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MISSIONS AND THE RISE OF THE WESTERN MATERNITY AMONG THE IGBO OF SOUTH-EASTERN NIGERIA

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MISSIONS AND THE RISE OF THE WESTERN MATERNITY AMONG THE IGBO OF SOUTH-EASTERN NIGERIA

By

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Report

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To the loving memory of my mother, Helen Ezekwem

Acknowledgements

When I visited Nigeria for research in the summer of 2013, my topic was barely defined. Enthusiastically, I went to the archives and collected documents broadly related to my subject - anything on medicine in Nigeria. By the time I returned to Austin and sorted my materials, it was clear that I needed a lot more work to be able to make sense of them, at least in the direction that I wanted. Since my research interests included the Nigerian civil war, I was tempted to write a Report on an aspect of that topic, and, therefore, shy away from my incomplete documents. Two individuals prevailed on me to face what I considered a challenge and make sense of the materials that I had collected. It is to them that I now turn.

My sincere gratitude goes to Henry Brands, who encouraged me to step into the unknown and take on this project, despite my concerns about my sources. The regular brainstorming sessions that I had with him, in which he asked questions that pushed me to think, helped me define my focus. He also read and shared his thoughts on every component of this project and brought to my attention things that I would, otherwise, overlook. I also appreciate the support of Toyin Falola, whom I refer to as the "brain store." From the time that I developed my research topic, he punched holes through every aspect of that topic, helping me to form a clearer idea of my research. I am grateful for the intellectual support.

I also thank the Department of History, University of Texas at Austin for the financial provision that I received up to this point in my graduate career. To Jacqueline

Jones, I am thankful for her encouragement and kind consideration. This research may have been unbearable without her assistance. I especially thank my friend and colleague, Cacee Hoyer, for being there from the very beginning and readily offering me commentaries. I appreciate Chukwuma Opata of the Department of History, University of Nigeria, Nsukka, for his assistance during my research at the University of Nigeria. To other colleagues who contributed to the success of my project in one way or another, I am truly grateful.

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The University of Texas at Austin, 2014

SUPERVISOR: Toyin Falola

This project examines midwifery in the pre-colonial setting, the nature of Christian missionary activities in Southeastern Nigeria, the colonial process of erecting the maternity, and the collaborations between traditional and Western midwives. The colonial history of Nigeria can be traced to 1885 when British claims to a West African sphere of influence received international recognition. However it was not until 1900, following the British government's acquisition of the Royal Niger Company's territories, that Nigeria was officially considered a British colony. Nonetheless, the groundwork of colonial rule in Southeastern Nigeria predated these eras and is attributed to the establishment of the London-based Church Missionary Society (CMS) at Onitsha in 1857, followed by the Roman Catholic Missions (RCM) in 1885. The rivalry that ensued between them led to the development of a medical mission and the launching of the Western maternity in Southeastern Nigeria, undermining traditional childbirth practices, and providing new forms of training and facilities for a new class of midwives.

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Chapter 1: Introduction

The Igbo people are one of the three major ethnic groups in Nigeria. They occupy part of Southern Nigeria and are surrounded by other ethnic minorities in the Southwest.[1]However, the Southeast comprises solely of Igbo communities and includes the Igbo-speaking states of Anambra, Abia, Ebonyi, Enugu and Imo. It is in this sense that the essay applies the word "Igbo land."

In contrast to other pre-colonial states in Nigeria and West Africa, pre-colonial Igbo land embodied a propensity for autonomy and was merely a collection of autonomous local units with no central authority beyond that of the village group. Though the peoples shared similar culture and language, it was not until the twentieth century that "Igbo land" emerged as an ethnic and administrative unit, with definite boundaries.[2]

The Igbo hinterland remained inaccessible to Europeans until the mid-19th century, following the discovery of the lower Niger River's course. Prior to this time, information about the peoples was obtained from accounts by the coastal inhabitants of the Niger Delta, who had a long history of contact with European traders dating back to the 17th century.[3] Missionary presence did not begin until 1857, with the establishment of

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[1] Percy Amaury Talbot, *The Peoples of Southern Nigeria: A Sketch of their History, Ethnology and Language with an abstract of the 1921 Census, Vol. 4*. London: Oxford University Press, 1926, 40-41.
[2] Axel Harneit-Seivers, *Constructions of Belonging: Igbo Communities and the Nigerian State in the Twentieth Century*, New York: University of Rochester Press, 2006, 16.
[3] Elizabeth Isichie, *The Ibo People and the Europeans*, London: Faber and Faber Limited, 1970, 18.

the Church Missionary Society (CMS) of the Anglican Communion and the Roman Catholic Mission in 1885.[4] Other smaller missions like the Presbyterians and the Methodists joined the field at a later period.

From the beginning, missionary enterprise in Southeastern Nigeria was a joint venture of missionaries, merchants, and colonialists. The earlier attempt by the CMS to penetrate Igbo land through the ill-fated Niger expedition of 1841 was inspired by the idea that the best way to stop the slave trade and establish Legitimate Commerce was by introducing commerce, civilization, and Christianity, in other words, the "Bible and the Plough."[5]

Realizing the need for communication during evangelism, mission schools were established not only to instruct the people in the English language but also to promote moral instruction and evangelical work. As a result of their preconceived scorn for indigenous African religions and customs, missionaries mounted campaigns against traditional medical practices. Christian converts were barred from consulting traditional healers. However, medical institutions were not established to any significant degree until the CMS and the Roman Catholic Mission commenced intense rivalry, in which medicine and medical supplies became a major tool for gaining leverage. This rivalry also spurred the development of maternities across Igbo land, though the number of maternities remained insufficient up to Nigeria's independence in 1960.

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[4] Harneit-Seivers, *Construction of Belongings*, 92; F. K. Ekechi, *Missionary Enterprise and Rivalry in Igboland 1857-1914*, London: Frank Cass, 1971, 4.
[5] Thomas Fowell Buxton, *The African Slave Trade and its Remedy*, London,1839. Reprinted London: Frank Cass, 1967, 306, 308-334.

The maternity was a distinct branch of colonial medicine first introduced by Christian missionaries. It was established in place of the maternal and childcare services of traditional midwives. Maternities also served as training centers for midwives. In the early part of the colonial era, they were instituted and overseen by Christian missions until the 1940s when the colonial administration took up healthcare as a core component of its colonial policy. Maternities existed in two forms: on the one hand, they were separate institutions, and on the other, they were attached to existing hospitals.

From the inception of missionary work among the Igbo, traditional institutions were regarded as barbarous and sinful. As such, they received little recognition by missionaries. The maternity was an attempt by missionaries to replace the services of traditional midwives with an institution that they considered modern. Nevertheless, since medical care for the indigenous people was not a foremost policy of missionaries, the establishment of maternities as an institution did not commence until the 1920s. Even with the new facilities, maternal care needs were not fulfilled by the new institutions, and people relied extensively on the services of traditional midwives, especially in the rural communities. The rural dwellers' reliance on traditional midwives and the chronic lack of facilities in these areas prompted the creation of a new kind of midwife, the community nurse, whose services closely imitated that of the traditional midwife. In view of the foregoing, this paper incorporates both traditional and Western midwifery in order to establish the interactions between both institutions of maternal care.

Scholars have paid little attention to the significant roles played by missions in the development of modern medicine and medical institutions in Nigeria. Greater consideration has been given to the impacts of missions on the education sector. E. A. Ayandele and F. K. Ekechi, who have made substantial inputs in the study of missionary innovations in Nigeria, focused on the socio-political impacts of missionary propaganda on the peoples.[6] Ekechi further provided insight into the rivalry between the Roman Catholic and Anglican missions in Igbo land. J. F. A. Ajayi, on the other hand, explored missions' contributions to the emergence of a new elite in Nigeria.[7] Nicholas Omenka's *The School in the Service of Evangelization* focused on the impact of the Catholic missions in Eastern Nigeria, and treated all but the establishment of health facilities or training schools for midwives, nurses and other health practitioners.[8] These books are the major essays on Nigerian history that study missionary activities in Nigeria. Other books, especially edited volumes, offer momentary glimpses into missionary work and the role of the church in establishing medical institutions in some parts of Nigeria, but there is little else.[9] This research, therefore, provides insight into Christian missionary impacts on

[6] E. A. Ayandele, *The Missionary Impact on Modern Nigeria: A Political and Social Analysis*, London: Longman, 1965; F. K. Ekechi, *Missionary Enterprise and Rivalry in Igboland 1857-1914*, London: Frank Cass, 1972.
[7] J. F. K. Ade Ajayi, *Christian Missions in Nigeria, The Making of a New Elite, 1841-1891*, London: Longman 1965.
[8] Nicholas Omenka, *Studies on Religion in Africa*, Vol. vi, Leiden: E. J. Brill, 1989.
[9] See Samuel Agubosi, "Christian Missions and the Development of Modern Health Services Among the Western Niger-Delta Peoples 1901-1960," in *Readings in Nigerian History and Culture: Essays in memory of Professor J. A. Atanda*, G.O. Oguntomisin and S. Ademola Ajayi (eds.), Ibadan: Hope Publications, 2002, 115-132; Jude C. Aguwa, " Mission, Colonialism, and the Supplanting of African Religious and Medical Practices,"

medical developments in modern Igbo land. It focuses on the maternity, a subject that has not been treated in Nigeria's colonial history.

The first part of the essay considers the structure of traditional midwifery among the Igbo, including a description of the traditional midwifes' responsibilities. The next section discusses the advent of Christian missions in Igbo land and the nature of their involvement with the Igbo people. Subsequent segments explore the evolution of the maternity, its relationship with traditional midwifery, and the training of a new class of midwives. The interesting rivalry between the Catholic and Anglican (CMS) missions is studied in terms of how it resulted in medical developments and the emergence of maternities. The paper ends with an evaluation of the interactions between traditional midwives and their Western-trained counterparts.

Sources for the research are mostly derived from the National Archives, Enugu, Nigeria, from where documents on indigenous medicine, midwifery, and medical developments were obtained. These collections contain information on the establishment and nature of the maternities as well as letters between the missions and the colonial administration. They also offer insight into the training, employment, and transfer of midwives within the local communities. The archive of the University of Birmingham, made partly accessible online, has documents on the activities of the Church Missionary Society among the Igbo. It provides information on health and sanitation, and the origins of the CMS medical missions. Secondary sources are used mostly to examine the

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in *Missions, States and European Expansion in Africa*, Chima J. Korieh and Raphael Chijioke Njoku (eds.), New York: Routledge, 2007.

penetration of the missionaries into Igbo land. The section on traditional midwifery and childbirth practices is based on unabridged oral accounts documented in unpublished theses from the University of Nigeria and documents from the Safe Motherhood section of the Ministry of Health, Enugu, Nigeria.

The project is limited by the fact that it is yet to incorporate colonial documents from the British National Archives, Kew, the British library, and that of the Church Missionary Society at the Cadbury Research Library, Birmingham. Besides the information from Nigeria's National Archives on the Roman Catholic medical mission, the RCM documents are yet to be explored. Also, in order to exhaustively discuss the interactions between traditional and Western midwifery, the collections of the foremost organizations that provided workshops for traditional midwives- World Health Organization and Department for International Development- need to be consulted. These documents will be incorporated in further research. Their absence at this time is tempered by the accessibility of some CMS documents through the online archives of the University of Birmingham, the files in Nigeria's archives, and some documents obtained from the Safe Motherhood section of the Ministry of Health, Enugu, Nigeria.

Throughout the essay, traditional midwives are not referred to as *Traditional Birth Attendants* (TBAs), a term that was created by the World Health Organization and generally adopted among Western healthcare agencies in reference to non-Western-trained midwives in developing countries. This reluctance stems from the fact that "Traditional Birth Attendant" portrays the traditional midwife as merely a birth assistant

devoid of any medical knowledge and medicinal administration. This representation devalues traditional midwifery in developing countries and denies that, in most cases, the traditional midwives' services begin from conception until childbirth. During this period, the midwife provides appropriate medical care to the patient and fetus, and administers herbal treatments at various intervals.

Chapter 2: Traditional Midwifery among the Igbo

Childbirth is as much a social as well as a physiological event, reflecting the social organization, beliefs, and priorities of the society in which the birth occurs.[10] Long before British colonial rule and the introduction of Western maternal and childcare facilities in Igbo land, traditional childbirth practices were in place. Like other aspects of indigenous medicine, traditional midwifery was based on roots, herbs and cultural philosophies. The responsibilities of the midwife began at conception and sometimes transcended that to include pre-conception. It lasted throughout the period of pregnancy until child birth. While a portion of midwives argue that their skills and knowledge of herbs were natural endowments from God or deceased family members who practiced the same profession, others received training under acclaimed midwives until they were qualified for independent practice.

Traditional midwifery in pre-colonial Igbo land was a highly gendered profession. Midwives were almost exclusively women, and men were isolated from most affair of childbirth. Women who discussed issues of labor with men were punished by their peers.[11] Husbands were rather occupied with appealing to their Chi – personal guardian spirit that directs his destiny - through sacrifices and prayers, to grant their wives safe

[10] Beverley Chalmers, *African Birth: Childbirth in Cultural Transition*, South Africa: Berev Publications CC, 1990, xiii.
[11] C.K. Meek, *Law and Authority in a Nigerian Tribe*, London: Oxford University Press, 1937, 52, 101.

delivery.[12] Afterwards, the male members of the extended family waited in anticipation until the infants were born.

Nonetheless, in cases of serious complications, a traditional doctor, either male or female, who often possessed medical and spiritual powers, was invited to aid delivery. Evidence of this collaboration was depicted in an early 20th century artistic depiction of childbirth found behind the shrine of a deity, Olugba, in the Igbo town of Owerri. In the sculpture, "a female attendant is shown standing behind her [woman giving birth], holding her shoulders, while in the front the midwife is receiving the baby. At the side is a medicine-man holding a bunch of leaves or some other charm to facilitate delivery."[13]

By the late colonial period, however, male midwives became visible. This new trend may be attributed to maternity needs in certain communities, and perhaps the hope for financial gain. The male midwives were mostly respected titled men and famous herbalists, and were therefore acknowledged by the community for their esteemed positions. It is possible that a few male herbalists cum midwives always existed in Northern Igbo land among the Nsukka and Abakiliki Igbo.[14] These herbalists were famous for their treatments of infertility and other gynecological ailments like fibroid.

No formal training existed for the midwife; however, those interested in the profession became attached to experienced midwives. They ran errands for the senior

[12] *Ibid*., 58.
[13] *Ibid*., 51
[14] Some of the midwives interviewed in different towns in this area in 2011 were men. Their date of birth fell between 1916 and 1925. In the same Northern Igbo area in contemporary times, it is not uncommon to see a male traditional midwife who is almost always a herbalist.

midwife and provided comfort and emotional support for pregnant women during labor. For the children of midwives who developed interest in their mother's duties or were taken along to birthing sessions, their authenticity was easier to establish. They were seen as the junior midwives. In addition to assisting their mothers during these sessions, they were assigned to take care of sick pregnant women. From here, the community's trust in the apprentices' abilities developed until they were allowed to take on more demanding responsibilities. The legitimacy of midwives depended on the success of their practice and the confidence of the community. Though young women received training as midwives, they could not practice independently until they were married and had children of their own. This was because communities reasoned that midwives would provide better maternal and childcare if they had children. In essence, midwifery was closed to unmarried or barren women.

Prior to conception, midwives played a role especially in cases of infertility. They advised the couple on appropriate sexual attitudes and medical measures to adopt. Where the case was deemed too serious for their interventions, and if the midwife was not skilled in the treatment of gynecological ailments, the couple was referred to a notable herbalist or traditional doctor who dealt with such issues.

Traditional midwives were central actors in the early stages of pregnancy. As soon as pregnancy occurred, the midwife's service was engaged. In some communities, a diviner was consulted to determine the appropriate midwife whose skills would be

blessed by God to carry out the successful care and delivery of the infant.[15] Afterwards, the pregnant woman had sessions with the midwife whereby her condition and that of the fetus was ascertained. She was then given herbal mixtures that she must take judiciously at specific times.

Though without any formal training, midwives believed that any abnormal increase in body temperature during the early stage of pregnancy could induce abortion; therefore, women were advised against taking hot showers during this stage, and fever was promptly attended to. They also massaged the back and abdomen of pregnant women to increase blood flow. This was also an opportunity to bond with the expectant mother. As the pregnancy advanced, the fetal position was checked, and if necessary, the fetus was repositioned. Skilled traditional midwives prided themselves in their ability to reposition a baby from the bridge posture.

Pregnant women were placed on diets. They were instructed by the midwives on appropriate and inappropriate nutrition. Fatty foods, which would enlarge the fetus and therefore make delivery difficult, were generally avoided. These included fatty meat, eggs, and pounded yam, the latter being the most important carbohydrate-rich staple of the Igbo. She was instead encouraged to eat more fruits, vegetables, and the appropriate amount of protein-rich food.[16]

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[15] Makata Eze, Interview, March 28, 2008, in Eze, Judith, *Traditional Birth Control in Iheaka, Igbo-Eze South LGA*, B.A Project, Department of History, University of Nigeria, Nsukka, 2008.
[16] *Ibid.*

Other dietary censures were placed on the expectant mother especially in the first four months of pregnancy. The Igbo have a common belief that the attributes of animals could affect the traits of a fetus. Therefore, pregnant women were proscribed from eating the flesh of slow-moving animals such as *nchi* (Grass Cutter) as this may impede the baby's ability to learn to walk; snails because they oozed saliva and could make infants becomes imbeciles; pig meat which was believed to induce abortion; or the flesh of any animal that died on its own, as this may cause a still birth.[17] Banana was believed to weaken the child, and was therefore avoided. Plantain, pumpkin, and walnut were avoided during the first four months of pregnancy. Additionally, pregnant women were advised against beholding ugly things like the monkey as this could cause her child to assume ugly features.[18] These rules varied from one part of Igbo land to the other.

Some of the taboos extended to the husbands. In some communities, expectant parents were barred from eating the meat of animals killed in honor of a deity and sold in the market. Here one is left to wonder how a couple would determine such meat. If this rule was broken, it was believed that a miscarriage could occur or an abnormal child could be born.[19] In other areas, husbands were prohibited from killing snakes as these were thought to embody some aspect of the human soul. Likewise, husbands could not refuse food cooked by their wives, otherwise, the new born would refuse food and die. They were to avoid carrying dead bodies, even those of animals, lest their babies should

[17] *Ibid.,* 269
[18] George Basden, *Niger Ibos*, London: Franc Cass, 1966, 169-176; Meek, Law and Order, 289.
[19] Meek, *Law and Authority*, 289.

die in the womb. These taboos were not absolute laws, but their breach could entail condemnation if things subsequently went wrong.[20]

The responsibilities of midwives during the antenatal period can be summarized thus: providing nutritional guide; ensuring the good health of mother and fetus; and determining appropriate fetal presentation, including position and size. In the case of the latter, women whose fetuses were suspected to be unduly large were given a leaf known as *Ahihara* which reduced the child's weight. In other cases, especially in Nsukka, the mid-rib of a plant *Egbe* (Dracaena arborea) was added to the medications.[21] While the memory of this leaf (*Ahihara*) has faded among contemporary Igbo, it is still widely used in Western Nigeria to regulate the size of fetuses and ensure easier delivery.

The beginning of the first genuine contraction was a crucial period. Once the earliest signs of labor manifested, the midwife was immediately summoned. Culturally, childbirth occurred in the expectant mothers' backyard or that of her father or grandmother. In some communities, however, child birth could take place in the midwife's backyard because the midwife had everything that she needed for the birthing process in her house.[22] Giving birth inside houses was considered a taboo up to the late

[20] *Ibid.*
[21]Florence Odo, Interview, April 4, 2008, in Eze, Judith, *Traditional Birth Control in Iheaka, Igbo-Eze South LGA,* B.A Project, Department of History, University of Nigeria, Nsukka, 2008.
[22] Meek, *Law and Authority*, 290; Nnanna Okorom, Interview, March 2, 2011, in *Traditional Midwifery and Child Care in Ebenator Ekwe Isu LGA Imo State, 1900-2005,* B.A. Project, Department of History, University of Nigeria, Nsukka, 2011.

colonial era when Christianity and Western attitudes had established deep roots among the people. No particular reason was ascribed to that practice.

On the midwife's arrival, she encouraged the pregnant woman to stay mobile in order to speed up labor. She accompanied the woman throughout this process, offering verbal comfort and reassurance. The woman was considered ready for delivery once she felt the urge to excrete or the perineum was distended. Delivery postures differed from one Igbo community to the other; however, the squatting position in which the woman sat on a stone or stool was more common. In this case, one or two female relatives or assistants stood, or sat on a higher stool, behind the expectant mother, holding her across the chest while the woman wrapped her arms around the assistant's neck. The knees of a restless woman were held apart by other female attendants or by the midwife who wedged her knee between that of the woman.[23] Another posture that was commonly assumed in Northern Igbo land involved the installation of poles in the backyards. During childbirth, women assumed an upright position and gripped the pole while the midwife was positioned to receive the baby. In any chosen posture, on no account was the baby allowed to touch the floor.

In cases of prolonged labor, the midwife administered palm oil on the patient's abdomen to induce contraction. Her throat may be tickled for the same reason. The tender frond of the oil palm tree was inserted in the throat, contracting the abdominal muscle and aiding in the baby's expulsion. Hot food that contained herbs and spices like *Uda*

[23] See *Ibid*., 290; V.E. Egwuatu, "Childrearing among the Igbos of Nigeria," *International Journal of Gynaecology and Obstetrics*, 24: 1986, 106.

(xylopia aethibicum) and *Utazi* (gongronema latifolium), believed to have properties that could contract the uterus, were given to the woman. These herbs not only aided delivery but also the discharge of the placenta. In dire circumstances, a traditional doctor could be invited.[24]

The midwife served a different social purpose at this point, that of the confessor. Persisting labor was sometimes attributed to infidelity. Midwives, therefore, urged women under such circumstances to confess any cases of unfaithfulness to their husband during her marriage in order to be spared of death during childbirth. Women whose baby's paternity was contested were lured to confess in this manner.[25] As indigenous medicine among the Igbo did not include any surgical expertise beyond minor operations involving circumcision, bone setting and facial scarifications, complications requiring surgery were commonly fatal as the mother sometimes died of exhaustion before alternative approaches could yield results.

The arrival of a new born was not announced until the placenta had been expelled and the baby had cried.[26] The umbilical cord was cut with a sharp traditional blade usually obtained from the raffia palm. Afterwards, the baby was cleaned with warm water while a hotter one was employed to massage the abdomen and pelvic region of the

[24] The traditional doctor in this case is a general term that covers the different branches of indigenous medicine. It is often used to imply a herbalist, doctor (dibia), and diviner. In some cases, traditional physicians are all these things at the same time. In other cases, they are simply a doctor, herbalist or diviner.
[25] See *Ibid.*, 290.
[26] Odo, interview cited; Felicia Agu, Interview, March 5, 2011, in *Traditional Midwifery and Child Care*; Basden, *Niger Ibos.*

mother. The hot water was supposed to stop blood clotting in the womb and cause easy flow of blood collected in the uterus. The baby was given a small amount of palm kernel oil and very little water. He/she was then covered in a local powder. Visitors and relatives applied same powder on their face and neck, and this sight at any locality signified the arrival of a new born. The placenta was then buried and a tree planted on that location to mark the birth of the child.

Before breastfeeding, the mother's milk was tested to ensure that it was safe for the baby. The milk could not be given the baby until it was certified by the midwife or other older women to be safe.[27] A small quantity of the breast milk was spilled on cocoyam leaves; if the leaf turned brown or showed signs of withering, the milk was declared unfit for consumption. Another alternative was to spill the milk on the floor; if ants failed to lick it, or they did and died, then it was identified as poisonous. To induce a reasonable flow of breast milk, the breast was massaged with oil from palm nut. Chewed palm kernel was also rubbed on the nipples to make it firm.[28]

The services of the midwife at the end of child birth were rewarded in kind. In some communities in Northern Igbo land, the midwife was considered to be "blinded" by the birthing process. In order to open her eyes, the family of the new mother offered different gifts and food stuff.[29] Among other communities, she was given a fee of one rod (a traditional form of currency), yams, and firewood. In communities like Mboo in Imo

[27] Basden, *Niger Ibos*, 125.
[28] *Ibid.*, 111
[29] Ewereji Rita, Interview, March 5, 2011, in *Traditional Midwifery and Child Care*.

state, the midwife was presented with a cock, a few days after childbirth, if the child was a boy. She pressed this cock on the mother and child saying, "I remove from you all evil spirits."[30] Then she sacrificed the cock at the threshold of the compound and took the meat home for her personal use.[31]

If a midwife lost mother and child during delivery, she was obliged to mourn them. During the mourning period, she desisted from attending to any pregnant woman. She applied camwood and *Nzu,* a local chalk, on her palms and face, indicating her loss. For as long as the chalk remained on her, no pregnant woman could engage her services. Such losses were a source of shame to midwives; therefore, they did their best to prevent the community's loss of confidence in their skills.[32]

In the Awgu division of Igbo land, the midwife had one final role after childbirth. One month after the birth of a child, formal rites of purification were performed. The new father invited the women of his kindred to a feast. The midwife attended and waved a yam over the head of the mother and child, saying, "May everything that comes into this compound be pleasant like this feast. The evil spirit shall not assail the mother and child, for I am now removing all evil spirits from this household." She then threw the yam on the ground.[33]

After birth, the obligations of the midwife ended. The care of mother and child was shifted to the woman's mother, who took care of her daughter and assisted her with

[30] Meek, *Law and Authority*, 292.
[31] *Ibid.*
[32] Janeth Nwosu, Interview, May 5, 2011, *Traditional Midwifery and Child Care*.
[33] *Ibid.*, 293.

caring for the infant for a period of one to three months. This period was known as *Omugwo*. It was a time of rest for the new mother. She also received instructions on childcare from her mother. Notwithstanding, midwives could be consulted on request in cases of illnesses peculiar to infants.

Across Igbo land, not all women engaged the services of midwives. There were those who became pregnant and carried it to full terms without consulting midwives. They took care of themselves based on general knowledge. In time of labor, they were assisted by any old woman available. In polygamous families, the senior wives and other mothers in the household assisted with childbirth in such cases. In these instances, the only requirement was that these assisting women had, themselves, passed through the experiences of childbirth. Midwives and herbalists were not involved except in cases of complications or prolonged labor.

Childbirth was a social occasion for women. This period was punctuated by rituals and ceremonies that were performed at specific times during and immediately after pregnancy, and represented the people's social values. The period of pregnancy reflected the Igbo society's social fabric. The families and communities of the expectant parents were intimately involved in the entire process. Soon after conception, the expectant husband visited his wife's village and offered a cock as gift to the priest or priestess of the earth goddess. The priest then prayed to the goddess whom he notified that the man completed the full marriage rites of their daughter; therefore, the goddess should offer protection to the pregnant woman and grant her a safe delivery. Afterwards, the husband

visited his wife's family to officially notify them that their daughter was pregnant. Around the fifth month, the couple made a formal visit to the woman's family where the husband presented his father in-law with palm wine, and gifts for the mother-in-law. The visit lasted for a few days, after which the pregnant woman received valuable gifts such as goats, fowls, water pots, and mortars from male members of her extended family.[34] These gifts were mostly items that would be of use to the woman whose family was about to expand. On return to her home, the expectant mother gave gifts, usually pieces of coconut and meat, to children in her husband's extended family - the future companions of her unborn child.

Some of the taboos instituted on the man during his wife's pregnancy ensured the control of physical and verbal abuse from the man. In some communities in Imo State, the couple performed a festival, Ajankita, at the end of which they promised to be pleasant and "sweet mouthed" to each other. The taboo that compelled men not to refuse food offered by their wives, to avoid the child's death at birth, also served the purpose of checking mistreatment. It offered emotional protection even for a disfavored wife. As children were a source of prestige to Igbo men, and the number of children that they had increased their social status, they were mostly bound to comply with the proscriptions placed on them.

Though traditional midwives had no scientific training, they determined and adopted birthing postures which harnessed the power of gravity to enhance the baby's

[34] Meek, *Law and Authority*, 285, 287.

expulsion. The most popular positions were the standing, kneeling, or sitting stances, with about two female attendants supporting the expectant mother in this posture, and providing her with emotional and psychological support. These poses were also adopted by midwives in seventeenth and eighteenth century England as it was believed to enhance contraction and aid speedy delivery.[35] As soon as advanced labor set in, the midwife positioned herself to receive the baby. Based on custom, the baby was not allowed to touch the ground. This was no meaningless taboo but a check on the midwife to ensure that the baby did not fall to the ground on delivery, and thereby come to harm.

Similarly, the rituals and proscriptions to which the midwife was subjected in the event of a mother's death or that of her new born ensured that she brought the highest quality of service to her craft, in order to avoid being discredited in her community. These measures appear unfair in cases where such tragedies were unavoidable, but they marked the value of life, and guaranteed that the midwife did not take her responsibility for granted. She was also duly rewarded for her success. Reproductive rites ensured the wellbeing of all.

After birth, the care of the mother and child went to the woman's mother, who spent at least one month with her during the new mother's time of rest and recovery. This arrangement again showed the social relationships of Igbo group. The purification rites and festivals that punctuated the end of childbirth reflected the Igbos' view of health and the belief that the supernatural is not far removed from the physical. These ceremonies

[35] Adrian Wilson, *The Making of Man-Midwifery: Childbirth in England 1660-1770*, London: UCL Press, 1995, 36-37.

involved prayers to God and appeals to ancestors to preserve the life of the infant. The festivities involved children from the newborn's kindred, the new mother's parents and their extended family, as well as the husband's relatives. Since the Igbo, during the period of study, believed in spirits and reincarnation, the festivals and the prayers that accompanied it reflected these views. This belief is reflected in the following utterance made by a young boy to the newborn during the feast that followed the new mother's purification, "if your father or mother sends you on a message, do not refuse to go. But if a spirit (ndi mmuo) sends you, do not go."[36]

Changes occurred in the institution of traditional midwifery in the face of missionary and colonial activities in Igbo land, and the foundation of Western medicine. These alterations were reactions to new religious, political and medical developments.

[36] Meek, *Law and Authority*, 294.

Chapter 3: Christian Missionary Enterprise In Igbo Land: Origins And Forms

Missionary presence in Igbo land was not unrelated to nineteenth century European commercial and political drive into the heart of West Africa.[37] An expedition that laid the foundation for the establishment of the Niger Mission and penetration of the Igbo interior was the ill-fated voyage of 1841, undertaken by traders, humanitarians, and explorers. The Church Missionary Society of Britain sent representatives among whom was Ajayi Crowther, the Yoruba ex-slave who later became the first African Bishop on the Niger.[38] The expedition failed as a result of rapid death from malaria. However, for the CMS, it was a partial accomplishment as they succeeded in establishing links with the King of Aboh, an Igbo town on the Niger coast.[39]

Notwithstanding, missionary work did not proceed due to government and commercial firms' unwillingness to continue with a second Niger expedition after the failure of 1841, and the CMS's refrain from undertaking such an enterprise without the cooperation of these agencies. In 1854 and 1856, the CMS joined another commercial voyage to the Niger in collaboration with Macgregor Laird, a Liverpool Merchant and sponsor of the expedition. By 1857, the first missionary outpost was established at Onitsha.[40]

The intermingling of religion and commerce occurred for several strategic reasons. The missions needed financial backing from the traders in order to survive.

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[37] John Du Plessis, *The Evangelization of Pagan Africa*, Cape Town, 1929, Preface.
[38] Ekechi, *Missionary Enterprise*, 1-2.
[39] *Ibid*., 2.
[40] *Ibid*., 6.

Therefore, early missionary stations were built near trading settlements.[41] However, this connection had adverse effects for the CMS. In the minds of the natives, there were no separation between the missionary and the trader. The missionary expansion was therefore viewed in terms of merchandise and not evangelism.[42] A journey into the interior, without ample presents for local chiefs, had little outcome. On the one hand, the indigenous peoples were interested in the new religion in so far as it created access to new merchandise, and chiefs tolerated the missionaries because of their interests in trade. On the other hand, conflicts between the people and the European traders spilled over to the missionaries as both were perceived as the same. In his letters, Hugh Dobinson observed that the congregation at Onitsha dwindled in the 1890s because of the Royal Niger Company's increasing unpopularity among the people.[43] The antagonism meted out to both groups in Onitsha in the event of any disagreements forced the Bishop on the Niger to renounce any joint enterprise with commercial agents.[44]

On December 5, 1885, the CMS monopoly of mission work in the lower Niger ceased as they were joined by the Holy Ghost Fathers, a Roman Catholic mission. The United Presbyterians soon joined in 1888, not from the Niger, but from the Cross River area towards Northern Igbo land.[45] A third group, the Primitive Methodist Missionary

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[41] Sir E. Hertslet, *Map of Africa by Treaty*, London: Her Majesty Stationery office, 1909, 127.
[42] C.M.S. CA3/04, *W. F. John to Crowther*, Onitsha, 22 March1879.
[43] *Letters of Hugh Henry Dobinson*, London, 1899, 52.
[44] Crowther, *Proposed Stipulation with the Authorities of Onitsha,* 4 January 1880.
[45] S.N. Nwabara, *Iboland: A century of Contact with Britain, 1860-1960*, New Jersey: Humanities Press, 1978, 53-54; see also Isichie, *The Ibo people and the Europeans*, 147-148.

Society, arrived in the scene around the Ibibio-Igbo border in 1909. There, they encountered hostilities from the people and could not retain converts because of laws issued by chiefs banning community members from stepping into the mission houses and churches.[46] By 1915, however, they had penetrated Northern Igbo towns where they met with more favorable circumstances.

Both the older missions and their newer counterparts benefitted from a new development: the imposition of colonial rule. In 1900, the Royal Niger Company Charter was revoked and the British government constituted the company's territories into a colony. As Britain attempted to extend their control into the interiors of Igbo land, they met with resistance which frequently resulted to war. A famous example of such war was the Aro expedition of 1901-1902 which was targeted at destroying the supposed hold of the notorious *Long Juju* on the peoples. [47]

As British soldiers fought their way into Southern Igbo towns, the missionaries followed in their wake, endeavoring to establish mission stations among the peoples. Prior to this time, even the CMS had not infiltrated the interior, but with the imposition of a colonial government which saw Christianity as a tool for subduing the people, the CMS was encouraged by the British High Commissioner to move inland.[48] The discovery of

[46] W. Christie, *Jubilee – A Story of Primitive Methodist Mission in Iboland 1910-1951*, Exeter: Townsend, 1930.
[47] The *Long Juju* was a famous and powerful oracle consulted from across Igbo land, and notorious among the Europeans as the main source of slaves from Northern and Southern Igbo land to the Cross River. See Harneit-Seivers, *Constructions of Belonging, 71.*
[48] Nwabara, *Iboland*, 54.

coal in Enugu in 1902 and the eventual construction of a railway across the territory also sped up missionary penetration.[49]

Breakthrough into the interior came with rivalry among the Roman Catholic, Anglican, Methodist, and Presbyterian missions. The rivalry was more pronounced between the CMS and the Roman Catholic missions. Increasingly, decisions made by the CMS became foreshadowed by the presence of the Roman Catholic Mission.[50] Crowther warned that the Roman Catholics would secure CMS converts if London failed to send more missionary staff and resources to occupy strategic locations.[51] Similarly, Catholic presence in Onitsha was spurred by the realization that the Protestants were well established in the area. They, therefore, did not want to be outdone.[52]

Having decided to settle in Onitsha, the Catholic mission had to overcome Anglican opposition. Therefore, they laid emphasis on works of charity, portraying the image that they had come for the people's welfare. They provided medicine and other items to the people in order to lure them to the Roman Catholic faith. As a precondition to providing medical care to sick children, they were baptized. The priests argued that baptism would ensure that those children would not die in sin. In reality, they hoped that the children would become converts of the Catholic religion and therefore be lost to the

[49] *Ibid.*, 218-219.
[50] See CMS, *The Church Missionary Gleaner*, Salisbury, London, June 1, 1915, 86.
[51] C.M.S. G3/A3/0, *Crowther to Lang*, 31 August, 1883.
[52] Ekechi, *Missionary Enterprise and Rivalry*, 73.

Protestant faith.[53] This approach to evangelism meant that many of the early converts comprised outcasts and the destitute.[54]

The CMS was startled by the Catholic Church's inroads into their mission fields, and conveyed their dismay to their London headquarters. Rev. Strong wrote thus,

> "they have taken from our school about a dozen children over whose parents they have exercised some influence. Medicines and presents of various kinds were benevolently and liberally given and by this they are hoping to become strong. Our school children living with them have all been rebaptized."[55]

In another report, Archbishop Johnson of the Anglican Church wrote that, "our school at Onitsha is half ruined, because the children are enticed away by promises of clothing, and by the certainty of being fed gratis."[56]

The clashes among the missions in Igbo land produced a result similar to the Berlin Conference of 1885 and its partition of Africa among the world powers. In 1914, a conference of missionary societies was summoned by the Rev. T. J. Dennis of the CMS. The conference held in Aba between January and February 1917, and was attended by the

[53] *Ibid*., 75.
[54] Isichie, *Ibo people*, 151.
[55] C.M.S. G3/A3/0, *Annual Report of Onitsha Station*, 1886.
[56] *Ibid.*, *Johnson to Lang*, 5 July 1888.

protestant missions.[57] In the meeting, the boundaries of each mission were delineated. Boundary questions, however, persisted among the missions up to Nigeria's independence.[58]

The Catholic-Anglican rivalry led to a different and unplanned development in the mission field: the adoption of education as a deliberate missionary policy and the rise of medical missions. Education was not totally absent among the CMS, the first missionary society in Igbo land, but it was not a dogma. From the beginning, the CMS established Sunday schools and elementary classes mostly in the church compounds and mission quarters.[59] They realized that evangelization could bear little fruit unless they found a way of making the people study the bible independently. This desire was the basis for establishing any form of education.

The first sets of students were young slaves and girls. This was because parents barred their male children from going to school, preferring to commit them to farming and crafts. Taylor reported that, "the idea of educating them [the sons] was ridiculed and laughed at as the greatest absurdity which the human mind could entertain."[60] The basic curriculum included Arithmetic, Geography, Basic English, Bible stories, Prayer, and

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[57] F.W. Dodds to the Secretary of the Primitive Methodist Missionary Society in London, *Resolution of a Conference of Protestant Missionary Committee, held at Aba, Southern Nigeria, 30 January – 1 February 1917*.
[58] See Ibid. for outlines of the meetings and the various boundary outlines among the Protestant missions. See also Nwabara, *Iboland:*, 57
[59] Samuel Agubosi, "Christian Missions and the Development of Modern Health Services Among the Western Niger Delta Peoples 1901-1960" in *Readings in Nigerian History and Culture: Essays in Memory of J.A. Atanda*, G.O. Oguntomisin and S. Ademola Ajayi (eds.), Ibadan: Hope Publications, 2002, 116.
[60] C.M.S. CA3/037, Taylor to Venn, 9 October, 1862.

Music.[61] With time, more people were attracted to the mission schools when parents realized that the slaves and girls could speak the "white man's" language and read his books. The level of education available was, however, low and almost entirely connected to the scripture. To the CMS, education "must… take a secondary place."[62]

Secular and secondary education, nonetheless, became an objective following the Roman Catholic move to establish this level of training as a way of luring people to their enclave. Their move was strategic as the Igbo had realized that education meant empowerment and access to good salary.[63] The Catholic missions established primary and secondary schools, with strong emphasis on teaching the English language. Since the CMS discouraged instructions in English, and only had infant schools, students were more certain to learn English language in Roman Catholic missions. They, therefore, graduated from the CMS infant schools to Roman Catholic elementary and secondary schools where they were easily rebaptized and converted into the Catholic faith. By 1908, RCM had established 27 schools with 2,793 students, thus instituting the first permanent school structure in Igbo land.[64]

The growth of the Catholic missions through education alarmed the CMS and caused them to abandon their lukewarm attitude towards education. They believed that the RCM's domination of the education sector would enable them to produce enough

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[61] Ekechi, Missionary Enterprise, 25.
[62] A. E. Clayton, *The Parting of Ways, Niger and Yoruba Notes, 1900*, 22-23
[63] Isichie, *The Ibo People*, 154.
[64] John P. Jordan, *Bishop Shanahan of Southern Nigeria*, Dublin: Elo Press Limited, 1949.

educated elites to dominate the country's political and economic future.[65] The CMS headquarters in London was constantlyly warned of the loss of grounds to RCM if the lack of support for education persisted. A secondary school was eventually established in Onitsha in 1901, in response to a Roman Catholic school in the same location. In this format, other secondary and industrial schools sprung up across Igbo land.[66]

The medical care offered by RCM resulted in the development of medical missions and modern health facilities. As already noted, the medical care did not come without its agenda. In response, the CMS proposed to the London headquarters that a medical mission be established in Onitsha to offset the activities of the Roman Catholic Church. They lamented that the people turned to RCM for medicine when they could not obtain it from the CMS.[67]

By accepting medical rivalry as a tool of evangelism, the CMS abandoned its policy that the use of temporal means for spiritual ends was unacceptable. They justified their new approach by hailing the work of mercy as worthy of Christian pursuit.[68] They argued that Jesus's work on earth included the saving of souls and healing of bodies, but it was quite clear that this change of attitude was a result of the Roman Catholic Mission's use of medicine to attract adherents.

From the resultant rivalry, dispensaries and health centers were established by the missions. Hospitals were built in Onitsha, the most notable of which was the CMS's Iyi-

[65] Ekechi, *Missionary Enterprise,* 179.
[66] *Ibid*., 194.
[67] C.M.S. G3/A3/0, *Henry Dobinson to R. Lang*, 5 May 1890.
[68] Ekechi, *Missionary Enterprise*, 77.

Enu Hospital, Ogidi. The CMS appointed medical superintendents to oversee the activities of its medical mission.[69] Other mission hospitals were founded in Ihiala, Uburu, and Afikpo, and became the precursors of modern medical facilities across Igbo land.[70]

By 1920s, the colonial government became active in establishing government hospitals and dispensaries, but these services were limited initially to Europeans until the 1930s when it was extended to African workers in the urban areas. As in the education sector, the government assumed regulation of the health segment but relied immensely on mission participation in providing training for potential hospital staff, extending health services, and manning posts in already existing hospitals.[71] The missions' impact in this regard became so vital to the colonial government that, in 1945, government expressed anxiety over the possibility of the closure of the CMS-owned Iyi-Enu Hospital and the RCM hospital at Ihiala.[72]

By 1940s, the colonial administration appropriated the power to grant missions rights to establish hospitals, maternities and dispensaries, and undertook the supervision of these facilities upon completion. Funds were extended to the missions for these undertakings. The Roman Catholic and the Presbyterian missions (renamed Church of Scotland Missions) became distinguished in the establishment and maintenance of

[69] C.M.S. *Niger Mission, Iyi-Enu Medical Mission Report,* June 30th, 1930.
[70] MINHEALTH 30/1/253, *Medical Development Owerri Province*, 4th November, 1946.
[71] *Ibid*., *The Secretary of States to the Colonies*, London, 22 January, 1948.
[72] *Ibid.*, C.M.S. 2325/1057, *Medical Development in Nigeria*, 29 September, 1945.

leprosy centers.[73] The excellence of RCM in this respect is no surprise considering that the early Catholic mission was founded on charity works such as care of lepers, outcasts, slaves, and other destitute class. It was on these backgrounds that the Western maternity was established, thus becoming a distinct part of health services in Igbo land.

[73] MINHEALTH 30/1/253, "Visit of His Excellency Sir Arthur Richards to the Ogoja Province," extract from File 1966, 23.

Chapter 4: The Establishment of the Western Maternity

In the initial drive towards Western medicine, only the Christian missions were engaged in the establishment of maternities. Though the colonial government eventually ceded the extensive provision of this category of medical care to local governments, the missions' work in this regard was greatly relied upon such that, as late as 1946, the only maternity homes that existed in Awgu division were two maternities maintained by the missions.[74] The inadequacy of maternities and trained midwives was so persistent that the government adopted a policy of converting existing dispensaries into rural health centers.[75] This shortage implied that majority of the people, especially those in the rural regions, still had recourse to traditional midwives and indigenous birth practices.

For much of the early colonial period, colonial medical services were concentrated in the coastal trading centers, and later expanded into other parts of Igbo land as European presence spread. The amenities were first created to serve Europeans, but gradually extended to African employees. The period after World War II marked a substantial increase in colonial concerns for indigenous peoples' welfare, partly in response to nationalist agitation. It was accompanied by a ten-year health plan in 1946, and efforts to increase the number of health facilities in the region.

Prior to this time, maternities in Southeastern Nigeria were predominantly for African needs; there were, therefore, no significant colonial investments in them. In

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[74] MINHEALTH 30/1/253, *Account of the Visit by His Excellency the Governor to Awgu on Saturday the 5th of October, 1946.*
[75] *Ibid.*, *Medical development Owerri Province*, 11th November 1946.

consequence, maternity services up to the 1940s were mostly provided by the missions until the period after 1945 when the government collaborated extensively with Christian missions to improve health care.

The provision of maternities assumed two forms. They were established as separate institutions, manned by separate medical staff. However, due to the lack of resources, maternity wings were attached to existing hospitals. In some cases, female wards served a dual purpose as maternity wards.[76] Maternal and child care were also provided in health centers which were situated in the rural areas. However, even with the conversion of dispensaries into rural health centers in 1947 in order to extend maternal care, many health centers lacked maternity zones and experienced midwives, therefore, pregnant women still gave birth at home.[77]

At the onset, maternities and training institutions for midwives were overseen by the missions who were the initiators of these institutions. In fact, the first maternity in Igbo land was established by the CMS in 1926 following the addition of a maternity wing to Iyi-Enu Hospital in the Onitsha Division.[78] By the 1930s, these services came under the regulation of the colonial government. First, a maternity was required to be registered under the Private Hospitals Ordinance.[79] Then its activities were regulated by a

[76] MINHEALTH 30/1/253, *Medical Developments in Nigeria*, "Inspection Notes Okigwe, 25-26 April 1947, 167.
[77] *Ibid.*, *Medical Development Owerri Province*, November 1946, 8.
[78] NAI, MH 1/1/6038f: *Annual Medical and Sanitary Report, Mission Activities,* 1945, 7A; R. Schram, *A History of Nigeria Health Services,* Ibadan: Ibadan University Press, 1971, 223.
[79] NAE MINHEALTH 6/1/22.

Government Medical Officer.[80] Each maternity was directly supervised by a Medical Officer and nursing sister.

The standard number of midwives per bed was one midwife per four- bed maternity, and two midwives per eight-bed maternity.[81] However, this was far from the case throughout the colonial period. In 1947, the Director of Medical Services in the Eastern Province lamented that two years must elapse before such a goal could be close to reality.[82] The whole of Aku town in the Nsukka Division had only one midwife at this time.[83] In another town in the Owerri Province, the shortage of nurses and midwives was such that patients' relatives moved into the hospitals or neighboring homes to take care of the patients themselves.[84]

Besides their ante-natal services, maternities doubled as training centers for midwives. These centers were administered by missionary establishments until 1946 when the colonial government made efforts to establish training centers. For a maternity or hospital to qualify as a training center, its registration with the Private Hospitals Ordinance must first be certified. The building construction plan was then forwarded to the Director of Medical Services for approval. The construction plan included details about the purposes of rooms and verandas, as well as the distance of the sanitary annex

[80] MINHEALTH 30/1/253, "Inspection Notes Okigwe."
[81] NSUDIV 12/1/38, *Midwives General*, "Employment of Miss Maria Offieh", 6 June 1957; MINHEALTH 30/1/253, "Medical development Owerri Province."
[82] *Ibid.*, MINHEALTH 30/1/253.
[83] NSUDIV 12/1/38, *Midwives General,* 51.
[84] MINHEALTH 30/1/253, "Nurses and Midwives."

from the wards.[85] The number of beds available in the maternities, and the number and qualifications of the training staff, were taken into account before approval was given to a hospital as a training facility. A Midwifery Board regulated the activities of the maternity cum training centers and gave their endorsement to such institutions.[86]

Two types of training centers existed, Grade 1 and Grade II training centers, though the latter was more prevalent across Igbo land until the mid-1950s. To be licensed as a Grade II training center, the maternity was required to register a minimum of hundred births per annum. It must have a minimum of ten beds, a full time nursing sister as a guarantee for continuous training, and a reasonably accessible registered medical practitioner.[87] Qualification as a candidate for the Grade II training centers required a *Standard 6* certificate, which was equivalent to an elementary school certificate.[88] Training lasted for three years.[89]

A glimpse into the structure of potential training centers is offered through an application to the Senior Medical Officer, Aba, for the elevation of the Ituk Mbang Hospital and Maternity, Uyo, into a midwifery training center. The hospital had 30 maternity beds, three doctors, and four Grade II midwives. One registered medical doctor

[85] NAE MINHEALTH 6/1/22
[86] Ibid., 1-3, "CMS Midwifery Training School," 29.
[87] Ibid., Ref. No. E.1.21/34.
[88] Ibid.; note that the standard of education was not equivalent to what it is today. The Standard 6 certificate at the time was acquired by young adults and not children as obtained today. Thus one should not think that midwives were by implication teenagers or pre-teens.
[89] MINHEALTH 30/1/253, "Medical Development Owerri Province," 8.

and one nursing sister were available to train the aspiring midwives.[90] In another instance, there were two European doctors and two nurses.[91] A proposed training school in Nnewi in 1950 had two nurses and the Medical Superintendent of Iyi Enu Hospital at its disposal.[92]

By 1947, seven Midwives Training Centers existed in Aba, Onitsha, Owerri, Umuahia, Emekuku, Ihiala and Adazi. The Owerri, Onitsha, and Aba centers were run by the CMS; the Emekuku, Ihiala and Adazi by the RCM, and that of Umuahia by the Methodist missions.[93] None were established by the government. Since the centers were insufficient in serving the entire region, applications by missions for the approval of more centers increased. Government also sought to establish its own centers.

Despite the colonial government's ten-year development plan in 1946, it could not establish more maternities due to shortage of trained midwives. Construction of new facilities was also hampered by the overstretching of man power, materials, and equipment in the Works Department.[94] In1947, therefore, an official colonial policy adopted missions' work in the medical field as an extension of government projects.[95]

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[90] *Ibid.*, 3.
[91] *Ibid.*, 41.
[92] *Ibid*., 43.
[93] *Ibid.*, 28.
[94] *Ibid*., "Co-operation with Voluntary Bodies."; Ibid., "The Relationship between Government and the Missionary and other Voluntary Societies in regard to the Development of Medical and Health Services."
[95] *Ibid*., "To the Secretary of States for the Colonies," London, 22 January, 1948; Ibid., "The Relationship between Government and the Missionary and other Voluntary Societies."

Financial assistance was provided to missions who were disposed to undertake the construction and extension of facilities, and the adaptation of maternities into training centers.[96] The previous medical development plan did not include missions in arranging for the country's medical infrastructure. However, government difficulties forced them to reason that, "Since the efforts of the missions will be complementary to those of the government, the provision for the equipment of government hospitals have been reduced by 60,000 Pounds."[97]

Facilities that resulted from these collaborations were constructed based on government specifications and maintained on government standards. The hospitals were mandated to admit patients of any race or religion. New facilities whose construction costs were borne by the government were regarded as government buildings occupied by the missions until such a time as the government decided to manage the buildings themselves. For buildings in which a government grant was given, they were owned by the missions for an agreed term. Existing facilities owned by missions in areas that lacked government amenities were offered grants for special purposes such as medical equipment.[98]

Hospitals and maternities that were considerably qualified enough to meet the requirements for training centers were concentrated in the urban towns. The standards set for them were not extended to facilities in the rural communities, thus, widening the gap

[96] *Ibid*., 169.
[97] *Ibid*., "Co-operation with Voluntary Bodies."
[98] *Ibid.*, "Co-operation with Voluntary Bodies."

between medical care in the rural and urban areas. For the rural communities, more emphasis was placed on the numbers of structures that could count as maternities, irrespective of the nature of the infrastructure or availability of skilled labor. Thus, in the 1940s rush to convert dispensaries into health centers which would somehow provide maternal care, little thoughts were given to the employment of new staff in these locations, who possessed skills as midwives. In these areas, it was a game of numbers.

The maternity was significantly patronized in the urban areas, mostly because the indigenous occupants of these territories were migrant workers and fortune-seekers who had been separated from their indigenous institutions. Maternal facilities were, nonetheless, overburdened. In the rural communities, it was fraught with considerable challenges. Midwives and maternities were simply insufficient. Awgu division, which comprised of several large towns, had only two maternities in 1946.[99]

Plans for more maternities were envisaged for the Awgu area by 1948. In Degema in the Owerri Province, only one medical officer served the entire district; therefore, he was away on tours for three weeks at a time and was unavailable to handle emergencies, including those related to childbirth. Thus, patients were left at the mercy of two or three nurses "who experiment on patients' lives."[100] Such emergencies often resulted in death. This was an image of the situation in most of Igbo land, especially communities that were not the center of missionary or colonial administration.

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[99] *Ibid*., "Account of the Visit by His Excellency the Governor to Awgu on Saturday the 5th of October, 1946."
[100] *Ibid*., 127.

Money also posed a challenge to the utilization of maternity services. Families that could not afford hospital bills simply went to the traditional midwives whose services were mostly repaid with gifts and/ or little monetary payment.[101]

Up to Nigeria's independence in 1960, these challenges persisted. In Ibagwa in the Nsukka division, the number of births was very low in November and December, 1960.[102] While the community council attributed the low figure to a possible mishandling of patients, and called for the transfer of the midwife, the health supervisor stated that the low figure in Ibagwa was because "most mothers prefer to be delivered by their own relatives."[103]

The initial approach to the challenges of inadequate maternities and midwives was the conversion of dispensaries into health centers in rural communities. These health centers provided ante-natal and post-natal care to women. However, in many cases, they had no maternity wards, and women delivered at home. In order to address this weakness –the shortage of staff and the sparse number of maternities – a new kind of midwife emerged. This was the community nurse whose services closely reflected that of the traditional midwife.

The community nurse was firstly a Grade II midwife who was then given further training in nursing and other aspects of health education. The training lasted for a year and half, and was divided into two parts. The first involved a refresher course on general

[101] *Ibid*.
[102] *Ibid*., 235.
[103] *Ibid*., 239.

nursing and midwifery. It lasted for six months. The second section was one-year training on public health, with emphasis on "domiciliary midwifery, home visiting, and child welfare."[104] At the end of the training, candidates wrote an examination conducted by the Nursing Council. Preferences for the selection of candidates were given to local governments who already had health centers or planned to establish one. [105]

Since the community nurse served as a domiciliary midwife who visited homes to administer her services, local governments took interest in acquiring one for themselves. They offered sponsorship to candidates who applied for such training. In some instances, they wrote to Grade II midwives, expressing interests in sponsoring them through the community nurse training. Such sponsorship covered the midwife's salary, tuition, allowance, board and lodging through the duration of the training. In return, the selected midwives signed bonds with the sponsoring towns stating that they would serve the community for five years at the end of their training. Failure to keep this agreement resulted in the midwife's reimbursement of the money spent on her training.[106]

The community nurse organized the maternal and child welfare services of health centers, and aided the supervision of other Grade II midwives in the area. According to Dr. E. M. Foulton, the community nurse "is trained to help the mothers in child birth, to cut and dress the umbilical cord of the new-born and to advice on the upbringing of children. She can become the best friend of everybody, always welcomed and greeted

[104] *Ibid*., E.1.4.193A/400.
[105] *Ibid*.
[106] *Ibid*., 85.

wherever she goes."[107] Her relationship with the community and the mothers, where it worked effectively, was close.

The community nurse held Child Welfare Clinics in which she advised mothers on appropriate childcare practices, a section for which the other trained midwives were not equipped. She also organized demonstrations on the mixing of infant formulas and other food substitute.[108] Hygiene was one of her main focus too. She visited homes momentarily, and where pregnant women could not come to the clinic during labor and childbirth, she readily visited their homes and conducted the deliveries.[109]

Though a community nurse in Nsukka Division reported that many mothers still delivered at home under the care of traditional midwives, they attended the child welfare clinics in greater numbers. Between January and September 1960, the community nurse in Nanka, Awka Division, recorded 1,049 ante-natal visits, and attended to 1,914 children in the centers. Fifty-seven deliveries were recorded during this period. Home-based services were as follows: ante-natal care – 35, deliveries – Nil, and treated children – 469.[110]

In the same period, the nurse at Nsukka health center recorded 390 attendances to the ante-natal clinic, of which 87 were new participants. Out of 539 attendees to the Child Welfare Clinic, 133 were new.[111] Thus, the impact of the community nurse was being felt

[107] *Ibid*., "The Future of the Community Nurse in an Independent Nigeria."
[108] *Ibid*., 216.
[109] *Ibid*., "Community Nursing Report by Patricia Eze."
[110] *Ibid*., "A Bulletin for Community Nurses in Eastern Nigeria," 6.
[111] *Ibid*., 8.

and attendance to clinics gradually increased. At the eve of independence, the number of deliveries by community nurses was still low. One nurse in the Nsukka health center attributed this to medical bills and mothers' inability to invite community nurses to their homes because of shame for their unsanitary environment.[112]

The profession of the western-trained midwife followed the path of its traditional counterpart. It was dominated by women. While there were occasional instances of a male traditional midwife, the archival and personal files of western-trained midwives does not show any single instance of a male midwife, thus reinforcing the gendered division that already existed in this field under the pre-colonial setting. The maternity also reflected a new kind of hierarchy. Africans were trained as Grade II midwives but were excluded from becoming Grade 1 midwives. Up to the 1950s, where it did exist, the post of the Grade I midwife was reserved for European personnel.[113]

[112] *Ibid.*
[113] *Ibid.,* 37.

Chapter 5: Interactions between the Indigenous and the Western

Despite the detached relationship between the indigenous and Western institutions of maternal care, they existed side by side for a long time, sometimes interacting with each other. The continued persistence of traditional midwifery in rural areas is unsurprising in the face of the limitations of Western maternity services. Most traditional midwives, however, deliberately adapted themselves to the new trend. On their own part, some trained midwives employed traditional practices and medications in their work.

In the bid to remain viable, the first tactic of traditional midwives was to familiarize themselves with Western practices. This was prevalent among younger midwives or children of older midwives, who not only had their mothers' knowledge, but also the privilege of basic Western education. Their elementary education qualified them for the Grade II training schools where they obtained training in Western midwifery.

Elderly traditional midwives and those who had no basic education resorted to attaching themselves to trained midwives and nurses who often had their small-scale private practices. Through this informal training, traditional midwives observed and learned Western methods, including the use of injections and tablets administered to expectant mothers during pregnancy. There were the other class of midwives who solely relied on traditional methods and herbs. This latter group comprised acclaimed herbalists whose knowledge and skills were attributed to spiritual endowments.

In one aspect of midwifery, the Western-trained midwives were no better off than their traditional counterpart. This branch was surgery. As observed earlier, traditional

midwives were not skilled in handling complications that required surgery. This weakness was not ameliorated by the new midwife. Thus, complications of this nature were not handled any better by the Western midwife.

By the 1960s, a National Herbal Association of Nigeria arose which incorporated all the practitioners of indigenous medicine. A branch existed in Southeastern Nigeria and its members included traditional midwives. This move was a bid to gain some form of recognition and legitimacy in a transformed society. The association discussed matters that concerned midwives, including hygiene. Certificates of membership were issued to midwives who belonged to this group. The certificates were displayed in their homes, which were frequently the location of their own maternities; otherwise, they were subjected to harassments by scrupulous policemen. The association was a move by traditional midwives to imbue themselves with some recognition in the face of a new Western institution.

On the other hand, several Western-trained midwives who acknowledged the efficacy of herbs and some traditional methods combined them with Western medicine. These midwives either grew up in rural communities and were, therefore, aware of effective traditional approaches to childbirth or had mothers or relatives who were traditional midwives. The latter was often the case. They learned the correct application of herbs, and used them to improve the condition of the expectant mother and her fetus. Local balms like palm kernel oil and other local mixtures were commonly utilized by

them. Herbal mixtures were used in the treatments of pregnancy-related ailments like bloated legs.

As a precaution, however, majority of this class of midwives avoided administering oral herbs to expectant mothers during the first four months of pregnancy and after the eighth month. This was due to fear that misapplication of dosage at the onset of pregnancy may induce abortion or have other undesirable effect on the developing fetus.

Student-midwives also visited acclaimed traditional midwives to obtain information on their management of pregnancy and childbirth. These midwives-in-training took the initiative to extend their knowledge base to incorporate traditional methods. They sought out respected traditional midwives with whom they scheduled appointments in the midwives' homes, where they received instructions on traditional methods.

Chapter 6: CONCLUSION

The maternity, as was introduced in colonial Southeastern Nigeria, had its shortcomings. Christian missions had limited human and financial resources to ensure the even distribution of maternities across Igbo land. As a result, facilities were restricted to areas that served as headquarters or strongholds of missionaries. From the beginning, therefore, the distribution of the earliest maternities was favorable to urban centers.

Despite the increased participation of the colonial administration in providing healthcare for the indigenous people since the 1930s, the unequal distribution of hospitals and maternities among the rural and urban areas persisted and was reinforced partly because the colonial government adopted missionary medical work as an extension of its services. Most of the expansions of medical facilities by the government were carried out through missions, thus, reinforcing the initial distribution pattern. In some cases, new maternities were constructed for some colonial divisions. In other cases, rural health centers and dispensaries were simply converted into maternities. As a result, the standards of maternal services in the latter circumstances were poor. Actual colonial health policy paid more attention to figures than to standard and training because these conversions did not reflect any change in the staff that manned them.

Due to this lapse in the maternity and the lack of facilities, traditional midwives still served as a core part of maternal care in Igbo land. However, a key contribution of the Western maternity to maternal care in Igbo land was infant welfare. Traditional midwifery provided more ante-natal and post-natal care to the pregnant mother, but there

were no regular care for the growing infant, except in rare cases where parents consulted the midwife over an ailing newborn. In the 1950s, the Western maternity included Child Welfare Clinics which provided regular care for children for several years after birth.

One can argue that various local governments' bid to sponsor and secure the services of a community nurse was initiated by the roles of traditional midwives in these societies. Traditional midwives were known in their communities and provided personal care to pregnant women. They were ready to take their services to the door steps of the people. The enticement of community nurses in these societies could be seen as an attempt to have a "modern" version of the traditional midwife.

The introduction of the community nurse in the 1950s to provide the personal attention given by the traditional midwife created more sensitization about child welfare clinics and the need for regular post-natal childcare. It did not change the peoples' reliance on traditional midwives possibly because the number of community nurses in each community was very limited.

To effectively study the history and development of the Western maternity, and understand its weaknesses and the directions that it assumed especially towards the end of the colonial era, such research needs to incorporate traditional midwifery. The two institutions of maternal care in Igbo land still exist side by side in the rural areas due to the unequal establishments of medical facilities from the onset of British colonization. A balanced history of maternal care in colonial Igbo land cannot be devoid of the Western or the traditional.

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