

Resilience of Traditional Midwifery in Southern Cameroons, 1922-1961

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Abstract

It is instructive that well organized healthcare systems existed in Africa before contacts with the outside world. During this period, midwifery services were prioritized because societal wellbeing depended on the quality and availability of child and maternity services. The arrival of European colonial imperialists with their assumed superior culture/civilization and their colonial economic agenda caused the introduction of Western biomedicine. This was intended in part to maintain a constant and healthy workforce for colonial exploitation. Drawing from the case of southern Cameroons, this paper sets out to examine the resilience of local midwifery practices in the face of an imposed Western biomedicine. The paper was informed by both primary and secondary sources. Archival information and oral interviews made up the primary sources while books, published articles and dissertations constituted the secondary sources. The descriptive historical approach was employed in the analysis of the work. The study submits that: African women were not passive subjects on issues of their reproductive life but agents that could reject imposed values and stick to their tested practices. The ideological and cultural arrogance that characterised the introduction of Western biomedicine had the unintended impact of galvanizing an unexpected resilience of the traditional medical practices. Consequently, appreciable change in favour of Western biomedicine was only witnessed in the period after independence.

Key words: Midwifery, Western, Traditional, Resilience, Southern Cameroons.

Introduction

Prior to the colonization of Cameroon and the imposition of Western Biomedicine and its component of infant and maternal welfare, traditional birth attendants managed health issues related to sexuality, reproduction and procreation. Pregnancy and delivery were incorporated within the African healing systems. These practices sustained the people of southern Cameroons and enabled them to carry on successfully with their economic activities for sustenance and livelihood. African midwives were the basic sources of assistance to pregnant and lactating women in the present day Northwest and Southwest regions of Cameroon. Prenatal care, birthing and post natal care were their primary responsibility in their different communities. Traditional birth attendants were the only available assistance in the communities and their services sustained women and children in pre-colonial times without any alternative. This was thanks to their natural environment and relief features that provided them with the necessary pharmaceutical herbs and roots as well as spiritual powers. However, with the arrival of colonialism, Cameroonians witnessed a change in the trends of events in British Southern Cameroons. Western bio-medicine was introduced within which infant and maternal welfare services were fostered.

Western biomedicine was first introduced by missionaries, who preached against traditional medicine and midwifery on the pretext that they were demonic, barbaric, superstitious, and ineffective¹. The high infant mortality rates during the era of British Administration of Southern Cameroons were blamed mostly on the

¹ Nixon Takor and Nkwain Clovis, "Herbal Potency, Ecological Threats and Changes in Medico-Spiritual Healing of Patients in the Kom Chiefdom of Cameroon", in Anthony Ikechukwu Kanu (Ed), *African Indigenous Ecological systems*, 2021, 258.

ineffectiveness of traditional birth attendants as well as the poor prevailing hygienic conditions². This came along with the European mission of civilizing the Africans which was echoed in article XI of the General Berlin Act of 1885 and article II of the British mandate Agreement over Cameroon³. British Southern Cameroonians who lived in the urban centres as well as around British plantations were influenced to access and patronise the available infant and maternity centres. Complicated cases of diseases and unknown complications during pregnancy pushed a few women to walk over long distances to access welfare centres. The resilience of African midwifery during the British era in Southern Cameroons was partly because most women trusted their cultural practices and efforts at putting in place hospitalized birthing never saw the light of day easily. The first maternity center in the territory was created in 1935 by the Mill Hill Mission in Shisong⁴.

African Midwifery Practices In Southern Cameroon

In British Southern Cameroons, the birth of a child was a significant event in the life of a family. It was seen as a bond that consolidated the unity in marriage and ensured the continuity of the lineage⁵. Before foreign rule, Southern Cameroonians had diverse ways of handling births. Women who were either trained or blessed by nature and the gods of their lands were entrusted the responsibility of caring for pregnant women. From conception to delivery, women were closely followed up by traditional birth attendants. These midwives took charge of challenges related to fertility, the health and welfare of the child/mother during gestation, child birth, and treated infections/ailments that affected the infants.

British Southern Cameroons had a wide range of ethnic groups that were brought together at different times and from different geographical locations. These different ethnic groups had developed well-structured African medical systems within which maternity and child welfare services were incorporated. Prior to European Colonialism, child birth existed and pregnant women, children and lactating mothers were cared for by traditional midwives and other elderly family members in the different clans. Diseases such as dysentery, malaria, yaws, sleeping sickness and leprosy affected pregnant women and children and therefore traditional midwives and other herbalists in these communities developed methods in treating and caring for these people within the context of African midwifery⁶. Infant and maternal welfare services were structured in three phases. There was the phase of conception and pregnancy (prenatal), child birth (birthing) and after birth (post-natal) care. The powers of traditional birth attendants in managing pregnancies and conducting deliveries were both physical and spiritual. While some traditional midwives were trained by their mothers, grand-mothers and other traditional midwives, others were naturally endowed with the skills⁷. The processes that culminated to child birth began at conception and went through to the early years after the child was born.

The desire to ensure continuity in the society pushed the different ethnic groups to develop infant and maternal welfare services within their different ancestral and cultural healthcare systems. These welfare services varied from one community to another. The common features of these services were the dependence on natural environments: herbs, shrubs, and an appeal to supernatural forces. It was strongly believed across the territory that child birth was done through spiritual and physical powers. According to Andeck, women in their first pregnancies and those with multiple fetuses were managed differently from other pregnant women⁸.

² Jean Allman, "Making mothers: medical officers and women's work in colonial Asante 1924-1945", *oxford Journal, Oxford university press*, 1994, history workshop N^o 38, 24-26.

³ Emmanuel Aloangamo, *The British Southern Cameroons, 1922-1961: a study on colonialism and underdevelopment*, (Madison USA: Nkemnji Global Tech, 2002), 6.

⁴ Bisherine Bongatoh Kiven, *Christian Mission Agencies and Mothers and Child Welfare Services in British Southern Cameroons: 1922-1961*, MA Dissertation in History, University of Bamenda, 2019, 34.

⁵ Rachel Nyongkah, "Traditional Midwifery in the Balikumbat Fondom of the Bamenda grassfields from pre-colonial to post-colonial era", *International journal of humanities and social sciences*, Vol. 8, N^o 3, 2018, 67.

⁶ Harri Rudins, *Germans in the Cameroons 1884-1914, A case study in Modern Imperialism*, (New York: Greenwood press), 345.

⁷ Virginia Nwachan Andeck, "Traditional Midwifery in Batibo: Precolonial- 1992, Trends and transmutations", DIPES II Dissertation in History, HTTC Bambili, 2019, 37.

⁸ *Ibid*, 43.

Prenatal care was essential and began before conception. For example, among the Bangwa of Lebialem, women were served with *ackondem* (a local herb) as a means of preparing their wombs to carry an embryo. During pregnancy, twined plantain ropes with other spiritual powers enchanted on them were tied round the pregnant woman's waist as a measure of avoiding miscarriage. Women during gestation were closely followed up by the traditional birth attendant who constantly gave them concoctions to drink as a means of ensuring that the baby was doing well in the womb. This cleansing was intended to limit the risk of infant mortality at delivery caused by premature rupture of membranes. Between 36 and 40 weeks of pregnancy, the women were not left alone. They were often placed on enema bi-weekly as a measure of preparing the birth track for a save delivery⁹.

Within the Ngemba's, women were prepared for conception through the consumption of *Ndouwre*, a local herb. This herb was mashed in water and given to the woman to drink. Upon conception, a mixture of other herbs (*Chihze*, *Mbandzemoh* and *nkarh*) and roots were prepared for the expectant mother to constantly drink in order to maintain the mother and child in a healthy state that could lead to a save delivery¹⁰. When the gestational age was about 22 weeks and more, the drinking of *Ndouwre* was reintroduced to the expectant mother. This was intended to cleanse the foetus, prepare the birth track and reduce the duration of contractions. Other concoctions were mixed with honey and served the expectant mother two weeks to her expected delivery date. This was to ease contractions, birthing and ensure the membranes in the placenta did not rupture prematurely¹¹. The quality and quantity of food intake was also controlled by the mother and mother-in-law of the expectant women. During gestation, vegetables and starchy foods were highly encouraged. *Nkarh* a local herb was boiled for the expectant mother to drink as a blood tonic¹².

The Wibum used *Nkohboh* in preparing the wombs of women towards conception¹³. Other concoctions were given to these women during pregnancy to ensure a healthy and safe child birth. Women were also advised by their birth attendants to consume vegetables especially huckleberry which was eaten with corn *fufu*. Herbs that served as blood level boosters were also given to these women¹⁴. Other prenatal services that traditional birth attendants were involved in included; treating infertility, miscarriages, abdominal pains, regular fatigue and loss of appetite. Herbs, spiritual enchantments, cleansing and other concoctions were given to women to prevent/treat diseases and infections during pregnancy. Women in such conditions were advised on the type of activities to engage in and the quality and quantity of food to eat. In Nso, during pregnancy, women were advised on the different meals to consume. At twelve weeks of pregnancy, the belly of the pregnant woman was robbed with powdered calm wood mixed with water every night and whenever they had to go out of the home¹⁵. This was to protect the woman from miscarriage and shield the child from any ill-intentioned family member. There were some specialized wooden dishes in which her food was served. These dishes had spiritual powers that protected the pregnant woman and the foetus and ensured a save delivery as well as post natal survival¹⁶. Whenever the herbalist or birth attendant found out the mother and foetus were being attacked spiritually, concoctions with palm wine were prepared and served to the expectant mother in a particular calabash dressed with cowries. The services of traditional birth attendants in most of the communities were complimented by those of herbalist.

After the prenatal/preparatory phase, there was birthing proper. This phase began at the commencement of contractions. The traditional midwife was informed of the contractions and immediately she left with the informant to the expectant mother's location. During this time, the traditional birth attendant made preparations to receive the baby. These preparations included the extraction of cotton from palm conches, which was to serve in cleaning the blood after child birth, a calabash for the expectant mother to exert pressure into so as to push out the easily baby and later the placenta. A spatula was also made available in cases of retained placenta. This spatula was inserted into the woman to provoke the ejection of the

⁹ Keng Christiana, (Native of Alloh village), in discussion with author, November 2022.

¹⁰ Asoh Rahel, (Native of Bafut village), in discussion with Author, May 2023.

¹¹ Lum Magdelene, (Native of Mankon), in discussion with author, November 2022.

¹² Ngwa Monica Sirri, (Native of Bafut Village), in Discussion with author, May 2023.

¹³ Tamfo Scot, (teacher), in discussion with other, March 2023.

¹⁴ Wila Serophine, (Native), in discussion with Author, March 2023.

¹⁵ Bime Leonard Fon, (Herbalist), in discussion with Author, 24th June 2023.

¹⁶ idem

placenta¹⁷. In some other ethnic groups like the Ngemba of the grassfields, the inner part of a plantain stem was given to women when the placenta was retained. The woman was expected to exert pressure on the stem to ease the delivery of the placenta. In Bafut, *Felarhreterh* a local herb was also given to the woman to chew in cases where the retained placenta was difficult to come out. In cases where the foetus to be delivered presented itself in a bridge (presenting the legs, arm or buttocks first) or transverse form (a horizontal presentation), the stomach of the expectant mother was massaged gradually to ensure a proper presentation (cephalic). In challenging cases, the midwife used her hand to adjust the baby in the uterus¹⁸. During this process, other elderly women were in the delivery room to give the necessary assistance to the midwife and often were experienced women and close family members.

Immediately after delivery, the traditional midwife was charged with the duty of disconnecting the child from the mother by cutting the umbilical cord. In Meta, the stem of *Pennisetum Purpureum* was used during this process¹⁹. Other ethnic groups like the Bangwa and Wibum used filled bamboo sticks in severing the umbilical cord²⁰. In disconnecting the umbilical cord properly, it was measured to the knee of the baby and that point was tied either with twined fibres from raffia palms then cut. Once the baby was successfully borne, small quantity of cold water was sprinkled on the child for him/her to cry so the midwife could evaluate and ascertain the possibility of survival of the child. Some of the aspects checked during this process included tongue tight, lungs infection and breathing. In case of any error, efforts were immediately employed to adjust the situation. The baby was then warmly wrapped and placed in a warm environment often by the fireside in a kitchen to maintain a warm temperature. The mother was cleaned, dressed up and given hot food to eat and in some cases hot water to drink. This was to provide her with the necessary energy and create a pathway for her healing to commence and progress under favourable conditions. The baby was then put on the breast so it could activate hormones (Prolactin and lactin) for the production of breast milk necessary for the survival of the child²¹.

The last phase of the process was the post natal care. After the traditional midwife ensured the child and mother were all in a good state that could ascertain their survival, she left them with the elderly mothers who were with her during the delivery process. The women provided the necessary care to the mother and baby. Palm wine and asthma weed were given to lactating mothers to ensure, a sufficient quantity of breast milk flowed that could sustain the child. The lactating mother was also fed with different meals that were rich in carbohydrates like cocoyam, corn fufu, and achu among others. Breast feeding was often between two and three years of age. This duration was to ensure the baby was fully grown to an age that the mother could conceive again. The prolonged breast feeding was also a means of contraception for the women. The traditional birth attendant paid regular visits to the mother and baby to ensure they were doing well in health²². At eight months, the baby was gradually introduced to solid food.

In cases where the baby was a boy, three weeks to one month after his birth, he was to be circumcised. The circumcision was often done by elderly male family members or the child was taken to an elderly man in the neighbourhood/community who was experienced in carrying out circumcision²³. In cases where the mother or child contracted an infection, the traditional birth attendant treated them with herbs, concoctions, cleansing and the performed some traditional rites. In difficult and complicated cases, assistance was sought from other herbalists. Ailments regularly treated in children included, whooping cough, malaria, measles, dysentery and stomach discomfort.

Efforts At Modernizing Midwifery In Southern Cameroons

When Britain took over the mandate to administer Southern Cameroons under the supervision of the League of Nations in 1922, Article II of the mandate agreement gave her the responsibility to ensure the social

¹⁷ Virginia Nwachan Andeck, "Traditional Midwifery in Batibo: Pre-colonial- 1992, Trends and transmutations", DIPES II Dissertation in History, HTTC Bambili, 2019, 41.

¹⁸ Andeck, "Traditional Midwifery in Batibo", 42.

¹⁹ Ibid, 42

²⁰ Keng Christiana, (Native of Alloh village), in discussion with author, November 2022.

²¹ Andeck, "Traditional Midwifery in Batibo", 42.

²² Ibid, 47.

²³ Ibid, 52.

wellbeing of the people of the territory. In this light, she made strides towards the institution of Western biomedical health care and within this were infant and maternal welfare services. In 1931, the British passed the midwifery ordinance which governed the practice in the territory²⁴. The terms of the ordinance required that to practice midwifery, a midwife should be trained and have a certificate from the Board of midwives²⁵. The ordinance therefore did not make provisions for traditional midwives on the premise that these midwives were unhygienic and lacked training. It was equally argued that the heavy loss of infant life was largely due to the faulty conduct of deliveries and the faulty treatment of new born/infants by native midwives and their mothers. In line with the provisions of the midwifery ordinance, provisions were made for the training of Grade II midwives. The training was done in Nigeria and when the Mill Hill Sisters in Shisong created the St Elizabeth Maternity Centre, they later created a training centre for midwives in Southern Cameroons²⁶. The training course lasted for three years and during this course, students received lessons on antenatal clinics and care, birthing, infant welfare clinics/care and first aid as well as the treatment of minor ailments²⁷.

In 1944, the British Provincial and Welfare Development Board ordered the creation of maternity units in all government hospitals. Added to this was an order by the same board to create Native Authority Maternities in the different Native Authorities²⁸. Upon the request of this board, the British colonial administration passed the Poison and Pharmacy Ordinance. This ordinance put in place conditions for local midwives to practice their profession. In this light, they were to obtain legal permission from the medical officer before dispensing medical care²⁹. By 1961, there were five government maternity centres, seventeen Native Authority maternity centres, nine mission maternity centres and two owned by plantation firms³⁰. Within these maternity centres, trained midwives carried on antenatal clinics, deliveries, infant welfare clinics and treatment of some ailments in infants and mothers to ensure survival and continuity. These welfare providers carried out sensitizations in churches, homes and girls schools to encourage the native girls and women on the need to drift from traditional birthing practices to modern western welfare services³¹.

Local resistance to the modernization of reproductive care

Though numerous strides were made towards the hospitalization of sexuality and reproduction (pregnancy and birthing) in British Southern Cameroons, there still existed antipathy among many southern Cameroonian women regarding being delivered in maternities and hospitals. In some cases like the indigenous Mbororo and Huasa', there were cultural restrictions that impaired them from accessing maternity units except in few extreme cases where the life of the expectant mother was at risk³². In the dying years of British rule in Southern Cameroons, the level of interest of the population in hospital birthing was summarized as being that of less interest in biomedical deliveries (see tables 1).

Table 1: ANC and delivery activities in Government and Mission welfare centers in Southern Cameroons in 1959

Center	N ^o of beds	ANC cases	Delivery cases
Victoria	30	2,922	441
Kumba	16	4,946	628
Mamfe	16	1,896	270

²⁴ Bisherine Bongatoh Kiven, Christian Mission Agencies, 35.

²⁵ The Board of midwives was put in place by the Midwifery Ordinance of 1931.

²⁶ Anna Foncha, (Retired Teacher), in Discussion with Author, 4th July 2023.

²⁷ NAB, 1626, Annual medical report, Southern Cameroons, 1954/1955.

²⁸ NAB, Sc(1944)1, Advisory Committee on Economic Development and Social Welfare, Cameroon's Provincial Committee For Medical and Health.

²⁹ NAB, Sc (1938)4, Medical Practitioners, Native Therapeutics.

³⁰ NAB, Sc(1959)2, Annual Medical Reports

³¹ Anna Foncha, (Retired Teacher), in Discussion with Author, 4th July 2023.

³² NAB, Sa/e 1936/2, Social Relations With Moslem Chiefs and their Women Folk.

Bamenda	17	4,703	477
Wum	8	2,230	148
CBM Bansa	14	1657	107
CBM Belo	12	576	397
CBM Mbem	4	391	108
RCM Njinikom	12	2646	395
RCM Shisong	15	7659	810
RCM Bafut	6	1584	86
RCM Nkambe	4	735	123
Basel Mission Bafut	4	8183	293
Basel Mission Nyasosso	12	415	203
Total		40, 525	4,486

Source: NAB, Sc(1959), Annual medical Reports

From table I, it emerges that local women took interest in antenatal services provided in the different maternity centres but there was a high level of antipathy among these women regarding being delivered by trained midwives. This is evident as out of a total of 40,525 women who visited the different mission and government maternity centres in the territory for antenatal clinics, only 4,486 (about 10%) of these women were delivered of their babies at the different government and mission maternity centres. This high level of reluctance in seeking the services of trained midwives during birthing could be ascribed to the inability of most expectant mothers to meet up with the maternity fee demanded by the different centres³³. With home based birthing in Southern Cameroons, there was little or no charges involved in delivery. Local midwives were compensated in kind with items like palm wine, firewood and farm work among others. This was often at the convenience of the family into which the child was born. In some cases, the child grew up and at maturity decided on how to compensate the midwife who delivered him/her³⁴. The introduction of a delivery fee by the British administering government in Southern Cameroons therefore scared away many women from exploiting the services of trained midwives.

To the above should be added the incidence of venereal diseases in Southern Cameroons. It has generally been argued that venereal diseases (Syphilis and Gonorrhoea) were foreign to Southern Cameroons. These diseases were introduced in the region following the regions increased contacts with Europeans³⁵. By the late 19th century both syphilis and gonorrhoea had become endemic in the territory. In British Africa, venereal diseases became most prevalent in the cities, which were mainly located on the coast. In 1927, C.E. Eeindorf (the British African Medical Officer) reported that his records on venereal diseases showed that over seventy-five percent of the population of the town between the ages of eighteen and forty-five years suffered from some form of venereal disease. With the growth of towns and increased communication networks and the introduction of wage labor, the disease became very widespread in the territory³⁶. Information of the incidence and prevalence of these diseases caused fear in most native women. The fear was mainly because venereal diseases caused premature births, miscarriages and regular lower abdominal pains in pregnancy. Added to this was the fact that African medicine had not discovered treatment for these foreign diseases. When most women from their biomedical results found out they were healthy such that

³³ RAB, NW/sd/a. 1955/5, Native authority Maternity Fee rules, June 1955.

³⁴ Andeck, "Traditional Midwifery", 56.

³⁵ Nkwam, "British Medical and Health Policies", 3.

³⁶ Ibid.

they could be delivered of their babies in conditions that could ensure postnatal and post-partum survival, they trusted their traditional midwives³⁷.

The persistence of traditional midwifery in most rural communities in the territory equally accounted for the gap between antenatal clinics and deliveries in maternity centers. The poor transport network that existed in the territory at the time coupled with the scarcity of maternity centers caused most women to depend on their traditional midwives. Most women in the suburbs found it challenging trekking over long distances to access maternity homes. For example from Ndu to Banso, Bangem to Nyasosso, wum to Belo where maternity centers existed was a tortious journey for a pregnant woman to cover during her last weeks of pregnancy. Their reliance on traditional midwives therefore became evident³⁸.

Associated to this was the fact that most women still doubted the strength of biomedical birthing as some cases of post natal and post-partum mortality were recorded in the different maternity centers. During sensitizations (in churches, homes and plantation farms) on western infant and maternal welfare services, the colonialist presented these services as benevolent gifts intended to save the local population from the pain of post natal and post-partum mortality that was rampant at the time. These campaigns blamed the local midwives for unhygienic practices, unskilled services and lack of advance equipment and techniques in managing delivery cases. Contrary to these perceptions put forth by the colonial officials of the efficacy of Western biomedical infant and maternity welfare services, women and children still died during deliveries³⁹. This caused disbelief in most women who trusted their traditional birthing systems which were enshrined in their customs and traditions.

These disparities in antenatal clinic attendance were not unique to government and mission maternity centres. Native Authority maternity centres were not exempted (see table 2). Though domiciliary deliveries were carried out by Grade II midwives of Native Authority maternity centres, most women still turned to prefer being delivered of their babies by their native midwives.

Table 2: Native Authority Maternity Center Activities in 1961

Center	Division	ANC Cases	Delivery Cases in medical centers	Delivery cases in homes
Mesaje	Nkambe	46	14	0
Njie Mbaw	Nkambe	128	8	0
Oku	Bamenda	149	87	0
Ndop	Bamenda	3,162	214	0
Babessi	Bamenda	207	30	0
Batibo	Bamenda	422	0	20
Bali	Bamenda	5,825	217	0
Mbengwi	Bamenda	419	49	0
Muyuka	Victoria	4,656	48	128
Tiko	Victoria	3,686	32	85
Buea	Victoria	3,527	65	147
Muea	Victoria	2,519	8	25
Modeka	Victoria	428	5	0

³⁷ Wirla Francica, (Native of Nso), in discussion with Author, 26th June 2023.

³⁸ Epole Precilia, (native of Bangem), in discussion with with author on 16th July 2023.

³⁹ RAB, NW/sd.1962/1, Annual medical Reports, 1961.

Wedikum	Mamfe	0	0	0
M'bonge	Kumba	356	10	0
Tombel	Kumba	227	65	0
Mbakwa Supe	Kumba	121	7	0
Total		25,878	859	405

Source: NAB, Sc(1959)2, Annual Medical Reports

From table II, Native Authority maternity centres also witnessed the disparity in number of antenatal clinic attendance and number of deliveries attended to by trained biomedical midwives. Out of the 25,878 ANC cases that visited the seventeen Native Authority maternity centres in British Southern Cameroons in the year ending 1961, only 859 were delivered by trained midwives in the different maternity centres. Efforts to increase the number of babies delivered by trained midwives led to the introduction of domiciliary deliveries. With this, 405 more women were delivered of their babies by trained midwives in their various homes. This did not still solve the problem as less than 5% of the women who attended antenatal clinics were delivered of their babies by trained biomedical midwives. One needs not dig deeper to realize that the glorious success of hospital birthing was achieved with the aid of traditional birth attendance as most of the cases of deliveries in the territory were managed by the latter. The violation of the 1931 Midwifery Ordinance and the Pharmacy Ordinance by traditional birth attendants was motivated by the desire of expectant mothers to continually rely on their services for birthing.

Conclusion

In pre-colonial Cameroon, women's authority stemmed from their productive and reproductive works. Women gained prestige from their roles as primary food producers and as child bearers. Child bearing was central in every community as the women and their health related issues were managed by local midwives. In managing the health of expectant and lactating mothers, cultural values were central in the activities of local midwives. The colonisation of Cameroon and its later partition opened up one part of the territory to British administration. In an effort to achieve its masked colonial agenda, the British colonial government in collaboration with missionaries, plantation authorities and Native Authorities made attempts at transforming pregnancy and birthing through western biomedical welfare services. In instituting this foreign medical system, laws and ordinances were passed that were intended to dominate local midwifery. The resilience of traditional midwifery during the British colonial rule in southern Cameroons was evident as most women resorted to having their babies delivered by traditional midwives despite the provision of Western maternity centres with trained midwives. Such reactions were provoked by doubts over the strength of hospital birthing, poor communication networks, the scarcity of maternity centres in the territory, and the humanism that characterised African midwifery. Antenatal clinic attendances were relatively encouraging as most women sought to know their status regarding venereal diseases that were uncommon in Southern Cameroons prior to colonization. Generally, the resilience of traditional midwifery in southern Cameroons was a response to western attempts at ideologically and culturally transforming and confining women through western education and biomedical practices.

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