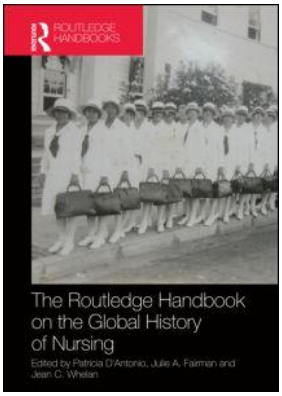

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ENGENDERING HEALTH

Pronatalist politics and the history of nursing and midwifery in colonial Senegal, 1914–1967

Jonathan Cole

> Quand nous amenons un garçon à l'école française, c'est une unité que nous gagnons; quand nous y amenons une fille, c'est une unité multiplié par le nombre d'enfants qu'elle aura.
>
> *(George Hardy,* Une Conquête Morale*, 1917)*

In 1964, four years after Senegal's independence, Madame Cissé Lary Seye, a Senegalese *infirmiére d'état* and *sage-femme d'état,* relocated from the capital Dakar to the remote eastern town of Bakel. Madame Cissé Lary Seye had begun her education at primary school, continued at secondary school, and received her professional training at nursing school. Assigned to this post with her husband and two children, she and her husband were placed in charge of running the local health post. According to Seye, at the time of her relocation, there was no maternity staff except for the local *matrone* (traditional midwife), who performed almost all the deliveries and care. Without a proper staff or provisions, Seye had to rebuild the maternity[1] from the ground up. She recalled the strain this had placed on her relationship with the *matrone*, who had run the maternity for many years. It was the arrival of Madame Cissé Lary Seye – a women with a Western education and medical training – that disrupted the operation of the maternity by the *matrone*, whose authority, in contrast, rested on her own life experiences as a mother, grandmother and midwife. In the end, the *matrone* would not compromise and Seye sought permission to train several young local girls to serve as her assistants in the maternity.[2]

Madame Cissé Lary Seye's retelling of this story, with both disappointment and pride, reflected the impact of colonial health policy on women's education and professional opportunities. Rather than focus on curing disease, the French administration of Senegal redirected its efforts towards preventive care, particularly concerns over hygiene and

health education. As we shall see, this shift reflected the colonial desire to impose a particular vision of health as a tool to control bodies and minds. However, Seye's story reveals the ways that the hegemony of Western medicine in Senegal was only partially achieved. Maternal and infant health policies seized upon the social and biological roles of women as a tool for producing a healthy work force. But through its focus on women, colonial health policy subverted women's traditional roles as wives and mothers while empowering them with new opportunities to define themselves as professionals.

This chapter examines how and why colonial health policies that aimed at remaking the African family in Senegal, and in particular at changing African child-rearing and birthing practices, provided a crucial impetus for the expansion of female education and marked the point of entry for women into medicine in the 1920s and 1930s as nurses and midwives. African women were to play an instrumental role in the French colonial civilizing mission. This role was directly related to their reproductive capacity, in a physical sense, but it extended farther than that. African women would be bearers of a new social and cultural order; they were to be the second front to colonial conquest, "a moral conquest," intended to capture the hearts and minds of the indigenous population. While at first this role was limited to the private sphere of the household, women's function within society as reproducers of the colonial social order gradually extended into the public sphere, transforming them first into good wives and mothers, and later into teachers, nurses, and midwives. To the degree that women embraced these pre-defined roles as a means of social and economic advancement, they also sought to exercise their own influence over their professional identities.

Colonial intermediaries and the construction of colonial rule

Female nurses and midwives were instrumental to the colonial-era health reforms aimed at promoting hygiene and preventive care, particularly around the issue of maternal and infant health. Indeed, in Senegal as in other parts of Africa, indigenous intermediaries – whether interpreters, soldiers, porters, nurses, or clerks – played a critical role in the expansion of empire and the day-to-day operations of colonial rule.[3] In the field of health this was particularly true, as the shortage of European personnel residing in the colonies forced colonial administrators to recruit and train indigenous actors as medical auxiliaries. Recent scholarship has only just begun to illuminate how these previously unknown "colonial middle figures" shaped the workings of the colonial state and left their imprint on the development of the health profession in Africa. John Iliffe, for example, traces the origins of the medical profession in East Africa back to a tiny group of nineteenth-century "pioneers" who received rudimentary medical training from local missionaries.[4] Iliffe goes on to chart these doctors' quest for professional recognition and autonomy, from the opening of the Makrere medical college in 1926, through the disintegration of the profession in the 1970s under Idi Amin, ending with an analysis of their role in combating the AIDS epidemic that ravaged East Africa in the late 1980s and early 1990s. While the context of British and German colonization provided the impetus for the emergence of the profession in East Africa, Iliffe demonstrates that

the quest for professional recognition and autonomy was part of a broader, more complicated narrative.

As scholars have begun to pay closer attention to the individual attitudes and motivations of those who pursued careers in the health professions, they have called into question the tendency to read the actions of these African intermediaries and other colonial personnel simply in terms of collaboration with or resistance to colonial rule. Indeed, African health personnel were in some cases despised and in others envied for their close ties to the colonial state. Nevertheless, these health personnel were hardly passive agents of the colonial regime. In fact, professional grievances, such as unequal pay, lack of professional advancement, and political marginalization, often placed African health personnel at odds with the colonial administration. In the end, the deployment of indigenous medical intermediaries in the service of imperial interests came back to haunt colonial regimes, as health professionals rallied around such grievances and marshaled their professional networks and affiliations towards a broader goal: national independence.[5]

Accounts centered on these binaries of domination/resistance and colonized/colonizer obscure the fluidity and complexity of the colonial encounter.[6] As Shula Marks demonstrates in her study on the history of nursing in South Africa, the obstacles South African women faced in their efforts to transform nursing into a "respectable" and autonomous profession could not be explained in terms of tensions between "black" and "white," or even male and female. Rather, the "divided sisterhood" that characterized the development of the nursing profession in South Africa represented the complex articulation of notions of race, class, and gender over the course of this history.[7] As Marks so powerfully demonstrates, the history of the nursing profession in Africa provides a productive lens for understanding the complexities of the colonial encounter and its impact on the everyday lives of African actors, particularly women.

The connection between gender and work reveals how notions of domesticity were fluid and contested. In particular, the introduction of nurses and midwives challenged existing hierarchies of age and sex. As Elizabeth Schmidt points out, the emergence of Western-trained nurses and midwives, culled from the local population, had the effect of eroding the power of traditional female healers and midwives. Nevertheless, such positions also permitted women a newfound autonomy and independence *vis-à-vis* their male relations, i.e. their fathers, husbands, brothers, and uncles.[8] The imposition of colonial rule thus subverted gender roles by replacing and in some instances reinventing relations between the sexes.[9] Along these lines, both Nancy Rose Hunt and Pascale Barthélémy illustrate how the training and employment of female nurses and midwives subverted gender norms and in the process created both opportunities and constraints for women living under colonial rule.[10] This chapter likewise explores the intersection and entanglement of the domains of power held by traditional female healers and midwives and the new professional class of female nurses.

From household to hospital

As the foregoing discussion suggests, nurses and midwives played a critical role in the elaboration of colonial rule, and more particularly the expansion of the colonial health services. Focusing on the case of Senegal, the following sections illustrate how the history of nursing and midwifery care can inform the study of colonialism in Africa. As we see in the first section, critical shifts in policy in the wake of the First World War afforded African women unprecedented opportunities for professional advancement as midwives and nurses. Furthermore, these reforms also placed new emphasis on the importance of female education, both in terms of improving the quality and quantity of female recruits for the nursing school and in regard to promoting a preventive health agenda, particularly around the twin issues of maternal and infant health. However, as the second section will show, colonial efforts to expand girls' education encountered the resistance of local actors, particularly that of parents who feared the destabilizing effects of Western education and culture on family life. These attitudes demonstrate how concerns over girls' education were driven not so much by the politics of the colonial encounter as by the local dynamics of African society and culture. The last section considers how nurses and midwives juggled the competing interests of work, family life, and social identity in their personal and professional lives. Specifically it addresses how "domesticity" redefined female authority for these women professionals.

The professional trajectory of female nurses in Senegal reveals much about the social dynamics at play in Senegal during the nineteenth and twentieth centuries. By the 1930s, the feminization of nursing was already well under way in France, yet in France's West African colonies African women were only just beginning to enter the profession. The absence of female health personnel was a result of the peculiar nature of colonial rule. French wars of conquest of West Africa in the nineteenth century gave rise to the need for medical auxiliaries to assist army surgeons and doctors and to administer care to sick and wounded soldiers. As the ranks of the colonial military mostly comprised African recruits, so too did this early corps of medical assistants. Thus, men formed the core of both the nursing and the medical professions from an early stage. African women's entry into the profession in the wake of the First World War signaled not only a dramatic shift in the evolution of the nursing and medical professions but also a sea change in imperial policy.

The appearance of female midwives and nurses in the 1920s and 1930s was linked to major changes in French colonial health policy. Following the First World War, the priorities of *Assistance Medicale Indigène* (AMI) were redefined to favor preventive health measures. In turn, these reforms not only expanded the range of services offered but extended the scope of these services to include areas outside the reach of existing public health infrastructure. In particular, new emphasis was placed on maternal and infant health.

French concerns over maternal and infant health in the colonies drew inspiration from metropolitan preoccupations. In France as well as in England, declining birth rates coupled with high maternal and infant mortality were seen as a cause for alarm, particularly in the face of the enormous casualties sustained during the First World War.

Fears of racial degeneration, particularly in relation to other imperial powers, prompted calls for the strengthening of the imperial body politic and the elaboration of an ideology of imperial motherhood.[11] These concerns were translated into the colonial context by the application of metropolitan measures to the colonies as well as through the growing emigration of French women into the colonies, particularly in their professional capacities as teachers, nurses, and midwives.[12]

Pro-natalist policies transplanted from France dovetailed well with the political economy of colonial rule. As hostilities drew to a close in Europe, France looked back to the colonies afresh, with an eye to capitalizing on the huge swaths of land that it possessed, straddling the continent from Cap Vert to the Somali coast. Administrators believed in the tremendous potential of their African colonies; they needed only a sufficient labor force to exploit it. Albert Sarraut had expressed this vision more precisely in his elaboration of the notion of *faire du noir*, literally translated as "[re]making of the black." The goal was to augment the population of its African colonies, in quantity as well as in quality. In this way, Sarraut linked the *mise en valeur*, or economic exploitation of the colonies, to the longstanding humanitarian goals of the French civilizing mission.

By virtue of their reproductive capacities, women were the central focus of this new health policy. Annual reports and correspondence from French administrators provided a grim picture of health in the colonies, particularly the high rates of infant mortality. Umbilical tetanus, dysentery, pneumonia, malaria, and hereditary syphilis were the most important contributors to infant mortality. As reports from administrators noted, these conditions were traced back to the fault of the mother, whose ignorance or carelessness endangered her children's health. The key to reducing infant mortality, Governor-General Carde wrote in his circular to the lieutenant governors of *Afrique Occidentale Française* (AOF), was "the education of mothers and the progressive penetration of notions of childrearing into family life."[13]

Initially, European women were asked to spearhead the objectives of the *Protection Maternelle et Infanitile* (PMI). Those who possessed formal training served as midwives and nurses in the hospitals and dispensaries of major cities such as Dakar and Saint-Louis. However, even those without formal training also played important roles. For example, administrators cited the important role played by the voluntary organization, Ladies of the Red Cross (*Dames de la Croix Rouge*), who operated a section for infant care three days each week at the *Polyclinique Roume* in Dakar, giving consultations for healthy infants, distributing condensed milk, soap, foodstuffs, and baby clothes to the mothers, and redirecting infants showing any signs of ill-health or malnutrition to the hospital or dispensary for follow-up care.[14] They also ran other charitable activities that concerned maternal and infant health, such as the *Gouttes de Lait* (Drops of Milk) and the *Berceau Africain* (African Cradle).

While reports highlighted the supportive role that the *Croix Rouge* and the *Gouttes de Lait* played in the fight against infant mortality, they also signaled the need to extend these services beyond the confines of the major health centers in cities such as Dakar and Saint Louis. However, the shortage of European personnel and the excessive physical demands of this work required the administration to recruit auxiliaries from the local

population. Thus, African female medical personnel such as midwives, nurses, and social workers (*assistantes sociales*) would play an indispensable role spreading the "discourse of the microbe."

A key event in the formation of this corps of female medical auxiliaries was the creation of the medical school in Dakar (*Ecole de Médecine de Dakar*[15]) in 1918. The medical school was intended as a gesture of appreciation for the important sacrifices that the colonies made in support of the war – a symbol of France's investment in the health and well-being of its subjects.[16] More practically, though, the school was a response to the urgent need for trained health personnel in the colonies.

Prior to the First World War, the colonial administration of French West Africa made several fitful attempts at promoting the formation of a professional class of trained assistants. An early effort in this regard was the recruitment of male medical assistants called *aides-médecins*, who were given two years of basic instruction on issues of hygiene, prophylaxis, basic medicine (*médecine usuelle*), and minor surgery. Still, doctors complained that these assistants were "incapable of assimilating the most basic and essential notions of medicine."[17] In order to execute their functions more competently, the assistants required further instruction in the fields of biology, chemistry, and the natural sciences, not to mention more than rudimentary knowledge of French. In response to these complaints, a preparatory section for medical studies was held on the island of Gorée in October 1916, and it was from these first students that the medical school drew its first cohort of (male) medical students: the *médecins-africains.*

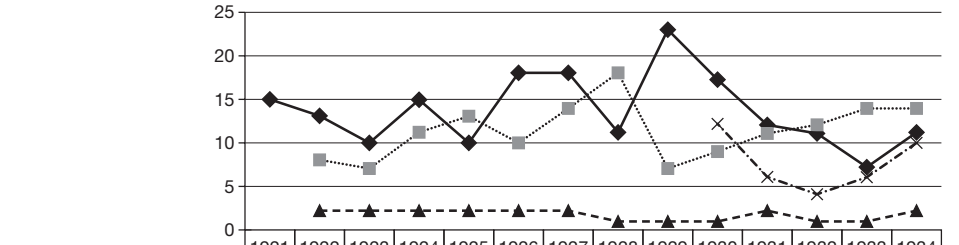
The first female students were admitted to the section for *sages-femmes*, or midwives, in 1918. To enter the program, these women needed to be eighteen to twenty years of age, and were required to hold a certificate of graduation from primary school and to pass a four-part entrance exam. In addition to these requirements, students had to submit a dossier that included a letter signaling their intentions to enter the medical school, a signed decennial agreement which stipulated that students would serve in the *Assistance Médicale Indigène* (AMI) for at least ten years, a birth certificate and clean bill of health signed by a doctor, a letter of good conduct from the director of their school of origin, and a letter from their parent or guardian endorsing their entry into school.[18]

In contrast to their male counterparts, who completed four years of study, midwives followed a three-year program. A special section for *infirmières-visiteuses* (visiting nurses) was added in 1930, which provided almost identical training but lasted only two years. After their first year of instruction, students could opt to complete the program in either nursing or midwifery. In both cases, the training provided to nurses and midwives reflected the overarching goals of the health services, particularly as they related to the issues of maternal and infant health.

Administrators stressed the practical as well as ideological importance of nurses and midwives to the colonial public health agenda. In the annual report for the health services of the colony of Senegal for 1936, the education of mothers and young women was put on par with curative measures. Citing the growing number of prenatal and postnatal consultations, officials insisted that the measures aimed at infant and maternal health not only would yield results, but also would provide good propaganda for the

AMI.[19] Midwives and nurses thus provided a critical point of contact between the colonial public health system and the indigenous population. The curriculum for nurses and midwives reflected their key roles as interlocutors for new ideas about health and hygiene, and more importantly as health educators.

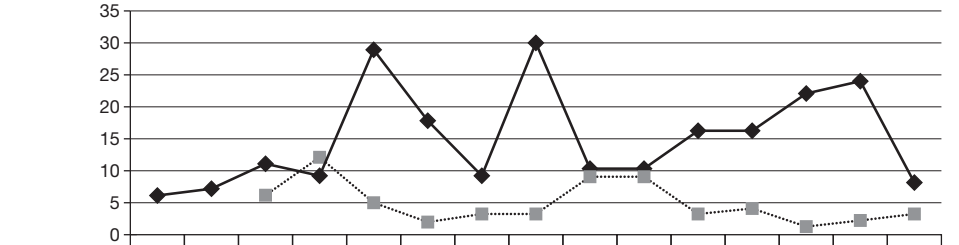
The medical school in Dakar thus provided an important springboard for women's entry into the profession of nursing. As Figure 7.1 illustrates, the female students graduating from the medical school significantly outnumbered men. Though women remained a minority in the field of nursing, as demonstrated in Figure 7.2, the numbers reveal a slow but steady stream of entrants to the nursing profession. Nevertheless, many officials lamented both the quantity and the quality of female recruits to the medical school. At the heart of the matter was the issue of girls' education.



	1921	1922	1923	1924	1925	1926	1927	1928	1929	1930	1931	1932	1933	1934
Sages-Femmes	15	13	10	15	10	18	18	11	23	17	12	11	7	11
Médecins-Africains		8	7	11	13	10	14	18	7	9	11	12	14	14
Pharmaciens		2	2	2	2	2	2	1	1	1	2	1	1	2
Infirmières-Visiteuses										12	6	4	6	10

Figure 7.1 Number of graduates from the Dakar Medical School by section, 1921–1934.

Source: Gouvernement Général de l'Afrique Occidentale Française (1934), *L'Ecole de Médicine de L'Afrique Occidentale Française (de son fondation à l'année 1934)*. Séries O: Enseignement de l'AOF 1895–1958, ANS O 161 (31). Dakar, Senegal: Archives Nationale du Sénégal.



	1940	1941	1942	1943	1944	1945	1946	1947	1948	1949	1950	1951	1952	1953	1954
Male	6	7	11	10	29	18	10	30	10	10	16	16	22	24	8
Female			6	12	5	2	3	3	9	9	3	4	1	2	3

Figure 7.2 Number of male and female nurses accredited at the Hospitals of St Louis and Dakar, 1940–1954.

Source: M'Baye, E.M. (2002), *Etude d'une profession de santé: Les infirmiers au Sénégal de 1889 à 1968*. Mémoire de Maitresse. Dakar, Senegal: Université Cheikh Anta Diop de Dakar.

The state of girls' education in the colony of Senegal prior to the First World War reflected the initial ambivalence of the colonial state to the question of girls' education.[20] While the reorganization of the colonies in 1903 ushered in the development and expansion of government schools, the first few decades of the twentieth century marked a reversal in terms of women's access to education. By the time the Dakar Medical School opened in 1918, only one girl for every 45 boys was enrolled at primary school in French West Africa. Though girls fared better in Senegal, boys still outnumbered girls almost 10 to 1 at government schools, with 448 girls to 4368 boys in 1922. Sex ratios at missionary schools were more balanced, with 349 girls to 308 boys. Only 32 percent of the total female population of Senegal received any sort of primary education.[21]

These persistent inequalities in women's access to education not only compromised the quality of these female health professionals, but also threatened to undermine the long-term goals of reducing infant and maternal mortality and promoting higher standards of hygiene and public health. In order to bridge the gap between male and female students entering the medical school, the *Conseil Supérieure de l'Enseignement* headed by the Inspector General for Education, Albert Charton, proposed the addition of a two-year program to fill the gap between the time girls finished primary school and their entry into nursing school. In line with this recommendation, the administration created the *Ecole Normale de Jeunes Filles de Rufisque* in 1940. The instruction offered to young women at the Ecole Normale in Rufisque differed significantly from that given to their male colleagues at the *Ecole Normale William Ponty*. Specifically, the curriculum of girls' education emphasized women's domestic roles as wives and mothers through lessons in childrearing and homemaking. Thus instruction in French language, math, and science was coupled with the domestic sciences (*économie domestique* and *enseignement ménagère*), which emphasized skills such as sewing, cooking, and cleaning. The aim was to inculcate in these young women an appreciation of their dual role as female functionaries, the "social" as well as the "domestic."[22]

The opening of the *Ecole Normale de Jeunes Filles* solved a key concern over the quality of women's education. However, it did not address a key factor behind lagging rates of female enrollment: parental resistance. According to Papa Gueye Fall, Director of the *Ecole Urbaine de Dakar*, there were many reasons that parents refused to send their girls to the French schools. Above all, parents feared that the French schools would turn their girls into *"desmoiselles"* who were more interested in flirting than fulfilling their religious or household duties.[23] These concerns were echoed in Denise Savineau's report *La Famille en AOF: La condition de la femme*, which stated that Muslim parents often refused to send their girls to school for fear that they would convert to Catholicism, lose their virginity, or simply emancipate themselves.[24] Parents further worried that allowing their girls to pursue their education would endanger their daughters' chances of finding a husband.[25] For these reasons, many parents viewed girls' education as a threat to the social order.

The administration took these concerns seriously. To guard against the potential for impropriety, female students lived a cloistered life at the medical school. They received free room and board, and were subjected to close supervision and strict discipline by the *surveillantes*, whose job it was to protect as well as nurture the moral character of

these female students. This not only served to assuage parents' fears of sexual deviance, but also protected the administration's investment in the education of these young female professionals.

Administrators also worked tirelessly to convince parents that the education their children received at the French schools not only would better prepare these young women for fulfilling the duties of the household, making them better wives and mothers, but also would provide opportunities for professional advancement. This potential for professional advancement was an important inducement for reluctant parents. As Mamadou Diouf, a former *infirmier d'état* (state-certified nurse) recounted, many Muslim parents began sending their children to French schools instead of Quranic schools because they worried that their children would not be able to compete in the job market against their Christian counterparts. Furthermore, facing the erosion of their rights as French citizens, parents in the four communes of Rufisque, Dakar, Saint-Louis and Gorée sent their children to French schools in order to meet the fluency requirement for establishing French citizenship.[26]

Women's professional transition from household to hospital, and ensuing debates about girls' education, thus reveal the complexities of life under colonial rule. In particular, attitudes to girls' education changed in relation to the reconstitution of colonial society. As Diane Barthel illustrates in her study of female professionals in Senegal, parents' educational backgrounds influenced attitudes to girls' education. Therefore, women whose parents worked as colonial functionaries enjoyed certain advantages in access to education compared to women whose parents were peasants. Nevertheless, the complexities of class position do not take account of the gendered dimensions of women's professional trajectories. As Barthel has argued, "the delicate balance of sex roles had been upset through colonialism's differential treatment of men and women."[27] The gains that women made in securing access to education and professional status were mitigated by a gendered appreciation of their labor. As we shall see in this final section, the struggle of female professionals to define themselves within a shifting cultural and social landscape elucidates how women confronted the challenges imposed on them by their own profession, but also by the social and cultural norms of their own society.

Prior to the administration's concerted efforts to recruit women into the medical field, women's place in the nursing profession was heavily circumscribed by a gendered appreciation of women's labor value. Those women who did gain entry into the profession, particularly in the period prior to the First World War, were often confined to the hospitals and dispensaries of important urban centers such as Dakar and Saint-Louis. In this capacity, they performed the domestic tasks such cooking, cleaning, and doing laundry. Women were seen as unfit for work in the "bush" where they would often be left alone and unsupervised, in a locale where they most likely did not know anyone and, in certain instances, did not speak the same language. As one retired state nurse (*infirmier d'état*) claimed, the task of running a rural health post was seen as too physically demanding for women.[28]

Even as women began to move on to higher levels of specialization and training, the gendered division of nursing labor persisted. For example, the male *infirmier-sanitaire*

(sanitary nurse) and the female *infirmière-visiteuse* (visiting nurse) were intended to serve as key mobile health personnel, ideally suited to fulfill the preventive health agenda of the reorganized AMI.[29] Both were tasked with exerting their influence on African society, notably by educating the populace in matters of proper hygiene and care. Their training also overlapped in terms of identifying and treating diseases such as tuberculosis, syphilis, and leprosy and the collection of demographic data. Still, their respective functions as health auxiliaries, within the structures of health as well as in relation to the communities they served, reflected gendered assumptions about women's labor.

The divergences between the male *infirmier-sanitaire* and the female *infirmière-visiteuse*, in terms of both their duties and their training, revealed a spatial division of labor that constrained the sphere of female action. The female nurse's duties centered on the domestic sphere, specifically aiding and advising mothers during pregnancy and childbirth. They provided mothers with essential information about childcare, instructing them on how to feed, clothe, and care for their children. These tasks confined female nurses to the sphere of the household, and provided them a degree of authority over matters concerning the female domestic sphere. The male nurse's role, on the other hand, engaged him in the public sphere as an agent of hygiene giving practical advice to the general population on matters of propriety, sanitation, and general hygiene. It was hoped that he would become a trusted counselor to the village chiefs, helping to advise and oversee measures taken to promote public health such as the provision of potable water, the disposal of waste, and the destruction of parasites, insects, and vermin linked to diseases such as malaria, plague, and yellow fever. He was also authorized to apply any measures deemed necessary for the preservation of public health, whether following state decree or the instruction of his direct superior. The male nurse thus enjoyed significantly more power and authority than his female counterpart.[30]

The inferior status of female nurses was further evident in their place in the hierarchy of personnel. While both the male nurse and the female nurse answered to a command structure in which the European doctor reigned supreme, the men typically enjoyed a higher position than women in the medical hierarchy, reporting directly to the European doctor or to the *médecin-africain* (the medical assistant). This male-dominated hierarchy further placed female medical personnel, including midwives, below their male counterparts. The female nurses thus reported to the *sage-femme africaine* (the African midwife), the European *sage-femme coloniale* (the colonial midwife) if attached to the maternity, or else to their male superiors, the *médecin-africain* or the European doctor. The irony of this subordination was that while the profession may have opened new doors for women in terms of social advancement, financial autonomy, and professional authority, it came at the price of submitting to a different set of patriarchal norms. The exigencies of colonial rule thus shaped women's entry into the nursing profession in seemingly contradictory ways. While colonial interest in the promotion of maternal and infant health opened up new opportunities for women in terms of education and professional advancement, women simultaneously found their roles within the nursing profession circumscribed by their gender.

Despite the limitations placed on women's role as nurses as well as midwives, administrators continued to signal the importance of these female medical auxiliaries

to the goals of the AMI. Colonial administrators hoped that female nurses and midwives would be vehicles for spreading notions of domesticity, hygiene, and cleanliness, among the local population. In certain instances, the authority vested in these roles gave women license to do things that other woman could not, particularly in the face of male authority.[31] However, what authority and standing these women had came from their relationship to the state and not to the society at large. Relocated to remote and sometimes alien communities, these nurses and midwives, educated in French schools and trained in the field of nursing and midwifery care, found themselves in an awkward position *vis-à-vis* the population at large. Teased for their *toubab* (i.e. European) ways, African nurses walked a fine line between their devotion to the profession and their desire to earn the trust and acceptance of the communities they served.

In this battle for hearts and minds, nurses and midwives not only confronted the skepticism of the populace but also bumped up against the entrenched interests of local healers and midwives. Initially, colonial administrators hoped that the introduction of Western-trained midwives and nurses would obviate the need for traditional midwives. This proved difficult for several reasons. First, the lack of personnel made this unfeasible. There were simply not enough nurses and midwives to administer to the entire population of the colonies, particularly those living outside of the major and secondary centers. Second, there was the issue of demand. Many women either preferred to give birth at home or were convinced to do so by their husbands or their families; thus traditional midwives remained relevant even in the face of the introduction of this new corps of female nurse and midwives. Finally, as women decided to forsake the help of the *matrone* and give birth at the colonial maternity or dispensary in increasing numbers, there were often not enough beds to accommodate them.[32] Expediency therefore dictated that traditional midwives be integrated into the ranks of health personnel, provided that they complete a short training course dealing specifically with infant and maternal health and hygiene, and submit to the supervision of colonial-trained nurses and midwives.[33] While some *matrones* accepted this bargain, and the material bonuses it entailed,[34] their subordinate position to colonial nurses and midwives clearly created tensions.

The introduction of Western-trained nurses and midwives challenged the autonomy and authority that traditional midwives had long enjoyed over matters of birth and women's health. In Senegal, as elsewhere in West Africa, women's authority traditionally rested on their social status as married, post-menopausal women. Furthermore, traditional midwives drew their expertise from their training as well as their personal experience with childbirth. The subordination to younger and more inexperienced women thus challenged not simply their autonomy but also their authority. The tensions that Madame Seye recalled between her and the *matrone* in Bakel echoed the experiences of other African nurses and midwives who served during the colonial period. Even as there existed mutual recognition, and in some cases respect of each other's craft, there remained an insuperable gap between the world of the modern midwife and that of the *matrone*.[35] The experiences of Seye, in this respect, challenge the narrow perception of these female professionals as pawns in a battle against native superstition and ignorance. Instead, their roles as intermediaries, or more aptly interlocutors for a Western

model of health care and medicine, reflect a more complicated story about the evolution of nursing and midwifery in the colonial period.

Conclusion

The politics of maternal and infant health left an indelible imprint on the development of nursing and midwifery in Senegal. Colonial health policies aimed at remaking the African family marked the point of entry for women into the health professions. These policies shaped the trajectories of female professionals in colonial Senegal and the colonial Federation of French West Africa as a whole. Nevertheless, the imposition of these measures was not a one-way street. Rather, the translation of these metropolitan concerns into the colonial setting marked a process of negotiation and dialogue between the interests of imperial policymakers and those of local actors. The history of nursing thus provides fertile ground for grappling with the complexities of the colonial encounter and exploring how aspects of race, class, and gender shaped the evolution of the profession as it was transplanted into France's overseas colonies.

Notes

1 In this chapter I use the word "maternity" to refer to the location where women receive their birthing care. In the context of colonial French West Africa, maternities could be attached to hospitals, but more often than not they were connected to rural dispensary posts. To call them "maternity centers," as the term is used in the context of US and UK history, would be misleading as it would overstate their autonomy in relation to the existing health infrastructure.

2 L.C. Seye, 2011. Interview with Madame Lary Cissé Seye, *ancienne infirmière d'état et sage-femme d'état*. This chapter draws on extensive archival research in France and Senegal and interviews with current and former health personnel conducted in 2010 and 2011. This was made possible thanks to the support of the Sigmund Martin Heller Traveling Fellowship provided by the Department of History and a grant from the Center for African Studies at the University of California at Berkeley. The sources consulted in Senegal were primarily from Series O and Series H in the Archives Nationales du Sénégal, dealing with education and health respectively. I conducted the interviews cited in this chapter with the assistance of William Carvallo and Badara Sissokho.

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6 F. Cooper, 1994, "Conflict and Connection: Rethinking Colonial African History," *American Historical Review*, vol. 99, no. 5, pp. 1516–1545.

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10 P. Barthélémy, 2010, *Africaines et Diplômées à L'époque Coloniale (1918–1957)*, Rennes: Presses Universitaires de Rennes; N.R. Hunt, 1999, *A Colonial Lexicon of Birth Ritual, Medicalization, and Mobility in the Congo*, Durham, NC: Duke University Press.
11 A. Conklin, 1998, "Redefining 'Frenchness': Citizenship, Race Regeneration, and Imperial Motherhood in France and West Africa, 1914–1940," in J.A. Clancy-Smith and F. Gouda (eds), *Domesticating the Empire: Race, Gender, and Family Life in French and Dutch Colonialism*, Charlottesville, VA: University Press of Virginia; A. Davin, 1997, "Imperialism and Motherhood," in F. Cooper and A.L. Stoler (eds), *Tensions of Empire: Colonial Cultures in a Bourgeois World*, Berkeley: University of California Press.
12 Conklin, "Redefining Frenchness," p. 71.
13 Gouvernement Général de l'Afrique Occidentale Française (GGAOF), 1926, *Instructions relatives à l'orientation et au developpement des services de l'Assistance Medicale Indigène, 15 fevrier 1926*, Series H (AOF), Archives Nationales du Sénégal.
14 GGAOF, 1935, *AOF – Inspection Générale Des Services Sanitaires Et Medicaux. Rapport Annuel: Partie Administrative Et Partie Medicale*. Series 2G. Dakar, Sénégal. Archives Nationales du Sénégal.
15 The medical school was later renamed *Ecole de Médecine Jules Carde* in honor of the former governor-general who had dedicated so much of his attention to the twin issues of education and public health.
16 J. Turritin, 2002, "Colonial Midwives and Modernizing Childbirth in French West Africa," in S. Geiger, N. Musisi, and J.M. Allman (eds), *Women in African Colonial Histories*, Bloomington, IN: Indiana University Press.
17 GGAOF, 1930a, *A.O.F. École de Médecine. L'école de médecine indigène par L. COUVY*. Séries 2G: Rapports périodiques, Première Tranche, 1895–1940, ANS 2G 30-58. Dakar, Sénégal. Archives Nationales du Sénégal.
18 Barthélémy, *Africaines et Diplômées*, 53–61.
19 GGAOF, 1936, *Sénégal. Service de santé. Rapport annuel: Partie Administrative et Partie Médicale*. Séries 2G: Rapports périodiques, Première Tranche, 1895–1940, ANS 2G 36-22. Dakar, Sénégal. Archives Nationales du Sénégal.
20 Quaranic schools had been the primary venue by which both girls and boys were educated.
21 Barthélémy, *Africaines et Diplômées*, p. 36; P.M. Diop, 1997, "L'enseignement de la fille indigène en AOF, 1903-1958," in *AOF, réalités et héritages, Sociétés ouest-africaines et ordre colonial, 1895–1960*, Dakar: Direction des Archives du Sénégal, pp. 1081–1096.
22 A. Charton, 1935a, *Conseil Supérieure de l'Enseignement, 1935: L'Education des filles et la formation des elèves-sages-femmes*. Séries O: Enseignement de l'AOF 1895–1958, ANS O 161 (31). Dakar, Sénégal. Archives Nationales du Sénégal; 1935b *La préparation des Elèves Sages-Femmes et l'enseignement des filles*. 1935. Séries O: Enseignement de l'AOF 1895–1958, ANS O 161 (31). Dakar, Sénégal. Archives Nationales du Sénégal. The instruction offered at the *Ecole Normale des Jeunes Filles* is described in detail in Barthélémy, *Africaines et Diplômées*. See also dossiers in the Archives Nationales du Sénégal relating to girls' education and the training of midwives and nurses, specifically ANS O 454 (31), O 212 (31), O 307 (31).
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24 D. Savineau, 1938, *Rapport de Madame Savineau sur la famille en AOF: les conditions de la femme. 1937–1938*. Séries 1G: Études Générales Thèses, Mémoires et Monographies, 1903–1978, ANS 1G 00021. Dakar, Sénégal. Archives Nationales du Sénégal, pp. 146, 183.
25 N. Guèye, 2003, *Etude d'une profession médicale?: Les sages-femmes du Sénégal de 1918 à 1968*. Mémoire de Maitresse, Université Cheikh Anta Diop de Dakar.
26 M. Diouf, 2011. Interview with Mamadou Diouf, *ancien infirmier d'état*.

27 D.L. Barthel, 1975, "The Rise of a Female Professional Elite: The Case of Senegal," *African Studies Review*, vol. 18, no. 3, p. 17.
28 Diouf, 2011. Interview.
29 The *infirmier-sanitaire* and the *infirmière-visiteuse* were rather specialized in their training and job duties. They were distinguished then from other health personnel who also wore the title of nurse (*infirmier/infirmière*).
30 GGAOF, n.d., *Programme de l'Enseignement à Donner aux Infirmiers sanitaires, aux Infirmières Visiteuses et aux Matrones Traditionnelles*. Séries H: Santé, Fonds de l'AOF, 1920–1959, ANS 1 H 102. Dakar, Sénégal. Archives Nationales du Sénégal.
31 P. Barthélémy, 2004, "Sages-femmes africaines diplômées en AOF des années 1920 aux années 1960: Une redéfinition des rapports sociaux de sexe en contexte colonial," in A. Hugon, ed., *Histoire des femmes en situation coloniale: Afrique et Asie, XXe siècle*. Paris: Éditions Karthala, pp. 119–171.
32 To remedy the problem of capacity and encourage women from more rural and remote areas to give birth at the clinics, the administration created *centres d'hebergement*, shelters for those who came to have their babies but had no other place to stay ANS 2 H 14.
33 GGAOF, 1940, *Instructions sur la lutte contre La Mortalité Infantile et Les Maladies Endémo-Epidémiques*. Séries H: Santé, Fonds de l'AOF, 1920–1959, ANS 1 H 102. Dakar, Sénégal. Archives Nationales du Sénégal; 1949, *Rapport sur la protection maternelle et infantile en A.O.F. 1949*. Séries H: Santé, Fonds de l'AOF, 1920–1959, ANS 2 H 14. Dakar, Sénégal. Archives Nationales du Sénégal.
34 Upon completing their training, these state-sanctioned *matrones* received a special kit that included some basic supplies such as scissors, tongs, gauze, and eye drops. They also received cash bonuses for the pregnant women they referred to the maternities. GGAOF, 1933, *Dakar. Hôpital Central Indigène. Rapport annuel (partie administrative et partie médicale)*. Séries 2G: Rapports périodiques, Première Tranche, 1895–1940, ANS 2G 33-20. Dakar, Sénégal. Archives Nationales du Sénégal; GGAOF, 1940, *Instructions sur la lutte contre La Mortalité Infantile*; GGAOF, 1949, *Rapport sur la protection maternelle et infantile*.
35 Turritin, "Colonial Midwives and Modernizing Childbirth"; Barthélémy, *Africaines et Diplômées*, pp. 195, 206.

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