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The transfer of European social policy concepts to tropical Africa, 1900–50: the example of maternal and child welfare

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Abstract

Concerns about a sinking birth rate and possible 'national degeneration' led to the implementation of various measures in maternal and child welfare across Europe at the dawn of the twentieth century. Infant health was strongly connected with the idea of population as both a national and imperial resource. In the colonies of the imperial powers, similar issues started to be addressed later, mostly after the First World War, when colonial administrations, who until then had predominantly worried about the health of the white European colonizers, started to take an interest in the health of the indigenous population. This article investigates the transfer of maternal and infant health policies from Britain and Germany to their tropical African colonies and protectorates. It argues that colonial health policy developed in a complex interplay between imperial strategies and preconceptions as well as local reactions and demands, mostly reifying racial demarcation lines in colonial societies. It focuses on examples from German East Africa, which became the British Tanganyika mandate after the First World War, and from the British sub-Saharan colonies Kenya and Nigeria.

Keywords British empire, colonial social policy, colonial sub-Saharan Africa, German empire, maternal and infant welfare

Introduction

Even if issues of social policy were not a priority of imperial rule, the decades between 1900 and 1950 witnessed the introduction of social services in many colonies of the European empires.[1] To this day, these structures continue to influence social policy in ex-colonies, a connection that has received little attention in scholarly work;[2] however, recent scholarship

1 James Midgley, 'Imperialism, colonialism and social welfare', in James Midgley and David Piachaud, eds., *Colonialism and welfare: social policy and the British imperial legacy*, Cheltenham: Edward Elgar, 2011, pp. 38–9.

2 Stephan Leibfried, Jane Lewis, and Christopher Pierson, eds., *The Oxford handbook of the welfare state*, Oxford: Oxford University Press, 2010; Michael P. Cowen and R. W. Shenton, *Doctrines of development*, London: Routledge, 1996. Neither work refers to colonial welfare.

has slowly begun to show an awareness about these issues.[3] Moreover, scholars of European social policy have to acknowledge that developments in Europe did not stop at European borders but were closely connected with events and changes in colonies and ex-colonies worldwide.

This article will deal with public health measures and, more specifically, with maternity and child health services for indigenous populations as part of the development of colonial social policy. Rudimentary beginnings of social services were being implemented in tropical non-settler colonies around the globe during and after the First World War, in the Caribbean, Africa, and South Asia.[4] Here I will concentrate on British and German sub-Saharan colonies in Africa between 1900 and 1950. I draw on examples from Tanganyika, Kenya, and Nigeria, thus bringing together three rather different colonial set-ups in order to analyse transfers of social policy. Tanganyika was a German colony (German East Africa) until 1918 and then a mandate territory under British rule. In this way, I have sought to highlight transnational colonial connections. Kenya and Nigeria were British tropical colonies that differed considerably. Whereas Kenya had a significant white settler population and was shaped by strong racial divides during the first decades of the twentieth century, Nigeria was administrated following the concept of indirect rule, at least until 1919.[5]

I will connect the development of welfare systems in both Britain and Germany with the transfer of some of the concepts and services to African colonies, analysing the manifold entanglements in the colonial situation and the diverse developments that these services underwent. I will argue that, in the case of maternal and child health, there was no clear transfer from imperial metropole to colony. Instead, these policies experienced a process of transformation based on a complex interplay of factors. What were originally seen as policies targeted at working-class families in Britain and Germany were shaped according to preconceptions about race and the special needs of 'backward' colonial settings. Local political, economic, and bureaucratic configurations – and, not least, the responses of African families – further mediated whether and how these programmes took shape.

Maternity and child services are an intriguing field for such an investigation, as they link various aspects of modern social and colonial policy. They serve as an important example for processes of medicalization and are also strongly connected with debates on population policy. From the late nineteenth century, healthy children were increasingly seen as the source of a strong nation and a mighty empire in most Western societies.[6]

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3 Miriam S. Chaiken, 'Primary health care initiatives in colonial Kenya', *World Development*, 26, 1998, pp. 1701–17; Midgley and Piachaud, *Colonialism*.

4 Lucy Mair, *Welfare in the British colonies*, London: Royal Institute of International Affairs, 1944; Leila Patel, *Restructuring social welfare*, Johannesburg: Ravan Press, 1992.

5 On Tanganyika, see John Iliffe, *A modern history of Tanganyika*, Cambridge: Cambridge University Press, 1979; on Kenya, see Bruce Berman and John Lonsdale, *Unhappy valley: conflict in Kenya and Africa, vol 1: state and class*, London: James Currey, 1992; on Nigeria and the concept of indirect rule under governor Frederick Lugard, see A. E. Afigbo, *The warrant chiefs: indirect rule in southeastern Nigeria 1891–1929*, London: Longman 1972.

6 For Germany, see Silke Fehlemann, *Armutsrisiko Mutterschaft: Mütter- und Säuglingsfürsorge im rheinisch-westfälischen Industriegebiet 1890–1924*, Essen: Klartext, 2009, pp. 25–8, 249–53; for Great Britain, see Jane Lewis, *The politics of motherhood: child and maternal welfare in England, 1900–1939*, London: Croom Helm, 1980, pp. 67–70.

Furthermore, the introduction of maternity and child services as forms of gendered politics was always tied to questions of reproduction and sexuality, figuring as key problems in colonial societies.[7] Research in African medical history and sociology has addressed issues of maternal and child health in single colonies but by no means comprehensively.[8] Comparisons between colonies, transfers between metropoles and colonies, and particularly maternity and child services in colonial Africa have received far less scholarly attention.

In the colonial world, health services were generally important tools for empire-building.[9] They were viewed not only as necessary for maintaining a colonial workforce but also as a help in gaining the confidence of the colonial population by offering some social services. Health measures could be used to control the body of the colonized and for comprehensive forms of social control, as David Arnold has argued for India.[10] Furthermore, health services were seen as transporting European biomedicine to the 'backward races', a process of colonization in itself.[11] Looking at Africa, the introduction of Western health as part of a civilizing mission in Africa could also serve as a general justification for European colonialism.[12] In African colonies such issues started to be addressed during and after the First World War, when the colonial administrations – until then mostly worried about the health of the white European colonizers – raised concerns about the sinking birth rates shortly before the outbreak of the First World War.[13] Since the colonized were seen mainly as a workforce and as necessary 'capital' to raise profit from the colonies, diminishing birth rates were perceived as a major problem. Taking these various issues into consideration, the article will examine general features of colonial health services, the problematic transfer of health policy concepts from the

7 Anne McClintock, *Imperial leather: race, gender and sexuality in the colonial contest*, London and New York: Routledge, 1995; Philippa Levine, 'Sexuality, gender, and empire', in Philippa Levine, ed., *Gender and empire: the Oxford history of the British empire*, Oxford: Oxford University Press, 2004, pp. 134–55.

8 Walter Bruchhausen, *Medizin zwischen den Welten: Geschichte und Gegenwart des medizinischen Pluralismus im südöstlichen Tansania*, Göttingen: Vandenhoeck & Ruprecht, 2006; Tabitha Kanogo, *African womanhood in colonial Kenya, 1900–50*, Oxford: Currey, 2005; Michael Jennings, '"A matter of vital importance": the place of the medical mission in child healthcare in Tanzania 1919–1939', in David Hardiman, ed., *Healing bodies, saving souls: medical missions in Asia and Africa*, Amsterdam and New York: Rodopi, 2006, pp. 227–50; Dennis A. Ityavyar, 'Background to the development of health services in Nigeria', *Social Science & Medicine*, 24, 1987, pp. 487–99; Deanne van Tol, 'Mothers, babies, and the colonial state: the introduction of maternal and infant welfare services in Nigeria 1925–1945', *Spontaneous Generations*, 1, 1, 2007, pp. 110–31.

9 Steven Feierman, 'Struggles for control: the social roots of health and healing in modern Africa', *African Studies Review*, 28, 1985, pp. 120–25. For a less critical analysis, see Spencer H. Brown, 'A tool of empire: the British medical establishment in Lagos, 1861–1905', *International Journal of African Historical Studies*, 37, 2, 2004, pp. 309–11.

10 David Arnold, *Colonizing the body: state medicine and epidemic disease in nineteenth-century India*, Berkeley, CA: University of California Press, 1993, pp. 8–10.

11 Shula Marks, 'What is colonial about colonial medicine? And what has happened to imperialism and health?', *Social History of Medicine*, 10, 1997, pp. 205–19.

12 O. A. Olumwullah, *Dis-ease in the colonial state: medicine, society, and social change among the AbaNyole of western Kenya*, Westport, CN: Greenwood Press, 2002, p. 6.

13 Otto Peiper, *Der Bevölkerungsrückgang in den tropischen Kolonien Afrikas und der Südsee: seine Ursachen und seine Bekämpfung*, Berlin: Schoetz, 1920.

metropole to the colony, and the transformation in maternal and child welfare measures when introduced in colonial settings.

Early colonial health policy in Africa

In most tropical non-settler colonies, the focus on military medicine, rather than other aspects of health policy, predominated in the second half of the nineteenth century and the beginning of the twentieth. Diminishing the mortality of European troops in the 'warm climate' of the tropical colonies was the highest priority for colonizers.[14] By the time that the sub-Saharan colonies had come under the control of the European empires at the end of the nineteenth century, the military approach remained a persistent feature.[15] Colonial medicine targeted the wellbeing of the white soldiers and colonizers and not that of African people, let alone their families and children. It concentrated on combating tropical diseases in order to allow European people to conquer and govern these territories.[16] Developing strategies against malaria, sleeping sickness, and parasitical diseases, using vaccination and hygiene campaigns, remained the core issues of the early colonial health services, mostly aimed at the protection of the European population.[17] In this context, tropical medicine took off as an independent discipline in the imperial metropoles, with the founding of the London School of Tropical Medicine in 1898 and the first German institute for tropical medicine in Hamburg in 1901.[18]

Beyond Europeans, male workers were the main patients of the early colonial health services.[19] The principal reason for opening up facilities to the African population at the turn of the century was the growing economic interest in a healthy and stable workforce, which was now needed for infrastructural measures as well as for the expanding plantations in tropical colonies. For instance, when colonizers started to build railways, most of the railway companies set up small treatment facilities for workers along the tracks.[20] In German East Africa, the government took over some of these treatment centres as general hospitals for

14 Philip D. Curtin, 'Disease and imperialism', in David Arnold, ed., *Warm climates and Western medicine: the emergence of tropical medicine, 1500–1900*, Amsterdam: Rodopi, 1996, p. 100; Feierman, 'Struggles', pp. 120–1.

15 Ann Beck, 'The role of medicine in German East Africa', *Bulletin of the History of Medicine*, 45, 1971, p. 173; Jane Turrittin, 'Colonial midwives and modernizing childbirth in French West Africa', in Jean Allman, Susan Geiger, and Nakanyike Musisi, eds., *Women in African colonial histories*, Bloomington, IN: Indiana University Press, 2002, p. 75; Wolfgang U. Eckart, *Medizin und Kolonialimperialismus: Deutschland 1884–1945*, Paderborn, 1997, pp. 299–300.

16 Feierman, 'Struggles', p. 120.

17 For German East Africa, see Eckart, *Medizin*, pp. 301–8, see also the health reports from the German colonies, where the chapters on combating tropical diseases took up most of the pages: *Medizinalberichte über die Deutschen Schutzgebiete 1903/04*, Berlin, 1905; *Medizinalberichte über die Deutschen Schutzgebiete 1909/10*, Berlin, 1911.

18 David Arnold, 'Introduction: tropical medicine before Manson', in Arnold, *Warm climates*, p. 3; see also Patrick Manson, *Tropical diseases: a manual of the diseases of warm climates*, London: Cassell, 1898. For Germany, see Eckart, *Medizin*, p. 73.

19 Feierman, 'Struggles', p. 123; Walter Bruchhausen, '"Practising hygiene and fighting the natives' diseases": public and child health in German East Africa and Tanganyika territory 1900–1960', *Dynamis*, 23, 2003, p. 102.

20 See, for example, Bahnbau der Usambarabahn, 'Nachweisung über die Krankenbewegung und Todersursachen über Farbige im Berichtsjahre 1911/12', *Medizinalberichte über die Deutschen Schutzgebiete 1911/ 12*, Berlin, 1915, pp. 328–9; see generally, Eckart, *Medizin*, pp. 352–3.

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Africans. If European hospitals allowed African patients, their treatment was kept in separate houses, often without necessary equipment.[21]

Maternity and child health were not addressed as a high priority in tropical Africa at the beginning of the twentieth century. This field tended to remain in the realm of the missions, which provided rudimentary Western medical services together with Christian education.[22] It was especially English Protestant missions such as the Church Missionary Society in East Africa that started to offer some medical services to the local population.[23] They perceived Western medicine as an aid in their fight for the Christianization of Africans, even if there were strong debates about the fact that medical services should never override the real aim of missionary work.[24] Nevertheless, the missions paid attention to mothers and children earlier than the colonial administrations. They saw it as their aim to combat the 'pagan and unhealthy customs' of the African population, especially practices around childbirth that were assumed to be dirty and barbaric, and to introduce European family models and morals. Missionaries were generally keen to intervene in the areas of sexuality and reproduction, which were strongly connected with the upbringing of 'good Christians'. For the missions, the argument that European civilization was superior was strongly entwined with a belief in the superiority of the Christian faith. By addressing sexual and reproductive health in the colonies, missionaries not only demonstrated their faith but also gained early access to children, who were both patients and potential converts.[25]

The beginning of maternal and child welfare in Germany and Great Britain around 1900

While health policy in the colonies focused primarily on the treatment of tropical illness, state health policy in Europe and also in some of the white settler colonies such as Australia and New Zealand – only targeting the white population – started to combine health issues with social policy and preventive measures before and around 1900. In Western countries in general, health policy now addressed the field of reproduction and of maternity and child services.[26] If we turn

21 For German colonies, see Nicole Schweig, *Weltliche Krankenpflege in den deutschen Kolonien Afrikas 1884–1918,* Frankfurt am Main: Mabuse, 2012, pp. 93–4; for British colonies, see Megan Vaughan, *Curing their ills: colonial power and African illness*, Cambridge: Polity Press, 1991, pp. 29–30; Anna Khalid and Ryan Johnson, 'Introduction', in Ryan Johnson and Anna Khalid, eds., *Public health in the British empire: intermediaries, subordinates, and the practice of public health, 1850–1960*, New York: Routledge, 2012, p. 7.

22 Charles Good, 'Pioneer medical missions in colonial Africa', *Social Science & Medicine*, 32, 1, 1991, p. 1.

23 Vaughan, *Curing*, pp. 58–9.

24 David Hardiman, 'The mission hospital, 1880–1960', in Mark Harrison, Margaret Jones, and Helen Sweet, eds., *From Western medicine to global medicine: the hospital beyond the West*, New Delhi: Orient Blackswan, 2009, p. 200.

25 Vaughan, *Curing*, p. 23; Randall Packard, 'Visions of postwar health and development and their impact on public health interventions in the developing world', in Frederick Cooper, ed., *International development and the social sciences: essays on the history and politics of knowledge*, Berkeley, CA: University of California Press, 1997, p. 95.

26 Lloyd Cox, 'The Antipodean social laboratory, labour and the transformation of the welfare state', *Journal of Sociology*, 42, 2, 2006, p. 107; Madonna Grehan Janet Greenless and Linda Bryder, eds., *Western maternity and medicine, 1880–1990*, London: Pickering and Chatto, 2013; Ann Taylor Allen, *Feminism and motherhood in western Europe, 1890–1970: the maternal dilemma*, New York: Palgrave Macmillan, 2005, pp. 8–9.

to Germany and Great Britain, the introduction of special programmes for maternity and infant care was connected with growing concerns about national birth rates and the health of the population in general. Declining birth rates, high infant-mortality figures, and the poor health of the lower classes seemed to jeopardize the future of the nation.[27] The declining birth rate, in particular, was seen as a phenomenon of degeneration. This was matched by an anxiety about the weakness of new-borns and offspring 'quality'.[28] Contemporary scientists and politicians agreed that only a growing population would secure progress as well as national and imperial interests.[29] Thus, the protection of maternity emanated from a desire for robust, healthy new-borns as a guarantee for the survival of the nation and the empire.

Furthermore, infant health care developed into an important concern not only for state agencies but also for the medical professions, the social hygiene movement, women's associations, and other groups.[30] Some of these groups also expressed concern about mothers and children in the colonial situation, sometimes earlier than the state administrations. For example, in Germany, the Society for the Prevention of Infant Mortality, which was founded in 1904, took up colonial issues shortly before the First World War.[31] In Britain, the 'National Baby Welfare Council' was established in 1916 and soon organized not only national but also imperial baby weeks in various colonies of the British empire with educational programmes.[32]

In both Great Britain and Germany, one argument predominated in expert discussions: mothers from lower classes should be held responsible for the ill health of their new-borns. 'Maternal ignorance' became the keyword of many debates around and after 1900.[33] The difficulties of raising small children without the necessary financial means or sufficient living space, as well as with poor drinking water, were willingly overlooked, even if contemporary research had already hinted at the connection between poverty, bad living conditions, and infant mortality.[34] Such arguments could also easily be transferred to the colonial situation, as they shifted the blame to the groups concerned and allowed a concentration on cheap educational and regulative measures.

If we look at the introduction of actual maternity and child services in both Germany and Britain, there were a number of similar developments along these lines. In Germany, health services began to address maternity issues early, strongly connecting them with a concern for

27 Deborah Dwork, *War is good for babies and other young children: a history of the infant and child welfare movement in England 1898–1918*, London: Tavistock, 1986, pp. 3–22.

28 Paul Weindling, *Health, race and German politics between national unification and Nazism, 1870–1945*, Cambridge: Cambridge University Press, 1989, pp. 188–9; Christiane Dienel, 'Der Niedergang der Geburtenzahlen und der Aufstieg der Ärzte in Deutschland und Frankreich bis zum Ersten Weltkrieg', *Medizin, Gesellschaft und Geschichte*, 12, 1993, pp. 147–76.

29 Petra Finck, 'Der Geburtenrückgang und seine Folgen: Bevölkerungspolitik im Deutschen Kaiserreich', in Petra Finck and Marlies Eckhof, eds., *'Euer Körper gehört uns!': Ärzte, Bevölkerungspolitik und Sexualmoral bis 1933*, Hamburg: Ergebnisse Verlag, 1987, p. 25.

30 Edward Ross Dickinson, *The politics of German child welfare from empire to the Federal Republic*, Cambridge, MA: Harvard University Press, 1996, pp. 50–6.

31 Elmer Schabel, *Soziale Hygiene zwischen sozialer Reform und sozialer Biologie: Fritz Rott und die Säuglingsfürsorge in Deutschland*, Husum: Matthiesen, 1995, p. 37.

32 *Ibid.*, pp. 500–1.

33 Tania McIntosh, *A social history of maternity and childbirth: key themes in maternity care*, London: Routledge, 2012, p. 26.

34 Anna Davin, 'Imperialism and motherhood', *History Workshop*, 5, 1978, pp. 14, 28–31.

the children of working mothers. Legal protection for working mothers had already been enforced in the German Kaiserreich in 1878 – even before health insurance was introduced under Bismarck in 1883.[35] The measures were aimed at mothers working outside the home and at the wellbeing of babies, since factory work was seen as particularly detrimental to the health of new-borns.[36]

By contrast, maternity protection laws were not the focus in Great Britain. Here, another aspect became more important: the introduction of infant health care, a policy that was strongly entwined with imperial and colonial issues. During the Boer War in South Africa (1899–1902), the deplorable health of the working-class conscripts was widely debated and led to a fierce discussion about infant and child health.[37] The results of the official enquiry of the Inter-departmental Committee on Physical Deterioration were published in 1904, with strong recommendations for improving the education of mothers.[38] Shortly after the report was released, British local authorities began opening counselling centres for mothers and their babies. They also employed women as health visitors, who called on mothers with new-borns, gave advice on care and nutrition, and encouraged breastfeeding.[39] The introduction of a 30-shilling maternity benefit through the National Insurance Act of 1911 turned out to be a more effective measure. However, the benefit only reached a fraction of mothers, since only a small percentage of the population was insured.[40] During the First World War the number of counselling centres for new-borns and children and the number of health visitors grew. In 1914, local authorities employed 600 health visitors; by 1918, they numbered over 2,500.[41] The 1920s saw ongoing growth in the whole field of maternity and infant care, following the 1918 Maternity and Child Welfare Act. This Act made it a duty for local authorities to provide a range of services to pregnant women, mothers, new-borns, and children, including the establishment of maternity wards in hospitals. Mothers could benefit from these services for free.[42]

In Germany, most cities established counselling centres for mothers with new-born babies after the turn of the century.[43] Nurses also tried to visit mothers with new-borns at home, but these visits were viewed more sceptically than they were in Great Britain. They seemed to continue the tradition of obligatory health visits by nurses that women receiving poor relief

35 Sigrid Stöckel, *Säuglingsfürsorge zwischen sozialer Hygiene und Eugenik*, Berlin and New York: de Gruyter, 1996, p. 261.

36 Ute Frevert, 'Fürsorgliche Belagerung', *Geschichte und Gesellschaft*, 11, 1985, p. 436.

37 Report of the Inter-Departmental Committee on Physical Deterioration, London: HMSO, 1904, p. 95.

38 *Ibid.*, p. 89.

39 Robert Dingwall, Ann Rafferty, and Charles Webster, *An introduction to the social history of nursing*, London: Routledge, 1988, p. 185; Ann Oakley, *The captured womb: a history of the medical care of pregnant women*, Oxford: Blackwell, 1984, pp. 34–7; Davin, 'Imperialism', pp. 10–1.

40 Elizabeth Peretz, 'A maternity service for England and Wales: local authority maternity care in the inter-war period in Oxfordshire and Tottenham', in J. Garcia, R. Kilpatrick, and M. Richards, eds., *The politics of maternity care: services for childbearing women in twentieth-century Britain*, Oxford: Oxford University Press, 1990, p. 41; Irvine Loudon, *Death in childbirth: an international study of maternal care and maternal mortality 1800–1950*, Oxford: Clarendon Press, 1992, pp. 209, 217–18.

41 Dwork, *War*, p. 211.

42 The National Archives, Kew (TNA), Public Record Office, MH 55/992, Ministry of Health, Reference Note 1, 'Maternity and child welfare, England and Wales', February 1958.

43 Stöckel, *Säuglingsfürsorge*, pp. 211–22.

and unwed mothers had to endure in the nineteenth century.[44] During the First World War, services expanded considerably.[45] From 1914 onwards, the wives of insured men also received a maternity benefit, as had been the case in Great Britain since 1911. At the same time the number of counselling centres also grew considerably, and in 1917–18, 1,020 new health centres for new-borns were set up across Germany.[46]

By the 1930s, both countries had established a fairly comprehensive health service for mothers and children, far removed from the first educational initiatives. The First World War can be seen as an engine for change in this context for Germany and Great Britain, with similar kinds of thinking about population health and national wellbeing emerging. The health services and the benefits that were introduced were based on the resources of two industrialized states with growing income from insurance and taxes, as well as a quickly developing social infrastructure. As for differences, the German health system for mothers and children focused much more on medical services covered by the expanding compulsory health insurance and less on public health services offered for free by local authorities, as was the case in Great Britain.[47] An aspect of social control featured in Germany, continuing a tradition of policing social care.

Developments in German East Africa, 1900–14: social policy arrives in tropical colonial Africa

These activities within metropolitan Britain and Germany did influence colonial policy in Africa, even if the discussions in the motherlands focused on the wellbeing of the nation and the allegedly endangered 'superiority of the white race'. In tropical colonies of European empires, efforts were directed instead at the 'inadequate' growth of the indigenous population, which would endanger the sustainment of a stable workforce. In German East Africa, medical officers complained about low birth rates and a high infant-mortality rate during the last years before the outbreak of the First World War.[48] Several articles in colonial journals and in the German East African press touched upon the danger of a dwindling population and a shrinking workforce in the East African colony. In most discussions, utilitarian arguments about the colonial workforce prevailed, but they were sometimes combined with humanitarian concerns about the poor living conditions of Africans.[49]

44 Silke Fehlemann and Jörg Vögele, 'Frauen in der Gesundheitsfürsorge am Beginn des 20. Jahrhunderts: England und Deutschland im Vergleich', in Ulrike Lindner and Merith Niehuss, eds., *Ärztinnen – Patientinnen: Frauen im deutschen und britischen Gesundheitswesen des 20. Jahrhunderts*, Cologne: Böhlau, 2002, pp. 33–4; Weindling, *Health*, p. 354; Cornelie Usborne, *Frauenkörper – Volkskörper: Geburtenkontrolle und Bevölkerungspolitik in der Weimarer Republik*, Münster: Westfälisches Dampfboot, 1994, p. 83.

45 Chirstoph Sachsse, *Mütterlichkeit als Beruf*, Frankfurt am Main: Suhrkamp, 1986, pp. 156–61.

46 Stöckel, *Säuglingsfürsorge*, pp. 265–6, 286.

47 Ulrike Lindner, *Gesundheitspolitik in der Nachkriegszeit: Großbritannien und die Bundesrepublik Deutschland im Vergleich*, Munich: Oldenbourg, 2004, pp. 60–3.

48 Schweig, *Weltliche Krankenpflege*, p. 95.

49 Johannes Michael Burgt, 'Zur Entvölkerungsfrage Unjamwenzis und Ussumbwas', *Koloniale Rundschau*, 1, 1914, pp. 24–7; L. Külz, 'Die seuchenhaften Krankheiten des Kindesalters der Eingeborenen und ihre Bedeutung für die koloniale Bevölkerungsfrage', *Koloniale Rundschau*, 6, 1914, pp. 821–30; anon., 'Bevölkerungsverschiebung oder Bevölkerungsabnahme in Deutsch-Ostafrika?', *Deutsch-Ostafrikanische Zeitung*, 6 June 1914.

The German Association for the Protection of Infants sent a petition to both the Reichstag and the Colonial Office in 1914 in order to ask for new measures to tackle the colonial problem.[50] The situation in Africa was clearly addressed with concepts developed in the metropole, as the words '*Sozialpolitik*' ('social policy') and '*Sozialhygiene*' ('social hygiene') now surfaced in the discourse of colonial medicine.[51] For the first time, the official 1911–12 medical report of the German colonies mentioned the topic of social hygiene and referred to statistics of infant mortality among the African population.[52] A survey conducted by the medical officers of each district in German East Africa found that, on average, women under forty-five years had only two living (and two deceased) children.[53] German colonial officials and medical experts perceived these rudimentary surveys as a strong warning about the future population growth of the colonies. Infant mortality was now recognized as a pressing problem. From 1910 onwards, these themes were particularly brought to the attention of medical and public hygiene experts by Otto Peiper, a military medical officer working in Kilwa in German East Africa.[54] He and his contemporaries saw that the spread of infectious diseases, such as smallpox, malaria, and trypanosomiasis, was one of the main reasons for high infant mortality. In their opinion, the impact of the diseases was inextricably connected with the lack of hygiene in African families.[55] German doctors and German colonial officials also blamed African mothers for inadequate nutrition, which resulted in infant mortality.[56]

The debate clearly followed discussion patterns from Germany, where working-class mothers were accused of deficient hygiene in their homes and of providing a poor diet for their infants. The argument of class was substituted by the argument of race, even if class still played an important role.[57] The blame was mostly directed at the poor, rural African population, and not at the upper strata of Indian and Arab merchants who lived on the coast of German East Africa as well. Additionally, the low birth rate in African colonies was interpreted as a consequence of uncured venereal diseases causing sterility and as an outcome of the inferior morality of the 'barbaric' African population.[58] Again, this line of argument reflected the European discussion on venereal diseases around 1900 that had focused on the spread in Europe in connection with the lack of morality of the lower classes.[59]

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50 'Eingabe der Deutschen Gesellschaft für Eingebornenschutz an den Reichstag und das Reichskolonialamt', *Koloniale Rundschau*, 7, 1914, p. 129.

51 Oskar Karstedt, 'Betrachtungen zur Sozialpolitik in Ostafrika', *Koloniale Rundschau*, 7, 1914, pp. 133–41.

52 *Medizinalberichte über die Deutschen Schutzgebiete 1911/12*, pp. 157–74, 180–4; *Medizinalberichte über die Deutschen Schutzgebiete 1907/08*, Berlin, 1909; *Medizinalberichte über die Deutschen Schutzgebiete 1908/09*, Berlin, 1910; *Medizinalberichte über die Deutschen Schutzgebiete 1909/10*.

53 *Medizinalberichte über die Deutschen Schutzgebiete 1911/12*, p. 184.

54 Otto Peiper, 'Über Säuglingssterblichkeit und Säuglingsernährung im Bezirke Kilwa Deutsch-Ostafrika', *Archiv für Schiffs- und Tropenygiene*, 14, 1910, pp. 233–59; Otto Peiper, 'Schwangerschaft, Geburt und Wochenbett bei den Suaheli von Kilwa', *Archiv für Schiffs- und Tropenhygiene*, 14, 1910, pp. 461–9.

55 Peiper, 'Über Säuglingssterblichkeit', pp. 10–11; see also Külz, 'Seuchenhaften Krankheiten', pp. 323–4.

56 Hugo Meixner, 'Säuglings- und Kinderernährung in Deutsch-Ostafrika', *Deutsches Kolonialblatt: Amtsblatt für die Schutzgebiete in Afrika und in der Südsee*, 15 April 1914, pp. 354–6.

57 Patrick Brantlinger, 'The genealogy of the myth of the dark continent', *Critical Inquiry*, 12, 1985, p. 181.

58 'Eingabe der Deutschen Gesellschaft für Eingebornenschutz', p. 129.

59 Lindner, *Gesundheitspolitik*, p. 285.

Surprisingly, in contemporary journals and publications, the devastating Maji-Maji War in German East Africa (1905–07) was hardly mentioned, even though it had actually killed many thousands of Africans, left huge areas in East Africa uninhabitable, and certainly had a decisive impact on population growth.[60] The impact of a new regime of work – involving the mass migration of men to plantations and to railway construction sites, thus leading to a break-up of families – was only partly acknowledged as a reason for the declining birth rate. Instead, forcing African men to take up paid labour in order to free women from work outside the home was seen as conducive to stable families and a growing population.[61]

In historical research, meanwhile, it is broadly agreed that the population in East Africa declined considerably between 1890 and 1920 as a consequence of colonial conquest, occupation, and new labour management. Altogether, this period can be labelled as the most unhealthy period in modern Africa. Paradoxically, as John Ford has argued, both British and German colonizers saw themselves as 'saviours' of the African people during this time. He suggests that colonial officials failed to note that they were an important cause of the health hazards that Africans had to suffer during and after occupation.[62] The enlargement of agricultural sites, settlements, and plantations meant that many areas were infested with malaria and sleeping sickness; more people now came into contact with these diseases; and the intensified transport of goods and people also encouraged the illnesses to spread.[63]

Instead of focusing on these causes, German experts put forward a variety of alternative proposals to combat population decline in the colonies. The 1914 petition of the German Association for the Protection of Infants called for a number of measures. The group concentrated on alleged cultural problems that were hindering a '*normale Volksvermehrung*' (normal population increase), such as abortion, child marriage, infanticide, and child abduction.[64] The enumeration of customs was more or less a reproduction of long-standing prejudices that Europeans had been cultivating against African societies. Since the group considered these narratives to be the reality on the ground, the German Association asked for laws forbidding these customs. It argued especially for banning polygamy and forbidding high dowries in order to lower the age of marriage.[65] Other recommendations were directed at high infant mortality, following those already familiar in Europe. African mothers should be supported through indigenous midwives and female auxiliaries who were to be trained in Africa. African auxiliaries would then educate African mothers in matters of hygiene and spread Western knowledge of birth practices and childrearing, for example of cleanliness during birth, of a certain clothing for children, or of regular bathing.[66] The planned

60 Ludger Wimmelbucker, 'Verbrannte Erde: zu den Bevölkerungsverlusten als Folge des Maji-Maji-Krieges', in Felicitas Becker and Jigal Beez, eds., *Der Maji-Maji-Krieg in Deutsch-Ostafrika 1905–1907*, Berlin: Ch. Links, 2005, 87–99.

61 Peiper, 'Säuglingssterblichkeit', pp. 44–5.

62 John Ford, *The role of the trypanosomiases in African ecology: a study of the tsetse fly problem*, Oxford: Clarendon Press, 1971, pp. 143–4.

63 Hiroyuki Isobe, *Medizin und Kolonialgesellschaft: die Bekämpfung der Schlafkrankheit in den deutschen 'Schutzgebieten' vor dem Ersten Weltkrieg*, Berlin and Münster: LIT, 2009, p. 17.

64 'Eingabe der Deutschen Gesellschaft für Eingebornenschutz', p. 131.

65 *Ibid.*, p. 132; Peiper, 'Säuglingssterblichkeit', p. 48.

66 Peiper, 'Säuglingssterblichkeit', p. 50.

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measures were directed at regulatory and educational endeavours that would be relatively easy to introduce in a territory without necessary resources and infrastructure. The focus on laws and regulatory means can be identified as typical of the German approach.

In practice, the undertakings were complicated and remained marginal in German East Africa. Very few births of African mothers were assisted by European midwives in the capital of the colony, Dar-es-Salaam: the numbers remained between just thirty and forty per year, as listed in the medical reports of the colony.[67] Shortly before the outbreak of the First World War, the governor of East Africa asked the Colonial Office in Berlin whether a few African women could be trained as midwives in Germany. But, because of widely held racial prejudices, the colonial administration in Berlin felt that training black African women in German hospitals would be inappropriate. The Colonial Office offered to send some German nurses to the few existing maternity wards in German East Africa. However, the governor of East Africa replied that there were hardly any maternity wards for African women. He suggested that African women tended to avoid giving birth in hospitals anyway. For example, one of the hospitals that accepted African women in Dar-es-Salaam targeted the Indian population of the city. African women were reluctant to use this hospital.[68] Thus trained African midwives would have been by far a better solution. The half-hearted attempt of the German East African administration to establish some measures during the last years before 1914 did not lead to any congruent services. The discussion in German East Africa and in the metropole only started to gain momentum in 1913–14. With the outbreak of the First World War, which soon reached the colonies, these endeavours stopped abruptly.[69]

In the British sub-Saharan colonies, discussions of infant mortality and declining birth rates started later, after the First World War. If one wonders why the discussion began earlier in German East Africa, several reasons can be identified that had little to do with Germany's style of maternity and infant care. First, the Maji-Maji War in German East Africa had killed a hundred thousand people, a fact that had led the colonizers to feel the population decline more acutely. Second, colonizers in German East Africa prided themselves on their scientific approach towards colonialism. The research institute Amani investigated biological and agricultural issues, many medical expeditions were led to the hinterland, and medical research into tropical diseases flourished.[70] Hence, even British colonizers in Africa perceived the approach in German East Africa to some extent as a role model in the fields of agriculture and medicine for their sub-Saharan tropical colonies.[71]

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67 *Medizinalberichte über die Deutschen Schutzgebiete 1908/09*, p. 169; *Medizinalberichte über die Deutschen Schutzgebiete 1909/10*, p. 233.

68 Schweig, *Weltliche Krankenpflege*, p. 96.

69 Ann Beck, 'Medicine and society in Tanganyika, 1890–1930: a historical inquiry', *Transactions of the American Philosophical Society*, 67, 1977, pp. 39–40.

70 Detlef Bald and Gerhild Bald, *Das Forschungsinstitut AMANI: Wirtschaft und Wissenschaft in der deutschen Kolonialpolitik in Ostafrika 1900–1918*, Munich: Weltforum-Verlag, 1972; Eckart, *Medizin*, pp. 303, 340–3.

71 See, e.g., C. T. Hagbert Wright, 'German methods of development in Africa', *Journal of African Studies*, 1, 1901–02, p. 36; Ulrike Lindner, *Koloniale Begegnungen: Deutschland und Großbritannien als Imperialmächte in Afrika 1880–1914* Frankfurt am Main: Campus, 2011, pp. 83–4; Ulrike Lindner, 'Colonialism as a European project in Africa before 1914? British and German concepts of colonial rule in sub-Saharan Africa', *Comparativ*, 19, 2009, pp. 88–106.

In the British empire, social policy and health issues were addressed earlier in the colonies of South Asia and Southeast Asia, as in India, Malaya, and Hong Kong.[72] In colonial Fiji, strong population decline led to an investigation into infant mortality, with a report published as early as 1896.[73] In the field of colonial health policy, Ceylon can be seen as a forerunner of development in the empire. It was generally considered to be the model colony by the imperial government, as a wealthy crown colony gaining responsible government by 1931 and establishing health services under colonial rule early.[74] In British South Africa, health services did focus on population control and child health much earlier than in tropical Africa; however, policies here were mainly concerned with preventing a national decline by maintaining a proper standard of 'civilized whites' and controlling the growth of the group of so-called 'poor whites', quite a different point of departure for population policy.[75]

New arguments and practices in colonial health care after the First World War

After 1918, Germany lost its colonies, and German East Africa became the British mandate of Tanganyika. Health policy in Tanganyika, as in Britain's sub-Saharan colonies, was now under the direction of the British Colonial Office. Yet there was still no coherent plan to develop colonial health policy in Africa, and services tended to be established by trial and error.

The arguments of British colonizers in Africa generally started to change after the First World War – a change that had a significant impact on the direction of social services. A first impetus was provided by the Treaty of Versailles, with the mandates of the League of Nations that emphasized the trusteeship of the colonial powers for indigenous populations. 'Colonial development' became the new keyword. Joanna Lewis has shown that this new ideology of trusteeship put a great deal of pressure on the mandate powers to invest in public health programmes, which had an impact not only on mandate territories but on all colonizing powers.[76] Secondly, international organizations such as the League of Nations Health Organization started to take a great interest in the health situation in Africa after the First World War. Their wish to develop international programmes influenced the colonizing powers in their outlook on colonies.[77] A third reason for the growing interest in preventive

72 Wan Faizah Wan Yussoff, *Malay responses to the promotion of Western medicine, with particular reference to women and child healthcare in the Federated Malay States 1920–1939*, PhD thesis, School of Oriental and African Studies, University of London, 2010; Kwong-Leung Tang, *Colonial state and social policy: social welfare development in Hong Kong 1842–1997*, Lanham, MD: University Press of America, 1998.

73 Lenore Manderson, *Sickness and the state: health and illness in colonial Malaya*, Cambridge: Cambridge University Press, 2002, p. 203.

74 Margaret Jones, *Health policy in Britain's model colony: Sri Lanka 1900–1948*, New Delhi: Orient Blackswan, 2004.

75 Susanne M. Klausen, *Race, maternity and the policy of birth control in South Africa, 1910–39*, Basingstoke: Palgrave Macmillan, 2004, pp. 6–7.

76 Joanna Lewis, *Empire state-building: war and welfare in Kenya 1925–52*, Oxford: James Currey, 2000, pp. 25–6; Vernon Marston Hewitt, 'Empire, international development and the concept of good government', in Mark R. Duffield and Vernon Marston Hewitt, eds., *Empire, development and colonialism: the past in the present*, Woodbridge: Currey, 2009, pp. 30–44.

77 Helen Tilley, *Africa as a living laboratory: empire, development, and the problem of scientific knowledge 1870–1950*, Chicago, IL: University of Chicago Press, 2011, pp. 177–81.

measures for mothers and children was the stagnating or declining birth rates in the East and central African colonies that had been detected through new and still rudimentary population surveys.[78] Population decline was now seen as a threat to productivity in British sub-Saharan colonies, just as it had been slightly earlier in German East Africa. Finally, from the mid 1920s onwards health problems were at last connected with issues of subsistence. As Michael Worboys has shown, the 'discovery' of malnutrition in Africa happened in 1925 in association with research on cattle diseases and on the diets of different African peoples. The consequences of this research for health issues were now debated, and new attention was directed to caring for and feeding children.[79]

The new interest in colonial public health was matched by a growing scientific interest in the colonies and a new trust in scientific expertise.[80] An outcome of this approach was Lord Hailey's famous and extensive survey of Africa, undertaken in the course of the 1930s and published in 1938, which provided a motivation for future colonial policy. The problems, shortcomings, and consequences of this Herculean undertaking have been extensively discussed in research, particularly by Helen Tilley, and are not my focus here.[81] What is noteworthy is that Hailey's report and his concept centred on community services, on so-called 'local native authorities', and not on the professionalization of African elites. His recommendations were already strongly disputed by contemporaries. They partly reflected the ideology of indirect rule made popular by the colonial administrator Frederick Lugard in his book on 'Dual Mandate' from 1922,[82] and possibly echoed the emphasis on local authorities that became widespread in British public social services during the 1920s. Hailey's report was certainly not taken as a blueprint for colonial social policy. However, it did strengthen arguments for the introduction of public health measures, as it underlined the connections between ill health and social problems.[83]

Influenced by these new trends, maternity services, health services for children, and the training of midwives became important topics of colonial health in British tropical African colonies from the 1920s onwards. As in German East Africa, reducing infant mortality and ill health seemed to be a fairly straightforward undertaking in the eyes of the British colonizers. They saw that they could improve population health through educational measures, not through costly investments in a large expansion of health services. The regulatory aspect that featured prominently in German colonial discussions was not taken

78 Nancy Rose Hunt, '"Le bébé en brousse": European women, African birth spacing and colonial intervention in breast feeding in the Belgian Congo', *International Journal of African Historical Studies*, 21, 1988, p. 404.

79 Michael Worboys, 'The discovery of malnutrition between the wars', in David Arnold, ed., *Imperial medicine and indigenous societies*, Manchester: Manchester University Press, 1988, pp. 210–11. See also Mary Blacklock, 'Co-operation in health education', *Africa: Journal of the International African Institute*, 4, 2, 1931, p. 205; William Malcolm Hailey, *An African survey: a study of problems arising in Africa south of the Sahara*, London: Oxford University Press, 1938, p. 1114.

80 Joseph Morgan Hodge, *Triumph of the expert: agrarian doctrines of development and the legacies of British colonialism*, Athens, OH: Ohio University Press, 2007, p. 8.

81 Tilley, *Africa*, p. 71; see also John W. Cell, *Hailey: a study in British imperialism, 1872–1969*, Cambridge: Cambridge University Press, 2002.

82 John W. Cell, 'Colonial rule', in Judith M. Brown and William Roger Louis, eds., *The Oxford history of the British empire, vol. IV: the twentieth century*, Oxford: Oxford University Press, 1999, pp. 240, 247.

83 Hailey, *Survey*, p. 1193.

up as strongly in the British discourse. Nonetheless, British colonial administrators viewed African mothers' lack of expertise in feeding their children as the main reason for high mortality rates. In this respect, colonial officials from both countries echoed the arguments that experts had used when blaming working-class mothers decades earlier. In Africa, deviant forms of maternal behaviour were now coupled with arguments of racial backwardness and local superstitions.[84] The British children's health specialist Mary Blacklock, who had travelled through many African colonies, wrote of the African situation in 1931:

> It is also being recognized that the appallingly high infant mortality rate and much of the ill-health of the people is due in great part to the ignorance of the women in the care of the home and the health of their children.[85] The many reasons for sinking birth rates – be it the impact of colonial wars or the repercussions of colonial rule on women who were forced to leave the home for paid work in order to earn money for colonial taxes – were rarely mentioned in the discussions.[86]

Some of the new measures in the colonies were supported by charities from the metropole, such as the so-called baby weeks. In Britain, these baby weeks – involving talks or teaching about feeding and upbringing, as well as prizes for the healthiest babies – were introduced in 1917 by female philanthropists from the bourgeoisie and aristocracy.[87] Since it proved a success in the motherland, the concept was exported to the empire with an annual imperial baby week from the beginning of the 1920s onwards. An 'imperial baby week shield' was the prize for the best local committee within the empire, and a 'prize baby' was chosen in every colony.[88] The whole procedure obviously originated in American and Canadian agricultural shows, and was transferred from livestock to humans.[89] Such baby weeks started in Lagos, Nigeria, in 1922 and three years later in Tanganyika. Mombasa in Kenya won the imperial baby shield competition in 1931.[90] The colonial administrations supported the newly formed local committees, as the competitions proved an inexpensive way of promoting the health of mothers and babies. At a typical exhibition in Tanganyika in the 1930s, 3,500 babies were examined, and a high incidence of various illnesses was detected. Some infants could be treated on the spot. However, there was no regular follow-up treatment.[91]

One of the first films made by the former Nigerian medical officer William Sellers covered one of these baby events.[92] It mainly concentrated on measures to combat the

84 For the substitution of race for class in the imperialists' arguments, see generally Brantlinger, 'Genealogy', p. 181.

85 Blacklock, 'Co-operation', p. 206; see also Mary Blacklock, 'Certain aspects of the welfare of women and children in the colonies', *Annals of Tropical Medicine and Parasitology*, 30, 1936, pp. 221–64.

86 Isobe, *Medizin*, p. 17.

87 'National Baby Week: preparations in all parts of London', *The Times*, 28 June 1917, p. 9.

88 'Baby Week competition', *The Times*, 11 July 1936, p. 11.

89 Annette K. Vance Dorey, *Better baby contests: the scientific quest for perfect childhood health in the early twentieth century*, Jefferson, NC: McFarland, 1999.

90 'Baby Week: imperial challenge shield', *Daily News*, Perth, 9 April 1932.

91 Jennings, 'Matter'.

92 Rosaleen Smyth, 'The development of British colonial film policy, 1927–1939, with special reference to East and Central Africa', *Journal of African History*, 20, 3, 1979, pp. 437–50.

bubonic plague, but also featured an infant welfare exhibition and baby week in Lagos in 1937. The sequences include a demonstration by a European woman to African women on how to bathe their children. European judges evaluated black babies in the show, and they also presented a large trophy, the imperial baby shield. It was clearly a European concept to compete for the 'best baby', assuming that such a competition would encourage mothers to invest more in the care of their babies.[93] Jennifer Beinart has described the presentation of the African babies at one of the shows in Accra as 'somewhere between a fatted calf at a livestock show and a star pupil at a school prizegiving'.[94] In the film, the exhibition seemed very popular, as many African people are depicted attending the occasion. African women are shown proudly presenting their winning babies, well-fed toddlers in European baby clothes. Clearly, the Western aesthetic concept of plump baby health was also exported to Africa. These events remained educational, however, and could not offer any substantial services to mothers and their infants.

International organizations were not active in the field of maternity and child health in Africa until after the Second World War. The Rockefeller Foundation mainly supported campaigns against yellow fever in West Africa from the 1920s onwards; the League of Nations Health Organization concentrated on sleeping sickness and tuberculosis in central Africa.[95] The Rockefeller Foundation did fund the building of hospitals in British African colonies from the mid 1920s. However, training centres endowed by the Rockefeller Foundation for African nurses, midwives, and auxiliaries that were more engaged in public health issues were only opened from the late 1950s: for example, in Karuri in Kenya in 1960.[96] Other charities, such as the Save the Children Fund, organized conferences and meetings such as the International Conference on the African Child in Geneva in 1931; however, they did not yet engage in local initiatives.[97]

The actual services run by the colonial governments in the 1920s and 1930s consisted of some outpatient clinics for mothers and children in a few hospitals and their dispensaries in the surrounding countryside. Midwifery and nursing training for Africans was also initiated in several colonies. However, support from the metropole remained scarce until the 1940s. Even though a Colonial Development Fund was set up in 1929, the huge financial problems of the 1930s prevented the launch of extensive programmes in the colonies.[98]

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93 *Anti-plague operations Lagos 1937*, directed by William Sellers, 1937, http://www.colonialfilm.org.uk/node/1526 (consulted 17 March 2014), minutes 11:50–13:10 on the baby health week in Lagos.

94 Jennifer Beinart, 'Darkly through a lens: changing perceptions of the African child in sickness and health, 1900–1945', in Roger Cooter, ed., *In the name of the child: health and welfare, 1880–1940*, London: Routledge 1992, p. 226.

95 Iris Borowy, *Coming to terms with world health: the League of Nations Health Organisation 1921–1946*, Frankfurt am Main: Peter Lang, 2009, p. 109; Mair, *Welfare*, p. 75; Steven Paul Palmer, *Launching global health: the Caribbean odyssey of the Rockefeller Foundation*, Ann Arbor, MI: University of Michigan Press, 2010, p. 57.

96 Maurice Nyamanga Amutabi, *The NGO factor in Africa: the case of arrested development in Kenya*, London: Routledge, 2006, pp. 109–11.

97 Dominique Marshall, 'Children's rights in imperial political cultures: missionary and humanitarian contributions to the Conference on the African Child of 1931', *International Journal of Children's Rights*, 12, 2004, pp. 273–318; Bruchhausen, 'Practising', p. 105.

98 Michael Havinden and David Meredith, *Colonialism and development: Britain and its tropical colonies, 1850–1960*, London: Routledge, 1993, p. 147; Hailey, *Survey*, p. 1164.

The year 1940 is often seen as a turning point in colonial development, with the introduction of the Colonial Development and Welfare Act. Indeed, this resolution put a strong accent on the development of social services in Africa and increased the sum invested in the Colonial Development Fund from £1 million to £5 million per year (for all colonies).[99] However, this sum was inadequate to establish any sustainable social services. The expansion of services in the motherland in the 1920s and 1930s, which also had a highly integrative function for British society, could not be transferred to a colonial environment with limited resources.

Scholars of African history have stressed the point that the Second World War accelerated all social developments within Africa. It intensified the need for more efficient social services that would grant some benefits to Africans, since African soldiers had been fighting on various fronts during the war. The war had taken a heavy toll on African societies in many colonies.[100] Furthermore, during the war the new National Health Service (NHS) was being shaped in Great Britain.[101] This development also brought a new enthusiasm for the colonies. Indeed the NHS's centralized organization and its strong commitment to preventive medicine influenced the colonial health services to some extent.[102] However, elaborate organizations such as the NHS required a comprehensive state structure that was non-existent in African colonies. Furthermore, those colonies had no industrial society that could produce a stable tax income to subsidize colonial health.[103]

Variations in maternity and child health services in Tanganyika, Kenya, and Nigeria under British rule

Despite new research in the 1940s and the new NHS in Britain, there was no clear strategy for a colonial maternity and child health service. The development of services varied substantially in different colonies until after the Second World War. In all three sub-Saharan colonies Tanganyika, Kenya, and Nigeria, missions offered some services for mothers and children. The few hospitals (more in Nigeria than in East Africa) started to offer outpatient clinics for maternity and infant health and opened some wards for women and children from the 1920s onwards. Colonial administrations also began to train African nurses and midwives in Western midwifery. Educational endeavours such as the baby week campaign took place in all three territories.

In the field of medicine, all colonies had been placed under a unified medical colonial service since 1934 and under a unified nursing service since 1940.[104] Moreover, in the

99 Havinden and Meredith, *Colonialism*, p. 218.

100 Lewis, *Empire*, p. 6; Joanna Lewis, '"Tropical East Ends" and the Second World War: some contradictions in Colonial Office welfare initiatives', *Journal of Imperial and Commonwealth History*, 28, 2, 2000, p. 62.

101 Charles Webster, *The National Health Service: a political history*, Oxford: Oxford University Press, 1998, pp. 6–24.

102 Janet Seeley, 'Social welfare in a Kenyan town: policy and practice 1902–1955', *African Affairs*, 86, 345, 1987, p. 545; Bruchhausen, *Medizin*, p. 468.

103 Lewis, *Empire*, p. 51.

104 Anna Crozier, *Practising colonial medicine: the colonial medical service in British East Africa*, London: I.B. Tauris, 2007, p. 21; Mair, *Welfare*, pp. 75–7.

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sub-Saharan British tropical colonies, there were not such strong conflicts between colonial health services and local midwives as, for example, in colonial India, where the local *dais* (midwives) were demonized and ousted.[105] The weak health system in the African colonies prevented such battles, even if local customs were always blamed for high infant mortality. In the African colonies under scrutiny here, one can observe quite different concepts and diverging developments. The three colonies certainly had different economic and political backgrounds, and different notions of indirect rule and decentralization were implemented. Furthermore, since there were few coherent plans for a colonial maternity and child health service throughout the empire or even throughout Africa, European medical experts within the colonies seemed to have an important role in shaping new services. In particular, the chief medical officers of the colonies, who often stayed in position for many years, could amass a considerable amount of knowledge and could influence the orientation of services.

Turning first to Tanganyika, the country became a British mandate territory after the First World War. The discussion in German specialists' circles on the population decline had not led to the introduction of any congruent maternity and child services. What the British administrators could rely on was the German medical infrastructure – the hospitals and dispensaries that the German colonial administration had established before 1914. The British administration took over gradually during the years 1916–20, from 1916, when Dar-es-Salaam and the north of the German colony were occupied, until 1920, when Britain officially became the administrator of the mandate territory Tanganyika under the League of Nations.[106]

The policy in the new mandate under both the first governor, Sir Horace Byatt, and his successor, David Cameron (from 1925 onwards), was directed towards the concept of indirect rule, with a focus on decentralization and implementation of local native councils. This was judged to be an adequate approach in a mandate territory, and had the benefit of avoiding a strong Westernization of society.[107] The first British medical officer of health, the Director of Medical and Sanitary Services, Dr John Owen Shircore, was convinced that focusing on the training of Africans in health care was the best way forward. His approach was in line with the policy of the governors Byatt and Cameron. He sought to work with the local native authorities and especially favoured older African women as future health educators, midwives, and nurses in carrying out the policy. However, since Shircore had no training facilities in Tanganyika, he needed to rely on the missions as educators and providers of services. The missions therefore received grants from the colonial government to establish maternity and child services and to train African midwives and auxiliaries.

This policy proved to be unique to Tanganyika, as neither Nigeria nor Kenya followed suit.[108] The cooperation with missions shaped child and maternity services in Tanganyika

105 Anshu Malhotra, 'Of *dais* and midwives: "middle-class" interventions in the management of women's reproductive health: a study from colonial Punjab', in Sarah Hodges, ed., *Reproductive health in India: history, politics, controversies*, New Delhi: Orient Longman, 2006, pp. 199–226.

106 Iliffe, *Tanganyika*, pp. 318–34.

107 Beck, 'Medicine and society', pp. 41–2; Andreas Eckert, '"Disziplin und Tränen": Erziehung, Verwaltung und koloniale Ordnung in British-Tanganyika', in Albert Wirz, Andreas Eckert, and Katrin Bromber, eds., *Alles unter Kontrolle: Disziplinierungsprozesse im kolonialen Tansania 1850–1960*, Cologne: Rüdiger Köppe, 2003, p. 187; Iliffe, *Tanganyika*, pp. 318–34.

108 Jennings, 'Matter', p. 226.

substantially and remained in place until the 1950s.[109] The missionaries preferred to train young girls, who were not 'contaminated by native customs', quite contrary to the priorities of the government, who would have preferred mature women.[110] Surprisingly, the model of the so-called communal Jeanes schools was not introduced into Tanganyika, even if it featured prominently in neighbouring Kenya.[111] This is a clear indication that there was no overall social policy, not even in all Eastern African colonies.

From the mid 1920s onwards, a growing number of examinations in ante-natal clinics were undertaken, as well as some deliveries in hospitals. Services were offered in missionary hospitals and dispensaries, but also in government-run facilities.[112] However, after some engagement in the 1920s, the colonial administration withdrew in the 1930s and left the rural areas in particular to the missions.[113] Government health services concentrated instead on combating tropical diseases: Tanganyika received more money for research into and control of malaria and sleeping sickness from the Colonial Development Fund than all other British African colonies between 1929 and 1939.[114]

Education and the training of Africans remained a considerable problem until after the Second World War. The chances for African people to receive sufficient education as a basis for formal health training remained very low in general, and even more so for women.[115] After the Second World War, in 1949, a plan from the London specialist Medical Officer Dr E. D. Pridie to build a central government school for the training of midwives and nurses, following the centralized schemes of the new NHS in the metropole, failed in Tanganyika. The missions therefore remained central in the local training of African medical professionals.[116]

In neighbouring Kenya, maternity and child services underwent a quite different development. Kenya suffered from an economic recession and from a strong population decline after the First World War.[117] Furthermore, with a strong settler community it had to tackle quite different problems from those of the mandate territory Tanganyika. The highlands were reserved for white settlement in Kenya where a strong group of white settlers, who already enjoyed some social services and who would oppose any costly social services programmes for Africans.[118] Even though the so-called Devonshire White paper of 1924 about the future development of Kenya stated that it was an 'African country', white settler interests continued to dominate colonial policy there.[119] Local native councils were

109 Bruchhausen, *Medizin*, pp. 463–4.

110 Bruchhausen, 'Practising', p. 104.

111 Richard C. Thurnwald and Thurnwald Hilde, *Black and white in East Africa: the fabric of a new civilization: a study in social contact and adaptation of life in East Africa*, London: Routledge, 1935, p. 242.

112 Bruchhausen, *Medizin*, p. 467.

113 Jennings, 'Matter', pp. 235–7.

114 Tilley, *Africa*, p. 175.

115 Eckert, 'Disziplin', pp. 190, 199.

116 Bruchhausen, 'Practising', pp. 106–7.

117 Feierman, 'Struggle', p. 86; Gordon Kamugunda Kahangi, *A history of East Africa: from ancient to modern times*, Kampala, Uganda: Wavah Books, 2006, p. 285.

118 Chaiken, 'Primary health care', p. 1704.

119 Kahangi, *History*, p. 280.

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introduced in 1924 to organize all forms of social policy for the African population and also to run local dispensaries with some medical assistance.

A political approach with a strong commitment to community medicine and hygiene prevailed. As a consequence, there were only six government hospitals for Africans in larger towns and twenty-three altogether in the so-called native reserves in 1936.[120] The missions also offered hospitals and medical centres for Africans; since 1903 several mission stations had successively opened hospitals and dispensaries.[121] Nevertheless, colonial health provisions for the three million Africans who lived in Kenya in the 1930s – according to rough estimates, since there had been no census as in other colonies – were inchoate and rudimentary.[122]

Services for maternal and child health care started late: the colonial reports in Kenya do not refer to these issues until after 1930.[123] Instead, A. R. Paterson, the Chief Medical Officer of Health since the end of the 1920s, was dedicated to hygiene and education.[124] He included baby shows and the education of African mothers in his efforts via government campaigns. Even if Mary Michael-Shaw, a specialist in venereal diseases and women's and children's health worked in the health services of Kenya between 1928 and 1934,[125] there was no long-serving Lady Medical Officer of Health as in Nigeria, who would concentrate on the development of maternity and child services in hospitals and dispensaries.

Instead, the Jeanes schools were thought to play an important role in the establishment of public health services. These training schools were set up after the visit of the Phelps Stokes Commission, a body of American educational experts, to East Africa in 1923. The system was adapted from one which had been judged as successful in Afro-American villages in the south of the United States. The general principle was that the Jeanes school was run on the lines of a model village, with the buildings and implements used that would be available in a typical African village. Married teachers were selected for training. The husband was required to study methods of 'village improvement' in agriculture, housing, and sanitation, while the wife was instructed to learn elements of child welfare and establish a rudimentary service for mothers and infants.[126] The couples were expected to develop the schools to which they were sent as community centres. In practice, this rarely worked out. Joanna Lewis has shown very convincingly that the Jeanes school experiment failed in establishing educational and social provision for African communities in the 1930s. Nevertheless, the school regime was praised by the British administration until the mid 1940s. The schools were used during the Second World War for military training and after the war for the demobilization and retraining of African soldiers, who could be turned into social workers and teachers.[127] Social services were therefore dominated by men in Kenya after the Second World War.

120 Hailey, *Survey*, p. 1165.

121 Kanogo, *African womanhood*, p. 166.

122 Hailey, *Survey*, p. 115.

123 Colony and Protectorate of Kenya, *Report for 1930*, London: HMSO, 1932, pp. 44–5.

124 Chaiken, 'Primary health care', p. 1705.

125 Crozier, *Practising*, pp. 95, 147.

126 Mair, *Welfare*, p. 34, see also Chaiken, 'Primary health care', p. 1707.

127 Lewis, *Empire*, pp. 226–7.

Maternity and child care suffered from this approach. In Kenya men dominated in the administration of maternity care until the 1940s.[128] This meant an upheaval of traditional roles that made the provision and acceptance of maternity care quite problematic. Owing to the bad schooling situation, women in Kenya hardly had access to the formal education necessary to prepare for medical training.[129] Only at the end of the 1930s did women start to work as nurses and midwives, having served formerly under male nurses and assistants. Trained women remained even scarcer than in other colonies until 1950–51, when the government finally started to train female nurses systematically. The first fourteen women were enrolled in 1951.[130] This late engagement with formal training can be seen as a major hindrance to the development of a comprehensive maternity and child health service.[131]

In Nigeria we observe another variation of colonial maternity and child services. As a West African colony, Nigeria did not suffer from a large population decline, as East and Equatorial Africa had done, and it had no strong settler community, as in Kenya.[132] Under Frederick Lugard's governorship until 1919, public health and hygiene measures for the African population were hardly important issues; health services were still centred on Europeans. Lugard even cancelled the plans for a maternity home in Lagos because he would not agree to have African personnel as staff.[133] Only through the changes after the First World War was greater weight placed on the training of African people in public health issues. Additionally, in the colonies in West Africa, especially in the Gold Coast, medical services had a longer tradition and were already united under a regional body in 1902. Thus, they obviously enjoyed a more congruent development than in East Africa.[134] Health weeks with 'baby competitions' started very early, in 1922, in Lagos, the main town of Nigeria. The colonial administration opened the first maternity hospital for mothers and babies, with clinics for child care and ante-natal care classes, in Lagos in 1925. During the first month it had 4,000 outpatients, but only 3 in-patients. This can be seen as typical for such services in African colonies: there were few working wards for African in-patients in the 1920s. Furthermore, most mothers did not accept hospital confinement. Many African women were used to giving birth surrounded by their family and local midwives, something that was not possible in a Western hospital. Ante-natal clinics and walk-in treatment were more acceptable alternatives.[135]

During the 1930s, maternity and child health services expanded considerably. The yearly reports of the colonial administration proudly started to list infant welfare measures from 1930 onwards and were highly optimistic about the sinking infant mortality. Officially, numbers went down from 296 per 1,000 births in 1919 to 127 per 1,000 births in 1939, but

128 Kanogo, *African womanhood*, p. 172.

129 For problems in women's education in African colonies, see Lewis, 'Tropical East Ends', pp. 44–5.

130 Kanogo, *African womanhood*, p. 191.

131 Lewis, *Empire*, p. 250.

132 Feierman, 'Struggle', p. 89.

133 Thomas S. Gale, 'Lord F. D. Lugard: an assessment of his contribution to medical policy in Nigeria', *International Journal of African Historical Studies*, 9, 4, 1976, pp. 634–5.

134 Crozier, *Practising*, p. 4.

135 Van Tol, 'Mothers', pp. 112–13.

statistics were hardly reliable because the number of all births was not properly known.[136] Another reason for the positive outlook was the fact that colonial reports had to some extent to follow unwritten laws, blaming native habits for unsuccessful medical intervention rather than any failures of the British colonial administration.[137] In the 1920s services remained centred on larger towns in the south of the colony and on Lagos; the Muslim north of the colony was hardly reached before the 1930s.[138]

The first Lady Medical Officer, Dr Greta Lowe-Jellicoe, who arrived in 1923 in Nigeria, played an important role in establishing maternal and child health services.[139] She had held posts in mission hospitals in Freetown, Sierra Leone, before joining the Colonial Medical Services – a quite typical career between missions and government. One important part of her duties was the training of African nurses in midwifery courses, training that began early and successfully in Nigeria compared to other colonies.[140] In the 1930s, Lowe-Jellicoe also started medical work among Muslim women of Katsina in northern Nigeria, and was able to establish some services there, where a male health officer could not have succeeded.[141]

The early arrival of highly qualified, long-serving, female European personnel was obviously an important reason for the relatively systematic development of colonial maternity and child services in Nigeria.[142] This argument was also stressed by contemporary specialists. After a tour of health services in British colonies in 1936, Mary Blacklock wrote: 'It seems necessary to draw attention to these facts, because it would appear that some colonial governments do not realize the very real need there is for the services of medical women, and the high standards of the work they can perform. In the colonies the need for such workers is often very much greater than in England.'[143] In England, nurses, midwives, and health visitors were mostly female professionals, who had easier access to pregnant women and infants. In the colonies things differed widely. European medical personnel were mostly male, and doctors were often not unduly concerned with issues of maternity and child health. Furthermore, they could hardly address pregnant women in person, owing to local customs or religious bans in many African societies.

In 1934, Nigeria already had 484 African nurses in different stages of training.[144] These women proved significant for negotiations and conflicts between colonial medical training and local medical practices. They could act as important intermediaries and 'brokers', a

136 *Annual Colonial Report for 1911, Northern Nigeria*, London: HMSO, 1912, Cd 6007-38; *Annual Colonial Report for 1916, Nigeria*, London: HMSO, 1918, Cd. 8434-33; in these reports public health services are not mentioned. From 1930 the infant welfare services are listed: *Annual Colonial Report for 1930, Nigeria*, London: HMSO 1931, p. 32. For the mortality statistics see van Tol, 'Mothers', p. 126.

137 Moses Ochonu, '"Native habits are difficult to change": British medics and the dilemmas of biomedical discourses and practice in early colonial northern Nigeria', *Journal of Colonialism and Colonial History*, 5, 1, 2004, p. 42.

138 Ityavyar, 'Background', p. 490.

139 Helen Callaway, *Gender, culture and empire: European women in colonial Nigeria*, Urbana, IL: University of Illinois Press, 1987, p. 95.

140 *Annual Colonial Report for 1932, Nigeria*, London: HMSO, 1933, p. 19.

141 Callaway, *Gender*, p. 95.

142 Feierman, 'Struggle', p. 123.

143 Blacklock, 'Certain aspects', p. 244.

144 Van Tol, 'Mothers', p. 118.

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crucial role, particularly in the field of maternity health.[145] In 1937, the yearly medical report boasted of 3,697 infants being examined and of 198 infant health clinics being held; there were now also 117 beds in 22 maternity wards.[146] Hailey's African *Survey* also listed 116 maternity and infant welfare centres run by missions in the 1930s.[147] Altogether, Nigeria had 57 African hospitals and around 300 dispensaries in 1936 for an African population of around three million.[148] Even if this was more than in the East African colonies, however, only a fraction of the population could receive health care.

After the Second World War, in 1946, Nigeria received a ten-year development plan. Colonial Development and Welfare funds were allocated and also went into the field of maternity and child services. The training of African nurses and midwives was a high priority.[149] At the beginning of the 1950s, Nigeria had one of the better-equipped health services of British African colonies, with a relatively high attendance record of women and children. Of course this was the result of parts of the African population accepting and integrating elements of European health care into their health concepts and behaviours. In particular, the new urban classes saw Western medicine and childbirth in hospitals as attractive options. In rural areas things were very different, and people still relied on local medicine. The pattern of colonial health services – being concentrated on the few colonial urban centres – continued to shape the health services in many newly independent states in Africa.

Besides the limited resources and the problematic racial divisions in the colonial situation that always had an enormous impact, clearly local circumstances, the reaction of African societies, the character of colonial rule in each colony, and the different concepts employed all strongly influenced the transfer of social policy.

Conclusion

Lucy Mair wrote confidently in her book on *Welfare in the British colonies* in 1944:

> Attendance at maternity hospitals and child welfare clinics is steadily increasing. The extension of clinics into rural areas must depend upon the number of educated girls available to staff them, and, except in the West African colonies, this is still very small. Nevertheless, great efforts have been made recently throughout east and central Africa to develop maternity and child welfare services. Information about them is spread through the Jeanes training centres.[150]

However, the actual development of maternal and infant health in Africa under colonial rule was far less comprehensive, as we have seen in the examples outlined here. It depended greatly on the organization of the rudimentary colonial social services in each colony, on the

145 Sean Lang, 'Obstetrics and obstruction: maternity provision in Madras 1840–1852', in Harrison, Jones, and Sweet, *From Western medicine*, p. 139.

146 'Public health work in the colony and protectorate of Nigeria during 1937', *Journal of Tropical Medicine and Hygiene*, 42, 1939, p. 383.

147 Hailey, *Survey*, p. 1168.

148 *Ibid.*, p. 118.

149 Callaway, *Gender*, p. 101.

150 Mair, *Welfare*, pp. 91–2.

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forms of training for Africans, whether in Jeanes schools or in more formal training facilities, on the medical officers of health – and, fundamentally, on their gender – and, finally, on the relationship with the missions. Within the framework of limited resources and racial demarcation lines, colonial health seemed to be an *ad hoc* policy, dependent on the actual surroundings and local developments.

Problems of sinking fertility and high infant mortality were addressed with the transfer of European social policy arguments and concepts to the colonies around the globe. In the case of the British and German colonies that have been under scrutiny here, this process of transfer was similar – despite different systems of maternal and infant care in each country's metropole, and despite differing configurations on the ground in each colony. Only the focus on regulative measures might be identified as a distinct feature of German maternal and child health policy. However, it is hard to compare these policies, as German engagement in East Africa stopped in 1914.

After twenty years of maternity services in British African colonies, colonial medical officers expressed their disappointment with the services and the remaining high infant mortality in the 1940s. To find reasons for the failure, many re-used old arguments: African mothers would take it for granted that a very large proportion of their children would die before maturity and would not realize what could be achieved by a better standard of child care.[151] Such forms of racial essentialism not only gave an easy excuse for European experts, but also made efforts at professional training for African nurses and midwives highly problematic and continued to shape colonial and postcolonial social services.

Other European experts, such as the missionary Lyndon Harries, who had been engaged in medical work in Tanganyika for decades, developed a more realistic judgment of the situation after the Second World War. He saw a native population still overwhelmed with disease. Far from blaming the attitude of the Africans he acknowledged that as long as local peoples faced famines and deep poverty, the health situation would not change.[152] This latter argument clearly hints at general problems of social policy in territories worldwide with limited resources, a large informal labour market, and a weak infrastructure. There was not enough tax income and no administration capable of delivering a systematic provision of curative medicine. Therefore, in the colonies, as well as in countries of the Global South with similar economic problems, cheap educational efforts and campaign-style actions prevailed in the field of health care.

The transfer of Western medicine to the field of maternity and child care clearly was an ideological programme of the missionaries and colonial administrators. Colonial officials believed that Western science should take a central place in colonial society, especially through the training of local personnel in Western nursing and midwifery. This amounted to forms of social engineering on a large scale. In the case of the baby shows, not only concepts of supportive and damaging motherly behaviour but also aesthetic concepts of a healthy child were transferred to the colonies, largely ignoring any forms of cultural difference. This was not a one-sided development, however. Local people accepted Western medicine to a

151 Bruchhausen, 'Practising', pp. 111–13.

152 Terence O. Ranger, 'Godly medicine: the ambiguities of medical mission in southeastern Tanzania', in Steven Feierman and John M. Janzen, eds., *The social basis of health and healing in Africa*, Berkeley, CA: University of California Press, 1992, p. 270.

certain extent as a new alternative to local traditions. For many, training in the health professions was seen as a chance for advancement in society.

As a last point, colonial services always favoured privileged groups. In colonial societies, the Europeans were the racially privileged group, with access to all available medical services from the beginning of colonization. Services for the non-privileged – that is, the vast majority of the African population – always suffered from limited resources. In contrast to the situation in many Western countries in the first half of the twentieth century, there was no attempt by social policy to foster social integration in colonial and postcolonial societies around the globe. It rather reified racial demarcation lines and racial stereotypes that made the institutionalization of comprehensive services difficult. Even if the privileged groups have changed over time, these patterns continue to shape social policy of many countries of the Global South today.

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