community – elites-to a nationalist movement.[424]

The IPDC did not make significant progress in the building of new maternity hospitals. The IPDC was however responsible for the expansion of the only available government maternity hospital - Adeoyo Hospital - for maternity and domiciliary services.[425] The inability of the IPDC to affect a change in the building of new maternity centers within this period was because of inadequate funds from the government to engage in such gigantic projects.[426] Certainly, while the establishments of health facilities were predominantly at the discretion of the colonial government who funds the projects, the Ibadan people through the IPDC are informed of the colonial government's intentions of executing more maternity building project. This was evidenced in the letter No. 128/467, from the Permanent Secretary, Ministry of Health, addressed to the IPDC, informing the council of the Government's intention to award capital grants for the building of Dispensaries and Maternity Centre's in the Ibadan Division and asking for suitable sites to be chosen by the Council.[427]

[423] NAI, *Southern Nigerian Defender*, 1944.
[424] Adeboye. 1996."The Ibadan Elite, 1893 – 1966.". 72-86
[425] NAI, File No: 3374, Ibadan 1/1, Ibadan (Provincial) District Council, 1956, 10
[426] ibid
[427] Ibid, "Meeting 17th April 1956",13

With this new level of relationship and understanding between the IPDC and the colonial medical administration, over time, the people of Ibadan through its representatives – the IPDC – unlike before, became more aware of colonial medical policies before they are implemented. This helped strengthened the IPDC's positions in policy debates and in making vital decisions that will be beneficial to the Ibadan people while relating with the colonial medical administration.[428]Taking a stand on health issues that will be beneficial to the Ibadan people was possible as a result of the IPDC's meeting regularly to discuss health related matters and engaging the services of trusted medical professionals and seeking and evaluating their expert opinions on certain medical issues. For instance, in two letters dated 10th and 12th May, 1956, the Iya Abiye of Ibadan - Chief Mrs. Leeming, M.B.E., S.R.N., S.C.M., replied to a question of staffing of a proposed government maternity facilities from the Secretary of the Ibadan (Provisional) District Council. She explained, that, the Clinics and Midwifery facilities to be establish by the government, need not be under any hospital or Medical Officer of Health, but would certainly need a nursing sister with midwifery qualification.[429] On 7 June 1956, another meeting of the Health, Rural Development and Social Welfare (a Sub-Committee created within the IPDC) was held. In the meeting, the Chairman of the sub-committee outlined the objectives of the meeting, which included discussions on the question of Maternity Services for Ibadan with particular reference to Domiciliary Midwifery.[430]

The process governing the decisions of the IPDC in connection to colonial maternal health policies depended on their evaluation of expert opinions of sourced medical professionals. With this, the IPDC became experienced in judging which medical system was more likely to be

[428]Ibid, 15
[429]Ibid, 14
[430]ibid

beneficial to the Ibadan people. When, for example, the question of making a decision of building a maternity home or engaging a domiciliary midwifery service, the IPDC after evaluating the opinions of the engaged medical professionals agreed to the building of maternity homes. This is reflected in the 1956 official records, where in a meeting the IPDC agreed to the governments' proposal for the establishment of Maternity Homes in Ibadan.[431] The decision of the IPDC to agree with the colonial government on the establishment of maternity homes also depended on a cognitive factor that suggest that the decisions of the IPDC is most times influenced by the colonial medical administration. For instance, Mrs. Lemming, one of the medical professionals whose expertise on the matter of maternal health were sort by the IPDC, and was advocating for domiciliary midwifery, informed the IPDC that the colonial government did not support the establishment of Domiciliary Midwifery in Ibadan. Instead, it suggested the establishment of Maternity Homes.[432]

Inspite of the parameters deployed by the IPDC in making health decisions that are beneficial to the Ibadan people, the IPDC is however conscientious in its activities which is subject to the review of the Ibadan people. Thus, in order for the people of Ibadan to feel the effectiveness of the IPDC, as well as to satisfy the urgency in maternal health related problems, the IPDC pushed for the quick execution of maternal healthcare projects. This concern made Chief S.A. Aminu, the Balogun of Ibadan in one of the IPDC's meetings, suggest that an appeal be made to the authorities concerned with the construction of new maternity homes, so that the Maternity Centre's might be built in Ibadan in order that Ibadan women might not speak ill of the present

[431]Ibid, 39

[432] NAI, File No:382/22/11, Ibadan (Provisional) District Council: Health, Rural Development and S. Welfare Minutes of. 1956,48

Provisional District Council.[433]The extent to which the IPDC further advocated for and solved most of the problems of maternal health care in Ibadan will be the object of the next sections.

The IPDC and Maternal Healthcare Service Delivery in Colonial Ibadan

The IPDC which aimed to manage and promote the development of maternal healthcare services based on the interest of the Ibadan people, played a crucial part as an intermediary between the people and the colonial government, and medical officers in addressing complaints on maternal healthcare services and provisions amongst women, especially expectant mothers. Complaints were more apparent in the areas of maternal healthcare workers and their treatment to pregnant women such that it sometimes escalates from public outburst and agitations to court litigations.

In order to solve the issues that form the basis of most of these complaints, the Ibadan (Provisional) District Council Office, for instance, on 26 June 1956, issued a letter to the Permanent Secretary, Ministry of Justice and Local Government, Western Region of Nigeria. They called the attention of the Permanent Secretary to an incident on the maltreatment of expectant mothers at the Adeoyo Hospital; the discrepancies in delivery fee; and the deplorable antenatal policies in the hospital. The letter stated;

> The attention of the Ibadan (Provisional) District Council was called to an incident, which occurred recently at the Adeoyo Hospital in connection with the treatment of Ibadan women attending antenatal clinics. The facts briefly stated were that several expectant mothers previously receiving attention at the clinics were suddenly turned away by the University College Hospital staff in charge, and were requested to seek for treatment from one or other private

[433]Ibid, 31

clinics in Ibadan, a list of which was there and then given to the women concerned.[434]

Before now, Olaitan Odunwo published a similar complaint in a newspaper article in July 1948. In the article, Olaitan states that;

> It is generally known to every individual that when one is admitted into the hospital the person admitted is entitled to pay six pence a day, which is termed as bed fee. My experience about some months ago has made me put forth this to know really the true position. About December 1947, a woman went to this hospital for delivery. Before delivery she was asked to send for a bar soap and a bottle of groundnut oil, which were brought and the woman delivered safely. After that, the husband was asked to pay bed fee of two shillings, and to pay another ten shillings and six pence as labor fee. These amounts were paid but no receipts were issued. About March this year, a friend's wife went to this same hospital for the same purpose, and she was discharged with the new babe without paying any labor fee. Now, I had a similar experience myself a few weeks ago when I sent my wife to this hospital for the same purpose. After delivery, I was asked to bring groundnut oil in small quantity and soap although these are immaterial but I was asked to pay one shilling as bed fee and ten shillings and six pence, which of course I did. As a married man I shall be very pleased in the interest of my fellowmen, and myself if the authorities concerned would let the public know what is to be paid exactly in all such cases; because when one pays and the other does not, it is difficult to understand. At the same time, the people

[434]NAI, File No: 1221 IBADIV 1/1, Ibadan District Council Hospital Adeoyo, Vol. VII 1st August 1952, 194

> would like to know where such amount should be paid, whether at the Government Treasury or elsewhere, where receipts could be obtained as there is no issuing of receipts for such amounts paid in the hospital.[435]

On 13 November, 1953, in another letter addressed to the Deputy Superintendent, University College Hospital, (Adeoyo) Ibadan, the IPDC, based on the complaints of happenings in the hospital stated, "…I attach herewith a "cutting" of Article entitled "No corset, No Medicine" from the Southern Nigerian Defender of even date." The allegations made are serious enough to require investigation, and your views are invited for the information of the Ibadan Native Authority.[436] In the article "No Corset, No Medicine" written by Omo Sanni, and published by the Sothern Nigeria Defender, it states;

> I am not an alarmist, but it is definitely certain that if the deplorable policy of the Adeoyo Hospital Ante-Natal Clinic in respect to 'No Corset, No Medicine' is not changed then there is no doubt that our pregnant women who go there for treatment are at the mercy of circumstances. I will quote an instance; just this morning, I was returning from Oje in a taxi and on reaching Iyana Adeoyo three women joined me and they started to narrate their tale of disappointment at Adeoyo. Briefly, these women were registered at the Hospital for seven shillings and six pence each. On reaching the Hospital today, a certain nurse asked each of the pregnant women whether they had their corsets on. Each replied she had but at home. This nurse then asked whether the corsets were purchased from the Hospital. The women replied in the negative. Then the

[435]NAI, *Southern Nigeria Defender*,Tuesday, July 30, 1948,3
[436]Ibid,305

> irate nurse with reddish eyes told them that they would never be treated unless they purchased at three shillings each from the stock in the Antenatal ward. The women declared that the nurse in question spoke with some official audacity. I then asked the women what next they intended to do. One said that she was disgusted. These nurses advertise so many things for sale. Things like children's caps frocks, socks, marmite, yeast, and a lot of others too many to mention. If you told them you have these things at home, they do not believe you. Their word is an order, which you are not allowed to question, the women further added. May the public be informed whether the Authorities of Adeoyo Hospital are responsible for this marketing side of Ante-Natal Clinic? What happens to the seven shillings and six pence paid when patients is refused treatment? Are official receipts issued for articles sold to patients?[437]

All of these different and growing complaints brought to the attention of the IPDC by patients and their families who patronize colonial maternity clinics and hospitals, and those published in the Newspapers, the IPDC after much investigation and consultations over the complaints, at its monthly general meeting, invited and subjoined by the Assistant House Governor, University College Hospital (Adeoyo) Ibadan, debated on the issues. They came up with the following resolutions;

i. That the Council views with grave concern the action of the Adeoyo Hospital Authorities in denying attention to about 300 pregnant women on Saturday the 5th of May, 1956, resulting in these women going in procession to Olubadan's house, and therefore demands satisfactory explanation.

[437]Ibid, 310; See also, NAI, *The Southern Nigeria Defender*, Thursday, November 12, 1953, 1 and 2

ii. That the Council regards this as a unilateral breach of contract on the part of the Adeoyo Hospital Authorities.

iii. That the Adeoyo Hospital Authorities be advised that all the social services being rendered in the Hospital hitherto should continue to be for the remaining period that the University College Authorities would be in occupation of the Hospital.[438]

These resolutions were reached immediately because in a way, the aggrieved pregnant women bypassing the IPDC and going directly to the Olubadan's house, is suggestive of the activities of the IPDC, thus making them seem unfit to represent the people on maternal health related crisis. Notwithstanding, the IPDC as a structure with customary backing has the right to make judgments and decisions on maternal health cases. More usually, healthcare judgment and decisions, especially that which concerns maternal welfare remained the foremost tool of the IPDC as the representative of the Ibadan people. However, in rare cases, the IPDC moves to taking up cases in the court of law. For instance, was a case filed by the Council, labeled; *Rex versus Ogunkoya and others; Memo: No. 3072/13/26.A of 25 September 1953,* in which the IPDC put particular pressure on the Medical Adviser of the University College Hospital to take up responsibility for the unpleasant incident. According to the council, information about this particular case reached its office on 28 September. The husband of a woman Adeoti appears to have brought his pregnant wife up to the dispensary for examination at 3 p.m. and the evidence states that the husband was told that the Medical Officer would see her the next day.[439] The husband and his pregnant wife protested, leading to a quarrel between them and the medical staff

[438]NAI, File No:1221 IBADIV 1/1, Ibadan District Council Hospital Adeoyo, Vol. VI, 1ST August 1956,219

[439]NAI, File No. 851/1, Oyo Prof. 1/1, Volume I, Medical Officer II For Oyo Province to be Stationed at Ibadan Request for. 1953, 28

on duty. At the end of the day, the woman had a miscarriage.[440] The IPDC took up the case on behalf of the couple, charging the health workers present at the hospital for failing to examine the pregnant woman on the said date. It also queried them for assaulting the woman when she complained of negligence. The IPDC subsequently referred the case to the district officer for further investigation. The IPDC took this position because of the possible tension it could provoke among the public. Public disapproval was consequence of the ineptitude of local institutions to respond to local needs. Moreover, it was natural for people in the locale to agitate to the power closest to them.[441] The power closest to them in this case was the IPDC. Steven Feierman based on his work in Tanzania, suggests that the management of health related complaints like other activities in the society, is shaped by those who control it. That is, the same power structures that shape domestic institutions, professions, and entire societies through state structures also shape therapeutic actions. The idea Feierman examines in his study, is the institutional control of therapeutic choice, whether in the lineage, household, profession, or state.[442]

In response to the allegations, the management of the Adeoyo Hospital explained that such situations occurred because of the paucity of facilities and staff to attend to the large and ever-increasing number of women requiring ordinary antenatal treatment at the Hospital. In a bid to meet critical health needs, they ration services by dealing only with cases, which are likely to be abnormal or complicated.[443]

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[440]ibid
[441]Toyin Falola and Matthew M. Heaton, *A History of Nigeria*, (Cambridge: Cambridge University Press, 2008),329
[442]Feierman Steven, Struggles of Control: The Social Roots of Health and Healing in Modern Africa. *African Studies Review* 2/3, (1985),80-83
[443]ibid

This event had significant implication on maternal health service delivery in subsequent years. The IPDC recommended the establishment of a number of maternity centers across the width and breath of Ibadan. It invented a domiciliary midwifery system, which enabled qualified midwives pay home visits and render antenatal services to expectant mothers.[444] The reaction of the IPDC to the aforementioned case in a way was to exhort the medical officers working in the hospitals and medical centers to be sensitive to their patients, especially expectant mothers.

The same intensity of fighting the perceived maltreatment of pregnant women was also undertaken on the subject of dispersing doctors and nurses not carrying out their duties judiciously in the maternity centers. This is evidenced in the IPDC's decisions of retaining or sending off any health worker they felt were not dispersing his/her duty well. For instance, on 12 September 1939, the Olubadan (king of Ibadan) weighed in on one of such cases. In a letter to the Director of Medical Services, the Olubadan, and members of the health committee wrote:

> The news has just reached us that Honorable the Director of Medical Services has arranged that Dr. W.C.Dale, who has been serving Ibadan for the past eight years should be transferred to Kaduna: this information, we confess, has given us a great shock and our sorrow knows no bound. Today, Dr. Dale in view of his pre-eminent qualities as surgeon is today registered by the entire community and placed in the position of one of Yoruba national gods "Obatala" or the god of hormone and to remove him from our midst at this hour is indeed a calamity. Dr. Dale, as known is one of the most generous, humane and kind-hearted Englishman we ever come across and no amount of adjective will enumerate in full all the good that he has done for all Ibadan. In

[444]ibid

> fact, we find in him a true altruist we are now sending this application to the Director of Medical Services to reconsider his decision and allow this good Doctor to remain with us until he reaches the age of retirement.[445]

In support to the IPDC through the Olubadan in Council, a petition was signed by seventy-two inhabitants of Ibadan, men and women, African and Lebanese, retracing the issues to 22 September 1939, and addressed to the District Officer, the Honorable Senior Resident and His Honor through the Olubadan-in-Council. The petitioners asked that Dr. Dale be allowed to remain in Ibadan until the time of his retirement.[446]

In same vein, a complaint was leveled against the committee in charge of Discipline and Appointment at the University College Hospital. In the complaint, Chief Akinwale a member of the committee stated that the University College was violating the clauses of the agreement she made with the Native Authority concerning Adeoyo Hospital. He added that no clause in the agreement justified the groundless dismissals and retirements of some of the N.A. workers there.[447] Chief Aminu the Chairman of the Discipline and Appointment Committee then rose and explained the situation. He said that that the Officer in charge of the Hospital brought three sets of people to his committee meeting with the following complaints:

i. Three pupil midwives were reported to be un-trainable.
ii. Two other girls were said to be slothful and slow.
iii. One pupil midwife could not complete her training during the specified period.[448]

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[445]NAI, File No: Oyo Prof 1/1, OY851, Vol. II, Medical Officer II for Oyo Province to be Stationed at Ibadan – Request For. 1953,53
[446]Ibid, 59 – 60, 66-67.
[447]NAI, File No: Iba. Div 1/1, 1221, Ibadan District Council Hospital Adeoyo Vol. VI, 1952,52k
[448]ibid

The committee then delegated Councilors Akinbiyi, Mr. Adeyemo the Treasurer and Mr. Adekunle the Secretary to make due investigations. The Officers in charge asserted that they were unbiased and added that their recommendations were in good faith and to the best interest of the patients whose cases might prove fatal by undue carelessness. The delegates then advised the Committee to sanction the recommendations of the Officers in charge. Some of those N.A. Employees were consequently warned or dismissed. Chief Aminu thus showed that Chief Akinwale's fears were unfounded.[449] Councilor Okunola maintained that the Officers in charge in their opinion were quite competent because life was not something to be trifled with and so advised that the decisions of the Discipline and Appointments Committee be upheld. Chief Adebisi was supported.[450] Chief Akinyele said that he had never heard of any of violation of agreement employment or dismissal in the Hospital independent of the Discipline and Appointment Committee. He assured Chief Akinwale that there should be no fear, as he perceived no trace of violation of agreement.[451] The Council then agreed unanimously to rule off the matter since the reasons for misunderstanding had been clarified.

In this contest, the community and the medical service in relations to the recruiting and laying-off of maternity health workers serves as an illustrative example that the decision of the IPDC in Ibadan was not biased, but was in line with the development of the maternity service. Whilst the Council was ready to go all out in defense of the patient, it also was able to maintain the standard of the practice by investigating the issues and establishing facts. It seems clear in practice that despite the committee's objective of voicing out the collective concerns of the patients in Ibadan and intervening on behalf of the patient, it was also able to resolve quite a number of the

[449]Ibid, 52K
[450]ibid
[451]ibid

maternal health crisis by professionally investigating the issues surrounding every complaint and making sure, they were genuine and adequately resolved.

The IPDC and Maternal Health Policies

We have noted how the IPDC scored reasonable succession the development of maternal healthcare service delivery in Ibadan. We now examine the intervention of the IPDC on colonial maternal health policies and measures used by the IPDC to ensure these policies were favorable to the indigenous people of Ibadan. Discussions in this section, focuses on the IPDC's debate on medical policies before its implementation, and the measures followed to ensure these policies are rightly implemented. It is important to note that, the IPDC as we deduce from previous sections, created a system that enabled the voices of patients to be heard, which thus, encouraged the continuous patronage of maternity centers by women in Ibadan. The IPDC was in fact, the first channel patients contacted in colonial Ibadan to present their dissatisfaction and grievances in the medical service.[452] In other words, the Council was the link to which the patients could call the attention of the colonial medical administration to the treatment gotten from the maternity centers. The council allayed the fears of the patient and called the attention of the medical officer in charge of maternal healthcare and obstetrics to the complaints made by patients. This meant that patient's experiences, as well as the maternal health services were in a way shaped by the Council.

The process governing the professional practice of midwifery in the management of maternal healthcare depended on the colonial maternal healthcare policies. Thus, the Ibadan peoples had become well experienced in judging which policy was more likely to be beneficial to them. When, for example, by the 1950s the Ibadan community through the IPDC had succeeded in

[452]NAI, File No: 1221 IBADIV 1/1, Ibadan District Council Hospital Adeoyo Vol. VII, 1956, 194

managing series of official and semi-official maternal healthcare complaints, which cut across colonial maternal healthcare policies that transformed the practice of midwifery in Ibadan.

Until the 1950s, however, finding an effective panacea to the constant complaints and agitations concerning the treatment of women and expectant mothers by medical officers needed a more systemic and bottom-up intervention. Therefore, it is important to state, that the IPDC developed the sense of nationalist movements during this time in Yoruba land and amongst the Nigerian people. Although, and as opined by Ajala, [453]the nationalist movement in Yoruba land between 1900 and 1940s was more of a religio-cultural than a political project. Nevertheless, from the late 1940s through the early 1950s, it became a political project, employing the Yoruba ethnic politics through which the IPDC like other groups in Yoruba land negotiated for more access to Colonial State resources. The IPDC's nationalist movement is linked with Chief Obafemi Awolowo's political project that assumed the Ibadan people like every other Yoruba state as a nation that should occupy a central position within the independent Nigerian political space, through the political ideology tied to Yoruba ethnicity.[454] There was a multiplicity of factors that contributed to the nationalist movement in Yoruba land. Such factors included the role of western education and enlightenment, the political elites, and the nature of Nigerian colonial politics between 1914 and 1959. The IPDC in Ibadan therefore, attaching itself to this political change, intensified its quest for better maternal healthcare resources just like the Egbé Ọmọ Odùduwà (EOO) founded in London in 1948 and launched in Nigeria in 1949, advocating for a greater social and economic

[453]Aderemi Suleiman AAjala, "Yoruba Nationalist Movements, Ethnic Politic and Violence: A Creation from Historical Consciousness and Socio-political Space in South-western Nigeria",. (Arbeitspapiere/Working Papers. Nr. 105, 2009),12
[454]ibid

development and political representation of the Yoruba people in the Nigerian state, in order to create a sense of nationalist belonging among the Yoruba people.[455]

Following the political trend in Yoruba land and in Nigeria generally, the IPDC who in its initial obligations had to file legal actions against colonial health workers and the medical service on behalf of patients, influencing health infrastructural projects, managing maternal healthcare crisis and criticizing health services that does not serve the people, among others, realized all of these interventions was insufficient to the overall development of western obstetrics and maternal welfare provisions to women in colonial Ibadan. As such, the IPDC recognized that there was a great need for members of the council to be part of the administrative board responsible for making and implementing health policies, especially those aimed at maternal and infant healthcare provisions and midwifery practices.[456]

In this vein, by the early 1950s the IPDC had began proposing for joint administration of the colonial medical facilities in Ibadan. This is so that the community can be part of the body actively involved in making policies, while it addresses the maternal healthcare problems from the scratch as it concerns and affects the people.

Some factors contributed to the preposition of the Ibadan District Council to be part of the policy making board on maternal health care from the 1950s. Firstly, throughout the year 1951, the University College, Ibadan, continued to use Adeoyo as a Teaching Hospital instead of a full General/ Maternity Hospital as requested by the community.[457] In reference to this issue, in 1948, the community through the Ibadan Native Administration was persuaded to agree and convert the Adeoyo Hospital from the status of Adeoyo as a full General Hospital to a purely Maternity

[455] Ibid, 13
[456]NAI, File No: 1221, Iba. Div 1/1, Volume VII, Ibadan District Council Hospital Adeoyo, 1st August 1952,424
[457]NAI, File No: 2931, IBADIV 1/1, Annual Report 1951,23

Hospital.[458] This is with the assurance that it was a temporary measure. Although Dr. Walker proposed the scheme, he pointed out that the conversion of a general hospital to a maternity hospital is not always satisfactory. The wards of a general hospital according to him, such as Adeoyo is, are of different design to those of a maternity hospital and their reconstruction is not inexpensive.[459] On 11 November 1948, however, an executed copy of the agreement between the Ibadan Native Administration and the University College Council relating to the use of Adeoyo Hospital as a teaching Hospital was endorsed. The negotiations from Adeoyo been a general hospital to a maternity hospital and now a teaching hospital became regarded as concluded.[460] After considerable opposition the Native Authority eventually consented to extend their agreement with University College for such further period as may prove necessary to effect the change over from Adeoyo to the new Teaching Hospital now in course of construction – probably three years.[461] This agreement did not sit well with the Ibadan people, as they have never disguised their uneasiness over this arrangement. At the IPDC's meeting held on 15 March 1950, the house recommended the disapproval of the conversion and recommended its extension to make it conform to modern Hospital standard.[462] Secondly, the Council resent and found it hard to understand a system, based on practice in the United Kingdom, whereby there is no single medical officer in charge of the hospital.[463] An instance of the protest made by about 500 women to the Olubadan of Ibadan was referred to, when they were refused treatment at Adeoyo Hospital as a result of lack of medical officer in charge.[464] Thirdly, the problem of finding a replacement to fill the vacant posts of a General Secretary and Medical Superintendent persists

[458]NAI, File No: 1221 IBADIV 1/1, Ibadan District Council Hospital Adeoyo, Vol. VI. 1956,52i
[459]Ibid, 52ii
[460]Ibid, 48
[461]NAI, File No: 2931 IBADIV 1/1, Annual Report 1951,23
[462]NAI, File No: 1221 IBADIV 1/1, Ibadan District Council Hospital Adeoyo, Vol. VI. 1956,43
[463]NAI, File No: 2931 IBADIV 1/1, Annual Report 1951,23
[464]NAI, File No: 3374 IBADIV 1/1, Ibadan (Provincial) District Council 1953,29 - 30

during this period and still lingered.[465] It was at this time, Col. Lemming, the General Secretary and Medical Superintendent at the time resigned in the middle of the year and for several months there was no General Secretary, with resulting confusion. After two temporary appointments, a substantive General Secretary was posted from the Lagos General Hospital in November. The posts of Medical Superintendent however, remained unfilled nor was there any candidate in view.[466]

The IPDC took advantage of these issues to pursue their ultimate agenda and propose to be part of the joint administration of maternity centers in Ibadan. This was in order to ensure, that there was a high level of sensitivity to maternal healthcare issues and inclusiveness of the plights of expectant mothers in the maternal health policies in Ibadan. This also, is perhaps because the medical officer and colonial medical government did not put into consideration the health of pregnant women in Ibadan before taking vital health and life altering decisions such as the non-provision of a Medical Officer in the Adeoyo maternity clinic.[467] Largely, the peoples of Ibadan also felt they were perceived as people who could accept whatever policy the medical officer and medical administration decides to implement.

For all these reasons, in June 1956, the IPDC advocated and proposed in a legal agreement for the incorporation and the joint administration of maternity centers by the Government and the District Council. The undertakings in item (i) and (vii) of the proposed legal agreement, furnished the Council with the right power to influence medical policies as it affects the people. The items stated that;

[465]NAI, File No: 2931 IBADIV 1/1, Annual Report 1951,23
[466]ibid
[467]ibid

i. The hospital shall be managed by a Management Committee composed of members approved at the meeting of the 18th February i.e. five Government members, five nominated by the District Council and two non-voting members representing University College Hospital.

ii. The Minister of Health shall prescribe rules for procedure at meetings, quorum, etc. Expenditure on the hospital shall be on the proportion 75% Government and 25% District Council as already approved by Mr. Adelabu.

iii. Government shall provide the whole of the working expenses of the hospital recovering the Council contribution at the close of each year.

iv. Income from the hospital shall be divided 75% Government and 25% Council. In case of default on the part of the Council in paying its contribution, Government will acquire an interest in the buildings of the hospital to the extent of the amount of the default the property being valued by the Department of Works. For instance if the whole hospital was valued at E150,000 and the Council defaulted in payment of E30,000, Government would acquire one-fifth interest in the hospital.

v. At any time before total acquisition by Government, the Council could re-acquire its interest by payment of arrears due.

vi. The duties of the Management Committee would be:

    a. To frame the budget and any supplementary budgets subject to the sanction of the Minister of Health;

    b. Inspect the hospital and carry out any improvements necessary for the good management of the hospital;

c. Investigate any complaints of the public;[468]

According to this proposed legal agreement, it would become legal for the people of Ibadan through the IPDC to facilitate every aspect of maternal and infant healthcare services and practices through representation in the colonial medical board as trusted members of the committee. The proposed legal agreement was passed into law officially on 31 December 1956, in line with the enforcement of the Public Health Ordinance in Ibadan to replace the Southern Provinces Sanitation Order.[469]

Prior to the agreement for a policy of joint management of Adeoyo Hospital, from January until December 1956, several meetings to discuss the future of Adeoyo Hospital and in particular to try to reach an agreement regarding the management of the hospital was held. In the first meeting held in February 1956, the meeting which was opened by the Minister Public Health, who put forward three alternatives;

i. Ibadan District Council to take over complete control of Adeoyo Hospital;
ii. Government to take over complete control of Adeoyo Hospital;
iii. Ibadan District Council and Government to share control of Adeoyo Hospital.[470]

In reply to this, Mr. Adelabu, the Chairman of the Ibadan (Provisional) District Council stated that, it was the Council's policy to retain as many institutions as possible without allowing them to get out of control. The University College however, had expanded facilities at Adeoyo during their stay beyond what any local government body could manage to provide without a subsidy. Adeoyo had grown to such extent that the Council could not possibly mange to run it unaided

[468]NAI, File No: 1221, Iba. Div 1/1, Ibadan District Council Hospital Adeoyo, Volume VII, 1st August 1952,424
[469]NAI, File No: 2931 IBADIV 1/1, Annual Report 1951,48
[470]NAI, File No: 1221 IBADIV 1/1, Ibadan District Council Hospital Adeoyo, Vol. VI, 1ST August 1956,415

and must be given subsidy. The Council had therefore agreed to a policy of joint management of Adeoyo Hospital.[471]

As a follow up to the meeting held in February, another meeting was held in March 1956 by the Secretary and the Chairman of the Ibadan District Council with the Ministry of Public Health, after a long debate, it was agreed in the policy of management that the Committee of Management which would control the Adeoyo Hospital after the University College would have vacated it in October, 1956, should consist of, five representatives of the Ministry of Public Health; five representatives of the Ibadan District Council; and two representative of the University College who would have no vote on any matter in the committee.[472] It was also agreed that the Ministry of Public Health should arrange to take over temporarily from the University College on behalf of the Committee of Management by October; and that the Ministry should supply the senior staff for the hospital while the Council should provide the junior staff. The Council agreed to the arrangement.[473]

The District Council in exercise of the power conferred upon the Council by Section 77 of the Western Region Local Government Law, 1952, and by Western Region Public Notice No. 26 0f 1956, the Ibadan (Provisional) District Council with the approval of the Minister of Justice and Local Government to whom powers of approval have been delegated,[474] discharged its function of policy making.

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[471]ibid
[472]NAI, File No: 1221 IBADIV 1/1, Ibadan District Council Hospital Adeoyo, Vol. VI, 1ST August 1956,408A
[473]ibid
[474]NAI, File No: 1221, Iba. Div 1/1, Ibadan District Council Hospital Adeoyo, Volume VII, 1st August 1952,52

The Ibadan (Provincial) District Council for example, on June 7, 1954, in a meeting of the Board of Management of the University College Hospital with members of the Ibadan District Council, agreed to consider certain proposals, which might be put into law. These proposals were;

a) That Adeoyo Hospital should be maintained as a general hospital and that if it were so maintained, the maintenance would be shared between the District Council and the Regional Government;
b) That reasonable provision should be made for the treatment of long stay orthopedic cases;
c) That, depending on facilities which might be provided elsewhere, a section of Adeoyo Hospital should be reserved for T.B. cases;
d) That the maternity unit of Adeoyo Hospital should be maintained in its present State.[475]

On 12 November 1954, as part of the resolution reached by the board of medical administrators and adopted by the Ibadan District Council at its meeting held on 2 November 1954, it was agreed;

> that the Council takes over the control of the Ante-Natal Clinic section of the Adeoyo Hospital in order to allay the fears of Ibadan people who are now seething with discontent over alleged ill-treatment and lack of proper care and sympathy that may result from the alleged impeding reshufflement of staff and section management now ably led by Mrs. Leeming.[476]

Also, as one of the first policies pushed by the IPDC and passed by the board, was agreeing to the suspension of some of the standing rules in maternity centers and considering in its place the following motion proposed by a member of the board, Councilor Dr. Agbaje;

[475]NAI, File No: 1221 IBADIV 1/1, Native Administration Hospital Adeoyo, Vol. V, 1956,326A
[476]NAI, File No: 1221 IBADIV 1/1, Ibadan District Council Hospital Adeoyo, Vol. VI, 1ST August 1956,342

> that this Council views with horror the scandalous neglect of Emergency patients with repeated loss of lives at Adeoyo Hospital and calls for an immediate remedy by Government and Ibadan University College Authority and an assurance that the situation will not be allowed to deteriorate. That between the hours of 2 p.m. to 7 a.m. daily there must be available and staying within the premises of the Adeoyo at least one doctor to deal with emergencies arising either in Hospital patients or coming as new admissions and that Government A.M.O.S shall be compelled to stay on duty according to roster. That Government shall provide without delay sufficient telephones to call professors and Doctors needed for emergencies and for the better organization of the Adeoyo University Teaching Hospital, which Government should release for the essential post of Medical Superintendent a Senior Government Officer who had worked and controlled Adeoyo.[477]

The motion was adopted unanimously after members had expressed their great concern and dissatisfaction over the treatment of emergencies at Adeoyo Hospital. The Council decided to press for a meeting of the Adeoyo Hospital Board of Management at the earliest opportunity for dealing with the resolution and to request the Director of Medical Services and the Senior Medical Officer, Ibadan to attend the Boards meeting.[478]

Conclusion

The story in this chapter reveals the ability of the Ibadan (Provisional) District Council to effectively advocate for better maternal and infant welfare services, which originated from the

[477]NAI, File No: 1221, IbaDiv 1/1, Native Administration Hospital Adeoyo, Volume V, 1956,303
[478]ibid

maternal health complaints of the Ibadan people, thus, leading to the development of the maternal healthcare services during the period of this study. This indicates the IPDC's exceptional insight into the politics of health and healing, especially amongst the Africa population. The case of Ibadan provides an appealing local example of the enormous role played by the community as against the patient in health and healing as suggested by some scholars.

The events in this chapter has offered a contextually sensitive framework within which to evaluate the way colonial medical administrators and medical officers' responds to agitations of patients as against the community; the IPDC – ultimately always serving a broader maternal and medical service agenda. The IPDC had been able to facilitate the maternal health interest of the Ibadan people since its inauguration. Clearly, from the Ibadan experience, a common front is more likely to influence health policies than from a lone stance. What is more, in justifying the purpose of the IPDC between the 1940s and 1960, the community held a place in the board where policies on maternal health were debated. As part of the board, they could call or condemn maternal welfare initiatives before it becomes law. Furthermore, they could openly criticize colonial medical administration and medical officers for principally not living up to the standard of modern maternal healthcare practice and services.

In a broader context, however, this chapter shows the highly organized way the African population in Ibadan achieved their interest on maternal healthcare. While this is not surprising, as it is the specific issue of the colonial state. This also goes further to help us understand the kind of local politics ongoing within the local space as regards health and healing. As most scholars have observed, there were immerse local struggles were the elite instigates the local population using different media to revolt or to protest against the colonial government. This way, they were showing to the rural and the urban public that the colonial government lacks the

capacity to improve the health conditions of the colonial subjects. It was not a specific agitation to the colonial government at the centre, it was a protest directed at the local political class. One way the colonial government sorts to cushion the issues around maternal health and healing, was to absorb the IPDC as best as they could into the maternal policy board set up by the Native Authority.

Chapter Six

Marginalized Wellness: Exclusionary Maternal Healthcare and Midwifery Services in Rural Ibadan, 1940 to 1950

Introduction

The history of maternal healthcare marginalization in rural Ibadan can be traced back to the 1920s when the British Imperial Government and other colonizing bodies – the Missionaries – initiated western biomedicine, which include, and led to the spread and development of western obstetrics in Ibadan. This was possible through the establishment of medical facilities, training of human resources for health service delivery, and the implementation of maternal and infant welfare policies. Nominally, the colonial maternal healthcare and midwifery service policies are expected to cover the vast urban and rural areas of Ibadan. However, due to shortage of medical officials, administrative convenience and financial incapacitation the colonial government focused the implementation of its maternal healthcare policies and welfare schemes in the urban areas of Ibadan and largely ignored the rural folks, hence, western maternal healthcare and midwifery services was disproportionately distributed between the urban and rural areas. This resulted in the rural areas having the highest risk of maternal and infant mortalities during this period. This is due to the unavailability of medical officers and a functional health facility. The purpose of this chapter therefore, is to firstly, give an account of the inequalities in maternal and infant healthcare delivery to improve our understanding of the disparities in the colonial states response to the challenges of maternal and infant mortality burden among the urban and rural population. By doing this, this chapter will demonstrate that geographical position links marginalization and social determinants of healthcare services. This perspective provides a critical lens in the evaluation of colonial policies in the implementation and development of

western obstetrics. Secondly, the chapter reveals how by the late 1940sthe marginalized people in the rural areas of Ibadan started challenging the colonial government's intentions towards maternal and infant healthcare by questioning the colonial states' 'exclusive' maternal healthcare policies in Ibadan.

In order to give a detailed account of the experiences of the rural people and measures applied to cause a change in the rural areas, the sections of this chapter are broken down as follows. The first part of this chapter focuses on the dilemma of maternal health in rural Ibadan; the second section offers a critical understanding of issues of maternal health outside the administrative centre of Ibadan; while the third part deconstructs the colonial states cosmetic approach towards maternal healthcare through the rural health policies of the 1950s in rural Ibadan.

Reference to maternal health in the rural areas of colonial Ibadan from 1940 to 1950 includes the parts of Ibadan marked as Oyo, Shaki, Fiditi, Iseyin, Oke-Iho, Otu, Ago-Are, Kishi and Iganna. In these mentioned areas, some characteristics stood out. Firstly, was the apparent administrative absence of the colonial government and the voluntary agencies – missionaries- in respect to the provision of socio-economic services including healthcare services. Secondly, while those in urban Ibadan enjoyed access to moderately well-equipped and well-staffed Maternity Clinics, Hospitals and Dispensaries, the rural population was still faced with outrageous neglect in the provisions of maternal healthcare services and in the establishment of maternal healthcare facilities. More so, even though health services had been extended to the native population, the quality of service was below standard. This is because healthcare service among Africans were serviced by a very few doctors and were poorly funded. In the rural Ibadan, it is worse and much of the job was done by the medical missions that were insufficiently funded by the colonial

government to manage both the health of Africans in the urban and rural areas as will be shown in the table in the next section. Thirdly, is the long-distance the rural folks in Ibadan had to cover to patronize health facilities in the Ibadan Township. These characteristics did not only have severe financial implications on the rural people, but also had an array of health consequences that affected the patronage of modern midwifery services.

The rural communities mentioned above, are about 1082 square miles apart from the closest urban area.[479]They are chosen as special areas for discussion because they are perhaps the most affected areas hit with maternal and infant mortality giving the absence of Maternity Hospitals and Clinics, as we will see as we proceed in this chapter.

Indeed, the perception of the missionaries and the colonial government on the African traditional medical practices of the Ibadan people, which was deeply rooted in their need to spread western medical ideas, was location based. This is evident in the missions and colonial government's failure to provide equal healthcare services in its colonial territories. Firstly, it is however important to state that the implementation of the policy for the provision of medical fund to support the expansion of health services to Africans led to the regular disbursement of grants in aid to the missions from 1929 to the 1940s as shown in the table below.

[479]NAI, File No: 06027 Oyo Prof., Annual Report 1921,17

Grants-in-Aid to Mission Medical Work, Nigeria 1929/30 – 1944/45

Year	General	Leprosy Control
	£	£
1929/30	6,000	4,776
1930/31	3,000	4,000
1931/32	500	4,000
1932/33	500	3,760
1933/34	1,000	3,550
1934/35	1,500	2,500
1935/36	1,500	2,700
1936/37	2,400	2,700
1937/38	2,600	3,500
1938/39	2,600	5,000
1940/41	1,265	5,000
1941/42	780	4,000
1942/43	780	5,200
1943/44	780	5,200
1944/45	400	11,000

Source: Sydney Phillipson (Appendix D), Report on Grants-in-Aid of the Medical and Health Services Provided by Voluntary Agencies in Nigeria (Lagos: Government Printer, 1949),55.

The general provisions of the grants in aid, includes infant and maternity welfare provisions to the natives of Ibadan.[480]The trend in the above table reveals the missionaries receiving financial

[480] ibid

backing annually to carry out healthcare projects, and yet a reduction in the funds given out by the colonial government to execute these health projects. Although the grants-in-aid to the missions remained minimal and dwindled over the years, it however, enabled the medical missions expand its maternal and infant welfare services in the urban areas of Ibadan, thus making the missions the major providers of maternity services in colonial Ibadan. More so, within this period, the African population in urban Ibadan had become more familiar about modern medical ideas, and had accepted and engineered the acceptance of modern medicine to their relatives in the rural areas.[481]

However, despite the continuous medical outreach for the spread of modern medical services to the entire "native' population and the recorded growth of modern medicine in the urban areas of Ibadan, in the rural areas of Ibadan, there were little to no significant changes in relations to the public health policy which was passed in the 1920s and which was based on the recommendation of colonial officials and other stakeholders. Consequently, people in the rural areas of Ibadan suffered undue maternal health challenges throughout this period and even until the 1940s.[482]

The Dilemma of Maternal Health in Rural Ibadan

Maternal and infant mortality in Africa was a very intriguing and sensitive discussion among missionaries and colonial officials during the nineteenth century that it necessitated the introduction of Western obstetrics on the continent.[483] The missionaries and colonial government, notwithstanding, the availability of traditional health and healing alternatives, believed the introduction of Western obstetrics would help alleviate the maternal and infant mortality crisis in

[481]Adams Matthew Digital Archives, CMS Outlook, June 1932.
[482]NAI, File No: 15S9/14, Annual Reports: Missions, Oyo Province, 1938, P.10 See also; Church Missionary Society, African General: Co-operation between the government and the Mission, 1926 – 1947,2
[483]ibid

Africa.[484] In colonial Ibadan specifically, among other factors, the missionary and the colonial government shared the same perspective even though it was more of a tactics for promoting western obstetrical ideas.[485] However, one of the core aspects of Western obstetrics through which maternal and infant mortality was to be eradicated was in the introduction of hospital-based healthcare services from the 1930s as I have elaborated in the chapter three of this thesis. The establishment of maternal healthcare infrastructure was extensively carried out in the urban areas of Ibadan, with just few poorly equipped dispensaries with occasional visits of missionary medical officers in the rural areas.[486]

It is important to state here, that the problem of maternal and infant mortality was not exclusive only to the Africans in urban Ibadan. Indeed maternal and infant mortality was an all-inclusive problem that affected both the urban and rural population.[487] Throughout the first three decades from the introduction of Western obstetrics in Ibadan, maternal healthcare and infant welfare in Ibadan Township was becoming standardized. - Maternity hospitals and clinics were established; African midwives and nursing sisters were being trained; midwifery schools were established; voluntary agencies and government partnership on maternal health were in motion; and schemes for maternal and infant welfare were being floated, amongst others.[488] While these developments in maternal health in the Ibadan Township affected the perception of Africans in the towns concerning Western obstetrics positively, it constituted a form of neglect and marginalization to the African population in the rural communities of Ibadan. First, it was not until the 1940s that

[484] NAI, File No: CSO 26/2, 13973, An International Year Book of Child Care and Protection (Publication), 1924,19
[485] NAI, File No: COMCOL 1, V/12, Abolition of Customs which are Detrimental to Native Welfare and Economic Prosperity, 1930,6
[486]NAI, File No: 43693/S.3, Development of Health Services (Revision 10 Year Plan). C.D.W.A. Scheme: 1949.
[487]Gould, W.T, "African mortality and the new 'urban penalty", *Health Place.;* 4(2*)* (June,1998)*171-81.*
[488]NAI, Annual Report of the Christian Missionary Society, 1928 – 1929, 25-26

the establishment of rural health centers was been considered by the colonial government in Nigeria.[489] By this time, the colonial government only started considering an order to extend and consolidate the reduction of the spread of disease caused by mass treatment in the health facilities in the Ibadan Township to the rural areas of Ibadan.[490] Although, prior to the 1940s every province had its system of Native Authorities dispensaries, which was designed to help improve and expand medical services from the Ibadan Township and for the distribution of preventive medicine amongst the rural population, but they were non functional. To ensure the functionality of these dispensaries, rural health centers were necessary.[491]

According to the plans of the colonial government, twenty-one rural health centers of a type that has proved of practical value in other countries would be required. In addition, it would be designed in such a way that the rural health centers will undertake antenatal and maternal care, child welfare, school medical work, control of endemic disease, improvement of village sanitation and hygiene, health education and domiciliary midwifery. The staff in each case will be responsible for the supervision and direction of a circle of improved Native Authorities dispensaries. They will undertake the supervision of practicing midwives and maternity homes, and an important part of their duties will be home visiting, home nursing and in particular, the development of health consciousness in the home by example, education, and propaganda.[492]All of the mentioned arrangements were three decades after the introduction of Western obstetrics in Ibadan. Despite these proposed colonial medical plans, the missionaries and the colonial government failed to roll out maternal healthcare facilities in the rural areas of Ibadan. This led

[489]NAI, File No: 43693/S.3, Development of Health Services (Revision 10 Year Plan). C.D.W.A. Scheme: 1949,14
[490]ibid
[491] ibid
[492]ibid

to the rise of maternal and infant mortality rates in the rural communities during this period. The annual report of 1949 and 1950 respectively, had in fact estimated infant mortality alone in the rural areas as 270 per thousand and that 500 per children under five die in the rural areas.[493]The periods prior 1949 show a deficit of statistical data to show the number of infant mortality in rural Ibadan. This in a way further validates the lack of administrative presence in the rural areas. Notwithstanding, as argued by development scholars, the rural population is always faced with a higher mortality rate than their urban counterparts.[494]This is because of the disproportionate distribution of health resources to the people in the rural and urban areas. One will expect the colonial state to spring into action and fulfill its rural health care plans especially with the high rate of mortality as seen in the 1949 and 1950 annual statistical records. Still, it did not trigger any sort of concern from the colonial government or voluntary organizations. This reflects the dilemma of maternal health in the rural areas of Ibadan and above all shows the deliberate colonial neglect and marginalization of the rural folks in providing essential healthcare services to the people.

The challenge of not having maternity hospitals and clinics in the rural areas meant that the rural population had to patronize the maternity hospitals and clinics in the Ibadan township. Easy accessibility to maternity hospitals, clinics and dispensaries are important in the provision of western obstetrics. Its importance permeates easy and increased patronage of such facilities. Yet, one of the striking challenges of maternal health in the rural communities of Ibadan is the geographical dimension of colonial marginality. This was based on the deliberate location of maternal healthcare facilities in the Ibadan Township by the colonial government without any consideration for the rural population. Although colonial reports on public health in the late

[493]NAI, File No: 2180/1, Oyo Prof/1, Rural Health Centre: Fiditi, 1949 – 1950, 37

[494]Heaton,T.B, Forste R. "Rural-Urban Differences in Child Growth and Survival in Bolivia" *Rural Sociology*,68, (2003),410–33.

1920s ascribed this mainly to "financial stringency", [495]the colonial government was deliberate in the establishment of these facilities in urban areas as it was at first, mainly established to serve the European population who predominantly settled in the highbrow areas before such services was extended to the African population working within the colonial bureaucracy in the urban areas.[496] The repugnant effect was with Africans in the rural communities of Ibadan in search of maternity services in the maternity clinics and hospitals in the urban centers having to travel long distances to get such services. While this was a major challenge the rural population was grappling with, there are accounts of European doctors been reluctant to go offer temporary medical services in the rural dispensaries due to the distance and the number of days they had to cover before getting to the people in the interiors of Ibadan. Consequently, the request by the Medical Traveling Officer for a vehicle that would facilitate supervision of rural health facilities in the 1950s.[497] This in fact goes to show the lack of empathy of the colonial government towards the colonial subjects in the margins by locating health facilities in urban areas that sometimes took the people in the rural community's days to reach.

The affordability of maternal healthcare services by the rural population in colonial Ibadan also posed a major challenge to rural Africans who above all odds still decides to patronize maternity clinics and hospitals in the urban areas of Ibadan. Scholars such as Folasada, Boldstad and Manda, Lalou and LeGrand, have in their studies highlighted affordability of healthcare services as a major determinant of maternal and infant mortality.[498] In the early 1930s, the American

[495] Great Britain Cmd 2774: Ormsby Gore's Report on Public Health in WA and his Itinerary. Sept. 1950,76
[496]NAI, Government African Hospital, Ibadan, 1926,26
[497]NAI, File No: CSO 26/2, 15216, Traveling Medical Officer and Native Administration Dispensaries, Vol. IV, 1930, 7
[498]Folasade I. B., "Environmental factors, situation of women and child mortality in southwestern Nigeria."*SocSci Med.51(10)*, (Nov. 2000),*1473-89;* Bolstad, W. M, Manda SO. "Investigating Child Mortality in Malawi Using Family

Baptist Mission Hospital, reportedly spoke of many patients from the rural communities of Ibadan - Oyo, Iseyin, Shaki and so on, who since over five years had patronized the mission hospitals in the urban areas and were responsible for providing a substantial monthly income and growth of the hospital through their payment on maternity services. However, by the 1940s, attendance from these areas had steadily decreased along with the hospital's income.[499] Hence, in March of 1946, the Baptist Mission Hospital had only gotten an income of £40 and for April £31.The reason for this according to the mission's administration was chiefly because the patients from the rural areas have not the money to continually pay for their hospital bills.[500]This also was due to the people's preference to small fees charged by other hospitals[501] and the conservative force discouraging the continuous acceptance of modern medicine amongst rural women as was the case amongst women in the urban areas in the 1920s.[502]Below is a table of hospital fees charged by the American Baptist Mission compared to other hospitals in Ibadan during this period:

and Community Random Effects", *Journal of the American Statistical Association.* 96, (2001),12–19; Lalou R, LeGrand T. "Child Mortality in the Urban and Rural Sahel" *Population: An English Selection*,9, (1997),147–68.

[499]NAI, File No: Oyo Prof. 1, Extension of Medical Service Direction, Control and Subsidy: Medical Mission,1946 135

[500]ibid

[501] ibid

[502] NAI, Annual Report, Ibadan Division, 1929,80

Table A: Hospital Fees

Item	April	May	Adeoyo	Oshogbo
Outpatient Med. Wk.	3d. to 5/0	3d to 5/0	2d	Free
Outpatients Surg. Wk.	6d to 5/0	6d to 5/0	4d	Free
Inpatients Med. Da.	1/0	1/0	1d	Free
Inpatients Surg. Da	See Operation Fees		3d	Free
Maternity 2 Da.	10/0	5/0	Free	Free
Maternity 7 Da.	20/0	10/0	Free	Free
Worm Treat. Adult	3/6	2/6	2d	Free

Table B: Operations Fees

Item	April	May	Adeoyo	Oshogbo
Big Abdominal	£5	£3	5/0 and up	Free
Hernia	£3-10-0	£2-10-0	21/0	Free
Hydrocele	3 10 0	2 0 0	5/0 and up	Free
Tonsillectomy	2 10 0	1 10 0	?	?
Eye ennucleation	2 0 0	1 10 0	?	?
Cataract	2 0 0	1 10 0	?	?
Pterygium	1 0 0	100	?	?
Entropion	1 0 0	100	?	?
D & C Uterus	2 0 0	1 0 0	?	?
Circumcision	5 0	3 0	?	?

Source of Tables A and B: Oyo Prof. 1, Extension of Medical Services Directing Control and Subsidy Medical Missions. 1939, 138

Details from the tables above, shows that at Oshogbo, all medical expenses were Free, except for a rare operation when the fees charged never exceeds two guineas. At Adeoyo, everything was free until in recent months. While at the Baptist Mission, fees were charged very strictly, for all who were not clearly in financial difficulties, according to the higher scale, until late in April, when the distressed financial condition of the people made a reduction imperative, if disastrous.[503]With this instance, illustrating the challenges of affording maternity services in the Ibadan Township helps further in analyzing the unsympathetic nature of colonial authorities to the plights of the rural population during this period – leaving them in a state of neglect and marginalization. In addition, maternity services in the Ibadan Township sometimes did not meet the expectations of the people in the rural communities. This was in terms of getting their money worth of services as some of the missions maternity centers in the Ibadan Township during this period had difficulties maintaining qualified nurses and midwives, especially those who run antenatal and welfare clinics as well as treating ordinary out-patients cases and simple ward cases.[504]

Although maternal mortality was a nineteenth and mid-twentieth century crisis in all of colonial Ibadan, it, however, took a toll in the margins. This is because, ever since the introduction of Western obstetrics, rural Ibadan has been deprived of the same benefits in terms of healthcare facilities enjoyed by those in the Ibadan Township. While modern maternal healthcare facilities were already in their formidable state in the Ibadan Township, in the 1940s, the colonial government established the first two rural health centers in the Western region of Nigeria – at Ilaro and Auchi respectively in 1949.[505] These rural healthcare facilities were established as a

[503] ibid
[504]NAI, File No: Oyo Prof 1/1, Extension of Medical Service by Direction, Control and Subsidy of Medical Missions Vol. III. 1946,366.
[505] NAI, File No: 195S, Oyo Prof. 1, Annual Reports Medical and Health Departments, 1949, 20.

model to be replicated in other rural areas in the region.[506] The rural area to which the majority of the indigenous population is located was home to over two-thirds of the population in Ibadan but had no basic maternity facility as at the early 1940s. On the other hand, the township of Ibadan with less than one-third percent of the population had maternal health facilities of a very good standard.[507] It was not until the late 1940s that the first rural health centre was established in Ibadan - the Fiditi Rural Health Centre.[508]

The Fiditi rural health centre which was the first rural health centre established in the margins of Ibadan during this period was expected to function like the Ilaro and Auchi centers that had already been functioning since the early 1940s and striving well. The Fiditi rural health centre was expected to serve an area of 300 square miles with a population of 30,000 people.[509] Nevertheless, the colonial government did not find it necessary to post medical staff to the centers as is required.[510]The facility was not only deficient of standard infrastructures; it was also lacking in trained midwives and nursing sisters. A greater majority of the users of this facility were rural African women. By implication, they were the ones greatly affected by the sub-standard maternity facility and a caricature of what was evident in the township. Little wonder to why the indigenous people in rural Ibadan mounted pressure on the colonial government for the expansion of medical facilities, while in addition, editors of newspapers and few colonial medical officials criticized governments implementation of public health policies.[511]

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[506]ibid

[507]NAI, Administrative Report on the Southern Provinces and Colony, 1926,12; NAI, Oyo Province Annual Report 1938,2.

[508]NAI, File No: 195S, Oyo Prof. 1, Annual Reports Medical and Health Departments, 1949, 20.

[509]Ibid, 21.

[510] ibid

[511]NAI, *the Southern Nigeria Defender*, "Editorial Comments", 20, 21,24,25,28 January; 26 November; 27 December 1944, all page 2. These demand more hospitals, improvement of medical facilities and complain of understaffing and the condition of rural health centres among other issues.

Available evidence suggests that the state of the rural healthcare centers which for instance had nonelectric light, water supply, easy means of transport among others, while compared to what was attainable in the urban centers inhibited the patronage of the sub-standard maternal health facilities provided by the colonial government.[512] At first, the attendance in the rural health facilities, for example, the Fiditi rural maternity centre was encouraging as 147 women attended the antenatal clinics and a total number of general attendances of 673, with women appreciating more and more the value of antenatal clinics in the rural areas.[513] The Native Administration Dispensaries and Welfare Clinics in the Township of Ibadan encouraged this early progress of the Fiditi rural health centre with the visits from Health Sisters that proved very helpful to the staff and local people. Unfortunately, drugs, dressings and equipment were not available in the quantities required and there was always a delay in obtaining supplies from the medical stores.[514] Because of challenges such as this, for instance, one case of difficult labor was removed from the Ijaiye rural health centre in Ibadan to the Adeoyo Hospital in the Ibadan Township where the pregnant woman was lucky to be delivered a male child. Two of such deliveries were attended to and assistance given to three women who sought attention immediately after delivery in the same instance.[515] In some other cases, the expectant woman and child were not lucky to be taken to hospitals in the Ibadan Township, as lives are lost in the process. This made the patronage of the rural health centers reduced drastically.[516]

[512] NAI, Health, Rural Development and Social Welfare Committee, 1947,20.
[513]NAI, File No: 2180/1, Oyo Prof/1, Rural Health Centre: Fiditi, 1949,36.
[514]Ibid
[515]ibid
[516] ibid

In other rural communities such as Ilora, there was no Rural Health Centre until 1954.[517] Regardless, with the opening of the Ilora Rural Health Centre, weekly clinics were conducted by mission's medical staff for antenatal care, infant and child welfare, and medical care of schoolchildren.[518] In addition, several adults received medical attention. 1,741 patients of whom 1042 were new cases attended the centre during the year. The total number of attendances was 8,571. 285 pregnant women attended the antenatal clinic…lectures were given to pregnant women on proper dieting and general care of themselves and during pregnancy. Despite this recorded progress notwithstanding the decades of the absence of such a facility and service in Ilora, there were still several challenges. Central among this was the unavailability of drugs in the health centre to treat various ailments. For instance, the vitamin B complex deficiency affected newborn infants even though the general health of the women was much better.

An important feature of maternal health in colonial Ibadan during this period is that the rural communities, which are home to the population most affected by maternal and infant mortality and in need of maternity services, are the ones neglected and marginalized. According to the 1953 annual report, the functioning maternity centers in the rural areas of Ibadan were just three - the Iseyin, Oke-iho and Ilaro Rural Health Centre's. In these three functioning maternity centers, the structures of the buildings were old fashioned. At the various health centers, although overall, they were showing marked improvements; as patients were taking advantage of the facilities provided for medical treatment and advice, attendances were however always fluctuating.[519] The most ironic situation in these rural health centers is that it was obvious the colonial government

[517]NAI, File No:15S9/14, Annual Reports: Missions; Ilora Health Centre: Summary Annual Report – January – December, 1954, 45.
[518] ibid
[519]NAI, File No: 195S, Oyo Prof. 1, Annual Reports Medical and Health Departments, 1949,291.

policy on maternal and infant welfare was not targeted at the African population in the rural communities.

Table A
Total Number of Cases and Attendances at the Rural Dispensaries, 1954

Rural Dispensaries	No of Cases	Attendances
Oyo	1647	11355
Fiditi	1165	7843
Awe	1374	6516
Ilora	522	4360
Iseyi	2423	12712
Otu	1081	3247
Shaki	2426	13601
Ago-Are	1780	7764
Okeho	2844	5443
Iganna	2160	9086
Kishi	2646	12476
Igbetti	1314	9113

Table B

Total Number of Antenatal Cases, Attendances, and Deliveries at the Maternity Centre's and Clinics, 1954.

Item	No of Ante-natal Cases	Attendances	No of Deliveries
Oyo	2841	4857	137
Iseyin	849	1161	62
Okeho	463	2193	83
Ilaro	601	1911	54

Source: Annual Report, Medical Work in Oyo Division, 1954. P.303

A major reason for the fall in the number of cases in the rural dispensaries and maternity clinics when compared to the number of attendances as seen in the tables above, was not as a result of the reversal in acceptance of western midwifery practices or from economic considerations, but because of the state of the facilities and the unavailability of Midwives or Nursing Sisters to attend to patients in the rural areas.[520]

"Maternal Healthcare Services outside the Administrative Area Has Always Been Pointless"

Why is maternal healthcare provision outside the administrative area important? As we have made bold in subsequent chapters, the rationale for the colonial states intervention on maternal healthcare stems from the need to "modernize" traditional midwifery practices with a view to increasing labor, efficiency and productivity for the colonial economy. Furthermore, and ideologically, Western biomedical development in the 20th century inspired the colonial state to transform the African traditional form of birthing which was believed to be injurious to the health of the mother and child, and a major cause of maternal and infant mortality. Hence, the need to transform the African traditional medical practice to one, that would guarantee the health

[520]NAI, 195S, Oyo Prof. 1, Annual Reports Medical and Health Departments, 1949. P. 293

safety of both mother and child. The underlying philosophy is that, African traditional birthing practices are not "modern" and cannot guarantee the safety of both mother and child. Therefore, since the African traditional birthing practices cannot be used in the British African colonies like Ibadan, thus, presenting western obstetrics to the locals became the sole responsibility of the colonial state as the major actor pushing for this change.

Primarily, in the introduction and development of maternal healthcare and midwifery services, the colonial government apart from making provisions of these services in the urban areas, did not see the usefulness of providing similar healthcare services in the rural areas of Ibadan (and rural areas of Nigeria in general), not until around the 1950s.[521] This is attributable (in part), to one, the overwhelming importance placed on health care in the urban centre. This is based on the believe that a healthy African population in the urban areas will reduce the spread of diseases and cause economic progress. Two, the challenge of financing any major project in the colonies by the colonial government and medical missions due to the aftermath of the great depression. Three, lack of professional medical officers, and four, the distinguishing features of indirect rule colonialism with its partial reliance on native institutions in Africa which ill equipped by education and temperament to cope with the changing colonial environment, affected and caused low and unequal levels of socio-economic and political developments in Africa.[522]Thus, the administration of the rural areas from the Ibadan centre appeared not to be without some

[521]James D. Graham, "Indirect Rule and the Establishment of 'Chiefs' and 'Tribes' in Cameron's Tanganyika,"*Tanzania Notes and Records*, Volume 77 -78, (June1976), quoted in John LLiffe, *A Modern History of Tanganyika*, (Cambridge: Cambridge University Press, 1979),4

[522]Acemoglu, Daron, Simon Johnson and James A, Robison,"The Colonial Origins of Comparative Development: An Empirical Investigation," *The American Economic Review* 91(5), (2001),1369-1401.See also, Boone, Catherine, *Political Topographies of the African State*,(Cambridge: Cambridge University Press, 2003)

difficulties.[523] It was because of this, prior the 1950s, the British colonial government left the bulk of the healthcare of the colonial subjects in Ibadan to the missionaries who pioneered Western obstetrics from the 1920s – over three decades to this period as I have examined in the third chapter of this thesis.[524]

The colonial state has invariably blamed its inability to provide maternal healthcare services and the underdevelopment of maternal healthcare in rural Ibadan on the shortage of professional medical officers, financial stringencies, and administrative inadequacies.[525] The identification of these problems has been accepted by the colonial government as the most rational and realistic explanation for the exclusionary maternal health care policies in Ibadan and the marginalization of rural Ibadan. There is no denying the fact that these reasons are important factors to be considered, especially in explaining and propagating colonial policies vis-à-vis the underdevelopment of maternal healthcare in rural Ibadan or its disparities with the urban areas of Ibadan.

However, it is important to state here, that the overzealousness of the colonial state to abolish the African traditional medical practices in the 1920s in Ibadan almost made the practice extinct in the rural areas and at the mercy of western maternal healthcare policies that hardly included the rural areas in its implementation plans. It portrayed the colonial government as one to be in complete control of the maternal and infant mortality crisis. Unfortunately, and with the turn of events, this proved not to be the case, as the colonial government was only able to execute its maternal healthcare policies in the urban centers. Consequently, rural Africans became

[523]NAI, Annual Reports Western Provinces: Building and Town Planning, 1948,195.
[524]See the Chapter three of this thesis for more information on maternal health and the medical missions in Ibadan.
[525] NAI, Annual Reports Western Provinces: Building and Town Planning, 1948,196.

automatically marginalized and excluded from colonial maternal health policies. Rather than become plaint victims of the colonial state, the rural communities expressed their displeasure through the subtle presence of social struggles as we would see in the next section.

In the rural areas where the colonial government was unable to provide maternal healthcare services, the locals continued with the African traditional birthing practices and it grew stronger in the rural communities. The limited popularity of colonial medical care in the rural area was not only due to the dilemma attached to maternal healthcare provisions. The locals in rural Ibadan preferentially opt for the traditional birthing practices because it was readily available. The traditional birthing practice in rural Ibadan involves a couple of phases. These phases includes; the period of confinement of the pregnant woman, administering of herbal concoctions, incantations and the final delivery of the baby. For instance, when the period of birthing the child is near, the pregnant woman is expected to be kept in confinement.[526] At the confinement, a medicinal bath water which is made by boiling certain herbs and barks of certain trees prescribed by the traditional midwife in a large earthen pot for several days which is used in bathing by the pregnant woman.[527] Immediately the pregnant woman goes into labor and starts having contractions, the traditional midwife usually an old woman) is summoned. The midwife comes with two or more elderly medicine men to run errands or fetch certain ingredients needed in the delivery process. The traditional midwife prepares all that is needed for the delivery, stays in front of the pregnant woman in labor and recites some incantations.[528] Amongst these incantations includes these words;

[526] Interview, "Abiloye Titilope"
[527] Interview, AbiloyeTitilope; Oripeloye Christiana, A patient who was delivered of two of children by a traditional midwife, Aged 62, (Sango, July 17, 2021); Jago Damilare, The husband of a patient who was delivered of a child by a traditional midwife, Aged 55, (Elewure, July 17, 2021).
[528] ibid

A kiigbebiewure,
A kiigbebiaguntan
Biewurebaloyun, a bi were;
Biaguntanbaloyun a bi were;
Iwo (mentions the name of the woman in labor), Oyunti o yunyi, were niko bi!

In English, the incantation reads as follows;

Sheep have no midwives,
Goats have no midwives,
When a sheep is pregnant, she is safely delivered,
When goat is pregnant, she is safely delivered,
You…in this state of your pregnancy will be safely delivered.[529]

After these incantations, the pregnant woman in labor and everyone present in the room looks straight at the face of the midwife and says, 'so is it!'This phase is known as the first stage of the delivery process called the "spiritual concentration."[530] After this stage, the pregnant woman still in the early period of contractions is led away by the midwife into a bathroom usually a short distance from her confinement room, stripped and bathed in the medicinal water. On their return to the room, the woman is wrapped in a piece of light clothe (usually white in color), and the next phase is to wait for the membrane to rupture. This could take hours or a day.[531] When the membrane eventually ruptures and the birth of the child is deemed to be nigh, the midwife and her assistant's takes positions on a mat prepared with medicine where two cushion are placed, and the woman now completely stripped naked is asked to kneel on the two cushions knees far apart. The midwife sits behind her on a stool, holds her up by clasping her under the arms. The woman is now urged to make forceful bearing-down efforts. Once again, the midwife repeats the incantations made at the earlier stage after chewing on some medicinal roots. As the child

[529] ibid
[530]Interview, "Jago Damilare".
[531]Interview, "Abiloye Titilope".

emerges, the woman is largely congratulated. The last phase is to wait for the emergence of the placenta or after-birth.[532]Thus, the practice the colonial state termed as "unhygienic" and "injurious" to mother and child, an obstacle to population growth and economic development via western obstetrics, could easily be translated by the rural folks as the only reliable and viable form of medicine against the propaganda of western biomedicine by the colonial state.

Colonial maternal healthcare policies that discouraged the African traditional midwifery practices but without offering the people a viable alternative contributed to the increasing number of maternal and infant mortality in the rural areas. Hospital based midwifery and modern midwifery practices encouraged by the colonial state, have only served to marginalize folks in rural Ibadan from benefiting from the same system those in the urban areas are benefiting from. Most of the maternal welfare schemes that have been set up since the 1920s in Ibadan do not benefit the people in the rural areas, not until the 1950s, when rural health reforms was made by the colonial state.

Before the 1950s, and irrespective of the neglect of the rural people on maternal healthcare service provisions, the medical missions have occasionally visited the people in the rural areas in order to cushion some of the effects of the colonial healthcare neglects. However, maternal healthcare, the second specialized and most popular medical service of the medical mission in Ibadan, could only achieve little success in the rural areas in terms of healthcare facilities, staffing, and service delivery.[533] Thus, by the 1950s, the medical missions have started asking for grants to service the maternal healthcare needs of the colonial subjects in the rural areas of Ibadan. This was because, towards the end of the 1940s and early 1950s, the people in the rural

[532] ibid
[533]NAI, File No: Oyo Prof 1/1, Village Maternity and Welfare Centres, 1942,409.

areas had started mounting pressure for the expansion of medical facilities on not just the colonial government, but also on the missions who were the major providers of medical services in Ibadan.[534]It is important to note that the missionaries at home were at this time also struggling financially to support the medical missions abroad especially after World War 2 due to the economic recession.[535] Hence, the inability of the missions to support the health needs of the Ibadan people substantially at the time. Therefore, mission's request for financial aid from the colonial government to support their maternal healthcare works contributed to the change in the attitude of the colonial government who were also under immense pressure from their home government to increase service delivery in colonial territories so as to sustain the image of the colonial government as a progressive enterprise.[536]This period coincides with the time when emphasis was made for more socio-economic and human investments in the British colonies.[537] Readings in the colonial archives also shed light on debates of colonial medical officers over the underfunding of dispensaries in the rural areas of Ibadan, and reiterating the opinions of the rural people in Ibadan about the long distances they had to cover to access the health facilities in the urban centre.[538]Alexander, McGregor and Rangers have described this period as a period marked with indigenous Africans continually voicing their opinions to colonial policies..[539] In the case of the people in rural Ibadan, it was a voiced opinion over their marginalization in the delivery of medical and maternal health policies and services by the colonial government.

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[534]NAI,the *Southern Nigeria Defender*, "Editorial Comments", 20, 21,24,25,28 January; 26 November; 27 December 1944, all page 2. These demand more hospitals, improvement of medical facilities and complain of understaffing and the condition of rural health centres among other issues.
[535]Vaughan. Curing Their Ills,56
[536]John. C. Mitcham, The Second Colonial Occupation: Development Planning, Agriculture, and the Legacies of British Rule in Nigeria, *Agricultural History* 93 (2), (2019), 369 – 371.
[537]ibid
[538]NAI, File No: CSO 26/2, 15216, Traveling Medical Officer and Native Administration Dispensaries, Vol. IV, 1930,7.
[539]Jocelyn Alexander, Joanne McGregor, and Terence Ranger, *Violence and Memorty: One Hundred Years in the "Dark Forests" of Matabeleland*,(Portsmouth N.H.: Heinemann, 2000),99.

In response to these developments, the colonial government in a 20th September 1946 archival document titled, "Development Plan Estimates 1947 – 4, Head 47 – Colonial Development and Welfare Scheme" indicated its interest to include and advance the establishment of Rural Health Centre in the Development Programme. This is mainly because of the considerable amount of domiciliary maternity work in outlying areas, which calls for supervision and development.[541]This domiciliary maternity work was a major concern for the colonial government (and the missions). This concern was probably influenced by the lack of standard rural healthcare and maternity services in the rural communities. This thus encouraged domiciliary maternity services and midwifery as the best and only available means of ensuring safe delivery and birthing practices at the time.[541] The system of domiciliary midwifery during this period involved the use of trained midwives (as opposed to untrained midwives) in home deliveries, with close supervision from professional medical officials. Domiciliary maternity services were initially conceived as core a components of the indigenous medical practice and knowledge system.[542] During the late 1940s, Leeming, suggested, as an alternative healthcare service given the paucity of health facilities, domiciliary maternity service, and it became a central feature of the maternal healthcare debate especially in the rural areas.[543]Leeming believes that Domiciliary Midwifery was the best for the (rural) Ibadan people given the soaring population and urgency of the matter of maternal and infant mortality. She argued that Maternity centers cater for the greatest good of the smallest number, whereas, domiciliary midwifery will cater for the greatest good of the greatest numbers.[544] The preposition of Leeming did not see the light of day, because, at the time, there were only Grade II midwives to carry out the project, and

[541] NAI, Medical Health Services Estimates Special Warrants and Expenditure Authorizations 1947/48, 1.
[541]NAI, File No:IbaDiv1/1, Ibadan (Provincial) District Council: Antenatal Clinics, Domiciliary Midwifery, 1956, 194.
[542]NAI, File No: IbaDiv 1/1, Health Rural Development and Social Welfare Sub-committee, 7th June, 1956,20.
[543] NAI, Annual Reports Medical and Health Department, 8th April, 1940,196.
[544] NAI, File No: 382/22/11, Health Rural Development and Social Welfare Minutes of 1956,23.

such midwives required close supervision to ensure efficiency. Unfortunately, these midwives were quite unsuitable for working on their own or in a patient's home where they could not be supervised effectively.[545] In the stead of domiciliary midwifery, rural maternity homes were suggested - where Grade II midwives can be deployed to and could be visited regularly by a midwifery sister.[546]

Colonial health officers writing in the 1950s believed that if the government wished to achieve immediate results of getting pregnant women who could not be accommodated at the Adeoyo Hospital in the Ibadan urban centre, that it was best to provide alternative facilities in the rural areas.[547] Some of these medical officers like Dr. Lawson suggested that it would be best to establish Maternity homes for Antenatal care and delivery in the first instance, and the development of a domiciliary service from such maternity homes could follow.[548] Dr. Lawson believed better-trained Grade I midwives would ultimately become available to be employed under less supervision. Arriving at this conclusion, provision was made for a Maternity Centre under the Rural Healthcare plan by the Regional Government.[549] Indeed, the inclusion of the establishment of a maternity centre in the Rural Healthcare plan of the Regional Government best explains the concern of the Medical Officer of Health, Ibadan,- Dr. H. W. Woolner about the efficiency of the Grade I midwives available if domiciliary midwifery were to be preferred to Maternity Centre's.[550]

[545]Ibid,22.
[546] NAI, File No: 382/22/11, Health Rural Development and Social Welfare Minutes of 1956,20.
[547] ibid
[548] ibid
[549] Ibid, 27
[550] ibid

Other information about the introduction of rural healthcare in the margins of Ibadan includes proposals about the development of medical and health services in Nigeria.[551] The information in this proposal gives insight into the people and their increasing demand for medical services. Concern for healthcare services not directly related to the urban centre began to come up from the 1950s – a period that coincides with the peak of nationalist movements in Nigeria.[552] This period helps unearth the nature of the involvement of the colonial government in rural healthcare, and response to maternal welfare. For instance, the proposal accounted for a small Government Medical Service, supplemented by voluntary bodies and a few private practitioners in the bigger cities.[553] Like the colonial medical officers in Ibadan, the proposal desires the development of local medical services for ten years. The local medical service will only be a modest framework, which the population should be capable of developing gradually into something more approaching the real needs of the country.[554] Although the missionaries pioneered the introduction of Western medicine and rural healthcare in Ibadan, this period saw the involvement of the colonial government in rural and maternal healthcare.

Deconstructing the Colonial Policies on Maternal Health in Rural Ibadan

Archival documents on the introduction of rural healthcare provide a glimpse into the politics of Western medicine and maternal healthcare in the rural areas of Ibadan. They also highlight the debate over the credibility of the colonial government in promoting "modern" maternal healthcare practices. In the late 1940s and early 1950s, the colonial government proposed to establish rural health centers. This was in paper, to consolidate the work of the medical missions, to respond to the pressure from the rural folks seeking better healthcare and also to reduce the

[551] NAI, File No: 43693/S.3, Development of Health Services: Revision 10 Year Plan, August 1945, 11B.
[552]Ikime, O. *History, the Historian and the Nation: The Voice of a Nigerian Historian*,(Ibadan: HEBN Publishers Plc) 178, 197. See also; Coleman, J. S. *Nigeria: Background to Nationalism* (Chicago: Chicago University Press, 1958).
[553]ibid
[554] ibid

alarming rate of diseases due to the mass treatment of patients in urban maternity hospitals and clinics, and generally, to assist in preventive medicine amongst the rural population.[555] The government proposed to set up a total of twenty-one centers of a type that has proved to be of practical value in other African countries. In this proposed rural health, it is expected, that the staff will undertake the direction of a circle of improved Native Authorities' dispensaries, and the supervision of practicing midwives, maternity homes, home visiting, and nursing, and the development of health consciousness through education and propaganda.[556] The colonial government set out objectives for the establishment of one or more first-class hospitals in each province of Nigeria.[557] These hospitals were expected to serve the African population in the towns in which they are situated and take in more serious and obscure cases from smaller rural hospitals in outlying areas. The latter in turn will draw their patients from circuits of village dispensaries supervised by medical officers in charge of the sub-areas.[558] The target for this plan was that healthcare would have gotten to the rural population by the end of the ten years development plan. Expenditure for this plan is expected to cover not only general hospital works but also maternity hospitals and maternity services.[559]

The government's Rural Healthcare and the Ten-year Development Plan for the rural communities were well received by the people, especially concerning rural maternal healthcare. Apparently, and disappointingly, the Rural Healthcare and the Ten-year Development Plan scheme for the rural communities were just a cosmetic move by the colonial government towards addressing the issues of rural healthcare. As time went by, and the wait continued with no visible

[555]NAI, File No: 43693/S.3, Development of Health Services (Revision 10 Year Plan). C.D.W.A. Scheme: 1949,14
[556] ibid
[557] Ibid, 12
[558] Ibid, 13
[559] ibid

rural maternity project insight, there were certain amounts of criticism in the local press about the inability of the colonial government to implement its plans to meet up the needs of the people in rural Ibadan.[560] The editor of the Sunday Times speaking on behalf of the rural communities decried the inadequate maternal services in the margins. He believed the colonial government only gave lip service to the plight of the people and has failed to heed the advice to build more Clinics and Maternity Homes since 1951.[561] He accused the government of doing absolutely nothing, hence the congestion at the Adeoyo Hospital. The editor stated that the solution to the present congestion at the Adeoyo Hospital in the Ibadan Township as the people could not wait for the completion of new buildings, which are only being proposed, is to hire well-furnished buildings for temporary use until the new buildings are completed. It also suggested that a sum of ten pounds be paid to patients for antenatal treatment and another sum of one hundred and seven pounds be paid at delivery.[562] The solution, the critics continued, "will help to increase the revenue of the government, and will also help defray the cost of paying the salaries of staff attached to these Clinics." For complicated cases, patients can be rushed to the Adeoyo Hospital.[563]

For the critics in the local newspapers, the colonial government's development plans into the expansion of healthcare services were not grounded in the realities and the immediate need of the teeming population in the margins giving the congestions in the hospitals in the Township. "The facts which have emerged from a week-long investigation within the medical institutions point to one fact – the Federal Government is dithering, to the peril of the taxpayers and the patients, on

[560] NAI, File No: 1221, Ibadan District Council Hospital Adeoyo, Extracted from The Southern Nigeria Defender, 9 May, 1956,181
[561] ibid
[562] ibid
[563] ibid

the all-important question of improving these hospitals."[564] The critics created an interesting intersection between rural maternal healthcare and the continuous congestion in the urban Maternity Clinics and Hospitals in projecting the negative implication in the politics of the colonial government: "The problem of congestion remains unsolved. Last week, I saw two expectant mothers sharing a bed there while many out-patients complained to me that they could not get the drugs prescribed for them at the General Hospital because they were not available."[565]

Another editorial of 9 May 1956 argued that the colonial government is "…Responsible for Present Hardship of Mothers."[566] The columnist, E. A. Leeming, a European Nursing Sister, of the Antenatal Clinic, Adeoyo Hospital, and the *Iya-Abiye* of Ibadan, believed the situation of maternal health in both urban and rural Ibadan could not wait the completion of new buildings, which are only being proposed. She revealed the politics of the colonial government by highlighting its irresponsive character to the plight of the people after been advised to build more Clinics and Maternity Homes since 1951, but failed to heed this advice and did absolutely nothing.[567]Leeming while giving her voice to the rural maternal healthcare situation suggested that, the government looks into domiciliary midwifery, as an alternative to the congestions in the Adeoyo hospital. This will be pending when the proposed new maternity hospitals and clinics will be built and completed. This she said will help reduce the current maternal and infant mortality in the rural communities, give expectant mothers a chance to good home delivery, reduce the complications from travelling long distances to urban centers for antenatal, delivery, and postnatal care, and put to use trained African midwives who just graduated from the Nursing

[564]NAI, *Sunday Time*s, May 12, 1957,7.
[565] ibid
[566]NAI, *Southern Nigeria Defender* 1956,8.
[567] ibid

and Midwifery schools. She continued that, for cases with complications, patients could be rushed to Adeoyo Hospital.[568]

The critics in the local newspapers revealed the politics of the colonial government, who had flagged rural health care and medical development plans respectively, to alleviate the maternal healthcare crisis in the margins.[569] According to archival documents, the colonial government "was responsible for deciding Maternity Hospitals to be built and how it should be run."[570] These documents have highlighted the relationship between the colonial government and the missionaries who helped provide healthcare services in the margins during this period.[571] They have also established the involvement of the government in the spread of Western midwifery practices in urban Ibadan.[572] However, the politics of rural maternal healthcare, a significant aspect of the government's rural health scheme in the 1950s reveals the "true intent" of the colonial government in the margins.

The colonial government and its plan for rural healthcare development did not see the urgency in the healthcare needs of the people in the margins of Ibadan if not for the criticism it got. As the content of the correspondence sent by the Director of the Department of Medical Services of Nigeria to the Chief Secretary to the Government in Lagos on the 23rd of December, 1946, reveals, that during his tour in the Southern Provinces and after discussion with Residents and other Officers in that area, he found it most advisable to make several adjustments to the programs of

[568] NAI, File No: IbaDiv 1/1, 3374, Health Rural Development and Social Welfare Committee, 16th May, 1956,34
[569]NAI, File No:43693/S.3, Development of Health Services (Revision 10 Year Plan). C.D.W.A. Scheme: 1949,14
[570] NAI, Scheme "A" Midwifery Service, Ibadan, 23 October 1949,52A – 52E.
[571]NAI, File No:Oyo Prof 1/1, Extension of Medical Service by Direction, Control and Subsidy of Medical Missions Vol. III.
[572] NAI, Statement of Policy Proposed by the Government for the Future Regulations of Grants in Aid of the Medical and Health Services Provided by Voluntary Agencies in Nigeria, 3rd April, 1950.

building priorities in so far it concerns the construction of new hospitals and extension of existing establishments and accelerated development of public health services in the Development plan.[573] As it turned out, rural maternal healthcare was appropriated by the colonial government to register its political relevance in a society struggling for proper healthcare provisions. The colonial government was not just using the rural health provisions and the development plan to pan out its politics, but deferring the extension of existing hospital establishment and promotion of preventive health measures originally planned to be constructed in three financial years beginning from 1948.[574] Although it is difficult to measure the height of the politics of the colonial government on rural maternal healthcare, the timely implementation of the rural health scheme and development plan would have been well received among colonial subjects in need of maternal healthcare in the margins of Ibadan.

Conclusion

The increased rural maternal health crisis, which was sparked off by the neglect and marginalization of the combined forces of missionaries and the colonial government in the margins of Ibadan, remained unabated even up till the late 1950s. It is part of the history of the development of Western obstetrics, from virtually, being a Western biomedical practice to becoming a medical practice in colonial Ibadan. Through this development, Western midwifery and midwifery practices extended their influences far beyond the boundaries of their origins. However, the rural Ibadan experience of these changes, as has been explored in this chapter, was one of neglect and marginalization. This chapter firstly has established that the inability of the missionaries and colonial government to provide if not the same but a reasonable level of maternal healthcare services available in urban Ibadan determine the dilemma of Western

[573] NAI, Medical and Health Services (Development) Estimates: 1947/1948, P. 17
[574] ibid

obstetrics in the rural communities of Ibadan. These realities are revealed in the rate and manner by which colonial subjects in the rural communities reacted to this administrative negligence. Through these realities, this chapter has revealed the true intentions of the colonial government despite its clandestine efforts of introducing Rural Healthcare Services. The greatest challenge of maternal health in rural communities is the politics employed by the colonial government. Rural healthcare was poorly funded. Lack of funds, health personnel, and the lack of maternity hospitals and clinics negatively affected the development of Western obstetrics in rural areas of Ibadan.

It is quite disheartening that the colonial government as analyzed in this chapter proposed and established Rural Health Centre's that were in precarious conditions. These established Rural Health Centre's were debilitated and does not have the necessary equipment and health personnel to make the centers standard. Hence, the colonial subjects in the rural communities were still faced with the challenge of travelling long distances to patronize maternity clinics and hospitals in the township. Critics concerned with the maternal health situation of the rural communities have not only challenged but also revealed the true intentions of the colonial government. However, despite the 'efforts' by the colonial government to remedy the situation, Maternal Healthcare in Rural Ibadan remained the same during the colonial period.

CHAPTER SEVEN

CONCLUSION

In the light of the foregoing analysis on "the social history of midwifery practices in colonial Ibadan, Nigeria, 1893 to 1960," made through a survey of some crucial themes, it is necessary to now attempt a conclusion.

In this thesis, I have examined the ways in which the Christian missionaries and the British colonial government introduced and implemented western ideas of midwifery in colonial Ibadan and its peripheries from the 1893 to 1960. In order to present the specificities of the missionaries and the government's agenda on midwifery practice, I analyzed the different venues through which the practice of midwifery was subjected to medical and institutional scrutiny as a vital aspect of the missionaries and the British colonial government's search for solutions to producing a healthy population – and by extension, promoting the Christian faith, good supply of human resources, establishing social control, and augmenting political hegemony. In this regard, I looked at the perceptions of the missionaries and the colonial government on the health and health practices of Africans, and how these perceptions informed the justification for the institutionalization of western midwifery practices in colonial Ibadan.

As a background to the thesis, in the chapter two, I provided the historical background to the introduction of western medicine and healthcare system in Ibadan from the 1890s to 1930s. Here I traced the emergency of and development of the western healthcare system in sync with infant and maternal mortality in colonial Ibadan. I detailed the perceptions of the missionaries and colonial medical officials on African health and healthcare practices and notes the justification for the introduction of western healthcare practice in the British colony of Ibadan. Indeed, the

involvement of the colonial government on maternal and infant welfare was a well-calculated political ploy to sustain the colonial economy as evidenced in the partnership of the colonial government with voluntary agencies, specifically the missions, to help advance the plans of the colonial office. Thus, I argued, the symbiotic relationship between the missionaries and the colonial government that led to the establishment of various maternity facilities and how it resulted in the patronage of these facilities by the locals. This relationship between the colonial government and the missionaries as I have argued led to the establishments of several maternal healthcare facilities, and the training of Africans as midwives.

In the ensuing chapter, I explored the contributions of medical missionaries to the development of maternal and infant healthcare and midwifery practices in colonial Ibadan from the 1920s through the 1950s. In this period, I examined deeply, the perceptions of the different mission on the African traditional birthing practices and how it influenced their roles and functions in the provision of infant and maternal healthcare in colonial Ibadan. I further argued that although the missionaries in Ibadan as in elsewhere in Africa were faced with financial challenges and human resources, they nonetheless overcame these challenges in their bid to reconstructing maternal health and midwifery practices through their partnership with the colonial government who funded missionary maternal healthcare projects through the government grants in aid scheme.

The next step in the campaign of reconstructing Africans midwifery practices in colonial Ibadan was to educate and train Africans in the art and science of western obstetrics. In the fourth chapter, I explored how the medical missions began the training of African nurses and midwives from the mid-1930s. The idea behind the training of Africans as midwives was that, once Africans were educated in western obstetrics, they would become agents perfectly conditioned to propagate the western ideas of midwifery. This, the missions and colonial government were able

to achieve, as trained African midwives in colonial Ibadan, as at the completion of their training, were assigned to missions' maternity clinics and dispensaries where their task included attending to infant and maternal cases, proper food preparation, and the teaching of the basic principles of hygiene and sanitation to the natives. The trained African midwives performed these task so effectively that by the 1940s, they became so popular amongst their people, helped promote Western obstetrics and became indispensable in maintaining missions' standard on maternal and infant welfare.

As this thesis has demonstrated, the missions' self-conscious objective of eradicating the high mortality and morbidity rate that predated the 1920s in Africa influenced their training of Africans in Ibadan. By training Africans, the missions ensured that western biomedicine was understood through a deliberate, systematized and organized effort by influencing the knowledge and practice of maternal and infant healthcare. For the medical missions, the process of training Africans and the functionality of the midwifery services offered would highlight the medical missions as successful in the field of maternal healthcare. Arguably, the concerns of the medical missions on maternal health that shaped their diverse agendas made it an unusually good fit in their achievements on improving maternal healthcare.

As has earlier been mentioned, trained African midwives became popular amongst the natives. In the chapter four of this thesis, I have showed a valuable uptrend increase in the careers, services and practice of trained Africans in western obstetrics from the 1940s through the 1960s. Beginning from the 1940s, African midwives had replaced European nurses and midwives, and had become the main providers of maternal and infant healthcare services amongst the African population in colonial Ibadan. Due to the emergence of the trained African midwives, missions and colonial midwives gradually retreated to the position of supervisors rather than healthcare

providers. The highlight of this chapter is in demonstrating how in the early careers and practice of midwifery by African midwives, they followed the legacy of the missionaries by continuing the process of educating African women on the western model of midwifery and providing women with maternal and infant knowledge whenever they had the opportunity. It is within this context, trained African midwives in Ibadan, became the face of western midwifery - as well as instructors of western hygiene, care givers to infant and pregnant women, educators to mothers and traditional birth attendants - *Iya-Abiye's*. It is undeniable however, that the successful development and wide spread acceptability of western obstetrics in Ibadan was based on the relationship that existed between the African trained midwives and the traditional birth attendants - the *Iya-Abiye's*. This relationship was however possible because of the reorientation programme initiated by the colonial government for the training of traditional midwives by trained African midwives on maternal healthcare.

In the fifth chapter of this thesis, I attempted an analysis showing the responses of the people of Ibadan to the development of western biomedicine. Here, I showed how despite the acceptance of western obstetrics by the people through seeking solutions to reproductive crisis by patronizing missionary and government maternity hospitals, clinics and dispensaries, they were also reactionary to unprofessional and sub-standard midwifery services offered to them during this period. The trajectory of the Ibadan (Provisional) District Council as an elite body which stood as intermediary between the people of colonial Ibadan and the colonial government to manage the maternal health complaints of the Ibadan people, combined with the IPDC's interest for the development of the maternal healthcare services helped bring this narrative to life. The activities of the IPDC proffer an in-depth understanding of Africans exceptional insight into the politics of health and healing. The IPDC also provides an appealing local example of the

enormous role played by African agencies as against the patient in health and healing as suggested by some scholars. The events in this particular chapter, has offered a contextually sensitive framework within which to evaluate the quick manner colonial medical administrators and medical officers' responds to the agitations of the Ibadan people through the IPDC as against the patient. As shown in the analysis of this chapter, the IPDC was able to facilitate the maternal health interest of the Ibadan people since its inauguration. Clearly, from the Ibadan experience, a common front is more likely to influence health policies than taking a lone stance. What is more, is that with the IPDC, between the 1940s and 1960, the Ibadan people were able have representatives influencing administrative decisions in the colonial medical advisory board where policies on maternal health were debated. As part of the board, they could call or condemn maternal welfare initiatives before it becomes law. Furthermore, they could openly criticize colonial medical administration and medical officers for principally not living up to the standard of modern maternal healthcare practice and services. In a nutshell, this chapter demonstrates the highly organized way the African population in Ibadan achieved their interest on maternal healthcare. This also goes further to help us understand the kind of politics ongoing within the local space as regards health and healing.

In the sixth chapter, I took a detour by specifically looking into the colonial maternal healthcare experiences of the locales in the margins of Ibadan as against the urban areas. From my findings, I was able to bring to light the intense exclusionary policies of the colonial government and the marginalization of the locales as far back when western obstetrics was introduced in colonial Ibadan. Here, I suggested that, the increased rural maternal and infant mortality in colonial Ibadan was sparked off by the intense neglect and marginalization of the locales by the combined forces of the missionaries and the colonial government who only focused the building of

maternity hospitals, clinics and dispensaries in the urban areas of Ibadan from the period western obstetrics was introduced in colonial Ibadan, up till the late 1950s. This chapter firstly, established that the dilemma of Western obstetrics in the rural communities of Ibadan is determined by the inability of the missionaries and colonial government to provide equal maternal healthcare services to the locals. This reality is revealed in the rate and manner through which colonial subjects in the rural communities reacted to this administrative negligence. It further revealed the true intentions of the colonial government despite its clandestine efforts of introducing Rural Healthcare Services in the late 1950s.

Aside the obviously increased maternal and infant mortality rates in the margins of Ibadan, the greatest challenge of maternal health in the rural communities was the politics employed by the colonial government. It is sad to say the least that the colonial government as analyzed in this chapter proposed and established Rural Health Centre's that were in precarious conditions. Not only were these rural healthcare centers poorly funded, they lacked the presence of professional midwives and health staff. These established Rural Health Centers were debilitated and does not have the necessary equipment to make the centers standard; that the colonial subjects in the rural communities were still faced with the challenge of travelling long distances to patronize maternity clinics and hospitals in the township. As this thesis suggest, the maternal health situation of the rural communities in colonial Ibadan have not only challenged colonial medical and administrative policies, it has also revealed the true intentions of the colonial government in providing welfare packages to the people in the margins. This is evidenced in the maternal healthcare crisis in the margins of Ibadan even until the end of colonial rule.

In conclusion, this thesis brings to light a subject matter of historical importance by offering and investigating a topic that has remained almost unexamined. By seeking to unearth the experiences of the Ibadan people who did not only experienced a new form of health and healing practices, but also contributed actively in its development, this thesis connects with scholarship that has situated Africans as active participants in the making of their history and not the generally perceived notion that Africans were dormant and passive onlookers in historical events. By analyzing the missionaries and colonial governments attempt at colonizing maternal and infant health through western midwifery practices as a historical process of negotiations and contestations, this thesis disrupts extant literature that tends to position colonial rule only as colonial oppressions versus anti-colonial resistance. This study considers the fact that western midwifery practice was both a contested and negotiated terrain, as well as a hybridization of both western and African traditional medical practice. As has been argued by others, colonial government's achievements on maternal and infant healthcare took place on the heels of compromise, which indicates that midwifery practice, after all, was not an easy site of intervention.

In using midwifery as a category of historical analysis, this thesis further opens the possibilities of historicizing African voices. By offering and discussing the different ways the people of Ibadan participated in a historical event and asserted their own agency, and by examining the experiences of Africans who became trained midwives, patronized colonial maternity hospitals, clinics and dispensaries, and traditional midwives who were incorporated into the health system, this thesis further disrupts elitist representation from the center of African historical discourses. In addition, this thesis connects the pragmatic frameworks of empire and colony so that the

histories of Africans would not be lost in historical narratives. In the end, while the introduction and institutionalization of midwifery practices afforded the British colonial government a degree of access and control to the socio-cultural and economic spaces in colonial Ibadan, the Ibadan people, by asserting their own agency in the colonial encounter, became the ultimate beneficiaries of the medical measures and developments the colonizers introduced through midwifery.

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