An overlooked WWI legacy: maternal and child health in sub-Saharan Africa

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An important legacy of World War I was the rise of maternal and child health care in many European centres;

a related yet overlooked legacy is the simultaneous transfer of these services to their colonial possessions during the years of conflict and those immediately following.

In England, the surge of maternal and child health care was prompted by humanitarianism and concerns about the loss of lives, plummeting birth rates, a depleted workforce, and the ability of the Empire to defend itself. Women's groups, medical associations, religious charities, and other parts of civil society contributed to the development of services. The provision of antenatal care, delivery assistance at birth, and health education in the areas of hygiene and nutrition - together with a better standard of living - led to improved health outcomes: infant mortality rates which declined by 7% from 1905 to 1913 fell by 20% during the period 1914-18. In some industrialised centres with little evidence of wage increases or water and sanitation improvements, infant mortality rates still fell significantly; in Wigan, England, it declined from 179 deaths to 117 (per 1000 livebirths) between 1913 and 1919.

Colonial administrators expressed similar concerns in sub-Saharan Africa during the war years about very high levels of infant mortality and the viability of the local workforce. The Imperialist rhetoric at the time was to introduce "modern and civilizing ideas" to the colonial possessions; the introduction of maternal and infant health in particular, "was designed to improve the colonial labor supply, pacify indigenous populations and promote modernization". The rise of humanitarianism and volunteerism seen in England spilled over into the colonies through volunteerism and provided the means to deliver maternal and child health services to Africans, mainly by medical missionaries.

Although reliable household survey data show that maternal and child health care has a large impact on childhood mortality (which is typically 50-100% higher for women who receive no antenatal care or delivery assistance at birth than for women who receive both) and medical missions provided 25-50% of maternal and child health care in sub-Saharan Africa throughout most of the 20th century, "little scholarship addresses their influence on African health care and health status" and a vast mission archive remains almost completely unexplored. This neglect is partially explained by the justifiable view that traditional missionaries (as distinct from the new breed of independent evangelists) were a colonial construct used to justify the actions of imperialist powers, and generally an embarrassment to academics.

Yet from the medical or public health point of view, evidence from Tanzania, Zambia, and many other parts of sub-Saharan Africa would suggest that traditional medical missions have been professionally staffed and managed - at least since the 1960s independence era. Indeed, studies suggest that, rather than being a source of embarrassment, medical missions have shown what can be achieved when health initiatives are planned and implemented as if ordinary people mattered. Delivered mainly by women working at the

grassroots level, often incorporating local knowledge and sometimes reproducing "aspects of indigenous models of the healer", they provided, in essence, family-centred health care.

Furthermore, medical missions often protected the communities they served from some of the most egregious policies implemented by the international community. For example, over the past 30 years or so—an era of deregulation, free flow of capital, and proliferation of other neoliberal policies—the IFIs and donor aid agencies (by their own account) implemented adjustment operations and health-sector reforms without paying attention to their impact on the most vulnerable. Their austerity measures typically led to a 50% cut in health-care expenditures in sub-Saharan Africa, a collapse of health-care systems, and a reversal of child survival trends.

In Zambia, where maternal and child health care fell into disarray and infant mortality rates skyrocketed, the World Bank (without a trace of irony) reported that "the people have nowhere to turn for help. Those (rural) buildings which have been historically PHC centers or district hospitals are empty shells. Many institutions are losing qualified health personnel, are utterly devoid of basic health materials". Yet in districts where medical missionaries delivered basic services to Zambians, quality and access by the poor were generally maintained by staying focused on the careful allocation of scarce resources to cost-effective care that targeted the most vulnerable. Although their catchment areas were more geographically remote, had higher levels of poverty and childhood malnutrition, more female-headed households, less food security, and were more vulnerable to drought, they provided 75% more assisted deliveries per head than non-mission districts and had childhood mortality rates that were 12% lower. In fact, so striking were the differences that statistical analysis of district data showed that neither poverty nor malnutrition but rather access to maternal and child health services explained variation in child survival.

As HIV gripped Africa in the 1990s, mission health facilities with strong community care networks were well placed to tackle the crisis at the local and household level and typically responded a full 10-12 years before the international donor community and national governments took substantive action. By 1988, mission facilities in Mbeya, Tanzania, for instance, had already launched robust programming that included a sweeping condom distribution initiative, voluntary counselling and testing, community education programming, home-support programmes, and eventually prevention of mother-to-child transmission programmes. In contrast, the World Bank, the lead donor in Africa's health sector, repeatedly eschewed involvement in the pandemic in favour of its health reform package. It warned in 1992 that, "an expanded role of the Bank in AIDS should not be allowed to overtake the critical agenda for strengthening health systems". It was only by 2000 that the donor community began to invest in the prevention and control of HIV, by which time 30 million Africans were dead or dying.

Negative sentiments towards missionaries have been bolstered in recent years by some Christian fundamentalists who have sought abstinence-only approaches to HIV prevention and by the appalling rhetoric of mission fringe groups that has encouraged the criminalisation of homosexuality in parts of sub-Saharan Africa - neither of which have

a bearing on the traditional medical missionaries under discussion. The risk, however, of dismissing missionaries as an embarrassment, too "intimately tied up with colonialism and exploitation" is that a one-sided view of events persists unchallenged (that of the military and bureaucracy); it means missing the opportunity to obtain a bottom-up view of colonial and post-colonial history, one that incorporates the voice of ordinary people (the so-called subalterns). Ironically this is the type of information that most national aid agencies now insist on when taking a "livelihoods approach" to development.

It also implies that lessons-to-be-learned are neither identified, nor acted upon, and that past mistakes will be repeated. For some, of course, failure to design and implement development strategies as if ordinary people mattered would help explain repeated policy miscues and the rise in inequalities in sub-Saharan Africa over the past 30 years. The simultaneous rise of maternal and child health care in sub-Saharan Africa and England is interesting because both were driven by the practical and the altruistic – a good combination when enduring social policy is the objective..