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AFRICAN TRADITIONAL MIDWIVES AND THE TRANSFORMATION OF MIDWIFERY IN COLONIAL GHANA

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This article examines the contest between African traditional midwives and colonial health officials in the transformation of midwifery practice from the mid-1920s to the end of colonial rule in Ghana. It shows that while there were no open confrontations between the two sides, African traditional midwives contested the colonial attempt to displace them from their work through the social and economic nature of their work and managed to frustrate the colonial government's agenda of reconstructing reproduction in the country.

1.0 Introduction

Since the mid-1970s, historians of women and gender studies and reproductive health in Africa have devoted a considerable amount of time examining the subject of colonial reproductive health policies and interventions in colonised Africa, and the repercussions of such policies and interventions in post-colonial Africa. Prominent amongst such studies are the works of Turshen (1977), Hunt (1988), Summers (1991), Allman (1994), and Thomas (2003), among others. These works have explored the role of gender in colonial health policies; the effects of medicalisation and hospitalisation of pregnancy and childbirth; reproduction as a contested realm of the colonial encounter; why women were selected as a target group; and how African women resisted, as well as embraced, some of the colonial reproductive measures. Their analyses show complex dimensions of the colonial encounter in terms of how 'ordinary' African women, through their individual and collective actions, forced colonial

governments to negotiate, rethink, and sometimes even abandon some of their public health policies and strategies.¹

Recently, a number of researchers, including Hardiman (2006), Kalusa (2007), Bala (2009), and Ncube (2012), while speaking to colonial forces of biomedical dominance and African forces of resistance, have also pointed out that these forces were not always antagonistic. There were many instances when the forces produced cooperation. Ncube (2012), in 'Making of Rural Health Care in Colonial Zimbabwe: a history of the Ndanga Medical Unit, Fort Victoria, 1930-1930s', argues against the historiographical position that polarises colonial medicine against indigenous medicine. He points out that for practical purposes, the colonisers at Ndanga Medical Unit in Zimbabwe had to come up with 'innovative endeavours to control disease on the one hand, and to fulfil broader colonial ambitions on the other' (p. ii). Africans, on their part, sometimes responded ambivalently and sometimes directly as they embraced or rejected the beneficial aspects of the colonisers' medicine. In other words, the encounter resulted in both conscious and unconscious efforts by the two parties in ways that were practical to European medics and meaningful to their African patients (Ncube, 2012).

However, as Headrick (1981) and others have suggested, and which is reiterated in this essay, biomedicine fundamentally arrived in Africa as a tool of colonial rule and domination and not as a tool for compromise. At first, this was to ensure that the Europeans themselves survived in the new environment. For example, it is estimated that about 77% of Europeans sent to West Africa in the early nineteenth century died of tropical diseases. Eight hundred and ninety out of 1,843 European soldiers sent to Sierra Leone between 1819 and 1836 died. In 1874, 2,500 British soldiers sent to battle the Asante in the interior of West Africa were given quinine to ward off malaria, and when many of the soldiers returned triumphantly, a new era of colonial rule and biomedicine began for European powers in Africa. When colonial rulers finally turned their attention to the health of Africans, they did all they could to curtail African health knowledge systems to ensure the success of their own measures. In this regard, the relationship between the two sides began on an oppositional level. Of course, the colonisers would eventually change their strategies, based on

¹ The works of Thomas (2003), Allman (1994), and Summers (1992), in particular, engage women's agency in the colonial reproductive encounter, suggesting that contesting colonial medicine was intermingled with varying degrees of acceptance and resistance.

practicality and reality, and so would Africans. In the 1920s, for instance, the British colonial government undertook a vigorous public health campaign against yaws in East Africa. The success of the campaign began to gradually reduce African suspicion toward colonial medicine (Ncube, 2012).

The Gold Coast Ghana, as with the rest of colonised Africa, was subjected to colonial reproductive reconstruction policies and interventions. The British colonial government, fearing that high maternal and infant mortality rates would have negative repercussions on economic productivity and socio-political stability, attempted to control women's reproduction from the late 1920s to the end of the colonial period, through the benign sites of maternal and infant welfare services and western midwifery education. Allman (1994) has provided a detailed analysis of the colonial government's maternal and infant welfare services; Asante women's acceptance, appropriation, and contestation of the colonial government's reproductive health programmes; and the collaboration of local chiefs in Asante with the colonial government to reconstruct gender relations (Allman, 1994). Akin to Allman's work, Hugon (2004; 2009-2010) has also spent over a decade examining colonial midwifery education.

Hugon's research into the history of colonial maternity in Ghana, and the medicalisation and hospitalisation of pregnancy and childbirth, reveals how the British colonial government succeeded in developing an 'esprit de corps' in the midwives they trained at the Korle-Bu Hospital from the late 1930s to the early 1950s. Her ethnographic work with Ghanaian midwives indicates that the colonial government managed to recreate a microcosm of the colonial world through western midwifery education and biomedical practices. Other important works on the medical scene in colonial Ghana include Addae's (1997) *The Evolution of Medicine in a Developing Country: Ghana 1880-1960* and Aidoo's (1982) 'Rural Health under Colonialism and Neo Colonialism: A Survey of the Ghanaian Experience'. Both Addae and Aidoo's works provide us with significant insights into the medical and health conditions in the country and the biomedical encounter between Ghanaians and the British colonial government. However, as important and as broad as these works are, the attention they give to how colonial health officials interacted with African traditional midwives in their midwifery work is very limited.

Hugon's work (2004; 2009-2010) is perhaps the most significant in terms of the introduction of midwifery into the country, but her work generally focuses on women trained in western midwifery practices, which adds to the limited understanding we have of the colonial encounter with African traditional midwives. While Allman (1994) has argued that the British colonial government had an ambivalent attitude toward traditional midwives and was equally not as stringent on them, searching through colonial records indicates the contrary. Colonial health officials had clear conceptions about traditional midwives and their place in the new biomedical environment. They simply saw traditional midwives as having a negative impact on midwifery work in the country, and, in many instances, they spoke plainly of their views about them. They loathed and despised the fact that the processes and management of childbirth were left in the hands of a group of people whose only contributions toward reproductive health were, perhaps, increasing maternal and infant mortality rates due to their unhygienic practices.

This article looks at the contest for the control of the reproductive space between African traditional midwives and colonial health officials in the transformation of midwifery practice in colonial Ghana, and the ways in which the contestation helps to broaden our understanding of women's agency in the colonial reproductive encounter. The reproductive encounter between African traditional midwives and the British colonial government is presented in broadly polarising terms because of colonial biomedical tactics and the general attitude towards such midwives. Nonetheless, it has also been indicated that the totality of the encounter cannot be understood just in terms of a dominance/resistance paradigm. There were many instances of conscious and unconscious collaboration and acceptance, with birthing mothers picking and choosing what they wanted to get out of the coloniser's medical offerings, and British colonial health officials sometimes giving in to women's demands so as to achieve some of their aims. African traditional midwives, on occasions, sent their patients to hospitals, and some even participated in the colonial midwifery training because they recognised the dangers of childbirth and thus sought alternative ways to better serve their patients.

In the early 1920s, the British colonial government began various health care campaigns to transform and control reproduction in the country. Assisted by voluntary organisations such as the British Red Cross Society, the League of Maternity and Child Welfare, and some mission churches, the colonial government ushered in a number of programmes, including maternal and infant welfare services and public health care

programmes, to reconstruct reproduction in colonial Ghana. Throughout the 1920s and 1930s, mothers were encouraged to participate in welfare programmes such as baby shows, birth registration, mothercraft lectures, childhood vaccination, antenatal clinics, weighing clinics, etc., and they were sometimes rewarded with gifts for participating.² Colonial health and medical officials argued that maternal behaviours such as mothers carrying their infants on their backs; allowing their infants to crawl about in dirt; breastfeeding for long periods; irregular feeding and sleeping patterns; ignorance about proper nutrition; and poor access to midwifery services were not only detrimental to the health of infants but contributed to the high maternal and infant mortality rates in the country. To purge maternal ignorance and to re-engineer a new obstetric practice fashioned on the colonisers' ideals, colonial officials fell on maternal and western midwifery education. Both of these solutions would put them directly in the path of African traditional midwives and would set the stage for the battle over obstetric care in the country.

2.0 African Traditional Midwives as Obstacles in Maternal Education

Colonial officials believed that all mothers could be ignorant, but that African mothers, because of their long working hours on the farm and in domestic service, were particularly careless and neglectful of their children.³ Therefore, mothers were to be educated on their basic responsibilities for maintaining personal hygiene, caring properly for children, and controlling filth in their domestic space. In February 1924, Governor Gordon Guggisberg wrote:

Once, however, that a nation has emerged from the primitive phases of its existence, education—with all that it comprises—becomes not only the first, but the only step towards progress, and the people of this country can rest assured that government is fully aware of this fact and is making every effort towards the desired end.⁴

² Allman (1994) has discussed in detail baby shows, baby baths, mothercraft lectures, and evangelism carried out by the Methodist mission into the homes of Asante mothers with the help of local chiefs.

³ National Archives of Ghana, Colonial Secretary's Office (CSO) 730/32. C. D. Williams, 'Memorandum to DPHS 3/9/31'.

⁴ CSO 18/1/135. 'Memorandum Relating to the Educational Policy of the Gold Coast Government as Reviewed by the Joint Session of Provincial Councils at Dodowa in July, 1936', 1-9.

Guggisberg's statement was not necessarily directed towards educating just women, but rather the entire population. However, his commitment to western formal education gave tacit approval to the maternal education activities. With the help of local chiefs, missionaries, and African Christian converts, colonial health officials entered the private spaces of Ghanaian women to educate them in effective motherhood skills. From 1923 to 1937, the colonial government and the mission churches Basel and Roman Catholic opened a number of welfare centres, particularly in southern Ghana, to provide preventive health care services to mothers and children. Mothers were encouraged to take their infants to the centres for a monthly weigh-in and assessment. During these monthly visits, mothers were advised on proper nutrition and diet and on infant sleeping patterns and proper clothing.⁵

While many of the maternal and infant welfare centres attracted significant numbers of women, colonial health and medical reports indicate that many women attended them for reasons other than the ones health officials had envisaged. For instance, a significant number of women went solely to seek treatment for their children's various ailments and not to listen to motherhood and preventive health care lectures. As reported by the Lady Medical Officer of Kumasi Welfare Centre, 'as the clinic becomes better known to the Ashantis the difficulty of confining the activities of the centre to welfare work becomes greater'.⁶ She added that nearly every child brought to the centre was suffering from some form of a disease. Out of the over 10,000 children mothers brought to the clinic in the 1935/1936 report cycle, only 9% came for well-child care involving inspection and maternal advice.⁷ In some cases, the centre was forced to attend to high-risk pregnancies and deliver babies even though they had no facility for such services.

In seeking curative rather than preventive health care, Ghanaian women successfully took advantage of the alternative medical care while resisting the colonial government's agenda of transforming their maternal behaviours through mothercraft lectures. In almost all the centres, health officials were overwhelmed with the influx of sick children and had very little time to focus on providing maternal education. Colonial health officials were compelled to accept what Ghanaian mothers believed should

⁵ J. M. Mackey, 'Health Branch Maternity and Child Welfare'. Report on the Medical Department, 1936, 36-37.

⁶ Ibid.

⁷ Ibid.

be the focus of the new health care system—curative medicine. The Deputy Director of Health Services, Dr. H. O'Hara May, in a memorandum to the Colonial Office in 1931, indicated that the various welfare clinics in the Gold Coast were about 99% curative and only about 1% preventive in scope.⁸ Dr. W. M. Howells, a senior health officer at the Health Service Department, expressed great regret for the infant clinics' loss of touch with the preventive side of welfare work. He lamented that the infant clinics were no longer welfare centres, but 'Children's Hospitals'.⁹ He noted that the large number of sick children that mothers brought for treatment allowed little time for the question of prevention, while the school health work, initiated as part of the public health care campaign to educate school children, had almost entirely disappeared.¹⁰

In the 1942 annual medical report, Dr. J. Balfour Kirk, the Director of the Gold Coast Medical Services, pointed out that the 'so-called welfare clinics have been allowed to degenerate into treatment clinics and educative and welfare work has been completely swamped by the huge wave of suffering childhood which has inundated them'.¹¹ According to him, welfare centres were 'being used as a combined maternity and sick children's hospital'.¹² Dr. Kirk blamed this state of affairs on the influence of traditional midwives on birthing mothers, but he was particularly angry at the health and medical officers for failing to provide direction and for their desire to ensure the popularity of their clinics in terms of the number of attendances year by year. He used the weighing clinics in England as an example of how the core principles of maternal and infant health education had been taken out of welfare measures in the Gold Coast:

In Europe the weighing centre is generally the place where demonstration in the care and management of infants are conducted, cookery lessons given, dress-making classes organised, and the general welfare of children impressed upon all who attend there for these purposes. Here the weighing centre appears to be merely a weighing centre and the mothers have to be continually pestered to bring their children there to be weighed.¹³

⁸ CSO 17/2/244. H. O'Hara May, 'Memorandum on Infant Clinics', 1931.

⁹ CSO 17/2/243. W. M. Howells, 'Memorandum on Infant Clinics', 25 April 1932.

¹⁰ Ibid.

¹¹ Public Records Offices, London (PRO) CO 98/54. 'Gold Coast, Report on the Eastern and Western Provinces for 1941-1942'.

¹² Ibid.

¹³ Ibid.

Dr. Kirk, and indeed many other colonial health officials, also argued that because traditional midwives concerned themselves with child health care beyond their poor practices of obstetric care, Ghanaian mothers had developed the attitude of waiting until their situations got to a frightening point before seeking 'expert' attention from the welfare centres, which were mostly ill-equipped to handle such situations. However, it is worth noting that not all colonial health officials agreed with this assessment. Dr. Selwyn-Clarke the senior sanitary officer for Kumasi pointed out on several occasions that providing women with what they needed was the only way to push forward the government's agenda of improving health and controlling reproductive behaviour in the country. In 1932, he had sent out a memorandum to the Lady Medical Officers in Kumasi, Koforidua, Cape Coast, Sekondi, and Accra to seek their opinions on curative health care at the welfare centres. In their replies, all the Lady Medical Officers shared the view that curative medicine could not be completely separated from preventive health care. The Lady Medical Officer at Koforidua, Dr. D. E. Stewart, was even more explicit in her opinion. According to Dr. Stewart, the majority of the women who attended the clinics on a regular basis came from a wide radius of about 20 to 30 miles, and certainly, they expected a bottle of medicine and a visit to the doctor when they made the trip to the welfare centre. To her, it was 'unreasonable to expect these women to pay some shillings for a lorry fare to bring a perfectly well grown infant to a clinic only to be told of its weight'.¹⁴

By the above intimations, Ghanaian women had every right to demand curative medicine, but more importantly, their actions, possibly influenced by the traditional midwife's work, were a direct contestation of the government's intrusion into the women's reproductive domain. As shown by Hunt (1988) in the Belgian Congo, the Congolese women contested the colonial government's reconstruction of motherhood and domesticity. In *Politics of the Womb*, Thomas (2003) also demonstrates that Kenyan women, while taking advantage of western alternative medicine, resisted any attempt to redefine their sexuality and other reproductive norms, especially in instances when the coloniser's ideals were contrary to their socio-cultural norms. However, Dr. Kirk and other like-minded health officials did not accept the notion that women should be allowed to choose what they wanted out of the new reproductive measures. Thus, instead of changing their health care delivery strategy, they singled out traditional midwives as the sole reason women were refusing to use the welfare

¹⁴ CSO 11/1/296. D. E. Stewart to Selwyn-Clarke, 'Memorandum on Infant Welfare Centres and General Principles', 21 September 1931.

centres as intended and the reason why infant and maternal mortality rates continued to be high in the country. To the government, removing pregnancy and childbirth from the control of traditional midwives and placing them under the direction of western-trained midwives and medical professionals would allow colonial health officials to effectively transform the reproductive behaviours of African women.

As indicated above, nothing in the available colonial health reports suggests that health officials in the Gold Coast were ambivalent in their attitude toward traditional midwives. To them, the only skill that entitled a midwife to her work was her experience in witnessing childbirth or having given birth herself. The traditional midwife, it was reported, preoccupied herself with superstitious things during parturition and lacked the scientific knowhow to manage childbirth.¹⁵ Such midwives were particularly blamed for umbilical hernia that frequently occurred in new-born infants. The medical officer in charge of the Accra Maternity Hospital, Dr. Grace M. L. Summerhayes, reported in 1929 that health officials often attributed the frequency of umbilical hernia among infants to the ignorant treatment by traditional midwives whereby they left the umbilical cord too long—the custom being leaving it long enough to reach the baby's knee. She, however, admitted that a 'certain proportion of babies born at the hospital also had umbilical hernia just as the babies delivered at home by traditional midwives. This showed that what was observed before was due to some racial congenital weakness'.¹⁶

Obviously, her belief in the medical expertise of health officials, as well as in biomedical obstetrics, caused her to assign the blame to the 'racial weakness of Africans' and not to any mistake health officers may have been causing. With health officials constantly pointing fingers at traditional midwives and/or African biogenetics, the colonial government moved on with its assumption that replacing such midwives with western-educated and licenced midwives would protect women and children from the malpractices of traditional midwives and thus change reproductive behaviours. These changes would, in turn, reduce maternal and infant deaths, and eventually decrease the high demand for curative health care.

¹⁵ CSO 730/32. 'Helen Hendrie to Duff, Reply to Duff Letter No. 133/31/30, Dated 20/5/32', 12 June 1932.

¹⁶ Ghana Medical School Library, Accra (GGCRMSD) 1929-1930, Grace H. L. Summerhayes, 'Report of the Maternity Hospital, Accra', Appendix F, 199.

A letter from a Lady Medical Officer to Dr. Duff, the Director of Medical Services in 1932, noted the perceived linkage between western midwifery and the achievement of government health goals in colonial Ghana. According to the medical officer, as far as West Africa was concerned, the colonial health problem was 'midwifery, yaws, and malaria'.¹⁷ He added, 'I think I am right in saying that in this country midwifery comes first. In the first place, there tended to be a hiatus between the antenatal and post-natal work. If a woman did not go to Korle-Bu [the government's general hospital], or employed a private doctor, she was cast back at the most critical time—the labour and neonatal period—on the tender mercies of the local mammy [or African traditional midwife]'.¹⁸ She argued that the central point or person in midwifery work should be a trained midwife, and the colonial government needed to put in the necessary structures to achieve this goal.

3.0 Transforming Midwifery Practice

The transformation of midwifery practice in the Gold Coast began in 1928 when the Accra Maternity Hospital was opened to provide maternity services and to train midwives. Placed under the leadership of Dr. Summerhayes,¹⁹ the programme was designed to link maternity work at hospitals and welfare centres with towns and villages and to popularise the services of western-trained midwives in the country. At the start of the programme, there were no specific guidelines or governing body to oversee midwifery education. Hence, in 1930, the Director of Medical and Sanitary Services introduced the Midwives Ordinance Bill in the Legislative Council.²⁰ Arguing for the passage of the bill, the Director focused primarily on the high 'amount of sickness and suffering and the high mortalities caused by childbirth in the country'.²¹ He compared the average maternal mortality rate of 15 per 1000 deliveries in the country in 1930 to that of the United Kingdom rate of 4 per 1000 for the same period.

¹⁷ CSO 730/32. Hendrie, 'Reply to Duff: No. 133/31/30'.

¹⁸ Ibid.

¹⁹ Dr. Summerhayes before the opening of the Maternity Hospital was already working as a Medical Officer at the Korle-Bu Hospital. She stayed in charge of the Maternity Hospital from 1928 until 1932 when Dr. C. D. Williams took over.

²⁰ The bill had already been read in a previous session of the legislative council, but it was not voted on because according to Dr. Nanka-Bruce 'the time was inopportune and the condition was unfavourable'. See CSO 5/1/326, No. 1488/30. 'The Midwives Ordinance 1931 Gold Coast Colony'.

²¹ Ibid.

The Director pointed out that nearly all the sickness and high mortalities in the country could be prevented by a skilled and efficient midwifery service and that it was no fault of mothers that their lives and the lives of the new-borns were exposed to the 'vast amount of ignorance and unhygienic treatment in midwifery in this country'.²² He argued that the passage of the bill would bridge the gap between the present poor state of affairs in the country and the colonial ideal of a trained service, and would protect the rights of those practicing. The bill was approved and signed into law in 1931 by Governor A. R. Slater.²³ The central goal of the bill was the achievement of a gradual displacement of traditional midwives from the processes and management of pregnancy and childbirth with western-trained midwives.

To fulfil this goal, colonial health officials recognised that confidence in scientific methods of obstetrics was not high enough in the country and traditional midwives were too numerous, with too many women depending on them, to displace them from their work immediately. In the 1929-1930 Medical and Sanitary Report, the Director of Health Services, Dr. Duff, wrote, 'Maternal welfare must be, it is feared, of rather slower growth and will be dependent largely on the rapidity with which the Gold Coast parallel of "Sairey Gamp"²⁴ can be replaced by trained midwives'.²⁵ The Ordinance, therefore, provided a scheme that allowed two groups of midwives to practise in the country. The first group consisted of African traditional midwives who, in spite of a lack of obstetric training in midwifery, satisfied health officials within a given time that they had been engaged in midwifery practice for a period of not less than two years. Once they completed basic training and the local chief vouched for their

²² Ibid.

²³ CSO 5/1/331, No. 1488/30. 'The Midwives Ordinance, 1931 of Ashanti'.

²⁴ Sairey Gamp was a midwife/nurse character in Charles Dickens' novel *Martin Chuzzlewit*, which was first published as a series from 1843 to 1884. Sairey Gamp was portrayed as dissolute and a drunk and became a notorious stereotype of bad secular midwife/nurse in the early Victorian era. In many instances, colonial health officials in the Gold Coast spoke plainly in their views about traditional midwives. They despised the fact that childbirth was left in the hands of a group of people whose only contributions toward reproductive health was, perhaps, increasing maternal and infant mortality rates with their unhygienic practices. Through measures such as antenatal visits, weighing clinics, birth registration, hospital birth, and the rest, health officials tried to dissuade Ghanaian women from patronizing the services of traditional midwives.

²⁵ GGCRMSD, 1929-1930. Stanley Batchelor, 'Report on Maternity and Child Welfare', 50-51.

good character, they could apply for their name to be put on the List of Unqualified Midwives maintained by the Deputy Director of Health Services, and they could practise in pre-selected areas in the country.²⁶

The pre-selected areas were designed to prevent the number of unqualified midwives from growing in the hope that with the growth of confidence in scientific methods of obstetrics, their disappearance would be accelerated and registered midwives would take their place.²⁷ The second category of midwives was to be known as Registered Midwives, and they were to be registered on the Roll of Registered Midwives once they had completed a training programme in midwifery. Before a person could apply to be placed on the Roll of Registered Midwives and allowed to practise in the country, she was required to undergo a course of training in a midwifery training school approved by the Board for at least 18 months. However, if a student entered the programme without any prior training in nursing education, the midwifery training took three years. The conditions of entry were satisfactory health and the passing of a general intelligence examination. The registered midwives programme was designed in such a way that those who completed it received government subsidies to encourage them to practise in rural areas where the majority of traditional midwives were concentrated in an effort to displace them.²⁸

4.0 African Traditional Midwives, Birthing Mothers, and Western Midwifery Practice

From 1928 through to the 1930s and the 1940s, the colonial government made significant inroads into medicalising childbirth through its midwifery programme and welfare services, but underneath this success was the constant tussle with traditional midwives and birthing mothers. In 1943, Dr. Kirk pointed out to the Colonial Office that the midwifery schools were producing corps of midwives who were not competent to conduct delivery in the patient's home using materials likely to be obtained there, as there was still a great reluctance of birthing mothers to give birth in the hospital environment. According to Dr. Kirk, the practical training of midwives should be conducted instead in the homes of patients and not in hospital wards where many mothers felt uncomfortable and

²⁶ Ibid.

²⁷ CSO 5/1/328, No. 1488/30. The Midwives Ordinance 1931 Gold Coast Colony. Enclosure 3: Report on an Ordinance of the Gold Coast Colony Shortly Entitled 'The Midwives Ordinance, 1931' No. 10 of 1931.

²⁸ Ibid.

where the midwife would spend the greater portion of her professional career. He admitted that while it was important for student midwives to learn how to conduct deliveries in the hospital environment to gain confidence, a vast and important difference existed in conducting a labour aseptically in hospital using sterilised equipment and attempting the same thing in a badly lit room, using a few calabashes to hold solutions.²⁹ As a result, even the average midwife could successfully carry out asepsis in the hospital, but was hopelessly at sea when the same principles had to be applied in the field.

Dr. Kirk conceded that the failure of trained midwives to perform effectively in the field or within the communities was the result of the method they used in teaching student nurses and midwives. That is, they taught students the elements of aseptic techniques in a hospital environment without providing reference to the field, even though student nurses and midwives were expected to work in communities outside of the hospital environment. The colonial government accepted Dr. Kirk's assertions and, in 1946, introduced a programme that allowed student-midwives to have field practice and to enable midwives to provide midwifery services directly in the homes of birthing mothers. The above directive was aimed at achieving two things. First, it was intended to curb the activities of traditional midwives who had not submitted themselves to be trained under the government's programme of unqualified midwives. The presence of western-trained midwives in the homes of expectant mothers would prevent them from accessing the services of these traditional midwives. Second, it was reasoned that it would be easier to talk about personal hygiene and effective mothercraft when conditions of filth and other bad practices were witnessed in the visited environment,³⁰ assuming that there would undoubtedly be filth in the African home.

As with the case of the umbilical hernia and the western-trained midwives' ability to perform effectively in the field, the traditional midwife took the blame for anything that went wrong with childbirth, even in cases where western scientific methods could not get any different results. Through measures such as antenatal visits, weighing clinics, birth registration, home deliveries, and the rest, colonial health officials tried to dissuade Ghanaian women from patronizing the services of traditional

²⁹ CSO 11/7/28, No. 3721 S. F. 5: Nurses and Midwives-Recruitment and Training. Alan Burns, 'Extract from File No. Conf. 3721 pg. 2: Proposal by Dr. Kirk, Director of Medical Services, 1943'.

³⁰ Ibid.

midwives. Indeed, the inclusion of traditional midwives under the 'unqualified midwives' provision in the Midwives Ordinance of 1931 came about only after the realization of the impracticability of immediately displacing large numbers of traditional midwives practicing in the country. Moreover, health officials reasoned that the introduction of 'Registered Midwives must not start with a group already tainted with bad practices; rather, they must be of a first-class material, for a badly trained midwife could do more damage than one who had no training but had long practice'.³¹

Soon the government discovered that transforming both how midwifery had been practiced in the country for generations, and impressing on women to utilise the services of western-trained midwives, was not so simple. While colonial records do not show any open confrontations between traditional midwives, birthing mothers, and colonial health officials, there were enough subtle contestations from such midwives and birthing mothers to significantly disrupt the colonial reproduction measures. Many midwives working in the communities, particularly those in the rural areas, reported that local prejudice was common towards western midwifery practice. Not only were women suspicious of western-trained midwives, but also they were reluctant to pay for their services. This caused the colonial government to institute measures that allowed western-trained midwives to take legal action against mothers who used their services but refused to pay.³²

With traditional midwives, a family thank you, a gift of foodstuff, or even a day's work in the farm by a family member was enough to pay for their services. Otoo (1973) argues, in 'The Traditional Management of Puberty and Childbirth among the Ga People, Ghana', that in many Ghanaian traditional societies, childbirth is regarded as a 'natural' event and an enjoyable family and community experience. In this context, childbirth serves as a symbol of a social event, and each time such an event occurs, there was abundant social support from both family and friends, as well as from the entire community. In other words, the social comforts associated with giving birth in a familiar environment and with familiar people were strong enough to prevent many birthing mothers from giving birth in a hospital environment and from accessing the services of

³¹ CSO 5/1/328, No. 1488/30. 'The Midwives Ordinance 1931 Gold Coast Colony'.

³² CSO 5/1/337, No.1488/30, S. F. 10. 'Midwives Notice of Steps to be taken against Women Retaining their Services in Childbirth but Fail to Pay their Fees'.

western-trained midwives where they would be surrounded by unfamiliar faces and where the whole experience is impersonalised.

Even before 1946, the colonial government had realised that the dependence of birthing mothers on the services of traditional midwives was not going to be resolved by the mere presence of western-trained midwives and/or instituting laws to compel payments. A lot more needed to be done in terms of engaging directly with traditional midwives, particularly those not practicing under the umbrella of the government's midwifery education programme. To gain some understanding of the views/positions of traditional midwives in their contest with the colonial government over obstetric practice, and how that contest mirrors conflicts between post-colonial governments and traditional midwives now commonly referred to as Traditional Birth Attendants in contemporary times, I interviewed a number of Traditional Birth Attendants on the subject. According to many of them, the efforts to displace them from their practice started with the colonial government but it did not end with colonial rule. Post-colonial governments have equally tried to end their practice by discouraging birthing mothers from using their services. One respondent stated bluntly, 'abrɔfo [white people] brought their medicine and practices and when we finally forced them to leave, we didn't make sure they left with all their stuff. Now we don't know where we stand even though many of us continue to be the primary providers of midwifery services in our towns'.³³

Another respondent stated:

In my town, I am the only person pregnant women can depend on. We are far from the nearest clinic and in spite of our chief's call for the government to provide our community with a clinic and a midwife they have not done so. Yet, every day they tell pregnant women to seek the services of doctors and trained midwives.

In a somewhat annoyed and frustrated tone, she added:

Once, we had to put a pregnant woman in labour with complications on a bicycle, could you believe that, a bicycle! To transport her to the next town, which is more than an hour and thirty minutes away. Absolutely unacceptable! I mean, I don't mind giving up my practice but I'm the only

³³ Interview with respondent 11 at Asakraka-Kwahu on 26 May 2009. All interviews were conducted by the author in the local language Akan of the respondents in their homes.

help women here have and if the government is not going to help, he or she or whoever it is should stop pestering us.³⁴

Indeed, all the respondents echoed the same story and one could understand their frustrations and could make the reasonable assumption that traditional midwives during the colonial era perhaps felt the same frustrations, especially as the number of health care centres was minimal during this period. As with the colonial government, post-colonial governments, beginning in the 1970s, with the help of the World Health Organisation and some non-governmental organisations, tried various strategies to incorporate Traditional Birth Attendants into the health care delivery system because of their inability to dissuade birthing mothers from patronising their services, as well as a lack of government health care services in all areas (Kruske and Barclay, 2004). Here, one respondent pointed out that, in the past, birth attendants had long years of apprenticeship in addition to having spiritual qualities:

Not everyone can just get up and deliver a woman safely. You have to be blessed to do such a job but now, the government is calling everyone to train as birth attendants, even people who have not had any experience in delivering pregnant women. But you know, this is a very special job so they can't stop pregnant women from coming to us.³⁵

The colonial government, on its part, directed that medical staff, including midwives, health visitors, and nurses, were to encourage traditional midwives to bring to the clinics the expectant mothers in their care for examination to ensure that the conditions for an unaided birth were satisfactory and that no pregnancy disorders or complications were present. In addition, they began to give practical demonstrations to traditional midwives whenever possible. In 1932, the Lady Medical Officer at the Accra Maternity Hospital, Dr. C. D. Williams, reported that a few traditional midwives were gradually beginning to bring their cases to the antenatal clinic. However, they continued to remain 'deeply suspicious that all we want is to spoil their practice',³⁶ which was, of course, exactly what was intended.

³⁴ Interview with respondent 20 at Oframase-Kwahu on 2 June 2009.

³⁵ Interview with respondent 7 at Kofiase-Dormaa Ahenkro on 18 June 2009.

³⁶ GGCMSD, April 1927-March 1928, 'Maternal and Infant Welfare', 34.

5.0 Conclusion

On some level, the benefits for gaining access into the private spaces of women in order to transform and control their reproductive behaviours were enormous for the colonial government. First, a healthy colonial population meant a reliable source of manual labour. Second, it reduced the government's long-term health expenditure, which, to all intents and purposes, had to be the bare minimum in order for them to gain the most out of their economic exploitation. In addition, they entered into the private spaces of Ghanaian women's lives to redefine their social normative practices and to impose European social values on them. The colonial government, through midwifery education, linked the private with the public spheres by rendering its western-trained midwives fully committed to promoting birthing practices in line with the coloniser's culture. Western-trained midwives cooperated with the colonial government, either consciously or unconsciously, by becoming their agents in the field. Essentially, they became vessels through which the colonial government attempted to reconstruct women's reproductive knowledge and authority in pregnancy and childbirth. They supervised deliveries and infant care, promoted health education, and trained traditional midwives.

African mothers also benefited from the new alternative medicine. Yet, as we have seen, traditional midwives and birthing mothers in Ghana and elsewhere in Africa had a voice during the reproductive encounter. In report after report, medical and health officials were frustrated with the slow pace with which mothers were using the services of western-trained midwives as well as in taking full advantage of the various maternity hospitals and welfare centres. Many researchers have shown that African women's acceptance of, or participation in, colonial reproductive reconstruction measures was not a sign of complete reproductive subjugation, as many contested the measures by rejecting, negotiating, or even appropriating the benefits of western obstetric practices. For some Ghanaian mothers, the lack of financial resources and access to government services caused them to ignore that there were any changes taking place that affected their lives. Others could afford the new services, but chose not to participate because of deeply held beliefs about the intentions of the intruders and their medicine. Some women participated by redefining the colonial agenda. The majority of these women welcomed hospitals and the western-trained midwife's ability to save mothers and infants in times of crisis, but did not otherwise participate in the

medicalisation and hospitalisation of pregnancy and childbirth, at least to the degree the colonial health and medical officials had wanted.

Some traditional midwives accepted the new way of obstetric practice by joining the colonial government's midwifery training programme to be certified as unqualified midwives, although the majority of these midwives continued their practice in the same manner. As argued by Summers (1991), and echoed by Allman (1994) in her discussion of maternal welfare in colonial Asante, colonial rulers planted on grounds to which they had very limited access, and at best, could only enter intermittently. In other words, colonial governments entered an environment they did not own and could not make their own. Their access and control was in many ways, superficial. What they had managed to implant was different from what they had expected. The colonisers, mindful of the importance Africans attached to childbearing and reproductive issues, anticipated that Ghanaian women—as birthing mothers, grandmothers, guardians, and as traditional midwives—would overwhelmingly welcome the 'superior' birthing techniques they had introduced. However, what emerged was a complex interplay of negotiations and contestations with women picking and choosing what they wanted out of the programmes and rejecting what they did not want or what did not conform to their understanding of reproductive health. In the end, not only did colonial health officials end up accepting the women's terms in the reproductive encounter, but traditional midwives, with their long history of managing pregnancy and childbirth coupled with their social relations with their patrons, were able to safeguard their influence and control over the reproductive space all the way into the post-colonial period.

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THE AFRICAN CHARTER ON DEMOCRACY AND GOVERNANCE: AN ELECTIONS CHECKLIST ON ZAMBIA

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African heads of state and government adopted the African Charter on Democracy, Elections and Governance (ACDEG) in 2007, and it came into force on 16 February 2012. The Charter is the first legally binding African treaty that takes a holistic approach towards the institutionalisation of democracy. This article discusses how Zambia, a state party to the ACDEG, measures up to its standards, taking Article 17, which is the main provision governing the conduct of elections, as an example. It seeks to demonstrate that Zambia falls short of the benchmarks set in the Article and should therefore begin to work to reform its laws and institutions in order to comply with the standards of the ACDEG.

1.0 Introduction

The African Charter on Democracy, Elections and Governance (ACDEG) was adopted on 30 January 2007 by the 8th Ordinary Session of the Assembly of the Heads of State and Government of the African Union, in Addis Ababa. On 16 January 2012, Cameroon became the 15th state to deposit its instruments of ratification of the ACDEG with the chairperson of the Commission of the African Union (AU), thereby triggering the ACDEG to come into force on 16 February 2012, pursuant to the requirement by the Charter to enter into force 30 days after the deposit of

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15 instruments of ratification.² The ACDEG aims, among its major objectives, to ‘promote the holding of regular, free and fair elections, to institutionalise legitimate authority of representative government as well as democratic change of government’.³ In fact, many of the principles enunciated in the ACDEG elaborate on the democratic principles of popular participation and good governance contained in the Constitutive Act of the African Union.⁴ The ACDEG is the first comprehensive and binding African treaty specifically setting common standards for democracy, elections, and governance.

Zambia is a state party to the ACDEG, having ratified the charter on 31 May 2011 and deposited the instruments of ratification on 8 July 2011.⁵ As a state party to the ACDEG, Zambia has a legal duty under international law to implement its standards at the municipal level. The Vienna Convention on The Law of Treaties 1969 states that ‘every treaty in force is binding upon the parties to it and must be performed by them in good faith’.⁶ African states are, however, well known for signing up to standards they have no real intention to honour. This is well illustrated by the dismantling of the SADC Tribunal by the heads of state and government following the Tribunal’s decision in *Campbell*.⁷ The *Campbell* decision ordered the Zimbabwean government to reverse a decision to appropriate farms belonging to some white farmers, in violation of human rights standards, as part of the government’s land reform programme Ndlovu, 2011.⁸ The ACDEG gives African leaders and governments an opportunity to depart from this legacy in order to show commitment to the rule of law and thereby rebuild the image of the continent.

Africa is still home to a variety of regimes. These include failed states such as Somalia; states in transition following revolutions such as Tunisia, Egypt, and Libya; dictatorships such as Sudan and Zimbabwe; and

² Article 48, African Charter on Democracy, Elections and Governance (ACDEG), 2007.

³ Article 23, ACDEG, 2007.

⁴ See Article 3, Constitutive Act of the African Union, 2000.

⁵ See ‘List of Countries which have Signed, Ratified/Acceded To The African Charter On Democracy, Elections and Governance’, www.african-union.org.

⁶ Article 26, Vienna Convention on The Law of Treaties, 1969.

⁷ *Mike Campbell and Others v. The Republic of Zimbabwe*, Case No. SADC: 2/07, 28 November 2007.

⁸ See also ‘SADC Tribunal Dissolved’, <http://www.kas.de/rspssa/en/publications/22940>.

functioning democracies such as South Africa, Cape Verde, Mauritius, and Botswana. There is thus a lot of work to be done to bring many more countries into the fold of functioning democratic states. Consolation can be taken, however, from the fact that since the AU came into existence, it has, unlike the Organisation of African Unity (OAU), generally been more willing to firmly and consistently denounce unconstitutional changes of government through military coups. Military coups in many instances have actually led to the suspension of governments from participation in the AU and the restoration of rights only upon the holding of elections. Examples include countries such as the Central African Republic in 2003, Togo in 2005, and Mauritania in 2005 and 2008 (Glen, 2012). However, the same standard has not been applied when it comes to regimes that have been willing to hold onto power by manipulating the electoral system, as exemplified by the tolerance of the Mwai Kibaki and Robert Mugabe regimes following the disputed and violent elections of 2007 and 2008, respectively. The cases of Kenya and Zimbabwe urge cautious optimism and show that it is too early to know for sure if the ACDEG will fulfil its purpose of consolidating, promoting, and protecting democracy in Africa. Only time will tell how effective the Charter will be. However, if its provisions are implemented dutifully and are keenly observed by African states, electoral democracy is certain to flourish in Africa.

This article intends to offer a checklist on Zambia in relation to Article 17 of the ACDEG, the main provision setting standards for elections. It will, however, initially give a historical overview of electoral democracy in Africa before specifically focusing on Zambia.

2.0 Africa's General Experience with Electoral Democracy

Systematic colonisation of the African continent was formally consummated at the Berlin Conference in 1884 and 1885, when the western dominant powers arbitrarily divided Africa among themselves into territorial units, without regard for existing states and kingdom boundaries, thereby grouping together those who may have been enemies and invariably separating those who were homogeneous (Ndulo, 2003).

Although there were incidental benefits arising from the contact with Europe during colonialism, colonialism caused massive disruptions of indigenous governance systems and instead introduced a system of governance that was centralised and elitist and exercised powers absolutely, permitting no room for dissent by indigenous people (Ndulo,

2003). Colonialism failed to bequeath a legacy of representative and accountable democracy, respect for human rights, or an equitable distribution of resources. Africans were generally excluded from government; the benefits accrued from mineral resources went to the development of European homelands, generally leaving behind wretchedness and poverty, especially in rural areas.

With the attainment of independence in the 1950s and 1960s, Africa was pregnant with euphoria, new hopes, dreams, and expectations. Multitudes attended public events celebrating this achievement. Many considered that their misery was over and that better days lay ahead. They considered it the end of slavery, repression, and exploitation, and the opening of a new door to economic prosperity. Politically, it was expected that the new indigenous governments would build viable autochthonous democratic states based on democratic inclusiveness and respect for human rights and the rule of law. Kwame Nkrumah, the first President of Ghana, captured these expectations well in his independence speech when he stated, 'Today we have awakened. We will not sleep anymore. Today, from now on, there is a new Africa in the world' (Nkrumah, 1957).

The euphoria of independence was short-lived. Instead of building viable, tolerant, and inclusive new democratic states that sprung from the will of the people and were accountable to the people, the new governments soon abandoned these expectations and reverted to the repressive 'governance' tactics of the colonial masters. As Hatchard, Ndulo, and Slinn (2009) observe, the new African president replaced the colonial governor both in fact and in deeds. In many cases, the independent African states behaved worse than the colonial ones and became characterised by four notable features: i) power consolidation and one-party rule, ii) corruption and wastefulness, iii) assassinations and disappearances of critics, and iv) military interventions.

By the 1980s, the retreat into authoritarianism seemed to be reaching its saturation point in Africa. People were tired of one-party rule and military dictatorships, gross corruption, assassinations, and the resulting mass poverty. Out of about 50 African states, by the 1980s, only Botswana and Mauritius had remained genuinely democratic and routinely conducted free and fair elections (Hatchard, Ndulo, and Slinn, 2009). In many other countries, elections, when held, were mere rituals meant to confirm the incumbent and *his* party in office. Africa had not yet had a female president during this period. Between 1960 and 1989, no election in the