

**A Hospital *in situ*:  
Maternity Nursing Practice in Freetown since 1892  
by  
Tara Dosumu Diener**

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**Doctoral Committee:**

**Professor Nancy Hunt, Chair  
Professor Joel D. Howell  
Professor Judith T. Irvine  
Professor Elisha P. Renne  
Professor Alexandra Stern**

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## Abstract

This study is an ethnographic history of nursing, midwifery, and childbirth in Sierra Leone. Combining rigorous attention to a historical *longue durée* as well as evidence collected via ethnographic immersion, this dissertation's focus is on care, dress, and prestige in a single West African hospital. It was researched and written as a contribution to the history and anthropology of medicine in Africa; it also engages with the literatures on bioethics, nursing, science and technology studies, dress, and visibility. It explores colonial and postcolonial clinical practices, and situates these as knowledge, visibility, and embodied memory. Its focus is the Princess Christian Maternity Hospital (PCMH) founded in Freetown, Sierra Leone by British missionaries in 1892. Nursing and midwifery staff at this hospital practice today amidst crumbling infrastructure. The lack of basic necessities and socioeconomic circumstances often mean that the hospital only receives emergent, destitute cases. All the while its nurses wear 19<sup>th</sup> century-era uniforms that suggest complex, color-coded hierarchies. This study asks what is at stake and for whom in this sartorial work. It also asks how the clinical and the historical intersect on the wards. How have the perceptions of maternity nurses informed habits of giving and seeking maternity care in Freetown? The questions emerged during 15 months of historical research and ethnographic fieldwork, mining archives in Britain and Sierra Leone, and interviewing and coming to know childbearing women, nursing students, and hospital staff of all grades at maternity centers throughout Freetown, notably PCMH. There, in particular, six months of intensive participant observation and semi-structured, in-depth interviews enabled much data collection and analysis. The arguments of this dissertation are several: Nursing practice at PCMH



emerged through decades with maternity care providers contending with varying degrees of scarcity, precarity, and inequality. The context is a sedimented one, requiring a sedimented, visual methodology. The practice of nursing, much like the city of Freetown, was established with British ideals on African soil; they have long been inflected by social and spatial practices. Practices of circulation, mobility, and nursing care have been translated across generations and also transformed. The seemingly anachronistic uniforms of PCMH nurses bear important evidence about intersecting logics revealing much about prestige, hierarchies, fame, humiliation, and implicit violence; consciously and unconsciously, these affective, material, and visual logics signify at multiple registers.

## Introduction

Hospital A has problems. Exterior security is heavy with electronic technology meant to restrict access, but behind the doors the image of order fades. Night shift is so under-staffed that an off duty EMT is recruited from the emergency department to initiate intravenous drips on children. Terribly lacking in human resources, this specialist referral hospital depends heavily on the labor of "techs": minimally trained all-purpose functionaries who fill in the spaces where doctors and nurses should be. The strain is showing. There are minor cracks, as rushed staff members administer medications without confirming patient identity. Simple supplies are lacking: a tube of petroleum jelly for a patient's chapped lips, a board to splint an arm with a temperamental IV. Abuses of the system proliferate, as patients are kept on narrow gurneys in the admitting department's holding bay overnight. While this practice often forces patients to pay a hefty deductible out of pocket (a charge that would be waived upon admission) it relieves the hospital from a full-fledged hospital admission, with its inherent record keeping and use of human resources.

There are also larger problems, indicative of deeper fractures in the system. Following a traumatic IV start, a nurse insists on administering medication in its oral form, obviating the need for an IV. The capsule is scheduled for administration in the early morning hours, and the half-awake pediatric patient chokes on it. When the child becomes hysterical at the nurse's insistence, the nurse argues that the medication does not come in a liquid form and the child will not be released from the hospital until she swallows the capsule, which has by now melted into a bitter

paste in her mouth. A family member pleads with the nurse to petition the prescribing physician to consider a different medication. The nurse returns 30 minutes later and wakes the patient, who has just fallen back to sleep, to administer a liquid dose of the same medication, a form which supposedly had not existed 30 minutes earlier. Upon discharge home, the family learns that a crucial and obviously indicated blood test was never ordered and that the dose of medication the patient has been receiving was prescribed and delivered at half the indicated strength. The physician in charge mentions this casually while advising the family to continue the medication at home using the full recommended dose.

Hospital B has problems, too. Security at the exterior gate is heavy: vehicles are stopped and their passengers interrogated prior to entry. Additional technologies such as patient registers and admission slips at the admitting department desk often restrict access, sometimes leaving patients waiting in pain while the correct documentation is compiled. Staffing is also a problem here. One particularly fraught day a single nurse is caught between shift changes, left to staff the entire admitting department herself as an ambulance approaches. This specialist referral hospital depends heavily on the labor of 'volunteers,' fully qualified but uncompensated nurses who often work for years at a time before being offered a paid position. These quasi-staff members may or may not be present on any given day. Hospital B's cracks are more obvious to even a casual observer: a common referral diagnosis is elevated blood pressure, yet there is only one blood pressure machine in the admitting department. The over-taxed machine works through the night shift but fails after the first three patients of the day shift. Abuses of the system are rampant, and staff members commonly charge patients money to purchase items that are provided free elsewhere in the hospital.

There are indications of deep systemic fault lines as well. One day nursing staff arrive to find that there are no physicians. After failed negotiations, the medical staff have gone on strike to protest wage and labor conditions. Nurses cope with patients seeking life-saving surgeries as best they can, but many women will suffer. A highly effective anti-hemorrhage medication is kept in a locked cabinet. The charge nurse knows the correct dose and route of administration, but she cannot access the medication because the resident physicians keep the keys in their pockets. The blood bank has the technology to instantly type and cross-match a sample, but the hospital supply is so critically low that patients' family members routinely solicit paid donors from the open-air vegetable market adjacent the parking lot. A young woman arrives in need of immediate attention, with birth imminent. After her information is painstakingly documented, two nurses transfer her to the hospital's only available wheelchair and rush up a steep concrete ramp through a guarded wrought-iron gate toward Ward 1. The ward supervisor turns them away: there are no beds available. Down the hallway, around the corner, down and up two more concrete ramps, they reach receiving Ward 2. Staff flatly refuse to admit the patient, arguing that her paperwork is not in order. One of the nurses sprints back to the admitting department, down and up, around the corner, down the hallway, through the gate, past the guard and down again to request the patient's chart. She returns moments later, breathless, to Ward 2 just before a baby's vernix-coated head emerges on the cracked vinyl seat of the wheelchair.

### **Stories from the past**

The seed for these reflections was planted while my daughter was a patient at Hospital A, located in the United States. While one of the "techs" was taking a medical history, our talk turned to Hospital B, located in Sierra Leone's capital city of Freetown and the subject of this study. Given the context of this conversation – a shiny new room in a state-of-the-art American

hospital – it is perhaps unsurprising that we began comparing the two. My description of Hospital B – Princess Christian Maternity Hospital (PCMH) – with its regular power outages, lack of consistently running water, high mortality rates, staff shortages, dearth of supplies, and malfunctioning equipment prompted the tech to ask: "How can they even call it a hospital?" The question plagued me, begging an answer. How, indeed?

While much has been written about the entangled histories of colonial medicine and competing concepts of health and illness in Africa, the ontological status of the hospital and its functions remains largely unquestioned.<sup>1</sup> All hospitals have institutional problems. There are stark geopolitical differences between Hospital A in the United States and PCMH. It is also clear that while both institutions deviate from a universalizing ideal, both are still hospitals, but how do we know this? Is there a core of elements adhering to the notion of "hospitalness," and if so what is done in such a place and who is to do it? To what extent does the notion permit varying degrees of lack and dysfunction? What assumptions accompany such distinctions?

Volumes have been written about health disparities and inequalities between the global north and south. For historians of technology, perhaps the more important comparison lies in the radically different relationship these two hospitals have with their institutional pasts. Hospital A's past is firmly linked to European Christian ideals of charity and benevolence. Its precedents were alms-houses, hospices and hostels intended for the elderly and infirm. Among the goals of such institutions was the provision of care for the dying, healing for the sick and wounded, and shelter for the deserving poor. In one wing of the massive complex in which Hospital A sits, a long

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<sup>1</sup> See Warwick Anderson, "Introduction: Postcolonial Technoscience," *Social Studies of Science* 32, no. 5/6 (December 2002): 643–58; Lynn M. Thomas, *Politics of the Womb: Women, Reproduction, and the State in Kenya*, 1st ed. (University of California Press, 2003); Stacey A. Langwick, *Bodies, Politics, and African Healing: The Matter of Maladies in Tanzania* (Bloomington: Indiana University Press, 2011).

corridor displays gilt-framed photographs of a succession of previous administrators. In another wing is a hallway lined with photographs of generations of smiling, white-coated medical school graduates. This hospital boasts a history filled with technological and pedagogical firsts, groundbreaking discoveries in biomedical science, and ever-increasing financial investments which have made infrastructural expansion and cutting-edge technologies the norm. If it is like similar institutions in the United States, this hospital's relationship to its history is indirect, the details trotted out occasionally and selectively, often linked to ceremonial moments and a rosy institutional memory.

(Hi)stories about hospitals in Africa are often of a different nature. The following narrative provides a glimpse of what it was like for one former colonial subject named Tamba,<sup>2</sup> now an elderly gentleman, to experience a colonial hospital in Freetown as a child in the mid 1950s:

They put me in that place and they would not let me leave. I was a boy, a small boy! I had contracted rheumatic fever and they would not let me go home. I was *terrified!* I was there, I was just a boy, and there were grown men! I was so scared. I was scared to death. There, when a person died, they just put a sheet, cover it with a sheet, and left the corpse. At night there was no light. Not *one* light. It was completely dark and I was lying there next to a corpse, with the corpse *right there!* They had me hooked to IVs, medicines, all these things. They kept me there for four weeks! Four weeks! In this place where people were sick, and just dying, dying all around me! As soon as they let me go, I *never* went back to that place. They sent me home to my grandparent's house and told me to come back in a week because it was a holiday. I *never* went back. I never set foot in that place again. I did some things, I treated myself. And then one day my heart was bad. I got so scared, I started to run back to that place. I thought I was going to die so I *ran*, as fast as I could. But when I got to Bathurst Street, it stopped. It stopped completely. My heart was better, and so I never, ever went back to that place again.<sup>3</sup>

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<sup>2</sup> In accordance with the conditions of the University of Michigan Institutional Review Board approval (Reference # HUM00045810), I use pseudonyms throughout to protect the identity of my informants.

<sup>3</sup> Interview with Tamba Sesay, his emphasis.

Like many other stories about the experience of colonial medicine *from Africa*,<sup>4</sup> Tamba's narrative makes a visceral link among "the hospital," extractive imperial regimes aiming to civilize and control, and missionary crusades to administer salvation to the bodies and souls of savages through the balm of Christianity and cleanliness.<sup>5</sup> *From Africa*, histories of encounters with biomedicine might begin with white people in white clothes whose actions ranged from paternalistic benevolence to extreme brutality. For many African students, medical history might begin with David Livingstone. A 21<sup>st</sup> century medical specialist in Africa often walks the wards of what was once a colonial hospital, the skeleton of a foreign body left behind, the bleached bones of its imported infrastructure jutting sharply from the landscape. This dissertation interrogates what a maternity hospital is and does from a Freetonian perspective, asking: how have Sierra Leoneans living in Freetown repurposed the sedimented debris of colonial medicine?<sup>6</sup> How might foregrounding moments of dissonance or incomprehensibility between 'African biomedicine' and 'biomedicine in Africa' prove useful for scholars seeking to destabilize received notions of technology?

The visual is a key mode of analysis here, as the dissertation draws anthropologies of medicine together with STS approaches to the visual production of knowledge. Working within and across disciplinary boundaries, it considers the role of visibility (all that pertains to seeing and being seen) in the formation of professional identities as well as the role of seeing in medical

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<sup>4</sup> I will remain ever grateful to Clapperton Mavhunga for impressing upon me the absolutely critical shift that happens when we take this phrase seriously.

<sup>5</sup> See Janice Boddy, *Civilizing Women : British Crusades in Colonial Sudan* (Princeton University Press, 2007); Nancy Rose Hunt, *A Colonial Lexicon: Of Birth Ritual, Medicalization, and Mobility in the Congo* (Duke University Press, 1999); Shula Marks, *Not Either an Experimental Doll: The Separate Worlds of Three South African Women: Correspondence of Lily Moya, Mabel Palmer, and Sibusisiwe Makhanya* (University of KwaZulu-Natal Press, 1996); Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Stanford University Press, 1991).

<sup>6</sup> For my usage here see Nancy Hunt's Debris Chapter in *Colonial Lexicon* and Ann Laura Stoler, ed., *Imperial Debris: On Ruins and Ruination* (Durham ; London: Duke University Press Books, 2013).

practice and standards of evidence.<sup>7</sup> It brings questions of visibility to bear on nursing within the context of global health and links studies of clinical narratives, grammatical categories, and medical discourse to bear on new source material: clinical nursing practice in an African maternity hospital.<sup>8</sup> This interdisciplinary approach seeks to link knowledge about the salience of dress to questions of visual representations of power, violence, and embodied memory.<sup>9</sup>

A recent wave of free healthcare initiatives removing user fees imposed by structural adjustment policies are based on the premise that most obstetric complications could be prevented or managed if women had access to a skilled birth attendant.<sup>10</sup> Yet new research indicates that even without the barrier of user fees, uptake of hospital maternity services remains uneven at best.<sup>11</sup> Cheryl Moyer asserts that one factor with profound effects on women's choices about where to give birth is "maltreatment at the hands of providers at a health facility."<sup>12</sup> This

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<sup>7</sup> Elizabeth Edwards, *Raw Histories: Photographs, Anthropology and Museums*, 1st edition (Oxford: Bloomsbury Academic, 2001); Brian Larkin, *Signal and Noise: Media, Infrastructure, and Urban Culture in Nigeria* (Duke University Press, 2008); Christopher Pinney, *The Coming of Photography in India* (New Delhi: Oxford University Press, 2008); Jan Golinski, *Making Natural Knowledge: Constructivism and the History of Science, with a New Preface* (University Of Chicago Press, 2005).

<sup>8</sup> Mark Nichter, *Global Health: Why Cultural Perceptions, Social Representations, and Biopolitics Matter*, 1st ed. (University of Arizona Press, 2008); Julia Hallam, *Nursing the Image: Media, Culture and Professional Identity*, 1st ed. (Routledge, 2000).

<sup>9</sup> Janice Boddy, *Civilizing Women: British Crusades in Colonial Sudan* (Princeton N.J.: Princeton University Press, 2007); Sharon Beishon et al., *Nursing in a Multi-Ethnic NHS* (Policy Studies Institute, 2000); Wolfram Hartmann, Patricia Hayes, and Jeremy Silvester, *Colonising Camera: Photographs In Making Of Namibian History* (Ohio University Press, 1999); Paul S. Landau and Deborah D. Kaspin, eds., *Images and Empires: Visuality in Colonial and Postcolonial Africa*, 1st ed. (University of California Press, 2002).

<sup>10</sup> Safer, Making Pregnancy. "Making pregnancy safer: the critical role of the skilled attendant." *World Health Organization: Geneva* (2004); Cheryl A. Moyer et al., "'They Treat You like You Are Not a Human Being': Maltreatment during Labour and Delivery in Rural Northern Ghana," *Midwifery*, Fear of childbirth and post-traumatic stress disorder, 30, no. 2 (February 2014): 262, doi:10.1016/j.midw.2013.05.006.

<sup>11</sup> Rob Yates, "Universal Health Care and the Removal of User Fees," *The Lancet* 373, no. 9680 (June 13, 2009): 2078–81, doi:10.1016/S0140-6736(09)60258-0; Mary Hadley, "Does Increase in Utilisation Rates Alone Indicate the Success of a User Fee Removal Policy? A Qualitative Case Study from Zambia," *Health Policy* 103, no. 2–3 (December 2011): 244–54, doi:10.1016/j.healthpol.2011.08.009; B. O. Olusanya, O. P. Alakija, and V. A. Inem, "Non-Uptake Of Facility-Based Maternity Services In An Inner-City Community In Lagos, Nigeria: An Observational Study," *Journal of Biosocial Science* 42, no. 3 (May 2010): 341–58, doi:10.1017/S0021932009990526.

<sup>12</sup> Cheryl A. Moyer et al., "'They Treat You like You Are Not a Human Being': Maltreatment during Labour and Delivery in Rural Northern Ghana," *Midwifery* 30, no. 2 (February 1, 2014): 262, doi:10.1016/j.midw.2013.05.006.



dissertation takes up these debates, drawing on a body of social science literature that reveals that conflicting images of nurses and nursing care in Africa foster expectations at odds with actual practices of maternity nurses, midwives, and birthing women. Too often, research has confirmed that these discrepancies contribute to violence in maternity wards, in the form of verbal and physical abuse, also found by Hunt in the Congo, by Allen in Tanzania, and by Sargent in Benin.<sup>13</sup> Based on this research clinicians have begun to look more closely at the links between "maltreatment" (physical and verbal abuse, neglect, discrimination, denial of traditional customs) and care-seeking behavior among pregnant women in Sub-Saharan Africa. This dissertation seeks to narrow the focus to a hyper-local, institutional and interpersonal setting.

Reproductive health journals often conclude that maltreatment is poorly understood and contingent, but of critical importance to the success of health policies aimed at achieving Sustainable Development Goals. With a few notable exceptions, much of this literature parks complex variables such as institutional and colonial history, class mobility and social hierarchies at the door of further research. This dissertation takes up the call for further research, with a focus on one clinical maternity setting in one African city.

## **Background and methods**

As a Sierra Leonean-American with a decade of clinical experience in obstetric and pediatric nursing, I was compelled to make PCMH – long the site of some of the world's worst

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<sup>13</sup> R Jewkes, N Abrahams, and Z Mvo, "Why Do Nurses Abuse Patients? Reflections from South African Obstetric Services," *Social Science & Medicine* 47, no. 11 (December 1998): 1781–95; N Abrahams, R Jewkes, and Z Mvo, "Health Care-Seeking Practices of Pregnant Women and the Role of the Midwife in Cape Town, South Africa.," *Journal of Midwifery & Women's Health* 46, no. 4 (July 2001): 240–47; Denise Roth Allen, *Managing Motherhood, Managing Risk: Fertility and Danger in West Central Tanzania* (University of Michigan Press, 2002); Nancy Rose Hunt, *A Colonial Lexicon: Of Birth Ritual, Medicalization, and Mobility in the Congo*, 1st Printing (Duke University Press, 1999); Carolyn Fishel Sargent, *Maternity, Medicine, and Power* (University of California Press, 1989). Jewkes et al, 1998, Hunt 1999, Allen 2002, 1989

reproductive health indicators – the focus of this dissertation. A mass exodus of healthcare workers during the long civil war of the 1990s left few trained professionals to cope with the reproductive needs of Sierra Leonean women.<sup>14</sup> Abysmal maternal and infant mortality statistics prompted new approaches in the decade following the war, culminating in the introduction of free health care for pregnant women and children under age five in 2010.<sup>15</sup> While statistics were improving before the 2014 Ebola outbreak, cracks in the approach had begun to emerge, and fundamental questions about the provision of perinatal care remained, leading me to ask how circumstances of extreme exigency shift questions of risk, expertise, and choice. This initial question was thrown into sharp relief at PCMH, the main clinical training center for Sierra Leonean nurses and midwives and the sole tertiary maternity care facility in a country with only a handful of obstetricians.

Upon entering PCMH to conduct preliminary research in 2009, I was immediately struck by a visual anachronism: nursing students wandering the wards in dazzling white 19<sup>th</sup> century-style caps and aprons. As a trained nurse confronted with crumbling hospital infrastructure, the lack of basic necessities such as running water and electricity, and a waiting area full of the country's most emergent and destitute cases, I left wondering what was at stake for whom in this sartorial memory work. When I learned that formal nursing education and training in Sierra Leone began at PCMH in the 1890s, my initial puzzlement grew into broader research questions. How have nursing and midwifery been taught and practiced in this hospital? How have these

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<sup>14</sup> J. Daniel Kelly and Mohamed Bailor Barrie, “Global Health: Will Positive Changes for Sierra Leone’s Health Professionals Mean the End of Its Brain Drain?,” *Journal of Public Health Policy* 31, no. 1 (2010): 112.

<sup>15</sup> Amy Maxmen, “Sierra Leone’s Free Health-Care Initiative: Work in Progress,” *Lancet*, 2013; John Donnelly, “How Did Sierra Leone Provide Free Health Care?,” *The Lancet* 377, no. 9775 (April 2011): 1393–96, doi:10.1016/S0140-6736(11)60559-X. J. Daniel Kelly and Mohamed Bailor Barrie, “Global Health: Will Positive Changes for Sierra Leone’s Health Professionals Mean the End of Its Brain Drain?,” *Journal of Public Health Policy* 31, no. 1 (2010): 112.

practices shaped and been shaped by national and global health discourses? In what ways have historical perceptions of risk and expertise informed habits of seeking and providing obstetric care in this institution? I spent 15 months conducting archival and ethnographic research, mining archives throughout Britain and Sierra Leone, and spending time with childbearing women, nursing students, Non-Governmental Organizations, and hospital staff of all grades at maternity centers throughout Freetown. In addition to conducting written surveys and using snowball sampling to arrange in-depth semi structured interviews, I spent six months engaged in intensive participant observation as a volunteer at PCMH.

In keeping with my interdisciplinary training, this dissertation weaves together historical and anthropological methods of research and analysis. Chapters one and two examine the mirrored infrastructures of city and hospital. The first chapter is an urban history, exploring Freetown in the *longue durée*. It begins with an archival excavation of the first permanent colonial settlement in 1797 and ends with an ethnography of movement through the city in 2011-2012. Chapter two provides an account of the hospital as it developed within the city, revealing the movement of maternal and child health (broadly) and PCMH (specifically) from the margins to the center of the colonial project in Freetown. Chapters three and four concentrate on practitioners: doctors and nurses. Chapter three traces the fraught history of African obstetricians alongside the emergence of Creole identity.<sup>16</sup> Chapters four and five provide an account of

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<sup>16</sup> Ample literature hotly debates what some argue was the conscious formation of Krio as a fabricated ethnic identity during the early 20<sup>th</sup> century. “Krio” as an ethnic designator for the descendants of groups who originally settled Freetown in 1797 came to be widely used over “Creole” by the 1940s. While the term “Creole” originally characterized a group of Freetown residents who were African-born but usually of ethnically mixed parentage, wealthy and socially elite, European-educated, often light in complexion, as Creole political power waned, “Krio,” began to gain currency. It is an accepted but still contentious term today, and I maintain the use of “Krio” to refer to the language and “Creole” to refer to people and processes throughout this work for the sake of consistency. For the crux of the debate, which is far beyond the scope of this dissertation, see Mac Dixon-Fyle, *New Perspectives on the Sierra Leone Krio / Cole*, Gibril Raschid, American University Studies.; Series IX.; History.; v. 204; (Peter Lang: New York, 2006).

nursing history in Freetown, concentrating on recurring tensions between the ideal and the possible. Based on archival documents, photographs, and oral histories, these chapters examine hospital maternity care in Freetown during key time periods: 1890 to 1910 (when PCMH was first established), 1920-1940 (roughly corresponding to the interwar period), the decades between the end of World War II and decolonization, 1961 to 1981 (the first two decades following decolonization), and briefly touch on developments from 1981 to 1991 (the decade immediately preceding the Civil War). Chapters six and seven draw primarily on interviews and participant observation to illuminate changes in maternity practice from the end of the Civil War in 2002 to the recent past of 2012. Chapter six situates the politics of authority and knowledge on the wards within a complex historical imagination, while chapter seven examines practices of seeing and knowing in the hospital as embodied, situated, and historically entangled elements of the clinical milieu.

This dissertation joins a growing body of interdisciplinary approaches to biomedical practice in the global south.<sup>17</sup> It is ultimately an excavation of the “hybridities, borderlands, and in between conditions” inherent in postcolonial technoscience.<sup>18</sup> Engaging with Karen Flint and Claire Wendland, it finds that the pervasive lack of resources in many African hospitals engenders a certain permeability, in which locally salient forms of knowing and doing, and heterogeneous social and spatial logics to interpolate universalizing discourses about what a

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<sup>17</sup> Alice Street, *Biomedicine in an Unstable Place: Infrastructure and Personhood in a Papua New Guinean Hospital* (Durham: Duke University Press Books, 2014); . Sjaak van der Geest and Kaja Finkler, “Hospital Ethnography: Introduction,” *Social Science & Medicine* 59, no. 10 (November 2004): 1995–2001; Stacey A. Langwick, “Articulate(d) Bodies: Traditional Medicine in a Tanzanian Hospital,” *American Ethnologist* 35, no. 3 (August 2008): 428–39; Debbi Long, Cynthia Hunter, and Sjaak van der Geest, “When the Field Is a Ward or a Clinic: Hospital Ethnography,” *Anthropology & Medicine* 15, no. 2 (August 2008): 71–78; Julie Livingston, *Improvising Medicine: An African Oncology Ward in an Emerging Cancer Epidemic* (Duke University Press, 2012).

<sup>18</sup> Anderson, “Introduction,” December 2002.

hospital is or should be.<sup>19</sup> In such an environment ideals may not exist not as clinical standards but rather as imaginaries of clinical practice. Focusing on the mutable nature of scientific authority, this section attends to practices by which the clinical is constituted, and modes by which technology, as the social practice of biomedicine, is coproduced, legitimated, signified, guarded, and deployed.<sup>20</sup>

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<sup>19</sup> Karen Elizabeth Flint, *Healing Traditions: African Medicine, Cultural Exchange, and Competition in South Africa, 1820-1948*, New African Histories Series (Athens, Ohio : Scottsville, South Africa: Ohio University Press ; University of KwaZulu-Natal Press, 2008); Claire L. Wendland, "Moral Maps and Medical Imaginaries: Clinical Tourism at Malawi's College of Medicine," *American Anthropologist* 114, no. 1 (March 1, 2012): 108–22.

<sup>20</sup> Michel Foucault, *The Archaeology of Knowledge & The Discourse on Language* (Vintage, 1982); Sheila Jasanoff, *States of Knowledge: The Co-Production of Science and Social Order*, International Library of Sociology, (New York: Routledge, 2004).

# Chapter One

## City Upside Down

### Introduction

Sierra Leone sits on the western coast of Africa with Guinea to the north and east and Liberia to the south. Approximately the size of West Virginia, its population is estimated to be just over six million.<sup>21</sup> Prior to the 2014-15 Ebola epidemic which devastated the economy and strained the healthcare system to a breaking point, Sierra Leone consistently ranked among the bottom ten countries in the United Nations Human Development Index, a measure assessing various aspects of health, education, and income.<sup>22</sup> Average per capita income was around \$340 and life expectancy hovered around 48. Freetown, the capital city, was designed for 250,000 people.<sup>23</sup>

Prior to the civil war, many Freetown residents maintained homes 'upline,' circulating along the dirt roads connecting country and city.<sup>24</sup> During the war refugees streamed in to the city, fleeing the violence of the countryside for the relative safety of ECOMOG<sup>25</sup> protection in Freetown. People walked towards the unknown at the edge of the ocean along shifting,

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<sup>21</sup> United Nations, 2011

<sup>22</sup> "Human Development Reports," accessed Feb. 2, 2009, <http://hdr.undp.org/en/countries/profiles/SLE>.

<sup>23</sup> Cole in Christopher Fyfe and Jones, Eldred P., eds., *Freetown; a Symposium* (Freetown, Sierra Leone University Press, 1968).

<sup>24</sup> Upline references the relationship between Freetown and the interior. It is literally a reference to the relationship between Freetown and the rest of the country as connected by the colonial railway city: "up the rail line."

<sup>25</sup> The Economic Community of West African States (ECOWAS), founded in 1975, is primarily an economic organization, but during the Liberian civil war formed a peacekeeping force, a "Military Observer Group" to assist member states' efforts to maintain political stability. In the late 1990s, ECOMOG troops pushed rebel forces out of Freetown twice before UN troops arrived.

precarious roads, some coming from as far as Kissidongou on the Guinea/Liberia border. They brought what they could carry – their language, their memories, and their children – to Freetown, in hopes of preserving an uncertain future. Bill Freund speculated incorrectly in 2007 that "many refugees in Freetown will return to their homes when they feel that safer conditions prevail," yet as the population surged to over one million during the war, refugees became residents, and today Freetown remains home to over one million people squeezed on top of one another, occupying every livable and unlivable inch.<sup>26</sup>

Freetown's city boundary begins at Sugar Loaf Mountain, 2,494 feet above sea level and ends at the Atlantic Ocean. In practical terms this means – among other things – that during the wet season from April to November monsoon rains make life particularly miserable for those at the 'bottom' of Freetown. The wealthy live in the hills, and socioeconomic status can be roughly indexed to topographical elevation. The poor are concentrated either on the coast, where fishing can provide food and income, or at the city center, where entire streets have been transformed into ad-hoc markets, making vehicle traffic impossible. Freetown's open sewers lead to the sea. Decades of land development and deforestation of the jungles once covering the hills have contributed to significant soil erosion, and during the rains the overburdened gutters demarcating sidewalk from road flood detritus routinely the streets, stalls, and homes of the city's poorest inhabitants, and to the gate of PCMH. Using mobility and blockage as lenses, a historically-grounded spatial analysis of Freetown's roads illuminates the politics of knowledge that influence mobility and blockage at PCMH.

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<sup>26</sup> Bill Freund, *The African City: A History*, 1st ed. (Cambridge University Press, 2007), 183.

The hospital meets the city at the road. Examining the city's history is key to analyzing the hospital within it, and unpacking and making sense of moments like the one above. In this chapter I demonstrate how knowledge -- historical, social, spatial -- mediates movement along Fourah Bay Road, Kissy Road and many others, laying the groundwork for later chapters to explore the ways in which different sorts of knowledge mediate movement through the hospital.

### **Mobility in the city**

In *The Social Logic of Space*, Bill Hillier and Julienne Hanson suggest that built environments always have both functional and social uses.<sup>27</sup> Focusing on buildings (rather than other sorts of built environments), they argue that buildings

Assemble elements into a physical object with a certain form: but...they also create and order the empty volumes of space resulting from that object into a pattern. It is this ordering of space that is the purpose of building, not the physical object itself. The physical object is the means to the end...insofar as they are purposeful, buildings are not just objects, but transformations of space through objects.<sup>28</sup>

In this schema, the ordering of space in buildings is really about the ordering of relations between people.<sup>29</sup> I suggest that the city, as a built environment, might be read like a building: as an artifact which, by ordering space, orders relations between people. Different versions of this

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<sup>27</sup> Bill Hillier and Julienne Hanson, *The Social Logic of Space*, Reprint edition (Cambridge University Press, 1989). Bill Hillier and Julienne Hanson, *The Social Logic of Space*, Reprint edition (Cambridge University Press, 1989), 1.

<sup>28</sup> Ibid.

<sup>29</sup> Africanist scholars have explored the sociopolitics of architecture as well, but primarily in non-clinical spaces. See Noëleen Murray, Nick Shepherd, and Martin Hall, *Desire Lines: Space, Memory and Identity in the Post-Apartheid City* (Routledge, 2007); Jean-Paul Bourdier and Trinh Minh-Ha, *African Spaces: Designs for Living in Upper Volta* (New York: Holmes & Meier Publishers, 1985); Rebecca Ginsburg, *At Home with Apartheid: The Hidden Landscapes of Domestic Service in Johannesburg* (Charlottesville: University of Virginia Press, 2011).



approach have imagined "people as infrastructure" and "space" as "the machine" through which the social purposes of built environments are expressed.<sup>30</sup>

This dissertation focuses on a hospital in a large urban center and thus engages with a large body of Africanist literature placing urban Africa within a distinct rhetorical genre: the "Post" city, in which Post colonial,<sup>31</sup> Post war,<sup>32</sup> Post industrial,<sup>33</sup> and Post apocalyptic<sup>34</sup> approaches see African cities as spaces of aftermath. This Afro-pessimistic "post" focus limits urban landscapes to spaces of or in recovery from one thing or another. Freetown has been the focus of a long history of "post" literature characterizing it as negative space. Staggering European death rates in the decades prior to quinine propelled the epithet the "White Man's Grave" to cliché status in traveler's accounts by the 1830s.<sup>35</sup> Richard Phillips, tracing Sierra Leone's discursive transformation from imaginary utopia in the 1790s to imaginary dystopia by the mid-19<sup>th</sup> century, wrote that despite being "clearly mapped on contemporary maps and sea charts" as integral to the Atlantic slave trade, travel accounts described Sierra Leone as "a place off the edge of the map, beyond the compass of geographical description."<sup>36</sup> This dystopian

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<sup>30</sup> A. M. Simone, "People as Infrastructure: Intersecting Fragments in Johannesburg," *Public Culture* 16, no. 3 (2004): 407–29. B. Hillier, *Space Is the Machine: A Configurational Theory of Architecture* (London, UK: Space Syntax, 2007).

<sup>31</sup> Achille Mbembe, *On the Postcolony*, 1st edition (Berkeley: University of California Press, 2001).

<sup>32</sup> Paul Richards, "West-African Warscapes: War as Smoke and Mirrors: Sierra Leone 1991-2, 1994-5, 1995-6," *Anthropological Quarterly* 78, no. 2 (Spring 2005): 377–402; Ian Stewart, *Ambushed: A War Reporter's Life on the Line* (Algonquin Books of Chapel Hill, 2002).

<sup>33</sup> James Ferguson, *Expectations of Modernity: Myths and Meanings of Urban Life on the Zambian Copperbelt* (Berkeley: University of California Press, 1999).

<sup>34</sup> Ibrahim Abdullah in Okwui. Enwezor, *Under Siege, Four African Cities, Freetown, Johannesburg, Kinshasa, Lagos Documenta 11, Platform 4, Documenta 11, Platform 4*, 454 p. (Ostfildern-Ruit: Hatje Cantz, 2002).

<sup>35</sup> Gary Stewart and John Amman, *Black Man's Grave: Letters From Sierra Leone*, 1st edition (Berkeley Springs, WV: Cold Run Books, 2007); Kenneth Macaulay, "The Colony of Sierra Leone Vindicated from the Misrepresentations of Mr. Macqueen of Glasgow [Electronic Resource]" 1827, <http://www.jstor.org/stable/60225804>.

<sup>36</sup> Richard Phillips, "Dystopian Space in Colonial Representations and Interventions: Sierra Leone as 'The White Man's Grave'," *Geografiska Annaler. Series B, Human Geography* 84, no. 3/4 (January 1, 2002): 2–3.

vision was refuted, but the "White Man's Grave" tag lingered well into 20<sup>th</sup> century.<sup>37</sup> Astute historians have pointed to the fact that this perception of Sierra Leone as a *white* man's grave elided the exponentially greater number of *black* settlers who perished during the settlement's early years. Literature published since the civil war of the 1990s, necessarily grappling with Freetown's war legacy, has inverted the trope, calling Sierra Leone the "Black Man's Grave."<sup>38</sup>

A particularly disturbing trend in urban Africanist literature has been the apocalyptic vein argued by sometime-historian Mike Davis, whose *Planet of Slums* begins with a story of treacherous passage: "Sometime in the next year or two a woman will give birth in the Lagos slum of Ajegunle...the exact event is unimportant and it will pass entirely unnoticed."<sup>39</sup> For Davis, this slum-dweller's birth is only part of the planet's inevitable Malthusian future, a vision of doom rising from the swell of African cities like Lagos to shatter the mirror in which development-minded urban planners envisioned success as an orderly post-colony. This imaginary figure closely parallels the nameless pregnant woman "Mrs. X" in Denise Allen's *Managing Motherhood, Managing Risk*: Exposing the problematic deployment of nameless faceless women "on the road to death" in service of humanitarian agendas, Allen finds "a story that shapes and then freezes this unfortunate woman's experiences – and thus by extrapolation all of the women she is supposed to represent – into a particular representation of facts. It is, ultimately, a story that conceals more than it reveals."<sup>40</sup>

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<sup>37</sup> Donna Haraway, "Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective," *Feminist Studies* 14, no. 3 (Autumn 1988): 580.

<sup>38</sup> Gary Stewart and John Amman, *Black Man's Grave: Letters From Sierra Leone*, 1st edition (Berkeley Springs, WV: Cold Run Books, 2007). All of these elide the women, British and African, who died alongside the men.

<sup>39</sup> Mike Davis, *Planet of Slums* (Verso, 2006).

<sup>40</sup> Allen, *Managing Motherhood, Managing Risk*, 218.

A more promising recent strain of urban Africanist literature seeks instead to emphasize the generative possibilities of African cities.<sup>41</sup> Freund perhaps christened this trend when he wrote that "more and more the city will be the place African futures are made."<sup>42</sup> This future-oriented work acknowledges the material problems of under-resourced overcrowding, but also sees the growth of African cities alongside much vibrant potential radiating from the global south.

This chapter aims for an analysis that works across the power gradient underlying "post" narratives while actively seeking the "radical multiplicity of multiple knowledges" created by those who work in the hospital and live (within) the city.<sup>43</sup> Rather than specifically past or post-oriented, this approach acknowledges the social and material past that haunts Sierra Leone's urban center while also examining the city as it is lived in the 21<sup>st</sup> century, alongside that past. Grounded in phenomenologies of space, this perspective concerns itself with urban routes, movements, and spatial practices.<sup>44</sup>

Negotiation is key to navigating the socially, physically, and historically crowded space of any large city. In this investigation of Freetown, I am interested in three senses of negotiation: negotiation as it is inherent in movement around and within physical environments, social negotiations guiding commerce and trade on the streets, and negotiation in the transitive sense,

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<sup>41</sup> Ato Quayson, *Oxford Street, Accra: City Life and the Itineraries of Transnationalism* (Durham: Duke University Press Books, 2014); Garth Myers, *African Cities: Alternative Visions of Urban Theory and Practice* (London ; New York: Zed Books, 2011); Abdou Maliq Simone and Abdelghani Abouhane, *Urban Africa: Changing Contours of Survival in the City* (Zed Books, 2005); Edgar Pieterse and AbdouMaliq Simone, eds., *Rogue Urbanism: Emergent African Cities* (Auckland Park, South Africa: Jacana Media, 2013); A. M. Simone, *For the City yet to Come: Changing African Life in Four Cities*, *African Life in 4 Cities*, x, 297 p. (Durham: Duke University Press, 2004), [http://hdl.handle.net/2027/\[u\]: mdp.39015059222961](http://hdl.handle.net/2027/[u]: mdp.39015059222961).

<sup>42</sup> Bill Freund, *The African City: A History*, 1st ed. (Cambridge University Press, 2007).

<sup>43</sup> Haraway, "Situated Knowledges," p. 580.

<sup>44</sup> Michael Jackson, *Paths toward a Clearing : Radical Empiricism and Ethnographic Inquiry* (Bloomington [Ind.]: Indiana university press, 1989).

signaling the coproduction of an end: to bring about, to achieve. I seek not to understand the logic informing movements through the city but rather the logic of the city as it is constituted and re-constituted by movement. Taking Achille Mbembe and Sarah Nuttall seriously is to read the creativity of everyday spatial practice as constitutive, and to explore the city as an work in progress. This history of maternity nursing in Freetown approaches the city as an archive of spatial and social practice; a framework for analyzing such practices within the hospital. Keenly interested in Mbembe and Nuttall's concept of the "creativity of practice," which reads the city through the informal "practices and imaginations of citiness" in the "other scripts...beneath the visible landscape," I use negotiation not to resurrect a tired trope of social science literature, but to place the rich concepts it signals into service in a new way.<sup>45</sup> These complimentary senses of negotiation situate a figure like Davis' dismissed slum-dwelling Lagosian parturient – who is engaged in the profoundly generative practice of bringing life into the world – within a more capacious narrative, while acknowledging the social and material constraints that might shape her perspective.

Ethnographic and historical records of urban movement from early colonial Freetown to the recent past provide key source material for a comparative analysis, as historical maps reveal traces left by centuries of everyday movement through the city. The first part of this chapter details a history of spatial practice in Freetown and informs later ethnographic observations about how knowledge shaped patterns of mobility and blockage on city roads I negotiated in 2011 and 2012.

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<sup>45</sup> J.-A. Mbembé and Sarah Nuttall, "Writing the World from an African Metropolis," *Public Culture* 16, no. 3 (2004): 347–72.

Beginning with a cross-century comparison between the first colonial settlement in 1792 and a re-imagining of the city plan as it was rendered in an 1815 map establishes a history of the "grid" at the city center. Comparing these early maps to a series of maps from 1892-1915 reveals that as the Krio language developed over the century, similarly eclectic yet purposeful patterns of movement revised the colonial grid. The shape of the city 100 years after it was founded reveals that the grid-like infrastructure of the early settlement had bent to accommodate the ways residents wanted and needed to use the city and trade routes and footpaths established around Freetown's famous Cotton Tree became an official part of the colonial vision superseding the colonial state's imaginary traffic patterns rendered in idealized form on paper. Maps from the middle of the 20<sup>th</sup> century provide further evidence of Freetown's 'modernization' as a process of overwriting and overlapping that joined elements of past and present, African and European, in a way that defied developmentalist agendas. The Cotton Tree became the center of a new national identity and formed the basis of a historical narrative for the decolonized nation-state in 1961.

Moving to the 21<sup>st</sup> century, the chapter closes with a focus on the politics of authority and commerce on the roads, and on experiences of mobility and negotiation around different kinds of blockage within the city in 2011-12. Since the hospital at the center of this study is located at the edge of this city, an ethnographically-informed analysis of movement and memory in the city's recent past provides valuable insight. My ethnographic observations suggest that Freetown, like PCMH, was a space mediated by social capital in the form of "collective tacit knowledge," collectively embodied and socially enacted but not readily or easily explained.<sup>46</sup>

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<sup>46</sup> Harry Collins describes this as "knowledge that the individual can acquire only by being embedded in society." Harry Collins, *Tacit and Explicit Knowledge*, Reprint edition (Chicago; London: University of Chicago Press, 2010), p.11.

## **Regular irregularity: A Creole city rising**

Like many postcolonial urban centers hugging the continent's coasts, Freetown occupies a site with a long pre-colonial history.<sup>47</sup> Archaeological evidence suggests that groups of people occupied the coastal space for millennia preceding establishment of the first formal British settlement in West Africa in 1787.<sup>48</sup> European trade ships have been stopping at the area known as King Jimmy since at least the 16<sup>th</sup> century to trade with African kings for access to the abundant, clear water flowing from the Alligator River to the natural harbor.<sup>49</sup> Indeed, Christopher Fyfe notes that Granville Town, the failed settlement established by abolitionist Granville Sharpe near Freetown in 1787, occupied a site which had been long inhabited but recently vacated by its African tenants on grounds that it was haunted.

However, unlike many other African urban centers that grew up organically, Freetown was surveyed by European investors in advance and extensively planned with unprecedented egalitarian and idealistic goals in mind. Its successive revisions reveal these utopian ideals met with a remarkably experimental reality on the ground.<sup>50</sup> Freetown's gradual expansion reflected changes in the social order not only between British colonists and black settlers, but also between the first groups of settlers and the subsequent waves of recaptured slaves the first groups came to consider socially inferior.

Imposing European logic on the West Coast of Africa met with mixed success. John Peterson, once head of African Studies at Fourah Bay College, wrote that Freetown's planned shape was:

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<sup>47</sup> For an exceptional overview of the pre-colonial history of African cities, see David Anderson and Richard Rathbone, eds., *Africa's Urban Past* (Portsmouth, NH: Heinemann, 2000).

<sup>48</sup> Christopher Fyfe, *A History of Sierra Leone*, vii, 773 p. ([London]: Oxford University Press, 1962).

<sup>49</sup> One early European explorer noted that it was possible to fill up all of a ship's empty water barrels in a few hours.

...meant to reflect the intended level of European civilization. [Governor] Clarkson ordered a rectangular block pattern of nine streets intersected at right angles by three others. Freetown was thus blessed with rational city planning then current in Europe and North America. The rectangular block represented the balance and order of things in the eighteenth century.<sup>51</sup>

Town planners imposing this utopian design on the land found that the grid only went so far on the mountainous terrain. The coastal soil they anticipated to be fertile proved to be rocky in the dry season and disappeared entirely during the rains.<sup>52</sup> Peterson suggests: "The whole idea of a Sierra Leone colony was a rational 'good'; it became a rational 'evil' only after it was clear the general plans laid down were woefully inadequate to deal with the specific details of life on a rocky peninsula along the West African coast."<sup>53</sup> Efforts to clear farm land higher up Mount Aureol only accelerated the process of erosion.

Since farming was not possible and provisions brought on ships were quickly exhausted, the survival of Freetown's first residents was precarious. Those who could negotiated with surrounding indigenous groups for the most basic need: food. British accounts suggest the commerce flowed in both directions; Governor Clarkson wrote in 1792 that "some days no less than 150 come into the town with various articles for trade; each of them has among our settlers one whom he calls his friend, with whom he barter his commodities."<sup>54</sup> After the French attacked and destroyed the settlement in 1794, the remaining settlers regularly ventured outside the city, which was walled at the time, to engage with the Temne speakers in surrounding villages to trade household goods for staple foods.<sup>55</sup> Thus beyond the city wall right angles

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<sup>51</sup> Fyfe and Jones, Eldred P., *Freetown; a Symposium*, 16.

<sup>52</sup> Henry Smeathman, a British botanist, visited the prospective site in the early 1780s and wrote back to England about the lush vegetation and evidently fertile soil. He was mistaken.

<sup>53</sup> See Peterson, "The Enlightenment and the Founding of Freetown" in Christopher Fyfe and Jones, Eldred P., eds., *Freetown; a Symposium* (Freetown, Sierra Leone University Press, 1968), p.20

<sup>54</sup> Diary of Governor Clarkson, 1792:91

<sup>55</sup> Fyfe, *ibid.*

ceased and social practice collapsed the space between insider and outsider at least long enough to permit trade.

The earliest maps of the city indicate two pre-existing routes led away from the settlement: Pa Demba's road, leading to south to Pa Demba's village, and King Tom's road, leading to King Tom's settlement west of the city. Both settlements were well outside the city walls. Settlers sought shelter along these trails during the French invasion of 1794. Some early residents used these trails to disappear into surrounding groups while others used them to disappear into the trans-Atlantic network of slave traders.<sup>56</sup> While these were certainly footpaths rather than official roads, they were established enough to merit inclusion, incising triangles that abutted the rectangular British streets on a 1797 colonial map. Pa Demba's road and King Tom's

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<sup>56</sup> Fyfe, *Ibid.*



road connected the city center to outlying areas. The point where these two roads intersect corresponds precisely to the present day location of the Cotton Tree.

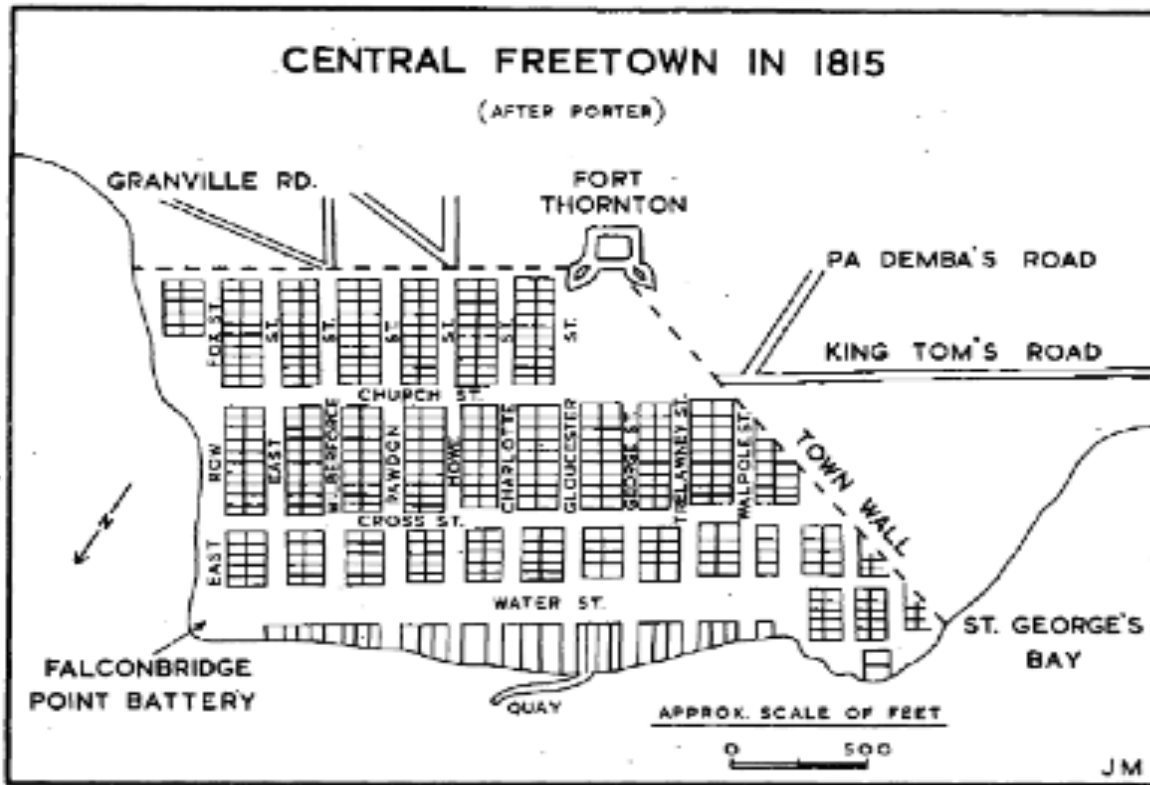


Figure 1: Central Freetown in 1815. Cotton tree at intersection of King Tom's road, Pa Demba's Road, and town wall

The Cotton Tree has many origin stories. Some claim it was planted by recaptured slaves, the seed carried with them from the West Indies. Others claim it was once the site of a slave market.<sup>57</sup> Fyfe writes that the first settlers went ashore singing hymns to stand under a great cotton tree. Elsewhere, he notes early accounts of a "great tree" under which the settlers were forced to hold church services, as the construction of a church was far down the list of British

<sup>57</sup> See James C. Scott, *Seeing Like a State: How Certain Schemes to Improve the Human Condition Have Failed* (Yale University Press, 1998).

priorities.<sup>58</sup> An 1834 traveler's account also mentions a great tree.<sup>59</sup> Indeed, examining successive maps of the city it becomes entirely plausible that this tree was the same Cotton Tree that has occupied the center of images of Freetown since at least the late 19<sup>th</sup> century. In photographs of and drawings of the heart of the city it is easy to spot a "great tree" rising above the fray.



*Figure 2: Postcard depicting Freetown in 1890 - View of Tower Hill. The Cotton Tree can be seen just left of center*

A "great tree" that had grown to this height by 1890 would have already been sizeable and visible from the surrounding hills decades earlier, and would have been an ideal site for meeting and trade. The well-traversed foot roads leading to and from town were eventually paved. Pademba Road (originally Pa Demba's Road) and Westmoreland Street (King Tom's road

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<sup>58</sup> Fyfe and Jones, 1968

<sup>59</sup> Rankin, F. Harrison, *The White Man's Grave: A Visit to Sierra Leone, in 1834*. R. Bentley [London], 1836.

on the 1812 map, leading to the area still known as King Tom) constituted two of the four roads leading to a large traffic circle in the center of town. In the middle of the traffic circle, which could be seen on maps by 1944, was the Cotton Tree. Rather than cut it down, the British not only left it in place but built their road around it.

Thus, the movement of Freetown's earliest non-European residents during conditions of precarity fundamentally influenced the city's colonial infrastructure and linked it to the pathways and patterns of sociality which long predated the arrival of Freetown's settlers. The wall which once protected the city inside from the danger and unpredictability that lay outside was built just to one side of where the Cotton Tree stands today. When the wall was dismantled, the circulation of people, goods, and ideas between adjacent settlements and the interior continued to flourish with the Tree as its point of reference. The stones that had been used to build the wall were repurposed as the foundation for a succession of buildings that what would eventually become the State House of the independent Republic.

This rational, ordered, experimental city was steadily populated by the descendants of nomads, outsiders, outcasts, refugees, and the unclaimed human freight of the Atlantic slave trade — a diversity reflected in the Sierra Leonean Krio language, an mixture of English, French, Portuguese and Yoruba. For at least the first two waves of Freetown's black settlers, Britain's "Black Poor" and American Revolutionary War loyalists resettled from Nova Scotia, a major draw to the unknown African coast was the promise of land for building and farming.<sup>60</sup> The land they were given took the form of numbered rectangles, with designated space in the back for gardening. The original plot numbers are retained today in rectangular compounds often

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<sup>60</sup> Christopher Fyfe, *A History of Sierra Leone* (Ashgate Publishing, 1993), 9.

occupied by multiple extended family dwellings whose irregular shapes and sizes thwart attempts to evenly distribute colonial space.

Early 19<sup>th</sup> century town planners attempting to maintain spatial order over the settlement met with varying degrees of success. Fyfe wrote that "within the city, planned by authority, there grew up the unofficial city, created by the inhabitants."<sup>61</sup> Most of these "unofficial" areas where waves of settlers clustered through the years remain today: Jamaican Maroons, rebel mercenaries recruited by the British in the early 19<sup>th</sup> century to fend off threats from the French and indigenous groups looking to stake a claim (or reclaim a stake) in Freetown, settled in the area now known as Murray Town (from Maroon town). In 1816, Congo town was laid in a yet another grid shape between Signal Hill Road and the Congo river as place to settle recaptured slaves from the Congo region. Foulah Town, with its predominantly Muslim Fula population, grew up on the easternmost border facilitating trade with Fula merchants already circulating throughout the Mano River region.

Changing city streets demonstrate that as people flocked to Freetown, its informal spaces grew to accommodate them. Kroo Bay, Freetown's largest and arguably most squalid slum, began as a settlement for Kru master seamen from the Liberian coast.<sup>62</sup> Their services were valuable in a busy city with a major shipping port, and some of these men eventually gave up their migratory ways to settle into a coastal stretch of west central Freetown, where Kru women began joining them in the 1880s. When the Kru, who initially settled on Water Street in the central business district, began to move further and further west, the governor exercised the right

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<sup>61</sup> Stephen J. Braidwood, *Black Poor and White Philanthropists: London's Blacks and the Foundation of the Sierra Leone Settlement, 1786-91* (Liverpool University Press, 1994);

<sup>62</sup> For an excellent study of the Kru in Sierra Leone, see Diane Frost, *Work and Community Among West African Migrant Workers Since the Nineteenth Century* (Liverpool: Liverpool University Press, 1999).

of eminent domain, obtaining a plot of land to serve as a sort of Kru reservation. Soldier and Fort streets were laid in 1817 at the base of Fort Thornton for disbanded soldiers returning from service in the 2<sup>nd</sup> and 4<sup>th</sup> West Indian Regiments. Colonial surveyor Pepys used Kissy Road as the base line for another grid of rectangular farm lots called Cline Town, but these were distributed at 1/5 the size that had been promised to settlers. By the 1850s, when the side streets and alleyways connecting these tiny, evenly spaced Cline Town plots had been bisected by the disgruntled settlers' footpaths and ad-hoc subdivided lots, the result was a labyrinth of odd angles.

Fourah Bay Road and Circular Road - the two roads eventually connecting PCMH to the city - were established in their current locations by 1818. Nichols Brook Bridge increased pedestrian traffic to and from the city shortly thereafter. Once the British were no longer at war with the French, the town wall was demolished and the city expanded west in lines of parallel streets past Maroon Town to form Regent Square, an area for wealthy residents on Bathurst and Wellington streets. The expansion was meant to make room for rich British merchants moving from newly-French territories back to Freetown to avoid high rent the French were charging, and by 1818 there were sixty stone houses in Freetown, a ten-fold increase from the number of stone houses in 1814.<sup>63</sup> However, these houses were not all built by British settlers. The first four waves of black settlers became the founding members of Freetown's social elites, actively cultivating an ethnic identity as Creoles. As the non-European population of Freetown grew exponentially during the 19<sup>th</sup> century, the housing boom took on an increasingly heterogeneous

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<sup>63</sup> Fyfe, *History of Sierra Leone*

nature, which shaped and was shaped by the increasingly complex social stratification among the city's black residents.

Following Catherine Coquery-Vidrovich, Sylvie Kande draws parallels between the evolution of Creole identity in Freetown and the evolution of Creole architecture.<sup>64</sup> Kande differentiates between Creolization and Kriolisation, characterizing the former as an amalgamation of the four groups who constituted Freetown's earliest settlers and the latter as the transformation of that group into a stratified, internally differentiated ethnicity characterized by "an extreme mobility, at once vertical (between classes) and horizontal (between communities)."<sup>65</sup> She argues that part of this process included a trans-Atlantic melding of design. Edward Davies wrote that the two story houses built by Krio social elites in the mid-19<sup>th</sup> century were increasingly constructed of imported materials and followed the plantation models found in the Caribbean and the southern United States.<sup>66</sup> Kande's history of Creole architecture suggests that for the better part of a century, the way buildings were constructed mirrored the emerging social organization of non-white Freetown residents constructing a social identity out of bits and pieces, memory and material drawn from different places and times.

Admixture was thus a feature of Freetown's physical and social infrastructures almost since the beginning. Davies contrasts the prevalence of circularity in pre-colonial Sierra Leonean dwellings and compounds against the angular "strictly geometrical...gridiron layout" of Freetown, and indeed, early 19<sup>th</sup> century maps suggest that this circularity was not entirely

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<sup>64</sup> Catherine Coquery-Vidrovich, "Villes Coloniales et Histoire Des Africains," *Vingtième Siècle. Revue D'histoire*, no. 20 (October 1, 1988): 49–73.

<sup>65</sup> Sylvie. Kandé, *Terres, Urbanisme et Architecture "Créoles" En Sierra Leone: XVIIIe-XIXe Siècles*, Collection Racines Du Présent, (Paris: L'Harmattan, 1998): 285. The author's use of the term Krio is anachronistic as applied to these early groups.

<sup>66</sup> *Edward Davies*, 'The Architecture of Freetown' in Fyfe and Jones, *Freetown: A Symposium*, p.119

subsumed by the colonial ideal but persisted underneath.<sup>67</sup> In 1835, visiting British missionary Mary Kingsley noted that the way Freetown residents lived disrupted the clean lines of the city. She characterized this as "regular irregularity...regular because the streets are wide and all run parallel to each other, but the houses are of very different sizes and interspersed with orange, plantain, and pawpaw trees, courts and gardens."<sup>68</sup> Building the "unofficial city" altered the single family plots to incorporate the compound style familiar in the country, with multiple dwellings squeezed onto small lots intended for single, European-style houses.

The Freetown of the 21<sup>st</sup> century is comprised of sedimented layers. Practitioners of this city must negotiate with numerous physical reminders of 19<sup>th</sup> century colonial life. The core streets of the business district were never widened beyond the 80-foot span of the 19<sup>th</sup> century plan. The gate through which slaves were led into the city upon liberation from passing ships following abolition in 1808 still stands next to Connaught Hospital, the country's major consulting and teaching facility. Connaught Hospital directly replaced the Colonial Hospital, which burnt to the ground in 1919, and which itself occupied a site that had once been the colonial prison. The stone husk of the original Fourah Bay College – established in 1827 as the first European-style institution of higher learning for Africans – crumbles, occupied by squatters and feral dogs while the institution still bearing its name looks on from its mountainous location. The Annie Walsh Memorial School – the first secondary school for girls in West Africa - remains in its original compound on Kissy Road, its 1850s core now surrounded by decades of out buildings, much like PCMH. Yet perhaps the most significant testament to the effect that the everyday movements of ordinary Africans had on revising the colonial city still stands, thrives in

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<sup>67</sup> Davies in Fyfe and Jones, Eldred P., *Freetown; a Symposium*, 120.

<sup>68</sup> Mary Church, *Sierra Leone, Or, The Liberated Africans: In a Series of Letters from a Young Lady to Her Sister in 1833 & 34.*, (London: Longman, 1835) p. 44.

fact, at the heart of the city. Excavating the landscape around Freetown's iconic Cotton Tree provides an excellent framework for understanding the links among mobility, memory in Freetown.

## **Hill Station**

Revision of the city plan through the movements of its residents was not limited to the effects of pedestrian traffic. A key example of the integration of Africans into spaces designed on European models was the settlement at Hill Station, a concerted effort and subsequent failure to write social stratification into the infrastructure of the city. From 1898 to 1902 all colonial administrators relocated from the city center to terrain high in the hills to the south of the city. The move had been called for both locally, by the sanitary inspector, but echoed similar movements taking place throughout colonies occupied by European settlers seeking to avoid malaria and the miasma of the city. Hill Station, with its dedicated rail line and houses built on concrete stilts, was a classic example of sanitation syndrome in action.<sup>69</sup> Yet unlike in other colonial cities, this move of British residents up and out of the city broke with over a century of cohabitation in which black and white and brown people had dwelt on the same horizontal plane. The insult was hard-wired into the city's infrastructure, as a train station was built in the center of town to carry British residents up to their airy homes.<sup>70</sup> Settling into bungalows that had come pre-fabricated from England, within the space of five years British homes dotted the hills and the settlement took on the name of its terminal rail stop, Hill Station.

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<sup>69</sup> Maryinez Lyons, *The Colonial Disease: A Social History of Sleeping Sickness in Northern Zaire, 1900-1940* (Cambridge University Press, 2002).

<sup>70</sup> The rail line cut what is now Signal Hill Road into the side of a mountain. On trips up and down passengers would be treated to sweeping vistas of Lumley beach, the lighthouse at Cape Sierra, and the sparsely populated marshes of the Aberdeen Peninsula.



The effort to segregate Europeans on the hill was unevenly successful from the outset. The administration failed to account for the fact that the demand for domestic servants would render this vertical border dividing Africans from Europeans permeable, as mobile Africans once again proved problematic for colonial plans. The mountain rail line leading to Hill Station was pulled up in 1928 when the construction of Signal Hill Road was completed. The increasing availability of automobiles and the new road provided an alternate means to travel from the city center to Hill Station; one which reduced the ease with which Africans could ascend to the hills but which resulted in a chronic labor shortage that the British hill dwellers complained about well into the 1950s.

The Hill Station segregation project in 1902 backfired. With the railway, Africans were provided a route to the hills and, by default, everywhere in between. In the decades since the road replaced the rail, the ease of transport for Freetown's residents resulted in a mountainscape where shacks and shanties, dwellings made of corrugated metal, shipping containers, and cardboard proliferate on slopes next to palatial, million-dollar walled compounds. Moreover, the fact that the U.S. embassy has continued to move further and further into the hills has established a regular taxi route for the African staff who have followed them, building houses directly in the shadows of their expatriate employers. Thus the line of transport designed to separate has instead joined wealthy elites with ordinary Freetonian laborers, as both groups circulate between the city hub and the relative calm of the hills.

## Modernity, Mobility and Maps

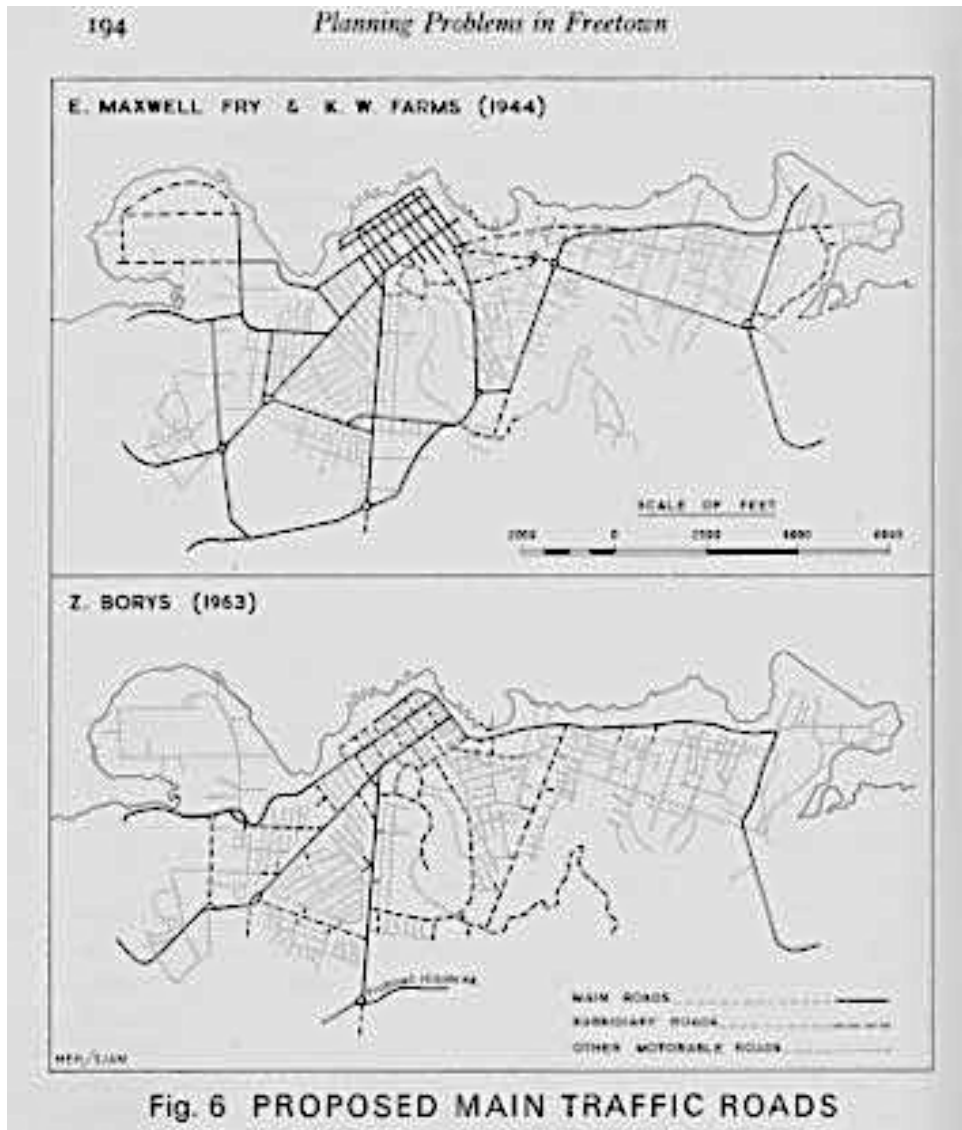


Figure 3: Imaginary traffic patterns from 1944 (top) and 1963 (bottom).

Modern expansion of the diaspora fueled by factors such as the growing popularity of West African Highlife music and a new, state of the art international airport at Lungi (just west of Freetown) together with the end of formal colonialism helped fuel an increasingly empowered cosmopolitanism in mid-20<sup>th</sup> century Freetown. The area planned as the posh Regent Square

suburb for wealthy whites in the 19<sup>th</sup> century had been repurposed by Sierra Leonean petty traders by the 1960s. R.J. Olu-Wright argued in 1968: "since the town cannot expand north or south, expansion has taken place laterally east-west within the city limits beyond...there has not been much change to the pattern of land use; rather, there has been much development within the framework of this pattern."<sup>71</sup> These savvy businessmen and women occupied the old, grand stone buildings at double and triple occupancy, and practices of buying and selling elevated negotiation to an art form. Writing extensively of trade within the city in 1968, J. McKay claimed:

The principle of bargaining to fix a price agreeable to both parties plays an important part in such trade, and one often has the feeling that the haggling that goes on is as much for the satisfaction of a love of bargaining itself as for the desire to fix a good price. *A man who is skilled in the art of bargaining acquires considerable social prestige*, and can put on a show full of interest for someone more accustomed to the much duller practice of paying a price fixed by the manufacturer...in Kroo Town Road most shops are open until late evening, and some of them well into the night...the street also becomes a centre of social life during the evening, the numerous bars and clubs adding their attractions also.<sup>72</sup>

McKay showed that in 1968 as now, ordinary people patronized neighborhood African traders for everyday purchases of perishable goods and quantities too small for European shop owners to bother with: two cigarettes, an envelope, half a dozen lumps of sugar. This sort of quotidian contact also provided a system of accountability by which small scale merchants could extend credit. Negotiating and haggling involved making deals with people, mobilizing and building social capital in order to gain prestige. Thus in this first decade following decolonization it was not only the grid-defying movements of Freetonians, but also the

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<sup>71</sup> Olu-Wright in *Freetown: a Symposium*. 1968:29-31

<sup>72</sup> J. McKay, "Commercial Life in Freetown," *Freetown; a Symposium* p.73. Emphasis added.

commerce they conducted within and between former colonial spaces that allowed local forms of sociality to flourish.

Revising modern Freetown also included the renaming of streets. The streets in the central business district were originally linked to the 12 British men who underwrote the philanthropic endeavor as the Province of Freedom. By the mid-20<sup>th</sup> century, names meant to commemorate colonial founders were overlaid by names resonant with non-European knowledge and memory significant to non-Europeans, such as Bobocombo, Fish Stone, Krojimi, and OkeMauri. Granville Road (originally named for Granville Sharpe, the abolitionist who spearheaded the efforts to found and fund the colony) became Kissy Street (named for an ethnic group who settled there) and following the 1991-2002 civil war, was re-named for Sanni Abacha (a controversial Nigerian president whose troops provided aid during the war). Cross Street became Wallace Johnson Street (named after the anti-colonial leader of the radical West African Youth League), Water Street became Lightfoot Boston street (named after the country's first Sierra Leonean governor general), and in 1971, Westmoreland became Siaka Stevens street (after the first president of the Republic of Sierra Leone).

Upon decolonization, the Sierra Leone Monuments and Relics commission chose Cotton Tree Station as the site of its new cultural museum. On this site members of the Sierra Leone Society, a cultural preservation effort organized by the Creole Dr. M.C.F. Easmon (who we will meet again in chapter three) shortly after independence, curated examples of indigenous art, cloth, and historical artifacts and cultivated a distinctly self-conscious narrative of the nation's past. The architects of independence re-appropriated a space that had been re-appropriated once before, overwriting the failure of the British segregationist impulse on a site whose significance was rooted in pre-colonial patterns of movement.

Mid-century Society proceedings show that conscious effort was exerted to carve British colonialism out of Sierra Leone's historical narrative. The Society-penned "Handbook of Freetown" emphasizes the role of non-British administrators in the early history of Freetown. Citing a charter granted by King George III in 1799, the Foreword written by the Creole Mayor of Freetown A.F. Rahman, proclaims that the Freetown city council is "the oldest local corporate body in West Africa. Our constitution dates as far back in modern times to the year 1893 when the Council consisting of a Mayor and fifteen Councillors was brought into being by the legislature."<sup>73</sup> Another Society production was *The Morning Star of Africa: or Tales the Cotton Tree Could Tell*, published in 1967 as an elementary school textbook promoting a revised narrative of Sierra Leone's history.<sup>74</sup> In this history for a new generation, the personified Tree – as proxy for the nation – narrated the emergence of Freetown as a Portuguese trade settlement. This story highlighted the 16<sup>th</sup> century Portuguese captain Pedro de Cintra, credited with naming the country *sierra lyoa*, the Lion Mountains, based on topography he saw from the sea. Drawing a straight line from de Cintra to the new nation, the Cotton Tree narrator skips over British involvement entirely. Paul Basu notes that the Tree was featured prominently on the first bank notes issued by the independent government.<sup>75</sup> While the image was replaced at some point during the 1970s it reappeared in 2006 following the Civil War. Thus the Cotton Tree was consciously mobilized by the first independent administration as a symbol central to the national narrative and again by a nation in recovery from the devastation and division of civil war.

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<sup>73</sup> "Handbook of Freetown," 1967, p.3 Edinburgh University Library

<sup>74</sup> Clarke, W. R. E. (1967). *The Morning Star of Africa: Or, Tales the Cotton Tree Could Tell of Freetown, Sierra Leone*. Macmillan.

<sup>75</sup> Paul Basu, "Confronting the Past? Negotiating a Heritage of Conflict in Sierra Leone," *Journal of Material Culture* 13, no. 2 (July 1, 2008): 233–47, doi:10.1177/1359183508090896.

The movement of the Cotton Tree to the center of national iconography and the erasure of the boundary between Hill Station and the city reflect tangible manifestations of historical patterns of spatial practice. Sierra Leonean networks of movement maintained social relationships and cultivated new subjectivities that altered the grid-like infrastructure of the colonial city. Thus while Hillier and Hanson argue that spaces order relationships among people in part by scripting their movements, these examples show how built environments may also be reinterpreted and reshaped over time as people move through them with their own meanings and relationships consciously in mind.

### **Mobility and the (f)utility of maps into the 21st century**

Graham Greene, the British travel writer and novelist whose 1936 *Journey Without Maps* was fabulously successful, did little to hide his disdain for the cartography of West Africa as he recounted of his trek from Sierra Leone to Liberia:

It would have been easier if I had been able to obtain maps. But the Republic is almost entirely covered by forest and has never been properly mapped...I could find only two large-scale maps for sale. One, issued by the British General Staff, quite openly confesses ignorance; there is a large white space covering the greater part of the Republic, with a few dotted lines indicating the conjectured course of the rivers (incorrectly I usually found) and a fringe of names along the boundary...the other map is issued by the United States War Department. There is a dashing quality about it; it shows a vigorous imagination. Where the English map is content to leave a blank space, the American in large letters fills it in with the word "Cannibals." It has no need for dotted lines and confessions of ignorance; it is so inaccurate that it would be useless, perhaps dangerous to follow it...But this is where Mr. D, the elderly Kruman, could help; he knew the Republic.<sup>76</sup>

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<sup>76</sup> Graham Greene, *Journey Without Maps* (Penguin, [1936] 1992).

Greene's frustration is echoed today by outsiders and newcomers to Freetown, those who do not *know* that the city exists in practice; paper and even digital maps are virtually useless, failing to account for topography – social or geographical – or the tacit knowledge required to move through the city. Freetown's residents know that in order to move through the center of town one must walk. In fact, the practice of pedestrians over the decades of the 20<sup>th</sup> century has rendered some streets impassable to vehicle traffic. While the colonial railway was meant to facilitate movement, it was laid straight down the middle of existing streets. Rather than facilitating passage, it instead split the road into two halves, creating a problem for pedestrians which these walkers in the city proceeded to solve by blocking the streets altogether and reclaiming the space from vehicles for the purposes of pedestrian-based commerce.<sup>77</sup>

Identifying the phenomenon that would result in a complete blockage of city streets by the 21<sup>st</sup> century, R. J. Olu-Wright wrote in 1968: "Competing claims by pedestrian and vehicular traffic necessitate the construction of footpaths which reduce the width of the road but ensure the safety of pedestrians."<sup>78</sup> Today, Sanni Abacha Street is so clogged with pedestrians no sane person would attempt to drive on it.<sup>79</sup> One must *know* the city in order to translate what can be seen on a map, and although even a semi-accurate street map is valuable currency, highly sought after by newcomers, such a map does little good in terms of actual navigation.

Like other two-dimensional images, maps carry a sort of truth claim, as some level of correspondence with the three-dimensional physical world is assumed. When it comes to

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<sup>77</sup> Olu-Wright in *Freetown, A Symposium*, p. 35

<sup>78</sup> *Ibid*, p. 36

<sup>79</sup> I have probably been the only person stupid enough to actually attempt this in the 21<sup>st</sup> century. With the help of a sympathetic, knowledgeable, and slightly amused pedestrian, I managed to move through the crush of bodies on Christmas Eve without injuring any of them, while maintaining possession of my vehicle and belongings, and suffering only a few dents and a cracked mirror.

Freetown, maps seldom represent material or practical reality. For one thing, the names of streets and places are often inaccurate or useless. Motor Main road, as it is 'officially' denoted on the map, for example, is not actually called Motor Main road by anyone who lives in Freetown, it is called Main Motor road. A bustling hub of *ocadas* (motorbikes) for hire is located at Bottom Mango, near Mamba Point guesthouse and an NP petrol station, but "Bottom Mango" does not exist on any map; it exists in social, linguistic, and spatial practice. Mends Street may look like a street on a map, but in reality it is a dirt trail tapering off into the grass. On a map, one end of Soldier Street looks passable but in reality there are houses built in the middle. The two-dimensional form of a map also neglects to render the degree to which topography influences the speed of passage. What appears to be a gentle bend on a the flat plane of a map becomes, in practice, a screaming terror with a 45-degree incline, a sheer drop-off on one side, a mountain of granite jutting up on the other, and oncoming traffic passing without regard for blind curves. One cannot gain this knowledge from a street map. What looks on a map to be the most direct route is hardly ever the fastest and may not, in practice, constitute a route at all.

We must frame the blockage of roads and the dubious utility of maps within a historical context, alongside a deeper narrative of roads as places of danger. That roads have long been precarious for Sierra Leoneans is evident in some of the earliest British accounts. In 1825, a British explorer named Alexander Liang documented evidence of "war fences," stockades of cotton trees which had grown up from defenses erected in the 1760s to keep Fula invaders from attacking the town of Falaba in the north east.<sup>80</sup> Peter Kup dates the practice to the Mane invasions in the mid 16<sup>th</sup> century.<sup>81</sup> Rosalind Shaw suggests that 20<sup>th</sup> century popular culture

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<sup>80</sup> Laing, Alexander Gordon (1825:351) *Travels in the Timanee, Kooranko and Soolima Countries in Western Africa*. London: John Murray.

<sup>81</sup> Alexander Peter Kup, *A History of Sierra Leone, 1400-1787: By A.P. Kup* (University Press, 1962).



images of roads as "bringers of death...have even deeper historical roots, drawing upon a slave-raiding past in which associations between death, 'bad' forms of commerce, and the terrors of 'Pa Road' a personalized, malevolent entity...were all too clear."<sup>82</sup> While roadblocks and defenses were meant to keep inhabitants safe from the roads (channels for the disappearance and commodification of humans as slaves) in some cases the intention to thwart danger was built in to the road itself. Ernest Graham Ingham, co-founder of Princess Christian Cottage Hospital and Bishop of Sierra Leone suggested:

You may learn much about the African by his roads. They are not roads, but the narrowest possible footpaths, cut often through solid bush, and so winding and circuitous that you constantly find yourself retracing your steps. A straight road is contrary to the genius of the people. And when we mark how helplessly unfortified their towns and villages are, we come to understand the precaution that anticipates the approach of an enemy, and takes good care that he shall come circuitously, and in single file.<sup>83</sup>

The next section of this chapter shifts to a focus on mobility and danger in the Freetown from the 1990s through 2012, illustrating the strategic shifting between knowledge and uncertainty, negotiating between seeing and hiding or obscuring from sight we have seen associated with mobility and roads thus far.

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<sup>82</sup> Rosalind Shaw, *Memories of the Slave Trade: Ritual and the Historical Imagination in Sierra Leone*, 1st ed. (University Of Chicago Press, 2002).

<sup>83</sup> Bp Ernest Graham Ingham and Thomas Clarkson, *Sierra Leone After a Hundred Years* (Seeley and Company, 1894), 263.

## **Precarity and possibility on 21<sup>st</sup> century Freetown roads**

One thing linking the problem of maps to precarity on the road during fieldwork in 2011-12 was that points of reference were not fixed. In fact, the roads themselves were constantly moving. Savvy Freetown residents could gauge the government's sense of urgency by the number of intentional traffic reconfigurations taking place in a given space of time. During the dry winter of 2011, Chinese contractors worked hastily to complete the essential elements of major road projects before the spring rains, moving roads on a daily, sometimes hourly, basis. Multiple simultaneous road construction projects constantly re-routed major traffic patterns affecting private vehicles and public transportation equally. On a Tuesday traffic might proceed down the four-lane Spur Road on the left, while proceeding on the right Thursday; one day the road might be a smooth surface 25 feet wide, and the next an earth-mover may have completely excavated a 30-foot swath of pavement in front of the petrol station. Once the summer rains came, a new kind of shapeshifting, unintentional and uncontrollable, began in earnest. Familiar roads spontaneously disappeared, their tenuous borders melting into the stalls and homes crowding the roadsides. Taking a road for granted, even momentarily, was to put oneself in peril.

The road construction also caused significant hazards to the construction laborers. It was not uncommon to see young men with bare heads and chests, wearing *afbak* (flip-flop sandals), clinging to the handles of jackhammers, shards of stone collecting around their feet. They often wore rags tied around their faces to prevent inhaling stone dust, or tied around their heads to keep sweat out of their eyes. During the dry season, plumes of dust thrown up by jackhammers mingled with the dust from the roads to create giant clouds of silt that seeped in through closed windows and settled into the cracks of dashboards and faces, turning trickles of sweat on the

brow into rivulets of salty mud. Only the wealthy could afford air conditioned vehicles, so the majority of drivers chose between the near-futile option of rolling up all the windows and the alternative of squinting their eyes and breathing through their shirts, hoping their airways were robust enough to filter the dust pouring in. With visibility close to zero, young men – and increasingly women – stood in the midst of traffic waving flags, bidding motorists to stop and allow a backhoe to cross. Usually, after three or four cars had squeezed past, the backhoe driver would simply start to cross anyway, and the flag-waver, now backed by steel, suddenly became a figure of authority. Road workers gathering around Chinese or Senegalese foremen to receive paychecks on Thursday evening took their lives into their hands every day. The pay was steady and decent and these youngsters trusted that their feet and lungs will make it through to the next pay period.

Many worried that the underlying goal of these projects, widening or otherwise 'improving' the roads, was itself dangerous, potentially resulting in the same detrimental effect as the recent re-surfacing of the road to Bo, Sierra Leone's unofficial second city, four hours east of the capital. Since that road was "improved" in the 2000s, traffic fatalities have increased exponentially. There were no speed limits, no shoulder, no street lights, and there was only one functioning trauma unit in the entire country.

The roads in Freetown were riddled with ubiquitous potholes large enough to swallow a vehicle. These were occasionally filled in with small rocks, gathered by stooped elderly men who stood next to them, vulnerable to traffic, hands outstretched, hoping for payment. Often, the craters were simply unavoidable. Small, agile taxis could usually weave their way around the largest but more substantial vehicles equipped with four-wheel drive, indispensable for reliable transportation during the rainy season, needed replacement tires, wheels, even entire axles on a

regular basis, adding to the expense of vehicle ownership. As one might imagine, vehicle ownership was a rare privilege of the wealthy. The most common modes of vehicular transportation in the city were taxis, poda-podas (mini vans), and ocadas. Each came with its own set of perils.

Hand signals in Freetown were a language of their own, and successfully negotiating mobility and building social capital depended entirely on the visual literacy required to interpret the basic signs. A rider on an ocada may signal as though s/he was patting down the air. This meant slow down, and was particularly helpful in case of a blind curve, where the ocada rider might be able to see something a driver behind them might not. It was, however, vexing should the rider (often working in conjunction with the driver) simply decide a driver was going too fast. The 'slow down' signal could then be combined with a swerve of the ocada to the middle of the road, making it impossible to pass.

An additional mode of transport, while as unpredictable, tenuous and potentially dangerous as any other, was also a means of building and storing social capital. This was the 'lift.' At its most basic form, it involved a hopeful person on the side of the road with an arm outstretched, palm up, asking for a free ride, and a non-professional driver with space to spare pulling over and to pick them up them. The driver indicated his or her final destination and the passenger indicated approximately where he or she would like to be let off, but the exchange would involve much more than this. First, there was the signaling.

When petitioning for a lift, important choices about safety needed to be made. As a single female in a four-wheel drive vehicle (as I frequently was, on my way to and from my field sites), I presented a good prospect to, say, a mother with several small children or a group of women on the way downtown. We would chat, exchange stories, blessings, and occasionally phone

numbers: all valuable forms of social capital. As with most forms of social interaction in Freetown, a 'lift' was a social opportunity during which carefully selected information (currency) was manipulated and traded. It could be the Freetown version of the elevator pitch. Passengers performed songs, promoted their printing or braiding business, attempted to secure employment for themselves or a sibling, and mined for useful bits of information, potential mutual contacts to enrich an eventual claim to patronage. A passenger who failed give me a phone number or ask for mine was the exception. Simply riding in a private car carried its own prestige. Friends at PCMH who knew I was leaving for the day would ask for a ride, even just up the street for a block, for the opportunity to pile – literally, sometimes sitting in layers on one another's laps – into my ancient, dilapidated, un-air conditioned Ford Explorer at the end of the day. I too benefitted from this, using it as an opportunity to conduct informal interviews and secure the loyalty of friends who kept an eye out for me and my vehicle. The one thing never exchanged was money. Social capital was the currency of the lift.

Traffic flares were unheard of in Freetown (thankfully, given the potential for roadside brush to ignite during the dry season). Instead, disabled vehicles were signaled with palm leaves laid in a pattern starting several feet behind the affected vehicle and leading diagonally out to the oncoming lane. Disabled vehicles presented a problem for everyone and, as such, were dealt with communally. Usually someone was stationed in front to wave leaves as well. There were no tow trucks in Sierra Leone in 2011-12. A car on the side or in the middle of the road could cause traffic to back up for miles. When this happened, men in the traffic jam would leave their vehicles to help push the car out of the way. Those who claimed mechanical expertise (whether they had any or not) stayed to determine the cause and get the car running again. If they were able to do so, the one who seemed to have been leading the effort would expect payment in one

form or another. The other participants and bystanders built technical knowledge and social capital for 'next time.'

In Freetown there was always a next time. Should the first, proximate group of individuals be unable to fix the car, more professional help would be sought. The driver would summon a network of family or friends to assist, designate someone to stay with the car waving palm leaves, and to fetch a proper mechanic. A vehicle left on the side of the road was fair game, and salvagers would swarm before nightfall, dismantling it entirely and hauling it away in pieces to sell at downtown stalls. Unattended vehicles were an impediment to the flow of traffic. Dealing with blockage on the roads was often efficient and social, and it kept traffic moving.

The road leading out of the city towards the peninsula was travelled almost exclusively by wealthy Sierra Leoneans, expatriates, and Freetown-based church or social groups escaping Freetown for the string of exquisite beaches at the weekends. On the narrow one-lane paths connecting the main road to the beach children commonly set up roadblocks. A rope would be left lying in the road until a car approached, at which point the boys (they were always boys) would run to pull the rope taut and stop the vehicle and ask for money: "We need money to eat" was the most common plea, but also "we need money to fix the road." The rope stayed tight until money was passed out the window, but the power here was negotiated. The driver was in a position to judge the boys' performance (and a consummate performance it certainly was), and could easily open a door and snatch one of the smaller children or simply not stop. It would be a rare child indeed who would hold tight to a rope attached to a speeding Land Rover, but this was the implicit threat. Somewhere between common decency and compassion, drivers who could be seen from the outside most often stopped. Casting a blind eye in this situation, running over a rope dropped at the last second, could be facilitated by the lack of eye contact. As one expatriate

informant with tinted windows told me "I don't make eye contact. I just smile, look straight ahead, wave, and keep on going."

In practice, an encounter with a traffic warden in the city was a similar game of chicken. Standing in front of a moving vehicle, a traffic warden armed only with a uniform, a badge, and a notepad to write down registration numbers, would hold up one hand and motion drivers to pull over with the other. A driver who failed to make eye contact could feign ignorance and keep on driving. Thus, on one hand, seeing was a civic duty. A responsible driver should see, acknowledge having seen, and correctly interpret the signal in order for the civil society of the commons of the road to function.

This civic duty to see remained in effect even in the absence of a sign. If a sign existed, whether a driver had not seen it or not, it was the driver's responsibility to abide by the authority the sign indexed. The only exceptions were for invisibility: tinted windows, a blue diplomatic immunity plate, or the cover of darkness. Tinted windows greatly reduced the possibility of eye contact, and without eye contact the basic communicative contingency of the social contract was null and void. A blue diplomatic immunity plate rendered a driver impervious to local law, as the authority it indexed was rooted on foreign soil. The civic responsibility in this case rested with the traffic warden, obligated to see the diplomatic plate and then not see, or forget having seen, any traffic violation. For those without tinted windows or blue license plates, darkness facilitated challenging authority of all kinds. The vision-dependent nature of authority was tacitly but officially acknowledged by the fact that there were no night shift traffic wardens.

The greatest mediator of safety on the road was sight. Seeing, being seen, and the power to render oneself invisible were the most significant factors facilitating or impeding mobility. In one sense, authority on the road depended directly on sight. This fact ensured employment for

those who tinted windows for a living. The sociopolitical power of a vehicle's occupant could be roughly indexed to the tint of the windows. Diplomats, wealthy bankers, expatriates, and politicians all had tinted windows. The president and his entourage had the darkest windows of all. While this provided a measure of privacy and status, its additional significance only became apparent comparatively, when driving a vehicle with clear windows. Remaining hidden behind tinted windows allowed drivers to avoid the gaze of beggars – usually victims of polio but occasionally also the blind, dwarves, and orphaned children – who crowded every busy corner. Potential thieves could look for valuables like purses and backpacks, and count and size up passengers through clear windows. This became particularly dangerous in areas such as Waterloo and Kissy in Freetown's eastern ward where blatant theft was common. Safely negotiating the one and only road out of town required knowing when to start rolling up the windows, hiding valuables, and locking the doors.

Travelling in groups was considered safer than traveling alone in Freetown, especially for children. Stories of roadside disappearances circulated widely. One informant explained: "If you don't take your time [be careful], they take your breasts, vagina, everything." Puzzled by the refusal of children to accept a lift, I questioned my adult informants and learned that the fear of the lone passenger was abduction, ritual murder, and evisceration. Reproductive and speech organs were rumored to be consumed in order to gain political power. The typical story involved a big luxury car with blackened windows and a big man or his henchmen under cover of darkness. In a cruel twist, victims themselves could be blamed for 'tempting the devil' by entering a car alone in the dark. In the fall of 2011 the story was powerful enough to prevent a lone schoolchild from accepting a lift from me in broad daylight on a busy road. In an upside down city of spectacular roadblocks, mass demonstrations of protest, funeral processions



stretching for blocks, Sunday thanksgiving parades, masked devils ten feet tall, the sudden (or delayed) appearance of presidential caravan, the thought that I might be taken for a body thief provided the greatest lesson about insider knowledge and danger on the roads.

### **Remembering war, revising the past**

Much of the physical damage caused by Sierra Leone's civil war was still visible in and around the city. Buildings – even the Youyi Building, housing many of the government's administrative departments – retained evidence of fire. Often, bodies themselves could serve as reminders of how the war undercut the networks on which mobility and social capital depended. The majority of the war amputees had been re-settled to the village of Hastings, in the hills about 40 minutes' drive from Freetown. Unlike victims of polio and dwarfism who populated Freetown's busiest corners, amputees were rarely part of the cityscape I observed. Foreign charities and small amounts of funding from the government kept them out of sight where, as social outcasts, they conducted whatever work they could – often farming or weaving hammocks and blankets to be sold at market.

Occasionally an amputee appeared in Freetown. A trader stationed outside St. Mary's supermarket at Hill Station sold colorful knit work to the market's wealthy tourists and ex-pat customers who could afford to pay the equivalent of \$12 for a pack of toilet paper. A young enterprising man named Ibrahim Bangura calling himself "Di Bag Man" sold cloth handbags at the airport. Both men advertised bespoke, custom work, capitalizing on links to wider networks of social currency, trading their own memories and disabilities for the historical imagination of a foreign public linking Sierra Leone's civil war to machetes and severed appendages. These men – more accurately, their absent hands – served as visible reminders of the ways in which the war

rent even the closest kin ties and contributed to a lack of trust which pervaded social interactions on Freetown's streets in 2011-12.<sup>84</sup>

Knowing about memory spaces was also a form of negotiating space in post-war Freetown. Maria Bergs writes that in the 2000s:

All over Sierra Leone there are new spaces and places of memory that were created during the conflict. People point out sites where atrocities occurred, where they were ambushed, sites of spirits, sites that have been re-appropriated...[these] are local sites of remembrance and often recalled, sometimes in passing; through gossip, spontaneously in a car driving up country, walking through the bush, or around a cooking fire.<sup>85</sup>

Bergs suggests that this recall involves "an element of choice" in contrast to the lack of choice people experienced during the war. Indeed, one informant who had been shot during the war told me of deliberately returning to the spot where the shooting had occurred. To his amazement, people remembered him and the shooting, coming out of their homes, shaking his hand, asking about his family.<sup>86</sup>

In 2011-12, I learned that spatial memory played a critical role in shaping insider knowledge of the city. Witnesses to the rebel invasion of January, 1999 told stories of terror which were often associated with place. As one informant told me: "during the war everything was in the bush. People gave birth in the bush. We were hiding in the bush. There was nobody in the hospitals. In fact, the rebels had taken those places over. There was no place to give birth

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<sup>84</sup> Catherine E. Bolten, *I Did It to Save My Life: Love and Survival in Sierra Leone* (Berkeley: University of California Press, 2012); Lansana Gberie, *A Dirty War in West Africa: The RUF and the Destruction of Sierra Leone* (Indiana University Press, 2005). See also Hunt's *Acoustic Register* on the visual trauma of absent appendages.

<sup>85</sup> Maria Bergs, *War and Embodied Memory: Becoming Disabled in Sierra Leone*, New edition (Farnham Surrey, England; Burlington, VT: Ashgate Pub Co, 2012).

<sup>86</sup> A. Benton, "Yu Get Fo Liv Positiv: HIV, Subjectivity and the Politics of Care in Post-Conflict Sierra Leone" (Harvard University, 2009); Rosalind Shaw, "Displacing Violence: Making Pentecostal Memory in Postwar Sierra Leone," *Cultural Anthropology* 22, no. 1 (February 2007): 66–93; Michael Jackson, "Storytelling Events, Violence, and the Appearance of the Past," *Anthropological Quarterly* 78, no. 2 (2005): 355–75.

properly so people just gave birth in the bush, on the road, on the side of the road."<sup>87</sup> Another story erupted from an uncle, completely unbidden, as we traveled out of Freetown to visit my grandmother in Bo. One minute we were discussing the price of petrol and the next we were back in 1999 when the rebels had come to Freetown. They called everyone to come out of their houses but his neighbor, a grown man, refused to leave. They shot his young son instead: "right there, right in the front of the house!"<sup>88</sup>

These stories emerged abruptly, intruding uninvited into conversations in a random, unpredictable fashion, not unlike the violence associated with the rebel incursion itself.<sup>89</sup> As it was the main route from my flat to the hospital, I traveled on Pademba Road almost daily. Once, while giving a friend a ride home, as we passed the Pademba Road prison (reserved for the country's most violent criminals) on the right, she pointed out a one-story house on the left.<sup>90</sup> With concrete walls painted a cheery yellow, its un-fenced patch of yard sat open to Pademba road almost directly opposite the prison. I had never noticed this house before. She recounted that this had been her extended family's home before the war, with several aunts, cousins, and their children sharing the roof with male family members coming and going. She had been about 12 years old when the rebels came.

As was their custom, the rebels had called everyone inside to come out. This was a common tactic, often resulting in the abduction or rape of young girls, the killing or maiming of

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<sup>87</sup> Interview with Ruth, June 2012

<sup>88</sup> Interview with Mohammed, March 2012

<sup>89</sup> This non-linear unpredictable time-bending way in which these stories erupted and unfolded in fits and starts and loops are classic characteristics of the trauma narrative. See Kurt Vonnegut's *Slaughterhouse Five* or Amy Tan's *Joy Luck Club* for similar examples in written form.

<sup>90</sup> Upon entering Freetown, the RUF made Pademba Road prison one of its first stops. Reports tell of a truck carrying plainclothes rebel soldiers pulling up to the prison gates and overpowering the few Nigerian troops stationed there, blowing the gates with grenades, and liberating around 600 prisoners. These men were armed and set loose as conscripts, bolstering the efforts of RUF to take the city.

men, and the conscription of boys into the rebel forces. The rebels then set the house on fire, and anyone attempting to hide inside would run out to be shot on site. Fatou's cousin had been about 18 years old at the time: "We were so scared for her. We prayed and prayed. We did not know what would happen to us" she said, staring ahead as the house faded from sight behind us. Fatou recalled how the rebels robbed them of whatever valuables they had on their bodies and left them to watch the house burn. She made no further mention of her cousin. Her family escaped further violence by moving into a tiny compound at the very back of another only slightly larger compound closer to the city center. This place I knew as her home was surrounded by concrete walls with shards of glass embedded along the edge and an iron gate. The house, while much smaller, also seemed safer, less exposed in its site at the back of a three-house compound on Soldier Street. The most striking aspect of Fatou's story was not the violence. The atrocities committed by the Rebel United Front (RUF) are well documented, and this episode of robbery and arson is relatively tame.<sup>91</sup> Much more remarkable was the fact that she told me this story after I had spent many months in Freetown and had passed the house with her countless times. I was left to wonder: did she think of this each time we passed the house? If not, what had triggered the memory that day? If so, how did she reconcile her trauma with the need to pass by the house so regularly?

Cotton trees, such as the one at the center of Freetown, are key to historical accounts of conflict and settlement in Sierra Leone. Reading visual signs of any kind requires familiarity

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<sup>91</sup> For more detail about the RUF invasion of Freetown, see Lansana Gberie, *A Dirty War in West Africa: The RUF and the Destruction of Sierra Leone* (Indiana University Press, 2005); Ibrahim Abdullah, "Bush Path to Destruction: The Origin and Character of the Revolutionary United Front/Sierra Leone," *The Journal of Modern African Studies* 36, no. 2 (June 1, 1998): 203–35; Ian Stewart, *Ambushed: A War Reporter's Life on the Line* (Algonquin Books of Chapel Hill, 2002); Patrick K. Feingold Muana, University of Wisconsin--Madison, and Wisconsin Union., *Representations of Violence: Art about the Sierra Leone Civil War / Corcoran, Chris*. (Madison: 21st Century African Youth Movement, 2005) contains spectacular visual interpretations of the Freetown invasion.

with their interpretive contexts. Mariane Ferme, working in rural Sierra Leone, describes a sort of landscape literacy in which only those who know the history of a place are able to interpret its material (including, for her, vegetative) traces, in which the 'process of history making and interpreting' is “embedded in the venatic lore” of the practitioners of the forest. Ferme notes that in Mendeland forests, pedestrians can make out the gentle mounds where houses once stood or the “sunken hollows” of old graves.<sup>92</sup> Only those with intimate knowledge of place, possessing a spatial memory, can interpret the signs and read the text that is the land.

Another story emerged on an afternoon when I went with a friend to visit the Military Hospital where she worked as a nurse. The barracks sit on top of a hill known as Wilberforce overlooking Freetown, a spot they have occupied for over 100 years. "34 Military" (named for the West African Frontier Force regiment it housed during colonial times) as the hospital is known, is part of a huge complex including schools, barracks, training grounds, and a police force.

As we pulled in my friend Sewa flashed her ID badge toward the man guarding the gate. She gestured toward a spot in the middle of the road, commenting that when the rebels came to Freetown they attempted to take Wilberforce Barracks, executing as many members of the Sierra Leonean Civil Defense Force as they could. She offhandedly mentioned that near the spot she gestured toward there had been a roadblock made of severed human heads piled on top of one another. As we proceeded on an impromptu tour of the hospital's medical/surgical wing I was numb, tuned out, recalling the images I had seen of such roadblocks. How could Freetonians like

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<sup>92</sup> Ferme notes that 'the presence of giant 'cotton trees' (*Ceiba pentandra*) among second-growth forest points to ritual spaces belonging to esoteric associations or to older settlement...in most cases only those who recognize the human plan that shaped the clustering together of certain trees know that these features of the natural landscape are ruins...thus "trees and other landmarks can be read as ruins – inscriptions of violent encounters or at least of abandonment of once-inhabited site – as much as decaying, destroyed buildings." Mariane Ferme, *The Underneath of Things: Violence, History, and the Everyday in Sierra Leone* (Berkeley: University of California Press, 2001), 25.

Sewa continue to travel roads haunted by such visceral memories?<sup>93</sup> Why had this story surfaced unbidden to mar the smooth idyllic image of children in green military school uniforms crossing the street holding hands? More importantly, why might she have chosen to share the story with me? I can only conclude that the spatial knowledge that triggered this story, parking near that spot on that hill, involved both memory and forgetting. Actively forgotten knowledge cannot readily be gained by asking. The skill of forgetting and moving on cannot be learned in the absence of necessity.

### **"Back to sender" and a revisionist rebellion**

Beginning with the north-eastern Kissi territory along the Guinea border, a heavily forested area that was only tenuously held by colonial powers and traveling in capillary fashion all the way back to Freetown following the Freetown-Bo road straight to the seat of government, the RUF used the ambiguous quality of Freetown's roads to sneak into the city. Eastern Freetown has been a locus of blatant theft and violence among young, unemployed men – “Raray boys” – since long before the war.<sup>94</sup> The area was the epicenter of riots against Lebanese traders during a rice shortage in 1919 and again in 1955 and 1956 when students protested against government corruption. It is also home to PCMH, which fell as a casualty to the rebels early. To touch on the subject of maps and insider knowledge again, it is helpful to know that on a paper map, Savage Street looks like a reasonable route from the hills of Fourah Bay College to Fourah Bay Road on

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<sup>93</sup> For more on haunted sites in rural Sierra Leone see “Paul Basu: Palimpsest Memoryscapes,” *Issuu*, accessed March 19, 2015, [http://issuu.com/paulbasu/docs/basu\\_palimpsest\\_memoryscapes](http://issuu.com/paulbasu/docs/basu_palimpsest_memoryscapes).

<sup>94</sup> Abdullah uses this term (Raray) alternately with ‘lumpen’ to signal a “male specific oppositional culture which easily lends itself to violence” existing in every African city: *Yanganda* or *Jaguda* boys in Nigeria, *hittiste* in Algeria and *bayaye* in East Africa and students who led the 1977 protests at Fourah Bay College. Ibrahim Abdullah, “Bush Path to Destruction: The Origin and Character of the Revolutionary United Front/Sierra Leone,” *The Journal of Modern African Studies* 36, no. 2 (June 1, 1998): 208. This area, staunchly anti-conservative, progressive, SLPP-held territory is also the area from whence the recent Ebola outbreak ‘came to town.’ For more on the history of this area as it relates to colonial projects, see Guillaume Lachenal, “Outbreak of Unknown Origin in the Tripoint Zone,” *Limn* 5: January, 2015.

the coast (where PCMH is located). However, the vaguest resemblance to a street ceased about halfway up the mountain's steep slope. At the other end there is only a footpath leading straight up the mountainside. RUF forces stationed themselves at this junction of jungle and footpath waited there until joined by their compatriots who had used the cover of the continuous flow of people through the Eastern edge of town, past the hospital gate, to scramble up that hillside with guns and machetes concealed in layers of clothing.

Today, a thick layer of asphalt is laid over the pockmarked concrete that covers the colonial-era rail line once running through the city. Paul Richards notes that the rail line was laid by British colonialists using African labor in order to facilitate extraction from the interior. Characterizing the war as a "crisis of patrimonialism" in which the 'bush' came to 'town,' he calls attention to the "rhetoric" of the rebels' actions as deeply rooted in this troubled history of resource extraction: "First you used our harbor and took us as slaves. Then you, and then you took our timber, ivory, and valuable mineral resources. But now we have been dumped into the darkness of the bush."<sup>95</sup> Richards writes of a strategically planted rumor in Freetown in early 1995 claiming that the rebels had already established a presence in the hills surrounding the city, and that Foday Sankoh, the RUF leader, would be carried along the old colonial rail line into the city to assume power on Easter Sunday.

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<sup>95</sup> Paul Richards and International African Institute., *Fighting for the Rain Forest: War, Youth & Resources in Sierra Leone*, African Issues, xxix, 182 p. (Oxford : Portsmouth, N.H.: The International African Institute in association with James Currey ; Heinemann, 1996), 32, [http://hdl.handle.net/2027/\[u\]: mdp.39015027490088](http://hdl.handle.net/2027/[u]: mdp.39015027490088). Richards' account, while invaluable for its informed contribution to documenting the war, misses its gendered aspects altogether as do so many other accounts of the war. Women have long held positions as chiefs and inherited property in Sierra Leone and their capacity for production was integral to the rebel's efforts. One of the RUF's signature tactics was cutting off women's hands in advance of the harvest, cutting off the food supply to entire villages. Women were also valued for their reproductive capacity and role in re-creating parallel family structure in the 'bush,' strengthening the RUF's claim that it was intent on reforming the structure of society. For more on this see: Chris Coulter, *Bush Wives and Girl Soldiers: Women's Lives Through War and Peace in Sierra Leone* (Cornell University Press, 2009).

While this did not come to pass, once inside the city, the rebels descended from the hills, joined those already on the ground, and captured the State House, the symbolic and material seat of government power.<sup>96</sup> Rhetorically reversing the pattern of colonial inroads into the country, they eventually reached Hill Station itself, where colonial officers had once sought health away from the African masses below. Fighting occurred along Spur Road, the road separating the "native" enlisted men at Wilberforce Barracks (to the north) from the officers (to the south). Using civilians captured in Freetown as leverage, they crept along a route that cut through the mountainous villages to the east, attempting to strike Hill Station from both directions.

I suggest the rebels' movements might be read as a spatial manifestation of the Krio saying "back to sender." In Sierra Leone this phrase is spoken to reverse a curse or "swear" by turning the evil power back towards the one who sent the curse: a process of what Clarke Speed calls "cosmological adjudication."<sup>97</sup> In emerging from the bush surrounding the area of Hill Station and Wilberforce, the movements mimicked, at a symbolic level, those of initiates emerging from the Poro bush, privy to both the secret knowledge of the Poro society and deeply impressed with the proper respect for elders who were to see to their welfare.<sup>98</sup> But the young men who emerged from these bushes were **not** impressed. As a politically-astute thirty-something cab driver told me while we sped past the empty houses the APC government had erected for delegates to the 1980 Organization for African Unity conference that burnished the

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<sup>96</sup> The state house stands on Tower Hill, former colonial military barracks and strategic defense site since 1794. Stones taken from the old city wall were used in constructing the foundation of the original state house, still standing in the center of the mid-century modern compound but no longer visible from the road.

<sup>97</sup> See Clarke Karney Speed, "Swears and Swearing among Landogo of Sierra Leone: Aesthetics, Adjudication and the Philosophy of Power" (University of Washington, 1991). The saying "Back to Sender" is common in medicinal uses in West Africa. For example, the Freetown-based comedy troupe The Professionals have recently published a video version of a production entitled "Ebola: Back to Sender," and a bio-prospecting group known as the Plant Genetics Resources Center has recently published on use of a "back to sender" charm in Oyo State, Nigeria.

<sup>98</sup> Bolten speaks of this network of obligation as "love," noting its collapse under the weight of extreme exigency in the wake of decades of corruption, as a contributor to the war.



All People's Congress's (APC) image in international eyes but bankrupted the country: "Our schools built that house. Our future built it." The youthful rebel combatants would have grown up in a country which, while among the poorest in the world, nonetheless boasted the world's highest per-capita Mercedes Benz ownership.<sup>99</sup>

The desires RUF leaders articulated were similar to those of the developmentalist mission: "Modern housing, healthcare, educational and recreational facilities," but framed alongside 21<sup>st</sup> century geopolitical concerns such as "affordable energy" and "appropriate technology."<sup>100</sup> Richards argues that the rebellion was largely propelled by a desire to overturn the African big men who had been unfairly distributing resources for decades, and to upend the 'backwardness' of traditional social structures of obligation. Peter Murphy's work in the mid-1970s demonstrated that the fabric of the traditional redistributive system was frayed, and that wealth of various forms was *not* well distributed, but hoarded and, like the secret knowledge with which it was associated, jealously guarded. Murphy argues that the Poro institution as he found it among his Kpelle informants, was one of "calculating elders who withhold more than they teach and use claims on withheld knowledge to keep the young under their thumbs."<sup>101</sup>

Railways covering slave trade routes were completed by 1898, and facilitated decades of colonial mineral extraction and the hoarding of wealth by a not only the colonial administration but also the corrupt independent government led for most of the 1970s and 80s by the conservative APC. The dense jungles at the Guinea-Liberia border region constitute a stronghold

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<sup>99</sup> Shaw, *Memories*, p. 203

<sup>100</sup> Krijn Peters and Paul Richards, "'Why We Fight': Voices of Youth Combatants in Sierra Leone," *Africa* 68, no. 02 (April 1998): 183–210, doi:10.2307/1161278.

<sup>101</sup> William P. Murphy, "Secret Knowledge as Property and Power in Kpelle Society: Elders versus Youth," *Africa: Journal of the International African Institute* 50, no. 2 (1980): 203.

of support for the progressive Sierra Leone People's Party (SLPP); this region was also the area through which the war crossed from Liberia to Sierra Leone.

Similarly, it was from the "bush," the forested hills above the city, that the rebels attacked the capital city, violently smashing layered, sedimented decades of "regular irregularity."

Carrying out what Richards calls "intellectual project," the RUF militants made subverting order their mission: the 'bush' came to 'town.' Physically separating families, limbs, buildings, and the fabric of social order, the rebels articulated the political goals of the rebellion, laying a forest order with geopolitical resonance over the rational rectangles of the colonial grid.

It is perhaps no coincidence that anthropologist Lansanah Gberie terms this criminal, anti-state power "street power."<sup>102</sup> People I met who had remained in Freetown during the war recalled a sense of numbness. The experience of seeing the dead bodies of friends, neighbors, and family members laying in the street day after day eventually reset the norm: "Going out to the street every day, seeing the body there, there, you never knew who would be next." On several occasions informants used the phrase "upside down" to describe the city in relation to the war. In terms of social behavior, as one informant told me, the war profoundly destabilized social mores, and the social weight of previously taboo behaviors (in this conversation the taboo was abortion) became relative to the war. The "upside down" city was also somehow out of sync with previous conceptions of the past, creating a sentiment that "I am not the first and I will not be the last." In the "upside down" city, the future was uncharted.

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<sup>102</sup> Gberie, *A Dirty War in West Africa*.

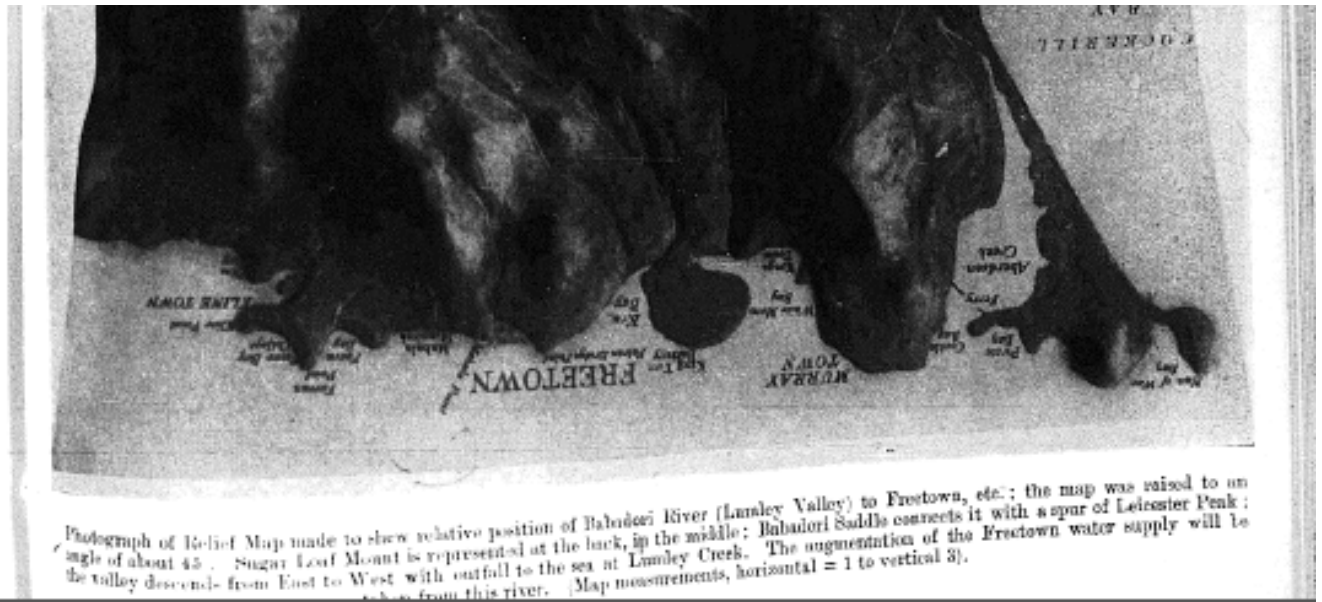


Figure 4: A map of the Sierra Leone coast from a 1911 British Annual Report. Note the competing directions of the written text.

## Conclusion

This chapter has interspersed the movements and voices of Sierra Leoneans with the writings of British missionaries, explorers, and colonial agents: outsiders for whom the city made little sense. While I have used these outsiders as touchstones to frame discussions of roads, trees, etc., they have also served another purpose. Like the map above they have articulated a knowledge whose vantage point is situated outside Sierra Leone. They have served to underscore the point that whether the city is "upside down" or not depends, in part, on where one is seeing *from*. Like any city, the collective, insider, tacit knowledge, the (in)visible, (in)tangible, spatial, social logic rendering this particular urban text legible can only be possessed by those who have written it over time. In Freetown, as in the hospital, the most valuable resource, that which permits movement of people and things, that which 'rights' the world is knowledge itself or, in some cases, knowing how to forget. In other words, while knowledge-brokering drives mobility of all kinds in 21<sup>st</sup> century Freetown, collective tacit knowledge is also about forgetting and

knowing when to *not* know.<sup>103</sup> Strategic forgetting facilitates the mobility of daily life and suggests a different sort of memory work: the work of remembering to forget. We will return to the tension between knowing and not knowing again in later chapters to examine how Freetonians have shaped nursing practice, and how this in turn has shaped the nature of the fundamental human passages of birth and death that take place within the hospital walls.

As the Krio language developed over the 19<sup>th</sup> century, localized patterns of movement revised the colonial grid. Movement around the Cotton Tree became part of the colonial vision. "Regular irregularity" characterized the city by the end of the 19<sup>th</sup> century and a measured chaos governed mobility in the Freetown of 2011-12. Comparing the maps of the original settlement with the shape of the city over two centuries later reveals that the way non-European residents wanted and needed to use the city prevailed as the city rose to meet them and hide their secrets.

This cartographic historical overview supports the contention that Freetown's inhabitants have created and maintained links between the past and present through spatial practice. The tense negotiation of social and material capital, visibility, semiotics, and the potential for danger on Freetown's streets comes to a crescendo at traffic intersections. Safely passing through intersections involves synthesizing and operationalizing different forms of knowledge, weighing multiple factors simultaneously, and decoding potentially conflicting signs. A working knowledge of how social capital and tacit knowledge facilitate mobility in spite of (or perhaps because of) the absence of maps may help us navigate the historically fraught intersection of road and hospital.

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<sup>103</sup> Rosalind Shaw, *Memories of the Slave Trade*, also Murray Last, "Knowing about Not Knowing"

## Chapter Two

### A Cottage Hospital in a Creole City

#### **Introduction**

A languid pause graces the bustle of the day, as the early afternoon heat swelters in, exhausting the last remnants of morning sea breeze. It is May, 2012. The outpatient department at PCMH in Freetown catches its breath. The morning's flow of pregnant mothers in and out of the department has ebbed, slowed, and finally stopped for a moment. The waiting room is full but everyone has been accounted for, signed in and shuffled on to the wards or checked off the list, waiting for the doctor.

We begin to think of lunch, checking mobile phones that charge in a tangle of wires on the floor connected to a power strip which is in turn connected to the hospital's tenuous electric supply. The matron teases the nursing students as their shift nears its end. The nursing students joke with each other, with me. The hospital hums around the little room, closed off from the road but close enough to hear the sound of hawkers and city traffic just outside the gates. Honking horns and Nigerian pop music waft in through open windows with the heat.

Then, faintly, a new sound slices through the hum. A siren. A pleading pulse – "Make way! Make way!" – growing louder. We all hear it and stop. We are ready, no need to notify the doctor or the labor wards: everybody in the hospital can hear it. And it goes on. And on. Seconds turn to minutes, stretched out over an impossible span of time, the steady forward rhythm of the minute hand on the ward clock jarred by the siren's syncopated wailing. "Make

way! Make way!" But in Freetown on Kissy Road at noon there is nowhere else to go, nothing to do but wait for the next vehicle to move. There is no shoulder. The sidewalks have been overtaken by stalls selling everything from coconuts to mobile phones. There is also no other route to the hospital – the country's only tertiary maternity care facility, the final destination for the worst of the worst emergency obstetric cases. There is nothing to do but wait. By the time I leave for home, entering the trickle of traffic heading away from the hospital, I can still hear the siren.

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Princess Christian Hospital's marginal location, on busy road in a city frequently paralyzed by standstill traffic, is a significant factor contributing to situations like the one described above, drawn from my field notes. This chapter explains how the hospital got there, why it stayed there, and perhaps most critically, how the colonial state came to embrace its missionary origins and consolidate them with state-sponsored maternity work at this facility on the far edge of town. Considering what was at stake for whom in the contests surrounding the hospital's establishment in 1892 and re-building after a fire in 1908, the chapter describes the ongoing struggles for funding that shifted responsibility from the Bishop of Sierra Leone to the Church Missionary Society in 1942, the hospital's appropriation by the colonial government as the primary maternity hospital in Freetown in 1953, and in turn by the Sierra Leonean government in 1961.

From 1892 to 1915 PCMH was known as the "Cottage" Hospital. Correspondence and Church Missionary Society documents from this era clarify how the small building originally imagined as a side project in the Bishop's back yard became a central focus of mission activity in

Freetown. Diocesan emphasis shifted from training African ladies while ministering to the poor in the 1890s to the Bishop's proclamation of a proper medical mission, intervening into established ways of seeking and providing medical care in the 1900s. When the original building burned to the ground in 1908, the specter of rebuilding provided an ideal opportunity for either scrapping the project altogether or consciously revisiting its original purpose. The hospital was reconstructed through a collaborative fundraising and planning effort, and when it re-opened in 1912, the institution formerly known as the Cottage Hospital had risen from the ashes as the Princess Christian Mission Hospital.

### **Mrs. Ingham's time and 'work' in the Cottage era**

On January 8, 1891, Josephine Ingham, wife the Bishop of Sierra Leone, wrote a personal letter to Church Missionary Society secretary Mr. Frederick Wigram. She began by recalling a conversation they had had in November 1890 about her "long cherished desire to see a Cottage Hospital in Sierra Leone, where two English ladies would reside as nurses, & try to train African women to follow in their own humane and noble steps."<sup>104</sup> In asking Wigram whether "our society, the C.M.S. would be willing to pay the salary or salaries of one or two lady nurses," she stressed her desire "to have the Head of the Hospital a fully qualified nurse, as she would have to teach others." Any candidates would also need to possess "tact and patience," as "the whole success of the plan would depend on those first sent out."<sup>105</sup> Ingham had been considering her plan for quite some time and had consulted Florence Nightingale herself, the foremost authority in the field of professional nursing, for advice before approaching the Society for funds.<sup>106</sup> While

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<sup>104</sup> Josephine Ingham to Frederick Wigram, Jan. 8 1891

<sup>105</sup> Ibid, emphasis in original

<sup>106</sup> Mrs. Ingham wrote a letter to Nightingale received October 31, 1891 asking for advice on the training of "educated African women" at the Princess Christian Cottage Hospital. No evidence of a reply exists. Lynn McDonald, *Florence Nightingale: Extending Nursing: Collected Works of Florence Nightingale* (Wilfrid Laurier Univ. Press, 2011), 573.

we do not have access to the content of this correspondence, Nightingale's writings from this time period suggest that she was reflecting on the profession at a pivotal moment when a British public were still debating whether nurses were more aligned with physicians, health, and cleanliness or with the Dickensian caricature of nurses in the form of the elderly, alcoholic, bumbling midwife Sairey Gamp.

Aside from the potential evangelistic benefit the Hospital would bring, Ingham provided Wigram with two additional reasons to consider her plea. One was that the head of Sierra Leone's medical department, Colonial Surgeon Dr. Ross, had promised to support the venture. The other concerned a growing number of educated but unemployed (and unmarried) graduates of the CMS-funded Annie Walsh boarding school for girls. "It has long seemed to me" she wrote, "that if only this can be carried out the problem What to do with our young women as they emerge from the 'Annie Walsh' would be solved!"<sup>107</sup> Unfortunately for Ingham, while Wigram himself might have agreed, the CMS Finance Committee in London did not. Wigram – a friend of Mrs. Ingham and her husband, the Bishop of Sierra Leone – presented Ingham's letter at a Committee meeting in March of 1891. The Committee denied her petition, claiming it "did not provide funding for nurse's salaries."<sup>108</sup>

Undaunted, Ingham sought – and eventually obtained – funds elsewhere, but not without controversy. Some Freetown residents were not convinced the city needed a "cottage hospital," asking: "where was the need for such a Hospital in Sierra Leone when there was another supported by Government?"<sup>109</sup> An 1893 issue of *The Gleaner*, a periodical detailing the activities of CMS missions throughout the British Empire, was exemplary of the tensions inherent in

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<sup>107</sup> Josephine Ingham to Frederick Wigram Jan 8, 1891

<sup>108</sup> General Touch, Finance Commission meeting minutes, March 1891

<sup>109</sup> *Sierra Leone Times*, July 11, 1891



missionary medicine in Freetown. The anonymous writer (likely the Bishop) foregrounded the Hospital's chief purpose to train educated African young women as nurses. This was the hospital's purpose as Mrs. Ingham had imagined it, but the author followed this with the articulation of a new justification. Stressing its status as the first and only medical mission in the Diocese of Sierra Leone, the author argued that the Hospital would provide an opportunity "to reach those spiritually, both Mohammedan and Heathen, who in no other way come under our influence."<sup>110</sup> The author noted that before any patient was seen, before any medication was dispensed, a church service was held including a prayers, sermon, and hymns played on the harmonium by one of the nursing Sisters: apparently, even patients who had been discharged home sometimes returned and attended these services. This newly-articulated function of the Hospital augmented the relatively thin justification previously offered for its existence (the transformation of Annie Walsh School graduates into trained nurses). The unique evangelizing potential of a medical mission, and the role of the nurse in that work, offset the fact that after a year of effort and expense, the goal of training African ladies had not been met.

However noble Ingham's aim had been, the text tells us that all was not quite going to plan, as an author contributing to the same issue of *The Gleaner* timidly noted: "we are not yet quite satisfied that the good training, which our English Sisters can give, is fully understood by the most educated of our women."<sup>111</sup> The author expressed confidence that in time "more young ladies will wish to take advantage of the facilities offered" but acknowledged that while 1892 had started out with three nursing probationers (students) in residence, only two remained at year's end. The year-end report of Sister Dorothy, hospital matron, echoed this general

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<sup>110</sup> *Church Missionary Society Gleaner*, March 1893, p. 6

<sup>111</sup> *Ibid.* In addition to the practical training the probationers were likely receiving on the wards, the *Gleaner* reported that the Matron gave a course of 12 lectures in Nursing during 1893 – to whom was unclear, but the Hospital collected the lecture fees.

assessment. While acknowledging that the two remaining probationers had made some progress, she held out hope that "the better educated African ladies will be induced to take up this work, as the Art of Nursing is one which requires a considerable amount of intelligence, and we feel it is a drawback to our present Probationers that they were not better educated."<sup>112</sup> It is worth noting that the drawback here was to the *probationers*, not to the hospital's efforts. Moreover, the Sister suggested that the hospital and the Society claim the 'young ladies' in question as their own while admitting, in the same breath, that the Mission had failed to adequately educate them.

Anticipating another criticism, Sister Dorothy acknowledged that while the Hospital was generally intended to serve the poor (though a separate ward had been built for paying patients), occasionally those who could afford to pay accidentally received medicine and advice for free. Reassuring "any of our keen critics... a constant 'weeding out' process is going on" she wrote "nearly every week some applicants are turned away as unfit to receive benefit from us, and amongst many of these, a bitterness has been shewn which is painful and unfortunate"<sup>113</sup> Thus a third strand of argument was woven in to the narrative supporting the Cottage Hospital's existence: its first and foremost purpose was training African ladies, but it would also serve to evangelize the heathen and administer charity care to only the *deserving* poor.

The preemptive strikes proved unnecessary upon publication of the first official report on the hospital in July of 1893. In a previous article, *The Gleaner* reported that when the first two nurses set up shop in 1892 they treated "a few" who attended the hospital; by September, when a Dr. Battersby stopped for two weeks while on his way back to England, "crowds" of patients patronized the new Hospital, and it was only "with difficulty that their number could be

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<sup>112</sup> Ibid. Dr. William Renner would say essentially the same thing 20 years later, indicating that the local perception of nurses and nursing had not yet become more attractive to the elusive educated Creole ladies.

<sup>113</sup> *The Gleaner*, 1893, p. 7

reduced."<sup>114</sup> Mrs. Ingham and her supporters had underestimated the extent to which the Hospital would be embraced by Freetonians in the East Ward of the city. The Hospital's Medical Officer Dr. A.C. Jackson reported treating 21 outpatients in August and 261 in September.<sup>115</sup> As people flocked to the new Hospital, the city rallied to the cause, and local sentiment changed dramatically after the hospital opened. *The Sierra Leone Times* published a lengthy appeal for community support:

This institution is a public one and to be kept up at all *must be supported freely and voluntarily by the public*. There is, can, and should be no government grant-in-aid or vote from the Church Missionary Society or its maintenance and if it is to be maintained it will have to be by ourselves, by all ranks of the community, by the rich man's guineas, the poor man's pence, the widow's mite.<sup>116</sup>

An attached list of subscriptions and donated goods suggested the voluntary aspect of Hospital was well supported in Sierra Leone and abroad. Over £480 as well as items for a sale of work, including dolls, parcels of cloth for bandages, and Bibles and tracts to keep on the wards flowed in from near and far.

Mrs. Ingham originally sought funds only to employ two British nurses to train educated African women. She did not seek to employ a physician. The *Gleaner's* March 1893 article suggested this was a deliberate omission, since "originally, it was by no means our intention to have the entire services of a Medical Man. Local Medical help was sought, but we failed to secure the kind of offices of local Superintendence, as we could not agree to the terms required."<sup>117</sup> It was not until the Chair of the Board of Management made a personal campaign

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<sup>114</sup> *Church Missionary Society Gleaner*, March 1893, p. 7

<sup>115</sup> "Medical Officer's Report," June 1, 1893

<sup>116</sup> *Sierra Leone Times*, Nov 12, 1892, p. 2

<sup>117</sup> *Church Missionary Society Gleaner*, March 1893, pg. 7

throughout London that the Society provided funds to support a full time physician. The nurses' salaries continued to be supplied by donations or, in some cases, by the nurses forgoing payment in favor of volunteering services.<sup>118</sup>

The first official *Annual Report* of the Cottage Hospital made social and institutional hierarchy clear in textual form, listing staff in descending order: first the Bishop, then the matron, staff sister and probationers. True to Josephine Ingham's original goal the purpose of the hospital – re-written in the first sentence in the *Report* – remained training educated African ladies in nursing. Thus while the missionary service was highlighted in an epigraph from the Bible's book of Galatians, "By love serve one another," the hierarchical imaginary of who was doing the loving and who was doing the serving was clear.

The narrative account provided by the *Report* also foregrounded the importance of strict order. Patients were seen only Mondays, Wednesdays, and Fridays from 7-10 am, and were required to provide a letter of recommendation. It is not clear what criteria the hospital administration used to determine who might be deemed worthy of providing such a letter, but securing one would have required the patient to have a favorable relationship with a literate, respectable resident of the city. During its first year the Hospital had two wards: one for African and European missionaries, who were charged a fee of £1 1s, and the other a free ward for women and children only. Visitors to the free ward were permitted only on Tuesdays and Fridays from 4 – 5:30 p.m.; the Report made no mention of a similar restriction for paying patients. These factors provide evidence that class and gender were both key factors mediating and ordering access to medical care and regulating space in the hospital's first year of existence.

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<sup>118</sup> The tradition of volunteer nurses working without pay was first documented in Freetown in 1886 and carries on to this day.

In addition to these regulations, all patients were expected to follow a set of rules. No inpatient was allowed to leave the Hospital without the doctor's consent. Family and friends were prohibited from bringing patients food from outside without consent of nursing sister in charge of the ward, no smoking was permitted on the wards, and visitors were prohibited from providing patients with "stimulants" (likely Kola nuts). The rules provide us with a sense of what sorts of obstacles to order hospital staff expected -- or perhaps did -- encounter, as well as the way Africans may have sought to interact with loved ones at the hospital. The rules secured and regulated flows of people and substances, establishing a boundary between inside and outside and setting a precedent for the hospital as a regulated space whose administrators selectively blocked or permitted passage.

There were also rules for the 'educated ladies' (only those between the ages of 18-25) who wished to train as probationers. The documentation required to begin training was modeled on that which British nurses wishing to serve in the mission field would have had to provide: a recommendation from the pastor of their church, a form – "to be had on application to Sister Dorothy, the Matron" – which included written permission of the girl's parents, should they be living, and a Doctor's certificate indicating that they were healthy and "free from organic disease."<sup>119</sup> The 'ladies' were required to provide their own 'suitable' clothing – here described only as "print dresses" – for the first year of training, with a uniform and £5 provided upon satisfactory completion of a year's training; the Hospital provided caps and aprons, housing, and a £5 raise in salary for the second year of training. First year trainees were thus clearly

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<sup>119</sup> "Conditions upon which probationers shall be received," *First Annual Report of the Princess Christian Cottage Hospital* July 1893, p. 4

identifiable by their print dresses, which would be in direct contrast to the sisters' whites, but would also serve to visually set them apart from the African patient population.

While the hospital treated all manner of patients, the emphasis on successfully ministering to children began within the first years. Echoing the *Gleaner*, the *Report* spoke of successfully gaining Christian influence over inpatients, especially Muslim children. Sister Dorothy wrote that “the week spent in the Hospital have been a very bright spot in their sad, loveless lives...when they first come into the Ward it was hard to get a word or smile from them, but before many days they were quite at home, enjoying their toys and picture books, and then, as the time approaches for them to leave, we hear continually 'Sister, I no want go home.'”<sup>120</sup> An outpatient department, which began taking patients later in the year, reported that a large number of those attending for outpatient services continued to attend church services at the Hospital, and Bible classes in nearby Cline Town.

Dr. Jackson, the resident Medical Officer, provided a favorable assessment of the Hospital's first year from his house on Fourah Bay Road, adjacent the hospital grounds. Preceding his statistical report with a brief narrative, he praised not only the Matron and Sister but also the 'Native Nurses,' whose "aptitude and interest" he had closely observed during his tenure, reporting confidence that "in time, and that, at no distant date, *really efficient Nurses will be trained, and then the object of the Institution will be realized.*"<sup>121</sup> Jackson's report shows an exponential uptake of outpatient Hospital services: from 261 in September, 1892 to 2439 in May, 1893. With 47 full admissions during the same time period, 29 Christian, 10 Muslim, and 11

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<sup>120</sup> Sister Dorothy, “Matron’s Report,” *First Annual Report of the Princess Christian Cottage Hospital*, July 1893, p. 9

<sup>121</sup> “Medical Officer’s Report,” Princess Christian Cottage Hospital, June 1, 1893

"Other Religious Bodies" there were only two deaths, providing evidence that the hospital was gaining a deserved reputation for successful healing among a diverse population of city residents.

Perhaps most striking of all accounts provided that first year was the financial report, which indicated that the Hospital was not only financially solvent but profitable. The balance sheet as from June 1893 showed receipts from donations, subscriptions, hospital fees, special offertories and the like in the amount of £630, while expenses totaled only £435. The emphasis on promoting "this branch of the Great Physician's work" among the suffering poor who were almost half comprised of non-Christians and thus targets for evangelism, emerged as the most important (or perhaps most defensible) justification for the existence of the Hospital. By the end of the *Report* the stated goal, the "**one** aim of the Doctors, Sisters, Nurses, and all those engaged in the Hospital" was no longer simply training African ladies in the art of nursing but "the alleviation of suffering, and soothing those in sorrow of mind or body, to the glory of God."<sup>122</sup> This internally conflicted account of the Cottage Hospital's mission and attempts to resolve narrative conflicts and possible misrepresentations within the text suggests that tension and uncertainty were fundamental elements of the hospital.

Hospital statistics showed steady increase in new patients attending the outpatient department the following year: between 150-200 each month during 1894-5 with a total of 124 admissions to the hospital, a considerable increase from the previous report. With the exception of June 1894, each month in which a death was recorded was also a month in which an operation was conducted. Muslims made up the majority of the new admissions. While the records suggest these patients were not interested in learning to speak English, they appeared to enjoy singing the hymns. A nurse named Sister Ward wrote of two girls "singing quite correctly" the words of "If I

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<sup>122</sup> *First Annual Report of the Princess Christian Cottage Hospital*, July 1893, p. 8, emphasis added

come to Jesus" and teaching them to another inpatient, a Muslim.<sup>123</sup> Those who were treated successfully and recovered generally attended services in the ward. Bible classes, one for girls and one for boys, were led by the African or "Native" nurses each Sunday, while the British Sisters led the church services. In this sense Africans were aligned with children while the British Sisters were aligned with God.

Mrs. Ingham, whose health necessitated her staying on an extended holiday in England in 1894, nonetheless gathered over 70 volunteers to serve as a "band of workers" to generate goods to sell to raise funds for the hospital. The Matron noted that at the 1894 sale there had been a "much larger amount of work and fancy articles for sale which generated a much larger amount of money."<sup>124</sup> Sales of work combined articles contributed from workers abroad with a local "Ladies Working Party" of African women implementing the sale itself. Together, these transnational efforts contributed to a prosperous first decade.

### **Crisis at the Cottage Hospital**

In early 1908 the Bishop of Sierra Leone reported that Dr. Mayhew, who had been serving as Attending Physician at the Cottage Hospital for three years, would shortly be released from contract and that "while he had done good work professionally he had not been entirely satisfactory in his relations with the sisters of the Hospital, being inclined to be somewhat rough in manner," and worse: "from the point of view of medical missionary work he had been of but little service."<sup>125</sup> But on March 26, 1909, a cable arrived in London from Freetown: "Hospital burnt out: no one hurt."<sup>126</sup> The Sierra Leone Diocesan Association, the body responsible for the

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<sup>123</sup> Hon. Matron's Report, p. 13

<sup>124</sup> E.G. Ingham, *1894-95 Annual Report of the Princess Christian Cottage Hospital*, p. 10

<sup>125</sup> Sierra Leone Diocesan Association (SLDA) meeting minutes

<sup>126</sup> SLDA minutes



administration of Hospital affairs, hastily called Mayhew - who was in London on leave - to provide testimony about the state of affairs at the Cottage Hospital prior to the fire. His testimony, drawing a picture of success in clinical matters, nurse's training, and evangelism, proved critical to the future of the Hospital.

First, Mayhew reported that "there had been more than 100 operations at the Hospital the past year" and that "the natives came most willingly to submit to whatever treatment was prescribed." The almost exclusively Muslim area on the eastern edge of Freetown, Fula Town, was immediately adjacent to the area occupied by the Bishop's compound where the hospital had been built. Mayhew reported that this population was still settling in large numbers in the neighborhood of the Hospital. Thus the settlement patterns begun in the 18<sup>th</sup> century had continued in spite of the presence of a Christian mission. Not only was the Hospital within a stone's throw of one of West Africa's biggest sea ports, its coastal site was breezy and north-facing, cool and conducive to the healing atmosphere of the ocean, and situated at the gateway on the road connecting one of Freetown's poorest areas of with the trading center of town, the seat of government, and the social elites in the city. The Cottage Hospital was strategically positioned for evangelical success.

Mayhew also reported that "the effect of PCCH on Colonial Government had been most considerable. The government now had 5 or 6 English Lady nurses as a direct result of the success of the PCH ladies."<sup>127</sup> This development suggests that during their terms of voluntary service to the Hospital, Colonial physicians Prout and Renner had appreciated the assistance of these 'trained Ladies' and embraced the notion that African ladies could also be so trained. Prout tied his observations to infant mortality and Renner to maternal and infant health, but for both,

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<sup>127</sup> SLDA minutes

the presence of the English lady nurse was the key factor without which the whole enterprise would collapse. Thus Josephine Ingham's original conception of the hospital as a nurse-training mission (in which no medical man was originally required) had been embraced by the colonial government.

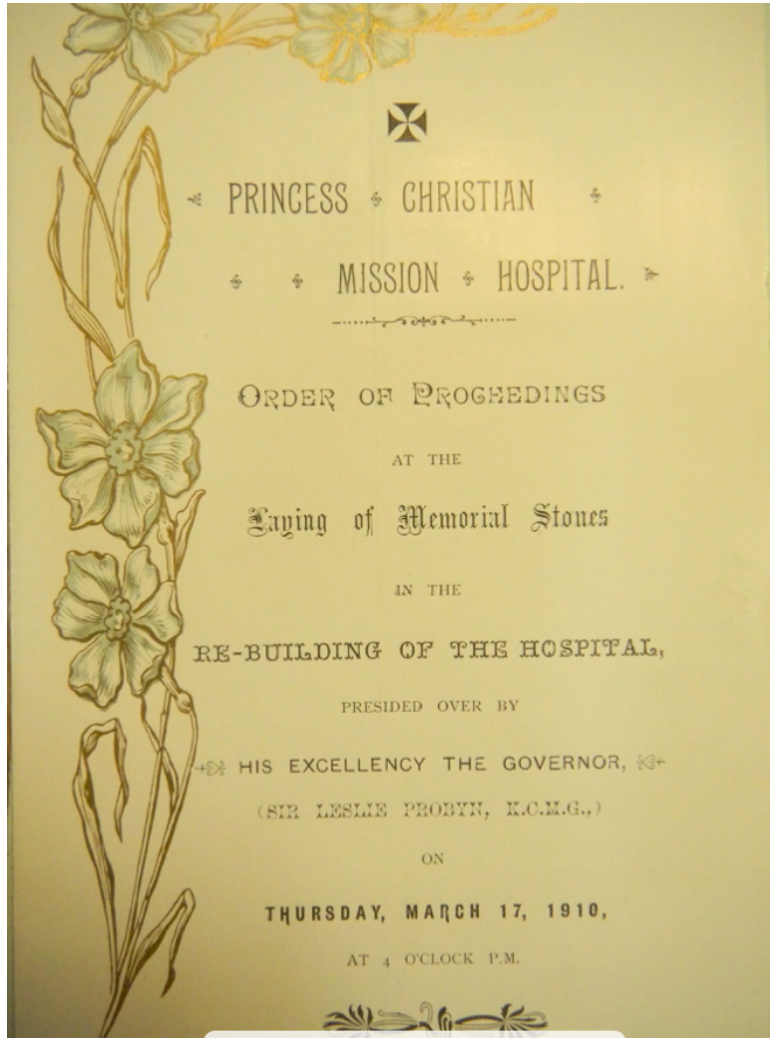
Mayhew's testimony of a medical mission in the midst of Freetown's 'heathen,' emulated by the colonial government, thriving in its work of operating on African bodies and (given the reports of the nurses and sisters) souls, gained the full, if temporary, support of the Church Missionary Society.<sup>128</sup> The chair of the meeting commended Dr. Mayhew, stating that "as Doctor he was ...most successful and that any misunderstanding between him and the sisters was entirely removed." Indeed, "the utmost good feeling prevailed throughout the staff whose cooperation was cordial and effective."<sup>129</sup> The personal connection underscoring character testimony seemed to be key: Canon Smith bore witness to Mayhew's character, noting his "general good influence...on the Christian side." Thus following the fire, the previous concern over the doctor's suitability to lead the hospital, evangelize the heathen, and get along with the sisters was subsumed under the need for a doctor to supervise what would likely be an arduous process of rebuilding. The Council actively forgot any previous tension and sanctioned the doctor's return, noting that they "appreciated his services highly and were greatly satisfied that he was ready to return to Sierra Leone when wanted."<sup>130</sup> This episode provides us with evidence that the ideal of harmonious clinical relationships was essential to the proper function of the Hospital – even if such harmony necessitated the revision of history.

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<sup>128</sup> The Society had resolutely refused to fund the missionary hospital endeavor and once the rebuilding project was complete it withdrew financial support; funding and administration of the voluntary institution was the sole responsibility of the Bishop until the State took over.

<sup>129</sup> SLDA Minutes

<sup>130</sup> Ibid.



*Figure 5: pamphlet announcing the stone-laying ceremony at the Hospital*

### **Sister Mary Ward, ambivalent missionary**

Nurse Mary Alice Ward had answered the call to serve at the hospital in Sierra Leone almost as soon as it went out. Having received her training at Tottenham with ringing endorsements from both professional and clerical colleagues, she played a key role in shaping clinical practice at the Cottage Hospital even before it was fully operational. Though she answered other calls through the years, travelling to the Gold Coast to assist during the Ashanti Uprising, she always made her way back to Freetown and to the hospital. Sister Ward's letters provide an intimate illustration of the ambivalence inherent in Church Missionary Society work

in Sierra Leone – a desire to soothe and save coupled with an often unacknowledged disdain for the subject in need of salvation.

Ward struggled to reconcile herself with the fact that she would be serving under a Creole doctor (Dr. A.C. Jackson) even before the Hospital began treating patients. Writing to her sister in the weeks prior to the new doctor's arrival, she lamented the fact that "He I am a little bit sorry to say is not an Englishman[,] he is of African American and German descent."<sup>131</sup> Yet she was quick to list both his British qualifications and the particular advantages of his African heritage. Explaining: "he was assistant surgeon at Guy's for some time also spent time at the Coast," Ward imagined the doctor's racial and social proximity to his African patients as a potential source of strength, suggesting "He will be better than an Englishman because he will be able to stand the climate. Also has some experience in native medicines which is very necessary as the people here have some very strong poisons which they give in cases of quarrelling or jealousy and the English Doctors can do nothing for them."<sup>132</sup>

Eventually, it seems Ward grew to trust the doctor's ability to treat not only African heathens but even European missionaries. In one letter she recounted the time a missionary named Mr. Alvarez had written her from the Fourah Bay College in Freetown, saying he was terribly ill with fever and had no one to care for him. Ward traveled there herself and found only "the native boys who were quite useless in illness."<sup>133</sup> She nursed him there for a while herself and then was able to get the doctor, who she only parenthetically noted was an African, to pay a visit and advise that Mr. Alvarez be taken to hospital. For Mary Ward, whose direct influence

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<sup>131</sup> Ward to Florence, Jan. 1891, p. 1

<sup>132</sup> Ibid., p. 2

<sup>133</sup> Ward to Florence, August, 1892

would stretch at least into the middle of the 20<sup>th</sup> century, it seemed that proper, successful clinical practice could offset essential African-ness to some extent.

Ward's correspondence suggests that the contradictions inherent in her position as both missionary and nurse trainer were influenced by her notions of gender propriety. On one hand, her correspondence provides evidence that she tried to understand the concerns of working men. She discussed the problems raised by a lack of copper and silver coinage in Freetown with a surprising open-mindedness. Businesses owners had resorted to paying African workers in stamps rather than coin, and the "natives" had taken their protest to the governor. She described soldiers and carriers returning from the war who were paid sums of more than £20, but since they could do little with it upon returning home ("going 'upcountry'") they had either melted it into jewelry for their womenfolk or buried it. Rather than react with shock, she was more pragmatic, writing: "I can't blame them exactly."<sup>134</sup>

Elsewhere she showed a glimmer of affection for "one little imp of a girl Florence by name [who] thought if a person took food before an operation they were bound to die so she managed to get some food on the quiet just before she was to have an operation thinking we should never be cruel enough to risk her death but we were strong hearted and hauled her off regardless of her cries 'I have done chop and I shall die oh!'"<sup>135</sup> She seemed fond of children but her perspectives on adult women, and nurse probationers in particular, were more circumspect. Expressing frustration, she wrote of "one of our brilliant nurses who has been with us nearly two

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<sup>134</sup> Ward to Florence, undated

<sup>135</sup> Ward to Florence, March 20, 1920

years made the tea in a hot water jug regardless of three tea pots that were staring her in the face[.] they seem to forget a thing as soon as they learn it."<sup>136</sup>

Ward's ambivalence towards Africans extended to social interactions outside of the clinical context. In another letter to her sister, she wrote of her desire "to visit with the Africans more but there seemed so little time. So often the Bishop has something on that he wants help for and our nurses are so busy it is difficult to see much of them. One seems able to get so little in touch with the Africans themselves, that is what I am keen to do."<sup>137</sup> We do not know, however, if it was the heathen Africans she wished to "touch" or those of the better social classes, the Creole ladies the mission targeted in its recruiting efforts. In a letter Ward herself retrospectively annotated as 'date 1919 or 20' she wrote of

The Florence Ward...a small room we had to spare so I turned it into a private ward for Africans I furnished it myself nicely and it was much appreciated. I called it after my sister. Mrs. Renner [the doctor's wife] was the first to use it. She lived with us I think we charged 30/ a week. Dr. Wright's old grandmother was another patient. We had several very interesting cases more from social than medical interest.<sup>138</sup>

Later correspondence notes that "Mrs. Renner stayed a fortnight in the FW and she so enjoyed being there and was so grateful I foresee that will be very popular."<sup>139</sup> In this letter she first described Mrs. Renner as a European lady but then crossed it out and wrote African. Ward's retroactive re-categorization suggests that the racial and social hierarchy imagined in the Hospital's self-conscious representation in the *Annual Reports* was more stable than the realities of social intermingling that had characterized Freetown for a century.

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<sup>136</sup> Ibid.

<sup>137</sup> Ward to Florence, January, 1920

<sup>138</sup> Ward to unknown, undated

<sup>139</sup> Ward to unknown, 1920

Persistent difficulty in obtaining and keeping probationers in the early days of the Cottage Hospital meant that Sister Ward often found herself caught between ideals and reality. Ward deemed a Probationer named Violet "hopeless as a nurse" and dismissed her. But while she had intended to replace her with a "very intelligent girl...a mulatto...she did not come nor send any word as to why she was not doing so."<sup>140</sup> To make matters worse, on the Saturday before the annual Sale of Work in 1895, a major event which required all hands on deck a probationer named Patience who had just completed her first year of training and told Ward she wished to stay on for a second suddenly resigned. Though there was one sister on staff, a Miss Jackson, whom Patience didn't get along with, Ward wrote that she and her British colleague Sister Everard:

Were very fond of the girl...she was the only one we have had who really likes to do anything for us personally, a wayward, affectionate, undisciplined girl, much quicker and with much more character than our other nurses. I was very sorry and told her she must not act in a hurry and also must give us some notice but that afternoon she went out and did not come back again. It was the end of the month and I had just paid her up, she had told the other nurses and sent for her belongings.<sup>141</sup>

Despite her disappointment and the evident frustration in the loss and the downpour that threatened the Sale, Ward felt that the sale would be a success "for there was such a nice spirit among the Native ladies" which she attributed in part to the hospital's Florence Ward. And indeed, by all accounts the sale was a rousing success: an extraordinary and spectacular Victorian fundraising shindig, representing perhaps the pinnacle of the era of cooperative relationships between Freetown's different classes of women. The records of the 1895 event described a veritable carnival. Creole and British women alike sold tickets, refreshments,

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<sup>140</sup> Ward to Florence, May, 5 1895

<sup>141</sup> Ibid.

clothing, "fancy goods," dolls, and books. There was a shilling stall, a sixpenny stall, a swing, a fish pond, and a total of £81 raised collectively for the benefit of the worthy and noble Hospital endeavor which met so many needs.

Unfortunately, one thing went terribly wrong. The cards for pre-ordering tea – a commodity in very short supply – were sent to the British ladies in attendance first and only then to the African ladies, after the British ladies had made their selections. While her correspondence does not make it clear who was to blame for this possible oversight, Ward overheard a conversation between "two very irate ladies, old helpers, saying 'there was never this distinction in Mrs. Ingham's time between white and black.'"<sup>142</sup> In an effort to smooth things over, Ward planned a separate tea for the African workers the following week at Bishop's Court where they could peruse items left over from the sale to buy at a discount. While the archival record does not include further insight into how this insult was perceived, the thoughts of those the "old helpers," who remembered "Mrs. Ingham's time" as one in which such "distinction" would not have been tolerated, suggests that the "nice spirit among the Native ladies" may have been short lived.

### **An uncertain state of things**

On the other side of Freetown at the Colonial Hospital, young patients were not faring as well. The colonial officer in charge, Chief Sanitary Inspector Dr. William Prout, wrote an 1897 *Report on the City of Freetown* that suggested a frustrated man searching for the a language strong enough to relay a wretched situation. He calculated what he called "infantile mortality" in the city at a rate of 400.8/1000, with an additional 37 unregistered stillbirths. Classifying the causes of infant deaths "as far as possible" under the headings fever, debility, starvation,

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<sup>142</sup> Ward to Florence, June 1895



exhaustion, nervous system, alimentary system, pulmonary system, premature birth, natural causes, and miscellaneous, he himself mocked the uselessness of these categories in accurately characterizing the cause of death. Perhaps they were useless to his purposes but when we consider the argument they present for the etiology of morbidity and mortality, the associated symptoms, and the imagined curative or preventative measures they suggest they provide much insight into the perceived relationship between social and environmental factors and the development of the concept of infant mortality beginning in 19<sup>th</sup> century Freetown.

While he wrote with authority and passion, he himself acknowledged the speculative nature of his data. In his capacity as Sanitary Inspector, Prout had commissioned a "house to house visitation of the whole town...to ascertain the manner in which excreta were disposed of in each case, the number of a house or yard using a closet and other details."<sup>143</sup> Unsurprisingly, Prout reported the problems with getting accurate figures because "the appearance of a Sanitary Policeman in the yard seemed to have a peculiar subversive effect on an individual's moral nature...I have frequently met with people who were quite incapable of remembering their own names."<sup>144</sup> Such early, invasive and frightening activities, would have populated the memories of the first generations of Freetown and informed their notion of colonial medicine and hospital work.<sup>145</sup>

Through the means by which the statistics were generated and the ways in which he analyzed them, Prout's *Report* provides a window into a period of tremendous uncertainty in obstetric practice and the precarity of maternal and infant lives in late 19<sup>th</sup> century Freetown.

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<sup>143</sup> *Annual Report of the Medical and Sanitary Department*, 1897, p. 9

<sup>144</sup> *Ibid.*, p. 10

<sup>145</sup> For more on Prout and his policies see Festus Cole, "Sanitation, Disease and Public Health in Sierra Leone, West Africa, 1895–1922: Case Failure of British Colonial Health Policy," *The Journal of Imperial and Commonwealth History* 43, no. 2 (December 10, 2014): 238–66, doi:10.1080/03086534.2014.974901.

Although most infantile convulsions are caused by fever, Prout categorized 'diseases of the nervous system' as 'convulsions,' which he attributed to improper feeding (a category which overlapped with diseases of the with alimentary system). 'Diseases of the pulmonary system' (bronchitis, etc.) he attributed to "exposure and improper clothing" which, in a country where the temperature ranges between 75-100 degrees Fahrenheit year round, provides evidence that Prout was still working within a climate-based theory of disease causation. Drawing attention to the 70 deaths he categorized under 'natural causes and exhaustion,' he railed: "'natural causes' conveys nothing, it simply means that the individual registering the death was unable to account for it."<sup>146</sup> While he reported an additional 70 deaths from fever, Prout argued that by combining the categories of fever and exhaustion (as those collecting statistics had done) "the inference was obvious, that these deaths must in some way be connected with the process of labour."<sup>147</sup> The vast majority of 'infantile' deaths (a total of 56) took place in the first week of life. Prout estimated 16 of these took place within the first 24 hours, claiming "there can be no doubt that they were due to the prolongation and mismanagement of labour."<sup>148</sup> We must ponder the circumstances leading Prout to attribute death from what was most likely malarial fever "to the practicing of unqualified individuals, druggists and others, but principally to the general practicing of midwives, whose qualifications for this work are of the flimsiest description, and whose ignorance in the majority of cases is appalling."<sup>149</sup> Prout's use of the phrase "infantile mortality" predates the use of the term in English language publications by several years.<sup>150</sup> Prout had identified a problem and a language to articulate it, but he had no solutions. It would not be

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<sup>146</sup> Annual Report, p.5

<sup>147</sup> Ibid.

<sup>148</sup> Annual Report, p. 7

<sup>149</sup> Annual Report, p.9

<sup>150</sup> A N-GRAM search for Infantile and Infant Mortality substantiates this claim, showing a spike in the interwar years and almost no use of either term in the 1890s.

until many reports later, years after his retirement, and until a war had come and gone, that the health and wellbeing of mothers and babies would move to the center of colonial discourse.

### **Infants: from mortality to welfare**

In one week in 1922, the *Sierra Leone Times* reported 20 deaths in the city of Freetown; nine of these were infants. Death statistics were a weekly feature of the *Times* and they provided evidence of the effects of infant mortality on ordinary Freetonians. Many of the infants were not named, indicating that they had not survived long enough for the naming ceremony. In one week in February, a stillbirth was recorded, the daughter of Mariama who lived on Guard Street. Occasionally the deaths were reported in terms of hours or fractions of hours. One infant, the son of Kerynor Wureh of 31 John Street, was reported to have lived 18 hours 20 minutes.<sup>151</sup> These figures, drawn from the reports of the Clerk of Cemeteries, represented formal internments or funerals. They reflect a notion of personhood more capacious than that offered by the colonial government, one in which Freetonians shifted the boundary of personhood to include those who lived only hours or who never lived outside the womb at all. If we do the math, using an average of 10 “deaths” per week reported in the *Times* multiplied by the 52 weeks in the year, each one tied to a family somewhere in Freetown, we get a more humanized perspective on the figure of 316 infant deaths listed in the 1924 official *Report*. Infant mortality was not only detrimental to the British colonial image of benevolent rule, it was grossly underestimated and likely personally devastating to residents who went to the time and expense of memorializing and interning an infant who had never drawn breath.

The interwar focus in maternal and child health and welfare was likely welcomed by Freetown residents. By mid-1920, maternity work was gaining momentum in the Church

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<sup>151</sup> *Colony and Provincial Reporter*, March 2, 1918

Missionary Society and the Colonial Government. A return of births and deaths was included in the colonial *Labour Report* for the first time in 1926. The archival record exhibits notes penciled into the margins, re-tallied figures, and underlined phrases making the government's interwar concern with population loss clear – the documents bear evidence of having been studied, re-consulted by multiple readers, and carefully analyzed. In 1925 the Medical and Sanitary Department instituted both Infant Welfare Clinics and Health Inspections of school-aged children in the city of Freetown. They began examining the teeth of pregnant women for caries and offering a venereal disease clinic three days a week at Connaught Hospital. The state also began to formally incorporate the Cottage Hospital into its statistical reports during the interwar years. The 1926 *Report* had been the first to feature detailed statistics of the work done there, albeit briefly. Efforts toward incorporation – at least on paper – continued and expanded in 1927. The *Annual Medical and Sanitary Report for the Year 1927* provided evidence of significant changes taking place in colonial medicine in Freetown during the 1920s, and suggested the directions the medical service might take in the future.

In his overview of "Maternity and Child Welfare," the *Report's* chief author Dr. Peacock, Director of Medical and Sanitary Services, combined the statistics on births and maternity attendances at PCMH with those of Connaught Hospital. Both figures appeared under the section heading "Maternity and Child Welfare," along with the general statistics for the year and summaries of the work in other major branches such as "Port Health Work." This collusion not only increased the sheer numbers of live births the government could claim as its own success, but also justified the "substantial grant-in-aid" it provided annually to the Hospital.<sup>152</sup>

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<sup>152</sup> In 1930 this grant was £460, compared to the £81 raised by the 1895 sale of work – a substantial sum even accounting for inflation.

Additionally, Peacock included the statistics but placed them separately within the sentence – the figures were not totaled, but given as "177 labour cases in the maternity ward of Connaught Hospital and seventy-eight at the PCMH."<sup>153</sup> This mode of delivering data would seem to establish comparison between the institutions at the same time details about the latter became a regular part of the Reports, with Connaught Hospital and the Colonial Government coming out in the lead. One would need to read much further into the appendices to learn that PCMH maternity ward admitted 520 patients to Connaught's 301, but the successful work of PCMH had, in one year, become significant enough – either to the Government of Sierra Leone or to the Report's audience – to garner multiple pages in the official state record.

The Report also bore traces of an interwar change of emphasis at the staff level. The Principal Medical Officer had been replaced by a Director of Medical and Sanitary Service; more significantly, there was a now Lady Medical Officer and the number of African (no longer "Native" but still clearly marked and subordinate) Medical Officers had increased to eight. Echoing a trend towards "district" or home-based care growing in British nursing at this time there were also now three Health Visitors – an increase over the two of the previous year. Thus overall the city's interwar medical service was more socially diverse than it had been in the previous two decades.

Appendix D, "Infant Welfare," provided a substantial amount detailed information about Freetown maternity work.<sup>154</sup> One notable change was the appearance of the Appendix itself. Whereas the physicians in charge of maternity work focused on accounting for and explaining maternal deaths, here the emphasis had dramatically shifted to saving babies, with two separate

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<sup>153</sup> A. Peacock, "Maternity and Child Welfare," in *The Annual Medical and Sanitary Report for the Year 1927*.

<sup>154</sup> "Infant Welfare," Appendix D in *The Annual Medical and Sanitary Report for the Year 1927*.

appendices and almost six full pages of text and statistics devoted to the matter. Other changes included the commencing of a regular antenatal clinic, the new presence of several district nurses (a term also used at this time in Britain for nurses who extended the sphere of hospital work into patients' homes after discharge), a further attempt to account for the ethnic identification of parturients listed as Creoles, Aborigines, Kroom, and Other, and a Mothercraft and Baby Competition held alongside Health Week just prior to Christmas.<sup>155</sup> PCMH was included in Appendix D, with missionary and colonial statistics and detailed accounts of work presented side by side: first the work of Connaught Hospital and the house at 99 Campbell Street (run by the male Dr. Wright), and then – under the subheading "Report on Infant Welfare in East Ward Freetown" – work conducted in and around PCMH.<sup>156</sup> The latter was written by the new Lady Medical Officer, Dr. Blacklock who was on a government salary but balanced her time between regular practice at PCMH and her duties as Inspector of Schools. These changes in format and staffing provide further evidence for the government's tenuous incorporation of the Missionary endeavor, and the formal alignment of missionary and government interwar agendas around "welfare."

### **A Lady Officer's success**

In 1926 a British missionary named Dora Earchy, reporting on a visit to Princess Christian Hospital, took pains to explicate the fact that it was *not* a Church Missionary Society-funded hospital but "a kindred piece of work for which the C.M.S. has very fraternal feelings."<sup>157</sup> Visiting West Africa under the auspices of the charity Save the Children, she spent time at the

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<sup>155</sup> The timing was clearly a strategic means of increasing participation. The weeks before the winter holidays were considered the festive season, when the poor would be more likely to benefit from a spirit of charity amongst the wealthy. The Competition would have been an additional means of generating income: over £25 in prize money was distributed among the winners.

<sup>156</sup> The government rented the basement of this private residence for this purpose.

<sup>157</sup> Church Missionary Society scrapbook of medical work, CMS archives, Birmingham, UK

Infant Welfare Clinic and delivered "addresses" to audiences at the Annie Walsh School, the teacher's college and the Kroo church run by the CMS. While her report provided us no information about Ms. Earthy's qualifications, she was apparently sufficiently qualified to give 'little talks' to the African nurses at PCMH.

Her report provides us with an idea of the daily activities at the Infant Welfare Clinics: Miss Macauley, the Health Visitor, weighed the babies who were then examined by the physician and Matron and moved on to the dispensary if medications had been prescribed.<sup>158</sup> A nurse recorded the name and address of each mother in a ledger book and another collected a penny for providing the mother with an infant welfare card. The card was used for recordkeeping, assuring mothers collected the free medicines from the dispensary only once. The Hospital also held what Earthy called "King Baby" competitions, which we will examine in further detail below.

Women from Freetown and beyond participated in Infant Welfare clinics in steadily increasing numbers. At PCMH, clinics were strategically held on Thursday, a market day, and so would also have been trade opportunity for women from outlying villages. While providing mothers a temporary respite from endless daily chores and a chance to socialize with one another and obtain individual medical attention for their infants, women also obtained paper certificates to prove their presence. This was a likely factor in promoting attendance, as both a birth certificate and a minimum number of six recorded Welfare visits were required as prerequisites for entering the Mothercraft and Baby Contest. Women quickly learned how to capitalize on this new system, as "those most deserving" were sent from each welfare center to Victoria Park in the

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<sup>158</sup> We will learn much more about the appearance of Miss Macauley in chapter four.

center of Freetown, where they were served tea on the afternoon of the judging. Dr. Blacklock noted that clinic attendance spiked accordingly in the weeks preceding the Baby Contest.<sup>159</sup>

Attendance records for 1927 at all clinic locations showed an increase each month, but all three of the *Report's* primary interlocutors noted PCMH to be especially well patronized by the poor Muslim community of the East Ward. The PCMH clinic was also attended by women from outside the Colony proper: 12% of women giving birth there came from the Protectorate (as opposed to 1% at Connaught), and sample attendances from two separate days at the antenatal clinic show almost half of participants were Protectorate residents. The Hospital may also have gained a degree of admiration for the fact that three "motherless infants" (interwar CMS language for orphans) were being raised there by nurses. Dr. Wright reported that of the 244 women who had attended the Connaught clinic the first year of its existence 136 had given birth: 70 in the hospital and 60 at home. In 1929 Dr. Wright recorded 86 hospital births vs. 105 home births. So while uptake in the rhythm of antenatal care and its material rewards quickly caught on, participation in the antenatal clinics had not yet translated into a marked increase in hospital births to the extent the administration might have hoped by the end of the decade. This is evidenced by the fact that the infant mortality rate in Freetown hovered steadily at an average of 370/1000 throughout the 1920s, little changed since William Prout's alarm over the rate of 400.8/1000 in 1897.

While the introduction of a Lady Medical Officer was in itself unprecedented among Government Officers in Sierra Leone, her approach to infant welfare was equally remarkable.<sup>160</sup>

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<sup>159</sup> For more on the problematics of baby judging contests, see Alexandra Stern, *Eugenic Nation: Faults and Frontiers of Better Breeding in Modern America* (University of California Press, 2005).

<sup>160</sup> Although in 1906, out of sheer desperation, the Diocesan Association "owing to the urgency of the need...decided that any application which might be made from a lady doctor might be considered but at the same time strong preference would be given to the appointment of a gentleman." SLDA minutes, April 1906.



As with previous *Reports*, the percentage of neonatal death and infant mortality featured prominently in 1928 and again the fact that almost half of these deaths occurred within the month following birth (and over 66% within the first week) were mobilized as particularly shocking statistics, a "clear indication of the need for more antenatal work and better midwifery, especially amongst the aborigines."<sup>161</sup> Dr. Prout had argued that the high infant and neonatal mortality rates were directly linked to lay midwifery practice amongst the 'natives' and Creoles alike. Dr. Blacklock suggested that while attempts to enroll and train educated, middle class ladies in the nursing profession had met with some success, the "need for more ante-natal work and better midwifery, especially amongst the aborigines" might be met from within those very ranks: "Our next step," she appealed "must be to make an attempt to give some elementary instruction to a selected number of older native women who act as tribal midwives."<sup>162</sup> In a manner similar to that of British colonial midwives in the Sudan who provided clean instruments for clitoridectomy, Blacklock seemed to have accepted the need to reconcile ideal practices with reality.<sup>163</sup> For the first time in the history of the *Report*, a colonial official suggested an approach more comprehensive than providing hospitals and staffing them with well-trained midwives might be necessary to bring infant mortality figures down. And while Prout had suggested training midwives in Freetown to practice "among the masses," he never considered training older, lay midwives in order to meet this goal.<sup>164</sup>

Blacklock took a further step: while citing "the ignorance of untrained midwives" and the "unwillingness" of women in the Protectorate to seek hospital birth, she acknowledged that

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<sup>161</sup> *The Annual Medical and Sanitary Report for the Year 1928*, p. 10

<sup>162</sup> *Ibid.*

<sup>163</sup> Boddy, *Civilizing Women : British Crusades in Colonial Sudan*.

<sup>164</sup> The strategy of providing lay midwives with additional training would return in the latter half of the 20<sup>th</sup> century, but its appearance at this earlier stage, like Prout's stress on Infantile Mortality, was comparatively unusual.

language difference might be a barrier (in terms of women seeking care from those who did not speak their language) and that "in the case of many of the poorer women with one or two children in the house it would appear quite impossible for the mother to leave the home to enter hospital."<sup>165</sup> A subtle capitulation had been granted: in closing her appeal, Blacklock acknowledged that "it was very difficult to change age-old native customs, and much tact, patience and sympathy will be required."<sup>166</sup> This British female medical practitioner had begun to attempt to grasp the attitudes of Freetonians toward hospital childbirth and to exhibit, to some degree, a cultural sensitivity about local birthways.

Those among the medical establishment had cause to listen to what Dr. Blacklock had to say. Writing in 1928, she noted that attendances at the PCMH Infant Welfare Clinic, held only one morning per week, had increased from 1,983 when the clinic first opened in 1925 to 8,012 by 1928. This figure far exceeded attendance at the two Government centers combined, which held clinics on three separate mornings and one afternoon. Moreover, positive words about the care received from the Lady Doctor at the Hospital (who would have seen each case individually, even if only to pronounce the child healthy) had apparently begun to spread beyond the primarily Fula residents of the East ward. Blacklock humbly attributed the sharp rise to "children belonging to Protectorate tribes now resident in Freetown among whom the first clinic was regarded with suspicion."<sup>167</sup> Yet even outside Freetown, news of the lady doctor had traveled.

The Doctor's comments about the clinics, usually held one day per week for four hours, are worth quoting at length:

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<sup>165</sup> *The Annual Medical and Sanitary Report for the Year 1928, p. 11*

<sup>166</sup> *Ibid.*

<sup>167</sup> *Ibid.*

"There was also this year an increase in the number of children coming from country districts, e.g. Colony villages, Bullom district, villages along the Rokelle River, and even from the Songo and Kwia districts.<sup>168</sup> From these districts attendance has naturally been irregular, many of the children being brought originally for injections for yaws; but a certain proportion of mothers bring back their children from time to time. It was indeed surprising the distance a mother will travel on foot or by boat for treatment of a sick child, and at a very early hour in the morning mothers from distant villages will appear at the hospital. Chiefly for these mothers whose idea of time and day of the week was often vague, I arranged with Dr. Beattie that any sick child of welfare age should receive free treatment on any day at hospital and, if necessary, be admitted...One would think the mothers would bring their children as a matter of course if sick; but until it was definitely explained to them many allowed their children to suffer without medical treatment until the next Infant Clinic.<sup>169</sup>

Blacklock had succeeded in achieving the biopolitical goals of the colonial state and her predecessor Dr. William Prout, in a new and successful way. Prior to her intervention, surveillance and provision of care for women and children in the Protectorate was generally left to the few medical officers stationed throughout the countryside. Estimates of infant mortality for some of these areas were as high as 50%.<sup>170</sup> Lacking adequate personnel and facilities, the government had resorted to a *laissez faire* approach since the declaration of the Protectorate in 1896, claiming that such figures, while alarming, were simply unreliable due to the lack of compulsory birth registration in the Protectorate.

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<sup>168</sup> Depending on speed and number of stops most of these areas would have been at least two days' walk from Freetown. The Bullom area alone was 35 miles away and across a wide river.

<sup>169</sup> *The Annual Medical and Sanitary Report for the Year 1928*, p. 11

<sup>170</sup> Dennison/Osment correspondence 1932.

While the spectacular success of yaws injections would have provided for initial contact, it was possible that the care provided by the female staff at PCMH, glimpsed in Blacklock's coordinated rule-bending for the benefit of sick children, kept a growing number of Protectorate women and children coming back to the Colony for treatment and surveillance. Patients presenting for Yaws treatment were virtually equal at Connaught and PCMH: attendance at Infant Welfare clinics was dramatically different. The Doctor's comments regarding mothers waiting until the weekly clinic to bring sick children for treatment (though they may have sought vernacular treatment first) provides some evidence that these women must have had faith in the Hospital medicine. The dramatic growth in attendance at PCMH vs. the Connaught clinic provides evidence that poorer women were beginning to show a distinct preference for the former, while the latter was still primarily treating Creole patients. The trend was not lost on the Director of Medical Services, who later noted that "this institution was popular with the natives and excellent work was being done."<sup>171</sup>

### **'Developing' hospital partnerships**

The government increasingly incorporated PCMH during the interwar years. As the Government continued its struggle to name and know its subjects in the interwar period, another, more striking change in the *Report* occurred: the parsing of populations giving birth in hospital into ever finer ethnic distinctions and sub-groups. The 1927 *Report* explicated and elaborated on differences in social class and ethnicity only euphemistically elsewhere alluded to when speaking of 'the better class.' The author, Dr. Peacock, wrote that "Creoles make full use of all maternity and child welfare facilities," while the "aborigines," availed themselves of antenatal clinics to a "satisfactory" degree but were "still reluctant to enter the hospital for their labours and only

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<sup>171</sup> *The Annual Medical and Sanitary Report for the Year 1933*

come as a last resort when complications occur.” Creoles represented the largest number of colonial hospital attendances, followed by “Kroo” and finally “Aborigine.” Peacock deemed current maternity hospital accommodations adequate for the population of the Colony but disconnected the availability of services from their appeal to Freetonian women. Unlike Dr. Renner, Creole intimately familiar with the vernacular and the modern, or Dr. Stewart, a British specialist with a capacious perception of social factors, Dr. Peacock made no attempt to consider the factors which might have influenced “aborigines” to shun hospital birth. The hospital was the discursively unmarked superior choice.

An examination of reports submitted in 1927 by Dr. Quintin Stewart, the British 'surgical specialist' newly in charge of several wards at Connaught Hospital, suggests that the new generation of colonial agents administering the colonies in the aftermath of World War I were perhaps less willing to assume a fundamental evolutionary inequality between European and African human beings or, at least, that the subject was still open for debate. His actions and words signal this shift. Upon assuming his post, he personally attended ("looked after") the surgical inpatients as a means of *training* extant African staff rather than surveilling them as an assumed indictment of their deficiencies. In his assessment of their skill level, he commented that "the ideas of the nursing staff on modern surgical technique were somewhat vague; to add to the difficulty none of the sisters had had recent surgical experience in England."<sup>172</sup> None of Stewart's predecessors had used the term 'sister' to apply to a non-European. Moreover, his attitude towards Sierra Leonean staff diverged from many of his predecessors in that he did not attribute their suboptimal skill level to a backwardness or racialized, innate character defect. He instead pointed to the lack of opportunity for exposure to the latest techniques which could be

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<sup>172</sup> *Annual Report on the Medical Services, 1927*

had working in British hospitals. He went on to suggest that "if a sister fresh from work in theatre and ward were appointed" this would address the problem with skill level and help prepare the staff for what would certainly be an increase in patients once the new surgical ward was completed. Stewart's omission of national origin was equally significant. He did not suggest that this sister need be European, only that she be *trained* in Britain, a shift that reflected changing conceptions of hospital work and hospital workers in the interwar years.

This perception of some measure of social equality extended to Stewart's recommendations for new hospital infrastructure. Choosing his words carefully, he, like Dr. Prout some 30 years earlier, made a direct comparison between the "state of things" in England and this Colony, arguing that if the administration wished to provide a decent surgical service, this should include:

Hospital accommodations for Africans of a status locally corresponding to our middle classes in England [as] I find that educated people of this category were reluctant to enter the wards of Connaught Hospital and perhaps have to occupy a bed next to a patient whose ideas about cleanliness may be distinctly primitive and whose disease may be somewhat obviously unpleasant. The question arises here just as in England where the middle classes find it difficult to obtain surgical care for much the same reason.<sup>173</sup>

Stewart's suggested infrastructural separation of social groups, implemented to some degree in both the old Colonial Hospital and in the original PCMH buildings, would not have been lost on the designers of a newly proposed Freetown Maternity Hospital. Indeed, the 1928 Report noted that due to "the severe tax on accommodation" at Connaught Hospital (in spite of

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<sup>173</sup> *Annual Report on the Medical Services*, 1927, p. 70

the relocation of all administrative functions in the old Law Court buildings following a 1919 fire), a new 28 bed ward – with "four cubicles for better class patients" was slated to begin construction.<sup>174</sup> Stewart's final recommendation was for a resident surgeon to assist him in the coming year based on the projected increase in cases. The recommendation was followed and the post filled the following year by none other than Dr. Milton Margai, the Colony's newly appointed African Medical Officer.<sup>175</sup> In what may be either coincidence or due to Margai's influence, legislation passed in Freetown in December 1929 amended the Births and Deaths Registration Ordinance to extend to "any town or place which has been declared to be a health district under the Public Health (Protectorate) Ordinance."<sup>176</sup> Legislation passed in London the same year in the form of the Colonial Development Act provided the mechanism for the Governor of Sierra Leone to seek and obtain funds to build a new Maternity Hospital.

### **The Short Life and long afterlife of the Freetown Maternity Hospital**

In a development I suggest was directly influenced by the success of PCMH, the colonial government began to plan the construction of a new maternity hospital in the 1930s. Internal government correspondence from 1928 shows that the increasing need for infant welfare work had already moved to the center of the colonial conversation. The state aimed to solve the problem of infantile mortality by subsidizing mission work and hiring more nurses and "medical men" to augment the work already underway, a strategy similar to the one proposed by Dr. Blacklock. Again statistics ("200 odd infant deaths per thousand in the Colony alone") were used to justify the need. What precisely would these increased numbers of maternity workers provide?

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<sup>174</sup> *Annual Report on the Medical Services*, 1928, p. 12

<sup>175</sup> Milton Margai, later Sir Margai, was the first Sierra Leonean man from the Protectorate to qualify as a medical doctor. Like Renner, he cultivated an interest in midwifery, educating and training lay midwives in the Protectorate in modern techniques. He would go on to become the country's first Prime Minister at independence and to make midwifery practice a central concern of his administration.

<sup>176</sup> *Annual Report on the Medical Services*, 1929, p. 7

Dr. Byrne, an agent of the Governor's office, supposed that "the new proposal will not achieve much numerically but it can do a lot of good by example and propaganda."<sup>177</sup>

Midwifery training was imagined as the key to the success of this new endeavor. Correspondence between government agents almost a decade later revealed the express strategy of selling the new maternity hospital as a center for training midwives and health visitors. Mr. Owen pointed to the benefits the success of the maternity hospital in Accra, Gold Coast which had proven "of great value as a teaching centre and in the saving maternal and infant life."<sup>178</sup> While saving lives was itself a noble aim, the colonial office memo also mentioned that the high numbers of infant deaths had repeatedly prompted "unfavourable comments" by the Colonial Advisory Medical Committee. Mr. Strang agreed, noting that Dr. Oakley, who was in charge of the Medical Department at the time, had convinced him of as much 18 months earlier but the funds had not yet been available. It was clear he was thinking of colonial development money as he added that such an endeavor might be difficult to translate into 'development' progress for the Home Office. While one official, a Mr. Downing, worried that the "development value" was "very indirect" and he was "not optimistic," another thought the proposal difficult but not impossible, writing:

At first sight the 'development' aspect of the scheme may seem small, but the saving of infant life at which it is aimed, and the improved physique which a maternity service (of which the scheme could provide the embryo) should secure, can be regarded as having 'developmental value', tho' the value may not be as direct as, e.g., that of a road.<sup>179</sup>

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<sup>177</sup> Byrne to Osment, Dec. 4, 1928

<sup>178</sup> Owen to Strang, March 1936. It is worth noting that the language is not about "reducing mortality" but "saving life." Concern for how the state cared for its subjects was reflected in the tension between humanitarian and statistical justification.

<sup>179</sup> Byrne to Downing and Strang, 1936.



"Judicious propaganda and persuasion" was suggested as the route to getting women from the Protectorate to present as candidates for midwifery training, which Mr. Byrne expected would take less than a year to accomplish. Indeed, propaganda seemed important to the success of new strategy. The Governor's office put out a memorandum in which the colonial secretary stressed the role of diet in the constitution of a proper body, arguing that nutrition during pregnancy and the post-natal period "may affect fundamentally the child's whole development." He reminded them that public health was written in to the Colonial Development Fund rules as a justifiable expense, and suggested that the notion of training midwives and health workers could be vaguely somehow also associated with this.

As it happened, in November of 1936 the Colonial Development Advisory Committee agreed to fund 50% of the cost to construct and equip a maternity hospital and training center (to be called the Freetown Maternity Hospital) as well as a road around the peninsula of Freetown. In the reply and justification for funding, Secretary Caine referenced Freetown's history of "enthusiasm for literary education" which had resulted in the Colony's educated men being siphoned off from Freetown, "the main reservoir for clerical posts in West Africa from Dakar to the Belgian Congo."<sup>180</sup> Caine echoed the Governor, claiming that the rise of education throughout West Africa had contributed to "a state of progressive decay" in the villages of the Freetown peninsula, in direct contrast to the advances made by 'natives' in the Protectorate. The Freetown Maternity Hospital was imagined as a means of keeping the Colony's human capital closer to home for the benefit of the "native" public.

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<sup>180</sup> Memorandum, Secretary Caine, Nov. 1936

## **Conclusion**

During the interwar period, maternal and infant welfare moved from the margin to the center of the British colonial project in Freetown. This move reflected increased international focus on maternal and child welfare, coincident with a period of unprecedented success in maternal and child welfare work at PCMH which was faltering financially but flourishing in terms of the production of new colonial subjects. Following World War II, the cash-strapped local government abandoned plans to pursue maternity work at the new Freetown Maternity Hospital it had built specifically for the purpose and shifted focus to the PCMH building instead. After transferring hands from the Bishop to the Church Missionary Society in 1942 and to the colonial state in 1953, PCMH again re-emerged as a dedicated Maternity hospital, a key site for ‘making do’ with scarce resources and ‘making new,’ producing healthy, modern subjects through intervention into childbearing and rearing.

The independent Sierra Leonean government assumed responsibility for PCMH and its recently re-Africanized civil service in 1961. This was followed by a brief period of prosperity in which the Milton Margai administration lavished attention on maternal and infant health and welfare throughout the country. With the institution of the APC and the Siaka Stevens regime in 1971, funding for the health sector steadily diminished and the hospital’s reputation declined. By the 1980s PCMH was remembered by my informants as “a terrible place.” Though it kept its doors open during the 1990s it was officially reopened (though it was never officially closed) by interim president Kabbah in 2006 as part of the symbolic end of the war. The 2010 introduction of a Free Health Care initiative for pregnant women and under-fives was quickly followed by the Ebola epidemic of 2014-15, and the long-term effects of the initiative have yet to play out in terms of ongoing attempts to establish the institution as a site of clinical excellence.

Princess Christian Hospital was built on the Bishop of Sierra Leone's property at the edge of Freetown for the sake of expediency and convenience, and as this chapter has shown, it has remained in the same location since 1892 for many of the same reasons. Its marginal position at the edge of both city and country make accessing emergency obstetric care in time to avert tragedy the rare happy ending for many women today. Understanding why the hospital is where it is helps situate what happens there as part of a history of rhetorical and ideological movements reflecting the changing city around it.

## Chapter 3

### A Differently Constituted Body: Clinical Racism and an Africanizing Medical Service

In order to terminate this neurotic situation, in which I am compelled to choose an unhealthy, conflictual solution, fed on fantasies, hostile, inhuman in short, I have only one solution: to rise above this absurd drama that others have staged around me, to reject the two terms that are equally unacceptable, and through one human being, to reach out for the universal.

Frantz Fanon, *Black Skin White Masks*

#### **Introduction**

Histories of late 19<sup>th</sup> and early 20<sup>th</sup> century Sierra Leone delve deeply into colonial racism.<sup>181</sup> Adell Patton's work illustrates the intricacies of relationships amongst Creole and British physicians, and touches on systematized colonial racism in Freetown's medical services. Christopher Fyfe's sweeping history of the Colony closes with an account of the injustice wrought by institutionalized racism in the colonial medical service. I find ample evidence to support Fyfe's argument that elite African physicians at the turn of the 19<sup>th</sup> century "could only look back to a Golden Age, the vanished era of Queen Victoria and of the departed recaptive and Creole giants," the sentence with which Fyfe's narrative closes.<sup>182</sup>

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<sup>181</sup> See Adell Patton, *Physicians, Colonial Racism, and Diaspora in West Africa*, 1996 and Murray Last, *The Professionalisation of African Medicine* (Manchester University Press in association with the International African Institute, 1988).

<sup>182</sup> Fyfe, *A History of Sierra Leone*, p. 619.

However, extending the investigation into the 20<sup>th</sup> century this chapter argues that the history of medicine, physicians, and hospitals in Freetown was more than an exceptionally egregious example of colonial racism. It finds that the second and third generation of Freetown medical professionals, fueled by their memories of experiences in the aftermath of this era, provided the raw material they used to negotiate their own future and claim a place within a new discourse of the independent African nation state. Chapter three moves beyond Fyfe's early colonial focus on British (and to a lesser extent Creole) men and sharpens Patton's broad focus on the experiences of Creole physicians throughout the British West African territories. Considering only Sierra Leone, and within that only Freetown, it provides a situated perspective on the waning years of Creolehood while also embracing the gains and losses of Creole physicians in the postcolonial era.

This chapter argues that institutionalized racial segregation fundamentally shaped Sierra Leone's maternity services, drawing attention to acrimonious debates in the 1930s that influenced the rigidly hierarchical medical system in the post-colonial era. In response to the humiliation of institutionalized segregation, African physicians sought to excel in the one field left to their provenance: reproduction. Over the first half of the 20<sup>th</sup> century, obstetrics, gynecology, and maternal/child health emerged as a sphere in which elite Africans began to forge a national identity.

Incorporating the experiences of several individuals key to a history of medicine and maternity on Freetown we turn now to the entangled histories of William Prout, who was British, and William Renner, a Creole, both physicians in active in colonial service at the turn of the 20<sup>th</sup> century, and to M.C.F. Easmon, a Creole whose narrative spans the time period from Renner's retirement in 1912 to Independence in 1961.

## **Dr. William Prout, rhetoric, and responsibility**

Dr. William T. Prout assumed charge of the Freetown Medical and Sanitary department in 1892. Prout had served voluntarily at the Cottage Hospital in the Medical Officer's absence and spoke at a public meeting of the PCCH board on about the subject of hospitals and nursing. His words provide us with an idea of how both were being shaped by the British colonial agenda. An analysis of his speech provides with evidence that the eventual bifurcation of Freetown's medical service was on his mind a full decade before the implementation of official race-based segregation and even as he sought to consolidate African and European support of medical services in the colony.

Prout first emphasized the non-governmental status of the Hospital, arguing that as a voluntary organization, it was beholden to the community for support. "Out here" he chided "we have got rather into the habit of looking to Government for support in matters of this kind and depending too little on our own efforts." It is clear here that Prout intended his 'our' to include of both European and African members of the audience. "It is upon the inhabitants of this city" he argued, "that the duty of assisting in the development of an institution like PCCH must eventually fall."<sup>183</sup>

Prout emphasized the need for the ideal African nurse to distance herself from her patients. He argued that "Foofoo and palaver sauce...and soups composed largely of red peppers" were not suitable for a patient with an inflamed liver; it was the duty of the nurse to learn that "a patient was not to have everything he asks for."<sup>184</sup> By invoking foofoo, palaver sauce, and hot peppers, Prout signaled that the ideal African nurse must know when to break away from

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<sup>183</sup> Prout's address, May 11, 1895

<sup>184</sup> Ibid.

'traditional' foods, and provided a medical rationale for a knowledge of other (European) diets. Emphasizing the degree to which proper clinical practice could distance a practitioner from 'native' patients, he claimed: "These results can only be attained by training, and by careful and special training, and it was this that the Princess Christian Cottage Hospital aims at supplying."<sup>185</sup>

Lest his call to action was muffled by the presence of a racially mixed company, Prout unequivocally shifted the rhetorical audience in his closing statement: the inclusive 'we' who had depended too much on government provision rather than 'our own efforts' at the beginning of his speech had become a resounding 'you' by the end. To reduce the "danger to yourselves and your relatives," Prout argued that his audience should provide critical financial support but also "do what is as important...send your daughters, and it is intelligent and well-educated ladies who are wanted, to be trained as nurses for the benefit of yourselves and the benefit of your fellow creatures."<sup>186</sup>

As we saw in chapter two, Dr. Prout was a staunch advocate for reducing infant mortality in Freetown, identifying links between labor attendants and infant deaths. Calling attention to statistics he found shocking, he suggested in his *Annual Report* to the British government that a maternity home where native midwives could be trained, followed by the registration of trained midwives, might be successful in combatting infant mortality in Freetown. In his Sanitary Report he chose to modify this plea for a smaller local audience, asking "the Municipality, whether, in the interest of their own fellow citizens, it does not fall within their province to initiate some scheme to remedy this evil and diminish this loss of life."<sup>187</sup> As with his speech to potential supporters of Princess Christian Hospital, the conflicting moral overtones were unmistakable.

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<sup>185</sup> Ibid.

<sup>186</sup> Ibid.

<sup>187</sup> 1894 *Sanitary Report*

Prout's concern was about population in the Colony, to be sure, and at an unprecedentedly early stage, but it was also suggestive of a moral imagination which he assumed "the Municipality" shared vis-à-vis responsibility to "their own fellow citizens."

The 1895-96 Annual Report on the Princess Christian Cottage Hospital began with a full-page photo of the old building and a new addition, a note on the brief return of founding patron Josephine Ingham, and a mention of Prince Christian Victor of Schleswig-Holstein's recent visit.<sup>188</sup> Dr. Prout was given a full paragraph of thanks and Dr. Ross, the incoming Medical Officer, a full paragraph of introduction. Incoming and departing staff were present in the pages but Dr. Renner, whose name appeared as an 'honorary medical officer' underneath Prout's on the cover, was curiously omitted from the written narrative for the first time, as were his qualifications from London, Edinburgh, and Brussels. Thus Report heralded the changing structure of the Hospital and the involvement of key European figures while eliding the presence and eminence of the Sierra Leonean Dr. Renner a full decade before the question of segregating the medical service emerged in London. What happened to so dramatically shift the social ground in Freetown, the utopian, egalitarian experimental city whose Africans and Europeans had previously occupied side by side? I suggest that the shifting loyalties displayed by Creole residents during the fraught closing years of the 19<sup>th</sup> century had much to do with setting the tone for the increasing tension in social relations during the 20<sup>th</sup> century.

### **Trouble in Freetown**

In 1896, Britain declared a Protectorate over all of Sierra Leone outside the Freetown Colony. Tensions between the British Colonial government and residents of the newly-policed

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<sup>188</sup> The name "Princess Christian" comes from Holschweig's wife, grand-daughter of Queen Victoria and champion of nursing, who lent her endorsement and a small bequest to the Cottage Hospital in return for immortality.



Protectorate began to rise in late 1897 when Governor Cardew, ignoring every bit of advice he was given about the subject, decided that imposing a flat tax on Protectorate dwellings would be a quick and easy way to raise money to build a railroad. Some chiefs who had close ties to the government paid the tax without question, but in many areas organized, armed protest began.

Church Missionary Society missionaries were not immune to rising tensions, and some in outlying mission stations were accused of spying and attempting to provide members of the Frontier Police and Governor Cardew with information on the movements of "insurgents." The Society had begun cultivating cordial relationships with groups in the Protectorate (then known as the Hinterland) as early as 1860, and had begun to carry out a plan to establish mission houses in Temne country, specifically Mapoli and Kagbantama, in 1896. Their timing could not have been worse. The Kings in the area, Bai Foke and Bai Bureh, claimed they had not granted permission for any settlements and "raised obstacles."<sup>189</sup> The CMS Finance Committee in Freetown thought perhaps "a certain Government tax had made them unfavourable to Missionary work."<sup>190</sup> Two "native" clergy were quickly dispatched in 1897 to try to smooth ruffled feathers until an administrative member of the Society was able to follow. The Reverend W. J. Humphrey, a long time veteran of the West Africa Mission who had served as Secretary for the local branch of the Society and as Principal of Fourah Bay College, left his wife of four years and two young sons in Freetown and made his way into the territory of Bai Bureh near Rotifunk just as tensions between the kings in the Protectorate and the Colonial Government peaked. Humphrey, along with several American missionaries, was murdered with a machete. His

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<sup>189</sup> Minutes of CMS Finance Committee meeting, October 1897.

<sup>190</sup> Ibid.

remains, which had to be obtained through subterfuge, were not returned for burial until many weeks later.

The events of what would come to be known as the Hut Tax War fundamentally altered social relations in Freetown. CMS missionaries, who had spent much time and effort reaching out to the heathen souls in “the Hinterland” were stunned. Though the number of Africans killed exponentially exceeded the number of European casualties, the events were quickly hung with hyperbolic prose, termed a "massacre" and a "slaughter" in letters home. One missionary reported that shortly after Secretary Humphrey was killed, "every means of communication had been cut off; the arrival of the English force and their consequent burning of villages set the country into confusion. The towns were deserted and we were obliged to stay in bushes and hamlets in order to not excite the rage and envy of unruly war-boys."<sup>191</sup> British residents of Freetown characterized the situation as terrifying.

1898 proved to be a major turning point for the Society, and by 1901 all activities outside Freetown – including a popular dispensary and dressing station at Port Lokoh operated by a sole female missionary – were turned over to the "Native Pastorate" until further notice. The Cottage Hospital was evacuated under guard of the newly formed Volunteer Force in Freetown. Sister Mary Ward, writing home to her sister in England, mentioned that there were no inpatients at the hospital in the days following the staff's exile for their own safety. She also mentioned "we have a very nice doctor but I am afraid we shall not be allowed to keep him much longer. I wish we might."<sup>192</sup> Governor Cardew was convinced that Creole elites in Freetown had been instrumental in inciting the "Hut Tax Uprising" as it was being called, and relations between the groups – who

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<sup>191</sup> T. Caldwell, Dec. 31, 1898

<sup>192</sup> Ward to Florence, May, 1898

had once coexisted in a remarkable atmosphere of social equality<sup>193</sup> – suffered irreparable damage. The meaning of the medical missionary work at the Hospital would be irrevocably altered. Dr. Renner, Ward's "very nice doctor" was appointed as honorary medical officer, and became one of only two African members of the Volunteers. Within four years he would be officially and permanently relegated to a subordinate post in the medical service. In the aftermath of the Hut Tax War, the tensions inherent in the medical missionary effort came home to roost.

### **William Awuner Renner, physician in Creole twilight**

At the end of the 19<sup>th</sup> century Dr. William Renner's career trajectory was exceptional, and his status as a pillar of the medical community unquestioned. Renner's mother had been a trader; the identity of his father is not part of the current record. He studied medicine in Liverpool and London, completing a final qualification in Brussels. His exploits became regular features of *The Sierra Leone Weekly News*, a periodical founded by Creole elites Principal May and Edward W. Blyden in 1884.<sup>194</sup> A column written by "a Freetown correspondent" (very likely Blyden, given the pro-African content and his role as a frequent contributor) wrote

It is a pleasing duty to recognize the laudable efforts and the successes attending the same of deserved country-man, Dr. William Renner the resident surgeon at Kissy, who is exceeding the expectations and highest anticipations of his friends. He has shown himself to be a man worthy of the honour and confidence reposed on him, and he is trying to do his best for the infortunate and helpless beings who are under his charge. May his life be long spared for the benefit and service of his country.<sup>195</sup>

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<sup>193</sup> See Mac Dixon-Fyle on the "special relationship" between British and Creole Freetonians.

<sup>194</sup> Christopher Fyfe (1996:496) noted that the *Weekly News*, "tended to approve anything distinctively African and deplored slavish imitation of European ways."

<sup>195</sup> *Sierra Leone Weekly News*, Jan. 14, 1886

Appointed as Assistant Colonial Surgeon in 1884, Renner was personally chosen to replace the Colonial Surgeon (a European) whenever he went on leave. He was transferred from Kissy on the eastern edge of town, where he had built a thriving and no doubt prosperous private practice, to Freetown in 1886. In 1891 he was appointed Justice of the Peace and Deputy Coroner.<sup>196</sup> From 1893-1895 he was the colony's acting Minister of Health. In 1897 he was one of only two Creoles trusted by Governor Cardew to serve as officers in the volunteer force defending Freetown against invasion during the Hut Tax War. Until 1902 he was the go-to replacement for British officers, stepping in to head the Medical Department during either the Medical Officer or Colonial Surgeon's absence.

In 1902 he served for the last time as head of the Sierra Leone Medical Department. That year, with the segregationist West African Medical Service (WAMS) beginning to take shape, the post of Colonial Surgeon became that of Principal Medical Officer, and a new post, Senior Medical Officer, was created. African doctors were categorically excluded from this post based on grounds that they were "socially ineligible." Dr. Hood, British and junior to Renner, was pulled in from a District Commissioner's office to act as Senior Medical Officer. The *Weekly News* noted that in the face of this "glaring...injustice" Dr. Prout had the "moral courage" to recommend Renner, not Hood, as his replacement while he was on leave in 1902 and again in 1904. The Governor of Sierra Leone heeded his request in 1902, but by 1904 the policy had taken effect to the extent that Governor King-Harman, a personal friend of both men, denied the request.

William Renner served in the segregated medical service for 11 more years but never again held a senior position (though his higher salary of £500 was 'grandfathered in') and was

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<sup>196</sup> SLWN, Jan. 1891

officially required to take orders from any member of the WAMS. In 1905, Prout had Renner appointed as the head of the new King-Harman Maternity Ward, a subsidiary branch of the colonial hospital. He reasoned that on one hand the move would encourage the attendance of African patients and on the other it would provide Renner with a separate place to practice "in which there would be less interference by junior officers."<sup>197</sup> Following his appointment to the King-Harman Ward, the *Weekly News* claimed "it was no wonder that on the establishment of the King Harman Maternity Ward the Authorities...desiring to popularize the Institution then regarded askance by the people, placed him in charge of it. They knew that he could attract the diffident and mistrustful people for whose benefit it was intended – and he did attract."<sup>198</sup>

William Renner's next moves need contextualization. "Fair words in the legislative council" delayed some effects of the formation of the West African Medical Service until a white paper issued 1909 codified the new policy.<sup>199</sup> In 1909, the same year that the White Paper was issued, as part of the general report on the medical services in the colony, Dr. Renner published the first report dedicated solely to the work of the King Harman Maternity Ward, a branch of colonial service "which has not been widely known and fully appreciated as it should have been during the period of its existence." In 1907, two years before Renner's first report and two years after his appointment, Blyden published a blistering series in the *Weekly News* claiming that the Europeanization of Africans would be their doom, a "fatal rule of degeneracy" from which only native customs could save them.<sup>200</sup> In interpreting this critique, we must bear in mind both the

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<sup>197</sup> Prout, *Annual Report on the Medical Services, 1905*

<sup>198</sup> *Sierra Leone Weekly News*

<sup>199</sup> Fyfe, 1993: 615

<sup>200</sup> *Sierra Leone Weekly News*, Aug. 1907

recently heightened racial tension in the colonial medical service and the political current which had grown ever more anti-Creole since the Hut Tax War.

Dr. Renner's series of reports on the King Harman Maternity Wards thus provide us with an example of an elite Sierra Leonean physician confronting the institutionalized racism of colonial medicine and grappling with rising Africanist sentiment amongst contemporaries such as Blyden. Through these reports, we can read how maternity and medicine articulated with histories of practice and of "Krio-lization," with the end of one era and a disenfranchised hero's struggle to find his footing in a new one. Renner chose to use the Report as a platform to educate British readers on Sierra Leonean midwifery practice. In his words, we can begin to see thoughts of "us" and "them" articulated. We can also see that Dr. Renner was not entirely sure which side he was on: Blyden's pro-Africanist or the emerging move to embrace Creole identity as an attempt to reconcile future and past.

### **Renner and maternity practice in Freetown in the 1900s**

Dr. Renner noted that while there had been a total of only 374 admissions from 1902-1908 in a city of around 47,000 people, the relatively small number was not surprising considering the 'great prejudice' against the Hospital which existed "largely due to native customs and traditions. It is not to be wondered why the colonial hospital and its European method of treatment do not find favor with [Africans]." He then provided an overview of some of these customs: "'sadaka' or charity – included practices such as making offerings to departed relatives before the period of parturition, "drinking certain decoctions" during the stage of parturition, and oiling the abdomen to render easy passage for the birth of the child. After birth, the placenta was not to be burned (as would have been customary in the hospital) but always buried in the earth with uterine surface turned up to prevent the patient from becoming infertile.

The practice of "bathing or squeezing the patient with hot water for a certain period" was intended "to effect, as they suppose, the closing of the pelvic joints which in their opinion have become loosened and require special attention." Renner also spoke of the practice known as 'Kommorjahdaying,' bringing the child into the parlor or open air on the 7<sup>th</sup> day (if female) or 9<sup>th</sup> day (if male). Renner noted that in order for this practice to be successful "there must be feasting and rejoicing with neighbors and friends and in some tribes dancing. If it was a normal case of labour the native midwife became a persona grata in the family, staying with them until the outdoorings and "being provided with her daily liquor at night during this period."<sup>201</sup>

Renner argued that inability to conduct these practices were only one reason why 'natives' did not come to the hospital to give birth, but not the main reason. Instead, the key reason was that giving birth in the hospital would render a woman vulnerable to witchcraft. He wrote that "It is in the Hospital that the Fetish man with his terrible medicine which he can send by occult means, and also the Witches, have power to inflict dire disease on or increase the malady or ailment of the patient."<sup>202</sup>

In order to remedy the fear of witchcraft Renner suggested that "diffusion of knowledge of physical laws and hygiene and enlightenment generally" were the only hope. While suggesting that the clergy might play a role, he pointed to enlightening the next generation through formal education, as early as primary school, suggesting that "anything that would enable the boys and girls to know of their own bodies and bodily organs would help to undermine and ultimately remove the terrible incubus or nightmare of superstition which weighs upon a large section of the native community." However, educated middle class Creole women

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<sup>201</sup> W. Renner, *Report on the King-Harman Maternity Ward* 1909, p. 19

<sup>202</sup> W. Renner, *Report on the King-Harman Maternity Ward* 1909, p. 20

weren't attending the King-Harman Ward in great number either. This he attributed to "natural delicacy" and their incorrect assumption that they would not have privacy. Countering these wrong assumptions also required knowledge, but here it was "knowledge of the methods of treatment pursued in this branch of the hospital."

The 1910 *Report* made it clear that those who sought help in the King-Harman Wards were in dire circumstances. 73 of the 97 admissions were due to complications upon admission, with the biggest category being fever. An additional 29 patients were classed as 'complications after admission.' The gravity of situations, together with the unmarried status of over half the patients (taboo to both British and Sierra Leonean) suggests that these were not cases in which the parturients came to hospital out of choice. Nineteen patients either presented with or developed hemorrhage. Together with two cases of dysentery, two cases of fulminating eclampsia, two mechanically difficult presentations, and one case of 'fever due to half a needle broken off in patient's hand some months before admission,' it was truly remarkable testament to the efficacy of the Ward that in all of 1910 only 5 maternal deaths occurred.

The *Report* consciously emphasized the medical knowledge and skill of the physician, and the success of modern medicine in handling difficult cases. Dr. Renner detailed procedures which would have required advanced technical knowledge and surgical skill. Rather than simply providing the number of "instrumental labour[s]" he broke the cases down: six applications of forceps and one each of evisceration and decapitation, perforation and forceps, and podalic version. A twin delivery was not simply recorded as 'twins' but 'twin labour with heads locked; first child breech, second child vertex.' A shoulder presentation had been "neglected," 'native treatment' had 'failed to effect delivery.' Renner did not miss an opportunity to make his case to the readers of the *Report*, primarily British medical professionals and colonial administrators.



The *Report* elaborated on each of the five recorded deaths separately. Renner made it clear that three of the five had previously been 'under the treatment of a native midwife.' The one case which would have set off red flags for most of his physician audience was puerperal fever. This disease, carried from patient to patient by unwashed hands or instruments, had been increasingly recognized throughout the 19<sup>th</sup> century and, by the early 20<sup>th</sup> was associated with unhygienic medical practices. This complication, coming as it did after hospital admission, required an explanation. Citing the high number of cases of puerperal fever among Creole women and the rarity of cases among 'aborigines' Renner pointed to specific childbirth practices among each group.<sup>203</sup>

In a change of tone that we must ponder, childbirth practices were cast in a negative light here, a distinct difference from the previous *Report*. Renner argued that major causes of mortality were poor hygiene and ignorance in births that took place outside the hospital, "the use by the lower classes of any sort of rags that have been kept for months during the period of pregnancy to be used on the day of parturition" and "the attendance of ignorant practicing druggists and half educated creole grannies or midwives" who conducted frequent and unnecessary vaginal checks without proper hand washing and use unsterile instruments.<sup>204</sup> The 'aborigines' on the other hand, were attended by women who conducted only external examinations on their 'patients.' Labor and birth took place at a location outside the village (a sacred grove or Bundo bush) which had been 'carefully cleared of bush, swept and rubbed and a new mat...laid for her use." Labor was attended by the head of the Bundo society and following birth the new mother was 'bathed with native herbs already prepared' and sent back to the village

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<sup>203</sup> This term, which was replaced by "native" or "African" in colonial records during the first decade of the 1900s, continued to be used by Creole elites well in to the 20<sup>th</sup> century.

<sup>204</sup> W. Renner, *Report on the King-Harman Maternity Ward* 1910, p. 23

within 24 hours. "From the first to last the patient runs no risk of suffering from Puerperal fever," he argued. Perhaps Renner worked to craft an explanation that simultaneously aligned him with the 'aborigines' (Blyden's "true Africans"),<sup>205</sup> distanced him from the ignorant, inept 'granny' midwives, and emphasized his status as a competent European-trained physician with a thorough knowledge of pathology.

While the *Weekly News* attributed rising maternity admissions to Renner's presence, Renner seemed ambivalent still, attributing it to the continuous presence of a "responsible European matron...maintaining the confidence of the people in the Institution."<sup>206</sup> Furthermore, containing treatment of gynecology patients to two days a week and separating them from the outpatient department had 'served to induce the shy and the delicate to attend for treatment.' In fact, due to the increase in gynecological work, he suggested that more equipment be provided and 'every facility given for the vigorous prosecution of the work.' To bolster this plea, he argued that from a 'humanitarian and social point of view' the provision of equipment was urgently needed in order to address the prevailing trend: a rising death rate and falling birth rate combined with smaller families, and an increase in the rate of sterility among the descendants of the liberated Africans and original settlers. Anticipating the counter-argument, Renner noted that the rising population in Freetown was not taking place among these descendants, but was instead due to an influx of people from the Protectorate.

The doctor's shift in tone seemed designed to refocus attention on the egalitarian origins of Freetown in the years following the Hut Tax War. The 'social' argument was based on a debt owed the founders, and a 'special relationship' between the descendants of Freetown's original

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<sup>205</sup> *Sierra Leone Weekly News*, 1900

<sup>206</sup> W. Renner, *Report on the King-Harman Maternity Ward* 1910, p. 22

settlers and the British. Christopher Fyfe pointed out the death of many prominent Creole leaders that occurred within a short span of time in the first decade of the 20<sup>th</sup> century and by 1910 the foundations of that relationship were shaking and shifting. As the old guard passed and the new guard, the West African Medical Service, replaced them, William Renner was one of only a few left in a position to speak and be heard on behalf of the Creoles.

The 1912 Report would be Renner's last. The 1912 staff list referred to him as Dr. Renner, but he signed his report on the King-Harman Ward "Awunor Renner."<sup>207</sup> In one final linguistic swipe at the establishment, he wrote "The four senior Native nurses were still maintained to carry out the work of this ward."<sup>208</sup> This was the first time he had mentioned African nurses working on the ward, and the first time he elided the presence and work of a European Matron for whom he had previously reserved such high praise.<sup>209</sup> The good doctor seemed to have a sense that nobody was listening by this point. He had been demoted from the Officer in charge of the entire medical department to the African in charge of one sliver of practice. The entire 1912 report was less than one page.

### **A new focus for African doctors**

This chapter has argued that following the institution of the West African Medical Staff, obstetrics emerged as the *only* field in which African providers were allowed free reign; specializing in Obstetrics and Gynecology was the only way they would not be 'interfered with', as Dr. Prout had put it, by junior officers. In 1909 Dr. Renner was mentioned only as the

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<sup>207</sup> In 1912, likely at the height of realization and alienation, Renner changed his name to Awunor-Renner, reflecting a clear association with his African heritage. He publicly announced the change in the Weekly News on 7<sup>th</sup> October, 1912.

<sup>208</sup> Ibid., p. 19, my emphasis.

<sup>209</sup> Awunor-Renner's presence had been similarly elided in the 1894 report of the Cottage Hospital.

"useful...medical officer to the female side of the hospital."<sup>210</sup> By 1913 he was virtually absent from the *Report*, and later that year, he retired.

Renner's retirement in 1913 occasioned two articles in the *Weekly News*. One, a glowing record of his achievements, noted that Dr. Renner had, "through study, energy and a love of achievement," built up a thriving practice when he was 'discovered' by the government and took up Colonial Service: "Native as he was, he nevertheless will carry with him to the latest hour of his life the proud boast that he was appointed Acting Principal Medical Officer of this Colony at a certain time." The author suggested that following the overt racism embodied in the West African Medical Staff:

When he should, due to arrangement which were most trying to flesh and blood, have retired in disgust from the public service with justification from all right-minded men, he nevertheless elected to stay.... the man was sunk in the patriot. We mourn, we deeply and shall ever deeply mourn the violence which has debarred distinguished men of our color from serving their own people under the shadow of the colonial hospital...the hospital shall never henceforth fill the hearts of negroes bot here and abroad with the same place it used to occupy in the past...but we shall delight in the form of Dr. Renner still passing and repassing among his people – not as a Government officer but altogether as one of themselves, advising, healing, teaching, helping all.<sup>211</sup>

Christopher Fyfe claims that the Creoles of the early 20<sup>th</sup> century recollected the Victorian era with nostalgia. If we read the *Weekly News*, it seems he was right. The end of an era was not lost on Renner: he had used his position to place Creole decline into a medical framework, to draw attention to the problem using a thoroughly modern, demographic approach. Blyden had prophesied the self-destruction of the Creole. Renner, caught between a multiethnic past and a segregated future, sought help from the Colonizer. While help eventually came it was

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<sup>210</sup> Forde, 1909

<sup>211</sup> *Sierra Leone Weekly News*, August 16, 1913, "by Nembana." Emphasis in original.

too little too late to stop the decline of the golden age, and it answered to a larger public than the Native medical staff of Freetown.

Upon his retirement, the Weekly News hoped "that two more black doctors" would be selected to fill posts in the Protectorate despite the objections of those in the WAMS. "It is really astonishing why white doctors should have such anxiety to attend to black patients. The blacks do not care for it." Dr. Easmon, Renner's token replacement, was "congratulated and wished all success."<sup>212</sup>

### **Dr. M.C.F. Easmon and the West African Medical Staff**

In 1934, seven doctors filed a complaint against the government of Sierra Leone.<sup>213</sup> The physicians protested racial segregation in the colonial medical service, arguing that the structure of relationships it instituted systematically disenfranchised and limited their professional activities. The perceived need to segregate the medical service in Sierra Leone had first arisen in 1902, resulting in the formation of the West African Medical Staff (WAMS). While the segregationist policy did have some effect on hiring and promotion during its first seven years, "fair words in the legislative council" delayed implementation of the WAMS until a white paper issued 1909 codified the new policy.<sup>214</sup> In the reconfigured service, African physicians were officially and effectively rendered inferior to European physicians regardless of differences in training, qualifications, years of service, or skill level. The new system had also instituted less remuneration, less vacation time, a cap on the extent to which black doctors could rise in the ranks, and, a slight the Sierra Leoneans found particularly egregious: a new set of official titles

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<sup>212</sup> *Sierra Leone Weekly News*, October 10, 1914

<sup>213</sup> "West African Medical Officers Petition for Revision of Conditions of Service," May 15, 1934

<sup>214</sup> Christopher Fyfe, *A History of Sierra Leone*, p. 615.

which prefixed "African" to their names. The WAMS elevated British officers to supervisory posts and relegated Africans to a separate and inferior service altogether.

The new system also made significant changes to the terms of compensation and governance, in that no African could be promoted to an administrative post or attain a salary higher than £723, regardless of years of service. While British officers would receive extra income in the form of a premium based on the difficulty of the post; Africans, as "natives" to the climate, would not. The practice of personal nomination of an appointing the officer to lead the medical service during a senior officer's absence, which had been in place for decades, was replaced with the practice of appointing the next most senior European currently stationed in the colony, regardless of other considerations.

The complaint (which its authors entitled "a memorial" perhaps intentionally underscoring the fact that things had not always been this way) objected to the absurd illogic of this arrangement. The petitioners pointed out that they had, since the White Paper, continued to accumulate years of service and age and now had every kind of seniority over less-experienced and younger WAMS officers who were technically and practically be their superiors. Arguing that the term "Senior Officer of the WAMS" was open to broad interpretation, they pointed out the inherent infantilization and blatant disrespect of these terms, writing: "there is a tendency for us to be regarded as junior and still on probation."<sup>215</sup> Citing one instance in which a young European physician with 15 months of service assumed charge of the Colonial Hospital,

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<sup>215</sup> Ibid. The signatories were operating under the assumption of a shared system of logic when what was expected of them was participation in what Fanon termed "neurotic" belief. Countering the illogic necessary to sustain discriminatory racist divisions of humans into superior and inferior categories, Fanon argues that "When someone else strives and strains to prove to me that black men are as intelligent as white men I say that intelligence has never saved anyone." Frantz Fanon, *Black Skin, White Masks* (Grove Press, 1968) p. 29.

effectively rendering him a senior "supervising" the work of African clinicians who all had over 10 years of experience, the authors charged that:

During the absence on leave of the Surgical Specialist, a junior and only recently confirmed European Medical Officer was placed in charge of the surgical wards. The Acting Director of Medical and Sanitary Services then detailed an African Medical Officer considerably older and of more than 20 years varied service, not excluding Surgery, to work along with him. This European Medical Officer objected so strongly that he had to be relieved and transferred.<sup>216</sup>

It was the Sierra Leonean officer, Dr. M.C.F. Easmon, who had so offended his European colleague. He was left in charge for only three days before being demoted to junior status again upon the arrival of a different European officer even less qualified than the first. "It appears to us" the petitioners continued, "as an anachronism for a man of 14 months service to deal out orders to brother professionals of over as many years of service."<sup>217</sup>

In reply, Dr. Oakley, acting director of Medical and Sanitary Services, argued that the West African Medical Staff was "a differently constituted body," one fundamentally incommensurable with its Sierra Leonean counterpart.<sup>218</sup> On one level, this was technically true: the WAMS was entirely constituted of white British physicians who had been recruited into the colonial service in England. But the very terms Oakley used to legitimize separating the two groups regardless of credentials, experience, skill, seniority, or even place of birth, underscored the fact that the real difference, the operative difference, was corporeal. The fundamental basis for this separation was unquestionably the skin color of the physical "body" in question.

In a curious irony within the new structure, European officers carried the "West African" title while African physicians sought to have the word "African" removed from theirs. For the

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<sup>216</sup> "West African Medical Officers Petition for Revision of Conditions of Service," May 15, 1934

<sup>217</sup> Ibid.

<sup>218</sup> W. Oakley, reply, 1934

African physicians, the change in nomenclature did not indicate a demotion in designated duties; as African medical officers their mandate was to "be entirely concerned with the indigenous population and especially with the poorer classes."<sup>219</sup>

The petitioners used historical analysis to strengthen their claim. Pointing to language practices dating from the 19<sup>th</sup> century, they argued that "African" connoted the term "native," and all the associated negative perceptions. The petitioners argued that officially calling them "African medical officers" could lead to a misunderstanding of their qualifications (which all had obtained in European medical schools), and had no historical precedent in Sierra Leone. Drawing a direct comparison between present and past nomenclature, they pointed out that prior to the WAMS there were only the colonial surgeon and his assistants, "with no further distinguishing adjectives," the African doctors argued that the "reasons advanced for justifying the formation of the WAMS can hardly carry the same weight or be as practicable to-day as they were in 1902."<sup>220</sup>

The group also used comparative analysis to strengthen their claims, noting that the "African" prefix and was not used in any other British West African Colony and that in India and the British West Indies, Indian members of the colonial medical service were not designated as Indian or West Indian, in spite of the fact that in the Indian service members of the "Subordinate" service had only local qualifications.<sup>221</sup> Moreover, in the WAMS there was no corresponding use of the term "European" to designate the British. They pointed out that the practice did not exist in Nigeria (where there was an African assistant colonial surgeon), and that in similar official positions in Gold Coast (in particular the Magistrates and solicitor general) "have not the word

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<sup>219</sup> Ibid.

<sup>220</sup> "West African Medical Officers Petition for Revision of Conditions of Service," May 15, 1934. Indeed, it seems that these qualifications were precisely why the WAMS was necessary. It was *because* there were so many highly qualified African physicians that the colonial administration sought to articulate an inherent British superiority.

<sup>221</sup> Ibid., 62.



"African" prefixed to their official titles." While their qualifications and professional status would be considered identical were they to establish a practice in Britain, they argued that the prefix caused "a definite tendency among lay and official circles for us to be regarded as Medical Men of a lower grade than our European colleagues."<sup>222</sup> The petitioners were acutely aware of social impressions made by their titles and the arrangements of print documents. They were closely attuned to shifts in relative position on the page, noting that in documents circulated to all medical staff, the names of African physicians were listed last and in documents requiring signatures the European medical officer always signed above the African and yet the only difference between them was race.

The petition was not well received. The notes made by one British official provide many clues as to the attitude of the administration. An anonymous reviewer commented that among other things, the petitioners lacked and 'legitimate grounds' for their grievance.<sup>223</sup> What might "legitimate grounds" for grievance have looked like? Even though European officials in Freetown were free to patronize any European physician on duty in the city, nearly all the European officials at Cline Town relied on the services of the African Medical Officer despite the objection of the British Medical Officer in charge of Freetown. As salary was established by the government, this patronage would have had no direct effect on reducing the European physicians' income. Moreover, British and Sierra Leonean physicians were equally qualified, so the objection could not have been raised over concern for the patients' safety. The basis for his objection could only be one of principle.

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<sup>222</sup> Ibid., 69.

<sup>223</sup> It is likely that the critic was Dr. Oakley himself, but the marginal notes are not signed.

Dr. Oakley, the Director of Medical and Sanitary Services, composed a detailed reply critiquing the petitioner's arguments on several grounds. Among the critiques raised was the timing. Oakley spoke directly out of both sides of his mouth claiming that while it was 'only natural for people to be ambitious and attempt to better their conditions,' the prevailing economic depression made the timing of the petition 'decidedly ill-chosen.'<sup>224</sup> Oakley suggested that this bad timing could hinder the ability of the medical staff to work together as a team. This is the one point of overlap in both documents, and it is worth noting, as it could be interpreted as signaling an appeal to a wider discourse, a global discourse of efficiency and harmony.

What the notes make clear is that everybody concerned – British and African, pro and against, clearly understood that these titles had power.<sup>225</sup> The weight they carried or the weakness they suggested was part of the medical infrastructure, and changing the words would be to change that infrastructure as well. Yet changing the infrastructure was definitely on Dr. Oakley's agenda. The same week that he sent his reply, he petitioned for almost £10,000 to construct a new European Hospital at Hill Station.

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<sup>224</sup> Oakley's reply, 1934

<sup>225</sup> Stephanie Newell's discussion of the politics of naming and anonymity in colonial West African presses is useful here. In her case study of Wallace-Johnson, she demonstrates how knowledge of both the legal importance and the structure and mechanics of British print naming practices could be skillfully manipulated to the benefit of African authors and the consternation of colonial officials. Wallace-Johnson "used techniques inspired by oral naming conventions to undermine the process of "proper" naming on which the British court depended" *The Power to Name*, 2014, p. 17



*Figure 6 Dr. M.C.F. Easmon*

In this photograph Dr. M.C.F. Easmon appears to be examining an infant. The photograph was taken by the West African Photographic Service in 1946, three years after the colonial government dispensed with the two-tier medical system, eliminating the West African Medical Staff and uniting all branches of colonial medicine into one service. 1946 was the year after Dr. Easmon's retirement, and images from the series were not published until the 1948 Annual Reports, a full five years after the integration of the medical service. Thus Easmon, by posing for the photos, was a self-conscious anachronism. His presence connoted the racial discrimination of the colonial era but also suggested an embrace of the new subjectivities that

modernity and development promised and the hope for change with independence on the horizon.

Easmon had fought his own personal battle to insert histories of African doctors into the British colonial narrative, to acknowledge their role as crucial for the future of the colonies. In a letter published in the *British Medical Journal* the year this photograph was taken, Easmon eviscerated an article written by a white British physician entitled “The Medical Future of the Colonies.” Responding to a spate of punitive salary reforms and pointing out his 32-plus years of service and his membership in the British Medical Association since 1912, he wrote: “Can it be then, then, that the writer seriously considers that we have no grievances or that they are too trivial to be considered? Very early in the article it is stated: ‘It is no exaggeration to say that before this war most people were profoundly ignorant of conditions in this Empire.’ This persistent overlooking and ignoring of the non-European civil servants in the Colonies is one of them.”<sup>226</sup> In this respect his effort, ignored by the *British Medical Journal*, had failed. But his vociferous attempt placed his appearance in the *Annual Report* within a context of decades of self-fashioning, and re-framing what it meant to be a professional Creole health care provider.

## **Conclusion**

Decolonization and the end of British rule were followed by the opening of the Sierra Leone National Museum. Dr. M. C. F. Easmon was at the helm of this endeavor, both administratively – as Chair of the Monuments and Relics Commission, obtaining the funding necessary to build and operate the museum – and materially, curating objects for exhibit from across Sierra Leone. His status as a reservoir for 'tradition' casts his curious presence in the 1948 *Annual Report* in yet another light. The text accompanying the image, and in fact all images

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<sup>226</sup> BMJ 1946; 1:219

from the series, reads: "Maternity and Child Welfare in Freetown, Sierra Leone: For the past 50 years, African doctors have been directing the Maternity Hospital and centre at Freetown, Sierra Leone. All the doctors and African nursing staff have been trained in England. The centre includes an ante-natal clinic, Labour wards, Lying-in-wards, Post-natal and Infant Welfare Clinics." I suggest that in this image, through the lens of hospital maternity care and the presence of Dr. Easmon, we can read a revisionist narrative of half a century of African medicine, co-produced with the colonial government.

Easmon would have known that this caption was only partially true, as African physicians in Freetown were relegated to a subordinate position which they embraced over time, but within which they flourished. Easmon and his contemporaries were highly respected community members and active in the formation of the Republic of Sierra Leone, but after a 1951 constitutional revision redistricted the entire country and decimated Krio presence in government posts, it became clear that the new Republic would favor residents of the Protectorate over Creole elites of Freetown. Perhaps, then, Easmon's presence in these photographs helps frame the curious persistence of "Cottage" in Freetonian parlance long after the Cottage Hospital was officially renamed. Easmon, stepping in to Renner's shoes as the head of maternity services in Freetown, was personally and professionally integral to claiming maternity services as "We Yone" (a Krio expression reserved for businesses owned and operated by Sierra Leoneans). The core of the Cottage Hospital was rebuilt after a fire with British pounds but by Sierra Leonean hands, and with bricks inscribing the names and well wishes of Freetown's residents who, in 1909-10, would have been in the midst of witnessing their Creole giants fall from grace. In brick and mortar, through photographic revision and discursive resurrection, the maternity work of Princess Christian Hospital played a significant role in shaping memories and

futures, serving as a site for what has long been a Cottage industry, performing 'the work' of social and physical reproduction in Freetown.

## Chapter 4

### Where are the nurses?

“Sickness of body and soul are everywhere; where are the nurses?”

Josephine Ingham,

Missionary founder and patron of Princess Christian Cottage Hospital, 1893

#### **Introduction**

This chapter uses visual data as key evidence to illustrate how racialized hierarchies accompanied missionary efforts to train nurses in Freetown and demonstrates how these hierarchies were passed on by Sierra Leonean middle figures as professional nursing gained social status and legitimacy. The chapter actively seeks to incorporate the female and African professionals involved in medicine and maternity in Freetown from the late 19<sup>th</sup> century through decolonization and to the recent past. It also begins the critical pivot of the dissertation: in seeking women’s voices and experiences and placing them at the center of the narrative to the extent possible, this dissertation contributes new data to histories of obstetrics, nursing, and the role of women in medicine in West African history.

With Josephine Ingham's words above as a guide, it first tracks the movements of British and Sierra Leonean nurses within a photographic frame and then tracks the movements of Sierra Leonean nurses within institutional and social hierarchies of the 21<sup>st</sup> century. This methodology

is informed by the work of contemporary scholars of colonial photography<sup>227</sup> as well as Nancy Hunt's recent work on suturing as a mode of writing history; yet while Hunt reflects on suturing as narrative anachrony, this chapter argues for a material understanding. Combining medical and visual analysis, it considers specific suturing techniques as processes of creolization, thinking about when and why they are used in surgical procedures, to argue that the language of suturing can provide a heuristic for thinking about the work of historical photographs.

Historians of the visual write that images of Africans were integral to the British colonial project in Africa rather than adjunct to it. Christraud Geary argues that since "photography, beginning with the daguerreotype in 1839, virtually accompanied the exploration of interior regions of Africa, the failure to exploit photographs systematically as source materials seems rather astonishing."<sup>228</sup> Killingray and Roberts stress the necessity of an approach employing "the critical use of the photograph in active counterpoint with words to nourish a sense of history at once more subtle and lively than either can be expected to achieve on their own."<sup>229</sup> Likewise, this chapter argues that visual elements of the colonial archive can and should be closely scrutinized as rich historical texts, *especially* within the context of colonial Africa.<sup>230</sup> Taking these suggestions seriously, this chapter employs a systematic analysis of photographs as visual texts.

What does it mean to treat the photographic image as a social text? For the purposes of this chapter it is to stress the construction, fixation, and dissemination of the image as an

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<sup>227</sup> For an excellent review of recent scholarship on visuality in African Studies, see Drew Thompson, "(Re)Exposing Old 'Negatives': New Discourses and Methodologies in Photographic Studies on Africa," *African Studies Review* 57, no. 3 (2014): 175–85.

<sup>228</sup> Christraud Geary, "Photographs as Materials for African History: Some Methodological Considerations," *History in Africa*, 13 (1986):93.

<sup>229</sup> "An Outline History of Photography in Africa to ca. 1940," *History in Africa*, 16 (1989):311.

<sup>230</sup> For an insightful discussion of working with the photograph as an archival document see David William Cohen's *Combing of History*, Chapter 5, "Pim's Doorway"



ethnographic record. In *Mythologies*, Roland Barthes works to broaden the definition of writing to include anything that conveys a message. "Pictures" he claims "become a kind of writing as soon as they are meaningful: like writing, they call for a lexis. We shall therefore take language, discourse, speech, etc. to mean any significant unit or synthesis, whether verbal or visual: a photograph will be a kind of speech...in the same way as a newspaper article."<sup>231</sup> This understanding of photograph-as-text complements the Geertzian notion that social discourse can be inscribed into ethnographic field notes, transforming "a passing event, which exists only in its own moment of occurrence, into an account, which exists in its inscriptions and can be reconsulted."<sup>232</sup> If images, like written texts, are a re-consultable account, then photographs also accumulate layers of meaning over time as they are read within different contexts and with different eyes. To take seriously the archival photograph as historical text is to critically engage with these layers of meaning. How have colonial photographs been constructed, reproduced, and pressed into colonial service?

Images of colonial medicine in Africa inscribed themselves into conversations with other images. Both multivalent and linked to a particular moment in time, photographs of the subject(s) of colonial medicine conveyed overlapping and often conflicting messages about the scenes they depicted. Their archival utility is perhaps greatest when they appear neatly, with captions, in sequence, but when there appear to be pages missing or when their legibility as part of a photo-narrative seems to break down. This chapter builds on an approach outlined by Natalie Zemon Davis, who takes the "'fictional' aspects of these documents [to] be the center of analysis...their forming, shaping, and molding elements: the crafting of a narrative."<sup>233</sup> This is not

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<sup>231</sup> Roland Barthes and Annette Lavers, *Mythologies* (Macmillan, 1972):219.

<sup>232</sup> Clifford Geertz, *The Interpretation Of Cultures* (Basic Books, 1977).19.

<sup>233</sup> Natalie Zemon Davis, *Fiction in the Archives* (Stanford University Press, 1990):3.

a theoretical exercise. The nature of photographs in the archive, which purport to document a truth, makes consciously addressing their polyvalence an absolute necessity. We must consider the "social life" of the photograph as a time travelling storytelling material object, and consider not only what the photograph is in the world – its place alongside other textual accounts of colonial medicine – but also what it does.

### **Best Practices in British Colonial Photography**

Late 19<sup>th</sup> and early 20<sup>th</sup> century British colonial audiences were accustomed to images of Africans circulating in the form of postcards. Postcards, close companions to the popular travel writing/safari genre, helped whites in the colonies and at home place themselves and their subjects. In *The Colonial Harem*, Malek Alloula describes the circulation of postcards between Europe and colonial Algeria as part of a "vast operation of systematic distortion," he writes: "The postcard is everywhere, covering all the colonial space, immediately available to the tourist, the soldier, the colonist. It is at once their poetry and their glory captured for the ages; it is also their pseudoknowledge of the colony. It produces stereotypes in the manner of a great seabird producing guano. It is the fertilizer of the colonial vision."<sup>234</sup>

Of this fertilizer Andrew Roberts argues that "until well into the 1920s, postcards discharged the documentary-cum-propaganda function of recording events and local activities as well as scenery and personalities."<sup>235</sup> Given the centrality of images to the colonial project in Africa, the fact that government publications of the colonies incorporated photography is not surprising. By the 1940s, when the photograph above was taken, British audiences would not

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<sup>234</sup> Malek Alloula, *The Colonial Harem*, First Paperback Printing (University of Minnesota Press, 1986), 4.

<sup>235</sup> Andrew Roberts, "Review: Photographs and African History" *Journal of African History*, Vol. 29, No. 2, (1988), p. 307

only have been familiar with circulating images of Africans, they would have come to expect them.

Visuality played a crucial role in the work of British colonial and missionary medicine in Sierra Leone. Jack Thompson argues that "how Europe thought about Africa in the nineteenth century was, to some extent at least, determined by the images which were reproduced in countless missionary periodicals and books."<sup>236</sup> Beginning with David Livingstone, the linkage among visuality, missionary efforts, and colonial medicine grew clearer in those images. Photography was a means for colonial physicians to influence the European perception of the "natives" they administered. Livingstone, in the 1858 expedition to Zambezi, employed his brother Charles as an official photographer. Acutely aware of the photograph's power to establish a narrative, Livingstone directly instructed him to photograph "not the ugliest but, (as among ourselves) the better class of natives who are believed to be characteristic of the race...and, if possible, get men, women, and children grouped together."<sup>237</sup> Christraud Geary also notes this tendency, writing that "aware of the official character of the archives, missionaries would carefully select what they sent there: in other words they would choose the "best" in terms of subject and quality."<sup>238</sup> This effort to circulate photographs that would create a positive image of Africans as well as the relationship between missionaries and Africans can be linked to the cultivation of a positive missionary self-image. This impulse toward illustrating success would reappear in late colonial-era medical photography, that which captured this most intimate form of ministry.

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<sup>236</sup> Thompson, T. Jack. *Images of Africa: missionary photography in the nineteenth century: an introduction*. Centre of African Studies, University of Copenhagen, 2004.

<sup>237</sup> Letter of David Livingstone to Charles Livingstone, 10 May 1858 in JPR Wallis, ed, *The Zambezi Expedition of David Livingstone 1858-63*, Vol. 2, 431.

<sup>238</sup> Christraud M. Geary, "Missionary Photography: Private and Public Readings," *African Arts*, Vol. 24, No. 4, Special Issue: Historical Photographs of Africa (Oct.,1991), p.48



Figure 7 Patients and Staff outside Princess Christian Hospital Sierra Leone, 1893

### **Waiting for the Doctor**

The photograph in Figure 7 was taken outside of the Princess Christian Cottage Hospital in most likely in summer of 1893. It appeared in the *Sierra Leone Messenger*, a quarterly publication of the Church Missionary Society, whose missionaries founded the hospital in 1892. The *Messenger* had two main purposes: to report home about the good work of the mission and to encourage donations. This photograph was commissioned specifically for inclusion in this edition of the *Messenger* and follows Geary's assertion that such photographs were examples of

how medical missionaries wanted to represent their best work. This image was included along with glowing reports of the Hospital's success in the *Messenger*, the voice of the Diocese of Sierra Leone in Great Britain, at the conclusion of the Hospital's first year of existence.

The photograph followed many conventions of late 19<sup>th</sup> century British missionary photography. Its subjects were loosely arranged, neither formally nor haphazardly, but organized so that every subject's face could be seen looking towards the camera. The photograph was taken outdoors and closely cropped, focusing the viewer's attention on the human beings in the frame rather than the building. Scrutinizing the photograph reveals a group varied in age, sex, class, ethnicity, and state of bodily health. Children and young men sat on the ground, distinguished-looking elderly men in waistcoats stood amidst women with bare shoulders. Millinery consisted of everything from bowler hats to head wraps made from strips of cloth. The photographer centered the image on one of three white pillars dominating the image, dwarfing the subjects and dividing the field of vision roughly into thirds. These are what Elizabeth Edwards would call the 'forensics' of the photograph, it's 'vital statistics.'<sup>239</sup> But what did the photograph do? What work may we enable it to do now?

The photograph participated in two competing discourses, both of which would have been familiar to the *Messenger's* audience. The first was a visual rhetoric which produced knowledge about Africans as part of the discursive process of mapping Empire in the latter half of the 19<sup>th</sup> century. This project of legibility, visually incising difference between subject and object, colonizer and colonized through sartorial and spatial practice, would have been easily decoded by the intended audience – missionaries and benefactors at home in Britain. In this

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<sup>239</sup> Elizabeth Edwards, "Folded in Time: Thoughts on a Photograph Album." Talk delivered at Eisenberg Institute, University of Michigan, March 24, 2014.

photograph the nurses were clearly delineated from the Africans by their white caps and uniforms; they were also clearly at the margins. The British "sisters" stood on the far left and Sierra Leonean "native nurse probationers," or students, stood on the right steps and balcony.

The photograph also participated the visual discourse of missionary medicine. Josephine Ingham, author of the accompanying article in *The Messenger*, characterized missionary medicine as that which "can reach people in a way which no ordinary mission can do, for it is when the body is sick and suffering that the services rendered by love and self-sacrifice are most likely to impress the mind."<sup>240</sup> Following this logic, Africans were seen as most susceptible to Christian conversion when they were physically ill. Needy African suffering should be at the center of this discourse. Accordingly, physical pain was visually materialized in photograph: a figure standing in the middle of the group with a conspicuous bandage wrapped around his lower jaw. Ingham asked the reader to reach out to the children in the image, these "suffering little ones...leading sad, loveless lives" by sparing a few toys and books "from our English homes for our black brothers and sisters."<sup>241</sup> The appeal to humanitarian action was based on an imagined human community whose borders were nebulous, context-specific, and underscored by the marginal position of the British nurses. Together in the photograph the figures became brothers (or sisters) yet remained Others.

The rhetorical tension between the competing discourses – essential alterity and the brotherhood of humanity – was visually mitigated by the position of the nurses. The *Messenger* named only four subjects in the photograph. The "two English ladies who have gone out to Africa to assist in relieving the sufferings of their African brothers and sisters"<sup>242</sup> were Mary

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<sup>240</sup> Ibid, p. 83.

<sup>241</sup> Ibid, p. 81.

<sup>242</sup> Ibid.

Ward and Alice Griffin. These British nurses appeared on the same visual plane as the patient population but not in their midst. In terms of the Christian faith, they were the living embodiment of Jesus' exhortation that his disciples remain *in* the world but not *of* the world.<sup>243</sup> Side by side with heathen and pagan, they provided a sense of British colonial presence as witness and aid to African suffering, and stood as proxy for the absent physician. In terms of the Christian faith, these women ministered under the Jesus, the Great Physician while at the same time ministering healing under the human missionary physician who had not yet made his daily rounds. With the apparatus and planning that would have gone into staging such a group photograph, it is worth considering the proposition that the physician was not essential to the Good Work done at the mission. If we take Geary's analysis in to account the "best" work, that captured in the photographic text, was that which was conducted between nurses and patients.

The only other named figures in the photograph were the Sierra Leonean probationers or nurses-in-training. These educated, Christian, ministering "natives," Agnes Thompson and Susan Cole, were just close enough to their British 'sisters' to merit white uniforms (provided only after successfully completing a full year of training), inclusion in the written text, and a marginal position in the photograph which mirrored that of the British sisters on the left margin as relative to their "suffering countrymen." The complex liminal figure of the "native" but named probationers constitutes an inherent rhetorical dissonance into the photograph. These women had a foot "in" *both* worlds. How might this tension be reconciled?

The photograph performed a process of *imbrication*. I use the term not in the common sense of sedimenting or tiling, but rather in the medical sense of overlapping tissue to close a wound. As a surgical technique, imbrication is not simply a process of approximating raw edges,

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<sup>243</sup> See the Book of John 17:14-19



but of layering and strengthening tissue structures. The discourses of the essentially Other African and of care provided on the basis of fundamental shared humanity were imbricated in this photograph. They were sutured together - fixed in time, fixed in relative space, and fixed to paper material - and circulated in this form which became, in the *Messenger*, a coherent message to be quickly read from beginning to end. Negotiating the rhetorical space between the suffering African and the civilizing British, we see the African nurse. The civilized savage: a moral dilemma resolved, considered a major success of this particular mission.



*Figure 8 Patients and staff, Princess Christian Mission Hospital, c. 1931*



The photograph in Figure 8 was taken c.1931 on the steps of what was then known as the Princess Christian Mission Hospital. The photograph was included in the personal papers of Mary Ward who retired from the Hospital in 1930, having spent over 25 years there first as nursing sister then as matron. The photograph was taken after Ward's retirement, likely during a return trip she made in 1931. Her caption, written on the back, claims "a record set at the weekly child welfare clinic of 401 participants on a Thursday morning." Indeed, attendance numbers for 1931 show over 12,000 visits by Sierra Leonean mothers and infants were made that year alone. A Dr. Elliott, who began work at PCMH in 1931 and maintained a relationship with Ward long after her retirement, wrote in an elegy that Ward "always 'went to Africa' on Sunday afternoons when I was unable to visit her. When I was able, she then got her photograph albums out and declared that she had been to Africa while I was away!"<sup>244</sup> This image was part of Ward's personal album, which contained images of her home and work in Freetown, its careful maintenance and display evidence of her effort to remember 'the work' as a successful venture.

Existing as part of Ward's collection in the archives, the photograph's yellowed hue and tattered edges suggest Ward's repeated holding and showing it, perhaps passing it around for closer inspection, and re-placing it neatly underneath the paper corners fixed to its size. In this, the photograph bears traces of the historical imagination of a missionary nurse remember social relationships in a particular, fixed way. In this arrangement British nurses were at the center and Sierra Leonean nurses directly adjacent. While both groups of nurses wore white, they were delineated from one another by different millinery: The British wore simple hats or the pith helmets of the colonial explorer and the Sierra Leoneans wore nurse's caps in a style seen

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<sup>244</sup> Cambridge University Library: Royal Commonwealth Society, Mary Ward collection, RCMS 134/1/a2.

elsewhere in 1930s British nursing uniforms. The photographer's efforts to achieve symmetry and balance did not go so far as to intersperse African and British nurses, but unlike the first image they do occupy the same visual plane. A figure I know to be a Sierra Leonean health visitor sat at the right hand of the British matron, acting as a visual "middle figure" mediating the space between her supervisor on one side and a breastfeeding mother on the other.<sup>245</sup> Her name was Miss Macauley.

This image was also a prime example of the conventions necessary for participating in visual interwar discourse. The subjects were outdoors. They were relatively evenly distributed on either side of the neatly symmetrical steps, which themselves aid in accomplishing the pyramid configuration common in hospital photographs at the time. Social hierarchy was made *explicit* in such photograph, both in Britain and the colonies, through the almost universal convention of placing the most important or senior figure/s in the social hierarchy at the center of the image. This figure was often seated (on a chair, never on the ground). "Following the nurses" in this case, we see that the British 'sisters' were now placed in the center of the frame and seated in chairs. A great deal of the social and economic diversity seen in the 1893 image is gone. This group is comprised entirely of women and infants or young children who appear not in fine clothing – as the man in a top hat did in the 1893 image – but in everyday *lappas* tied around their bodies and scarves tied around their heads.

By the 1930s, the British colonial government had intensified efforts to map the people of Sierra Leone. Interwar pronatalist policies aimed at registering and monitoring pregnancy and supervising childbirth became key technologies of increased surveillance, eventually leading to a

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<sup>245</sup> For the definitive work on middle figures, see Nancy Rose Hunt, *A Colonial Lexicon: Of Birth Ritual, Medicalization, and Mobility in the Congo* (Duke University Press, 1999).

reorganization of the Hospital as a dedicated maternity center. This photograph marked the year that a major census was taken throughout the country, the first to seriously consider inhabitants of the Protectorate (inland areas closer to the Guinea and Liberia borders). The 1931 census was part of a push to create new knowledge about these newer colonial subjects, to locate, count, order, name, and know them in increasingly intimate ways. The Mission Hospital attracted more and more numbers of women during the interwar years, and an increasingly large number came from the 'upcountry' Protectorate. The Infant Welfare Clinic was frequented by women from the capital city of Freetown and well beyond. With this in mind, I make one final 'forensic' observation. It should be noted that there were roughly 200 infants in this photograph and only two of them were crying. In the continued effort to impose British order over African chaos, this photograph mirrors the imagined role of maternity care and PCMH in interwar Freetown as a site for the promotion of colonial *order* and *symmetry*.

The photograph accomplished two important things. First, like the 1893 photograph this photograph again brought together competing forms of colonial discourse: one a visual, spatial rhetoric which – this time even more sharply - *incised difference* between the British and the 'natives.' The other was the globalizing medical discourse of the interwar period which focused attention on promoting the health and welfare of mothers and babies throughout the African continent and beyond. The two colonial projects were overlapped and fixed together in the photograph.

### **Making it Official**

By the 1940s, photographs of Africans were circulating in the growing discipline of anthropology. As a discipline, anthropology is historically (and problematically) linked with

government efforts to "know" the other.<sup>246</sup> Colonial governments often employed anthropologists in these efforts, and their work rippled in circles far beyond academia. Photography was an integral part of that endeavor too. One of the most famous of these early projects, *The Nuer*, was written by a founder of British social anthropology, E.E. Evans-Pritchard.<sup>247</sup> His highly influential work in Sudan incorporated numerous photographs. In fact, a massive collection of Evans-Pritchard's ethnographic photography of Sudanese people is currently housed at the Pitt-Rivers museum at Oxford, England.

The trend towards incorporating images reached the highest form of official accounting for imperial activity in the latter half of the 1940s. *The British Colonial Office Annual Report on Sierra Leone for the Year 1948* participated in a familiar visual discourse. At 56 pages, it was the first of such reports published since 1939, when the publication of all annual reports on British Colonies ceased on account of the World War I. As such would have helped reorient the British public to its foreign subjects and set the tone for the British relationship with Africa in the strange new landscape of post-war Europe. The 1948 issue heralded a major shift in the genre: prior Annual Reports were solely text-based. It is likely that the new format was reflective of a new scrutiny of colonialism, a heightened sense of accountability and the need to differentiate British efforts from those of communists and Nazis. It was also instrumental in informing a readership eager to know what good funding diverted to the Colonies in the lean reconstruction years was doing. The changes were significant; in addition to the fact that the new series would cover only a portion of the Empire and would highlight "progress" made during the war years, as part of the new reader-friendly format all Reports would have a "pictorial cover...four pages of

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<sup>246</sup> Kings Sierra Leone, "KING'S IN THE FIELD: Connaught Fashpack," *KING'S IN THE FIELD*, May 16, 2014, <http://kingsinthefield.blogspot.com/2014/05/connaught-fashpack.html>.

<sup>247</sup> Edward Evan Evans-Pritchard, *The Nuer: A Description of the Modes of Livelihood and Political Institutions of a Nilotic People* (Oxford University Press, 1969).

illustrations...and a map."<sup>248</sup> This information provides evidence of the prominent role visuality played during the move towards African independence and the end of formal empire.



*Figure 9 Student Bendu doing microscopic work*



*Figure 10 Student Adi-Pratt is seen conducting an experiment*

Figures 9 and 10 above were taken in 1946 by an agent of the West African Photographic Service, a propaganda arm of the now defunct Central Office of Information in London. They are

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<sup>248</sup> HMSO: Great Britain Colonial Office Sierra Leone Report, 1948.

part of a large series of photographs held at the Royal Commonwealth Society archive in Cambridge. Several images from the series were used in the 1948 *Annual Report*.

The series' internal coherence bore many similarities to photographs taken across British-held territories during the latter half of the 1940s. They were usually taken indoors and featured just a few subjects, almost all of whom were "natives." They were meant as illustrations of glossy new texts describing work accomplished, in this case the 'social and economic progress of the people of Sierra Leone.' To this end they overwhelmingly depicted action and labor – subjects were photographed doing things rather than standing still looking at the camera. The trend reflected the turn toward realism popularized by war photography in the 1940s, which created an expectation among European viewers that what the camera captured in the field was the truth.

An examination of the set of photographs included in the 1948 *Report* provides clues to the image of colonialism Britain wanted to project in the years immediately following the war. In the larger series of the goal was to visually render the readiness of colonial subjects to assume the reins of independence a *fait accompli*. The block of text accompanying figures 9 and 10 reads:

A college where young Sierra Leoneans can learn to become agricultural instructors, primary teachers, and forest rangers is run by the Sierra Leone Government at Njala, a day's journey from Freetown, the capital. On successful completion of their training, the boys are appointed to stations in the interior where their work is of the greatest help in combating illiteracy and ignorance and in spreading the rudiments of modern agricultural and forestry knowledge...The College is well equipped with visual aids, scientific apparatus, and a recently installed talking cinema unit. The social life of the College includes football, cricket, indoor games, library and

reading rooms and a Literary Circle. The staff of two Europeans and five Africans are seconded from the Agricultural and Education Departments. A large measure of responsibility is delegated to the students who govern themselves through an elected committee.<sup>249</sup>

In most cases throughout the series, this accomplishment was rendered as an uncontested visual narrative alongside texts such as this. Central in the majority of these photographs was the success of colonial 'development,' and the Africanization of the colonial administration. Through images of often named subjects, African competence, industry, and technical knowledge were on display, up close and personal. The nature of the photographs chosen for inclusion in the *Annual Reports* (such as figures 9 and 10), suggests that successful illustrations of development and progress only worked when the photographer – the colonial administration's equivalent of the 'man behind the curtain' – remained behind the curtain.

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<sup>249</sup> "Young Sierra Leoneans Train For Battle Against Ignorance. Njala Training College." London: Central Office of Information. Archives of the Royal Commonwealth Society, 1868-1990



Figure 11 Miss Macauley, Senior Health Visitor

The process of imbrication was quite advanced in Figure 11. The British missionary nurse was gone, replaced by a Senior Sierra Leonean Health Visitor, the same woman who had weighed the infants during Dora Earthy's 1925 visit and sat in line with the matron in the 1931 image. In this image, nursing authority and social status were centered in the form of Miss Macauley, the named subject in the photograph, standing in fashionably strappy white pumps and a stylish bob in contrast to the African women with headscarves and bare feet. The *Annual Report* of 1932 tells us that Miss Macauley, who was listed as the fourth African nurse (thus still not a "sister") in charge of the East ward and but employed by the colonial government. Also trained in England and with a CMB, as the sole health visitor for the East Ward where PCMH was located, Macauley made 4457 visits herself vs. 3798 from the colonial hospital health visitors combined, "tracing and visiting the mother and child and giving advice to the mother and



attendant about feeding, clothing, bathing, and caring for the baby."<sup>250</sup> Macauley appeared in the photograph performing the clinical work of surveillance and civilization that her British predecessors taught her, making a direct link between the Hospital as Mary Ward imagined it and as it would be realized by the agents of the independent state upon decolonization. Following the movement of the nurses we may note that African nurses moved from the margin in 1893 to a position adjacent the British Matrons in the center in 1931. With the central figure of Miss Macauley, by then a 20-year veteran, and the absence of any British supervisor in a single image from this series, we may conclude that by 1948 the Mary Ward figure had not left the frame; rather, she haunted it in the form of her proxy, Miss Macauley.

## **Conclusion**

This chapter has argued that photographs and visual representations of colonial hospital work performed a work of imbrication, stitching together overlapping layers of discourse the way a surgeon overlaps layers of incised muscle to reconstruct a functioning organ. In the late colonial era, with decolonization on the horizon, staged photographs attempted to finish this work, covering over layer upon layer of competing visual and medical discourse with the photographic equivalent of what some medical students refer to as the "Holy Grail": the subcuticular stitch. This technique is often the final step in a caesarean section, concealing the extensive work of uterine reconstruction following surgical birth by placing the suture material just below the skin's surface. The subcuticular stitch is used to close a wound when minimum disruption in skin integrity is desired. This technique – also used in cosmetic surgery – is said to approach achieving the 'invisible scar.'<sup>251</sup> As we followed Miss Macauley to the center of the

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<sup>250</sup> Annual Report of the Medical and Sanitary Department for the Year 1933, p. 23

<sup>251</sup> Durai and Ng, "Subcuticular Stich: a Review of Various Methods." *British Journal of Hospital Medicine* 2009 70: Sup5, M74-M76

frame, we noted her crisp white uniform but also her fashionable, modern hairstyle and her stylish (if impractical) white pumps. In the photograph and in her role in the development of Freetown's maternity services, Miss Macauley joined Mary Ward to the revisionist caption promoted by the departing colonizers and to the social complexity signified by her the attire. If the photograph imbricated, the figure of Miss Macauley embodied the Creole nature of nursing.

## Chapter 5

### A Uniform Profession? Nursing since 1961

#### **Introduction**

This chapter argues that the hierarchies imported with the British model of nursing mapped on to pre-existing Sierra Leonean social hierarchies, creating tension after the categories of nursing were modified in 1961. It suggests that the proliferation of categories, codified in nursing uniforms, contributes to conflict on the labor ward. 1961 was a critical year for nursing in Sierra Leone. This was the year when the newly-independent nation of Sierra Leone, the National School of Nursing, and the Nylander Multi-Purpose model of nursing emerged almost simultaneously. With the withdrawal of the British rule in 1961: "The old scheme for the training of nurses, which produced the Sierra Leone State Qualified Nurses, was found to be unsuited to the needs of the country. The basis for this scheme was much more suited for an advanced country with a temperate climate as its emphasis was more on curative rather than preventative medicine."<sup>252</sup> The Nylander model created a new category: a distinctly Sierra Leonean nurse whose credentials were tailored instead to serving the needs of the new nation. The precise nature of a "fully multi-purpose nurse" was distinctly gendered, as only women trained for

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<sup>252</sup> Valerie M. Nylander, "The Multi-Purpose Nurse of Sierra Leone," *International Journal of Nursing Studies* 6, no. 4 (November 1969): 183–88, doi:10.1016/0020-7489(69)90032-7.

obstetric, gynecological, and pediatric nursing and only men trained for surgical theater nursing. "The two years' scheme leading to State Enrollment was designed to produce a multi-purpose nurse who could eventually operate anywhere in Sierra Leone - in the general hospitals, tuberculosis units, paediatric hospitals, in midwifery and in the public health field."<sup>253</sup> The Nylander model mandated nurses to become proficient in all areas of practice and required that they rotate through hospital wards and stations throughout the country.

### **Nursing after Nylander, 1981-2012**

During the decade before the Civil War, from 1981 to 1991, post-Nylander nurses attempted to maintain links to British clinical preceptors while deepening and formalizing connections to other groups of nurses in West Africa. Neither attempt fully succeeded, and by the outbreak of civil war in 1991 many of the remaining "last generation" of British-trained nurses had fled the country for safer and greener pastures. Healthcare spending declined so sharply during these years of massive government corruption that nurses, like many other civil servants, were left working for wages that were promised but rarely came.

When war broke out in 1991, many of Freetown's professionals stayed put, never imagining that the trouble at the border would reach the city. When it became increasingly apparent that this was an almost certain eventuality, those who could leave did so. In the mid-1990s, as most of the country's qualified medical and nursing staff sought asylum abroad while the RUF continued its campaign of terror, the Ministry of Health created a new category: the Traditional Birth Attendant (TBA).<sup>254</sup> This explicitly gendered category melded "traditional"

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<sup>253</sup> Ibid., p. 184

<sup>254</sup> The trend was not limited to Sierra Leone but part of international efforts to broaden access to women's healthcare. The architects of the program owed much to the groundwork that had already been laid. Dr. Blacklock at PCMH in the 1930s and Dr. Milton Margai in Ministry of Health the 1950s and 60s worked to capitalize on the existing skills and knowledge of women already assisting in childbirth in rural areas.

forms of legitimate authority with a biomedical model of reproductive health, drawing support from elders of the women's secret society (the Soweï or Sowò) as a "make do" strategy.<sup>255</sup> Unlike narrower categories of health workers such as dressers or dispensers, TBAs could draw on plural sources of authority, securing a place in both the bureaucratic apparatus and the Sande society. Thus maternity care again provided a means of achieving status and legitimacy and social mobility: this time for less educated but socially powerful, knowledgeable women from rural areas. However, the physical mobility of a TBA remained constrained.

Since the war, the categories of people providing varying degrees of skilled maternity care have continued to evolve and subdivide. In 2011-12, those who had qualified locally (within Sierra Leone) as nurses fell into one of two categories: the State Enrolled Community Health Nurse (or SECHN) who had completed two years of training and the State Registered Nurse (SRN) who has completed three years. There were also Nurse-Midwives, State Registered Nurses with an extra 18 months' training in midwifery theory and practice.<sup>256</sup> Wards were managed by Ward Sisters whose combination of seniority and education placed them into quasi-administrative roles. The Ward Sister only intervened in hands-on care if a situation was unusual or emergent and requires an advanced skill level. Finally, there were the Matrons. These women occupied the office on the top floor of the Hospital. From this perch, they could overlook the ocean, take tea on silver trays, and exercise dominion over resources of all kinds. The sign

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<sup>255</sup> Amara Jambai and Carol MacCormack, "Maternal Health, War, and Religious Tradition: Authoritative Knowledge in Pujehun District, Sierra Leone," *Medical Anthropology Quarterly*, New Series, 10, no. 2 (June 1996): 270–86.

<sup>256</sup> Although one informant, a midwife from South Africa became livid when I asked her about the extent of midwifery training at the National School of Midwifery, located in the same compound as PCMH. It seems that midwives can become qualified simply by watching deliveries. Actually demonstrating the skills required to deliver a live infant successfully were not necessary to achieve midwifery certification and the purple striped uniform that accompanied it.

outside the Matron's office in 2011-12 forbade nursing students from entering the Matron's office if they were not attired in the proper uniform.

### **Creole Uniforms**

The following five images come from "Freetown Fashpack," a blog maintained by King's College London, who have an educational partnership with Connaught Hospital, the main Government Hospital in Freetown. The captions are as they appear on the website and the uniforms are identical to those worn by staff at PCMH.<sup>257</sup> The last image is of Mary Ward.

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<sup>257</sup> Kings in the field: Connaught Fashpack, <http://kingsinthe field.blogspot.com/2014/05/connaught-fashpack.html>, accessed April 10, 2016. Images used by permission of Jo Dunlop.



Figure 12 “Fatmata is a first year state enrolled community health nursing student (SCHN). Each year she will add an extra blue stripe to her nursing hat but will remain in the blue and white until she becomes a trained nurse.”



Figure 13 “State registered nursing students (which requires a higher entry qualification than the community nursing students) wear this pink uniform every day of class. Their year of study is identified by the stripes on their nursing hat.”





Figure 14 “As a fully trained state enrolled community health nurse Adiatu has also broken free of the blue and white and now wears a grey uniform with lace edged and white hat to work each day.”



Figure 15 “Agatha is a fully qualified state registered nurse and required five 0 Levels to be accepted into the three year nursing course at COMAHS . State registered nurses wear all white uniforms with a red belt. There are no hard rules about the type of belt, I've noticed the elasticized variety with a jeweled clasp is quite popular. Agatha picked hers up from PZ market in town, Freetown's shopping epicenter.”



Figure 16 “The boss lady Matron Kamara is identified by her white hat and blue belt. The four stripes on her epaulette indicate that she is the most senior nurse in the hospital.”





Figure 17: Sister Mary Ward, c. 1898

To say that the Sierra Leonean nurses' uniforms are anachronistic is to miss the fact that they are based directly on British models. To focus on their historical significance alone would be a mistake because it holds the assumption that British nurses in Freetown are also thing of the past, gone with decolonization and the Africanization of the medical services. In fact, the British never left. Charity and educational organizations have been circulating nurses and midwives from the UK since at least the 1970s. They have come to provide humanitarian assistance in times of great need, and acted as final exam proctors up until the 1980s, certifying that new nurses met British standards.<sup>258</sup> As the 2015 deadline to meet the Millennium Development Goals loomed they came more and more frequently to run skills-based workshops. These brief courses, ranging from a few hours to a few days in length, were meant to demonstrate basic and best practices in nursing, technological innovations, and life-saving clinical techniques. I attended such a course in 2011 and learned that the present-day relationship between the British and Sierra Leonean nurses is still permeated with elements of hierarchy, and that the nurses of Freetown – in uniform and in clinical practice – are still very much in conversation with their British counterparts.

### **“I want to bring myself up”: prestige and pride nursing profession**

Nurses are proud of being nurses. Many of the nurses on the wards were volunteers who turned up every day, in uniform, and worked alongside those who had been “absorbed” by the civil service. Some of these worked other jobs, some came in hours early to sell home-made food or other goods before donning a uniform and picking up slack on the wards. Some relied on the help of boyfriends or lived with parents while they waited to be hired. To be clear, official employment was much preferred and when rumors that the government was “absorbing” nurses

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<sup>258</sup> Interview with Elizabeth Bangura, June 2012

at this or that facility, staff would be sparse that day as hopeful volunteers waited in line to prove their qualifications and receive an official assignment. Official employment came with a regular salary which, however small, was a boon to the unpaid volunteer, but it also came with NASSIT<sup>259</sup> pension, a prize beyond measure meaning that one would not need to rely solely on the charity of relatives in old age. But nursing carried a social currency of its own. When I asked one friend who had volunteered for three years and still hadn't been hired why she kept showing up every day she answered "I want to bring myself up." Together with keeping up skills learned in nursing school, the idea of elevating oneself to a higher social status was the most common reason given for volunteering. This tacit acknowledgement that being a nurse was an end in itself was acknowledged at the administrative level. At one meeting of "in charges" I attended, staff from PCMH, the National School of Nursing, even the Ministry itself, scores of grievances were aired. These included the constant shortage or lack of basic supplies, low wages, no time off, and an exponential increase in workload since the Free Health Care initiative was launched. A senior level administrator for the Ministry of Health replied "The Ministry cannot afford to pay you enough. Just be happy you are a nurse. God will bless you."<sup>260</sup> While some teeth-sucking and hand-waving ensued, the answer carried weight.

The inverse of pride is shame. The rigid hierarchies among maternity nurses at PCMH meant that the exercise of power often came at the expense of parturients. Uniforms performed some of this work, asserting pride of place for the wearer in public – this could be seen throughout Freetown as nursing students in blue and white uniforms carried themselves with an erect dignity even while traveling muddy sidewalks or crammed into taxis. Yet uniforms also

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<sup>259</sup> Sierra Leone's National Social Security and Insurance Trust.

<sup>260</sup> In the Krio language "God bless you" is not an empty aphorism, but a tangible good. As a key informant told me, to say "God bless you" was worth more than money.

signified fine grades of superiority and inferiority inside the hospital, as the following story demonstrates.

The young woman arrived by ambulance, visibly dirty and wearing ragged, stained t-shirt riddled with holes. She was 21, it was her first birth, and it was clear she had been laboring for some time, as her eyes were closed and sweat pooled in the creases of her face. Her husband was with her as was another male, likely an uncle or brother. Dr. Kargbo, a senior attending physician, happened to be in the OPD, so he directed the men to bring her to the adjacent examination room where, upon checking for cervical dilation, he promptly began shouting: “Can I get a nurse in here? Nurse! In here now!” The several nurses in OPD stood and looked at one another, finishing their snacks, until the woman began to grunt loud enough to be heard from the other room. The birth was imminent. “Labor ward! Labor ward!” they cried. Her male family members had faded into the courtyard outside and there was no time to wait for transport so Binta and I transferred the woman into a wheelchair and ran, pushing her ourselves up the incline where someone, years ago, had cemented over the concrete steps of the iconic doorway to the old building. It took both of us to push her through the gate at the top of the ramp and down the hall to the labor ward. The midwife in charge met us at the door and said “Yonder! Go! Take her to Domi.” Domi is short for the Domiciliary Midwifery wing, a space once reserved for private paying patients but long since converted to another open ward. Domi received fewer patients the labor ward simply because it was further from the OPD and more difficult to get to.

By this time the baby’s head was crowning, plainly visible between the woman’s legs. If she coughed or sneezed the head would be delivered. So we rushed on to Domi 1, the labor and delivery side of the wing (Domi 2 was for postpartum cases), through a long corridor, down a steep concrete ramp connecting the new and old wings of the hospital and back up a ramp on the other side. When

we arrived seven midwives in purple uniforms glared at us from inside the ward. Some lay on the beds with their shoes off, sucking on bags of water, text messaging on mobile phones, chatting casually with one another. They glared at the woman. No one moved. The nurse in charge said “We don’t want her here. Take her away.” There were no other patients in active labor. The woman was moaning, grunting, her head lolling to one side. I attempted to hand the chart off to one of the midwives, who refused to take it. Binta explained the situation – that there were no beds in the labor ward, that the birth was imminent. She invoked the name of God, got down on her knees crying “I beg, I beg!” She held her hands together, pleading, negotiating with these women to take charge of a patient who was clearly their responsibility. Finally, one of the midwives slid off the bed and another followed. Shuffling over to the woman they pulled her out of the wheelchair and up the makeshift wooden steps leading to the bare rubber mattress where she would give birth.

As we left her behind in their hands I was furious, incredulous, astonished, and hustling to keep up with Binta as she bent over, leaning on the wheelchair. Then we passed her male relatives, wild-eyed with fear or anticipation or likely both. Rather than explaining where his wife was Binta pushed the wheelchair towards the husband saying “No. You take this down. You made us wheel this patient up by ourselves, you can go take this down and give it to the doctors.”

I asked, repeatedly, what had just happened – why these midwives had refused to take the patient? How could they do such a thing? She was evasive, refusing to answer my questions, staring straight ahead. Just before we arrived back in the OPD she muttered under her breath: “when you are become a nurse, you become cursed.”

In this example, Binta’s subordinate rank was immediately identified by her grey striped uniform. Her inferior training (18 months as opposed to the two or three years required to qualify as a midwife) made her a target for the reinforcement of clinical hierarchy. Like the British



midwives trading in free lunch and certificates, the midwives of Domi 1 commanded a performance of their own, one which shamed the performer in front of her foreign friend.

### **Uniforms as Social Currency**

These visually striking uniforms worn by all nursing and midwifery staff and students at PCMH reflect an elaborate system of color-coded ranking and identification mandated by the Ministry of Health and Sanitation. The uniforms are complemented by a range of accessories, some (starched white caps, elaborate metal scrollwork belts) appearing to come straight out of Victorian England and others (scrubbable rubber shoes, upside-down timepieces worn on the lapel) representing the latest innovations in clinical attire. In Freetown, one cannot simply go to the uniform store and purchase a nurse's uniform. Like the education, training and status with which it is associated, the uniform must be composed. In fact, the state-mandated fabric from which State Enrolled Community Health Nurse's uniform must cannot even be purchased in Sierra Leone; it must be purchased in The Gambia. The 21<sup>st</sup> century nurse's uniform is a semiotic bricolage, bringing together African and European elements from past and present in a material form that conveys a nurse's place in the administrative hierarchy instantly. I learned this in a particularly tense encounter with a traffic warden.

In May of 2011, I was placed under arrest, in my hired Ford Explorer, for the fifth time. The charge was a malfunctioning windshield wiper. On my way home from PCMH, I had three student nurses in the vehicle with me, all of whom argued with the arresting officers that I was a nurse, working at the hospital, and that they should release me. As a Fulbrighter, my well-being was to a certain degree the responsibility of the U.S. Embassy, and by arrest number five, I had Yusuf Kamara, Public Affairs Officer, on speed dial. Yet neither a phone conversation with him nor with the vehicle's owner (who was ultimately to blame for the faulty wiper) were enough to

secure my release, and the arresting officer insisted we proceed to the Central Police Station for booking. I eventually lost my temper and began yelling loudly in a furious mixture of shrill Krio, profane English, and hot tears. I pulled the nurse card, the Sierra Leonean-American card, the American citizen card, and the "pickin wellbodi" card. I pulled every card in the deck. Finally, I pulled my blue uniform and operating theater shoes from the back seat and something clicked. The officer's face twisted into a scowl: "Wetin mak yu nor de tell me yu na nurse?" Why hadn't I just told her I was a nurse? I was released immediately, free to go about my business provided the wiper was fixed the next time the officer saw me. As this story attests, the uniform itself can remove roadblocks and facilitate mobility. As Jennifer Craik suggests, it can impose conformity but also facilitate subversion.<sup>261</sup> It can also trump other, non-visual forms of authority and power.

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<sup>261</sup> Jennifer Craik, *Uniforms Exposed: From Conformity to Transgression* (Berg, 2005).



Figure 18: A nurse in Freetown wearing a uniform shirt made of fabric marking the 50th anniversary of the Sierra Leone Nurses Association. Commemorative fabrics are used throughout sub-Saharan Africa to visually document important people and events. This cloth features the emblem of the Association: Florence Nightingale's lamp. The cloth may only be purchased from the Sierra Leone Nurse's Association. Photo by Tara Dosumu Diener, 2012

## Conclusion

This chapter has argued that much like the photographs in chapter four, nursing uniforms in 21<sup>st</sup> century Freetown perform a work of stitching together past and future. indexing a diverse cache of social capital that can be mobilized on demand. Yet unlike the photographs, uniforms can be consciously and continuously amended, inflected with elements of past and present, the materiality expressive of a nurse's devotion to the calling in the form of the bright white shoes and crisp collars so difficult to maintain while traveling via cramped *poda-poda* or taxi to work in a busy, dirty urban center.

In the same way that obtaining the elements necessary to compose and embellish a standard uniform involves mastering multiple distinct and guarded bodies of social, scientific, and geographic knowledge, wearing the uniform demonstrates mastery of the system. The continued presence of British nurses complicates the significance of sartorial practices that divide Sierra Leonean nurses into multiple, distinct, ranked categories. I suggest that nurses in Freetown today actively engage with and trade in the social currency of the uniform while also maintaining visual links to a distant past, one in which the exchange rate was much more in their favor.

## Chapter 6

“These nurses today, they are strict-o!”

### Situating Clinical Violence

#### Introduction

While medical ideals at PCMH may be imagined as yet unachievable clinical standards, it is also helpful to emphasize imaginaries of clinical practice which, together with embodied memory and institutional history, enfolded the otherwise inconceivable into a vernacular lexicon.<sup>262</sup> Clinical practices incomprehensible to an outsider and incompatible with global clinical standards may be read as an embodied archive of situated knowledge, referencing a locally resonant logic and legitimacy. Working with Joel Howell's tripartite definition of hospital technology<sup>263</sup> (as material object, as practice and process, and as knowledge), this chapter examines the sociotechnical infrastructure of things (gloves, an infant care center) and processes (shift report, recordkeeping). The analysis considers the theories of medicine these things and processes index, highlighting moments of dissonance between these theories and those informing globally dominant Western biomedicine. Analyzing moments of dissonance, I observed some

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<sup>262</sup> Nancy Rose Hunt, *A Colonial Lexicon: Of Birth Ritual, Medicalization, and Mobility in the Congo*, (Duke University Press, 1999). also Claire Wendland.

<sup>263</sup> Joel Howell, *Technology in the Hospital: Transforming Patient Care in the Early Twentieth Century* (Baltimore: Johns Hopkins University Press, 1996).

processes of over-writing, re-purposing, and re-appropriating technologies that resonated with the vernacular.

I have previously argued that during the course of the 20<sup>th</sup> century nurses emerged as the acting administrators of PCMH. This chapter describes examples of nurses disciplining themselves, their juniors, laboring women. I argue that nurses maintain a precarious power by in part by permitting or denying passage across boundaries that re-animate and re-inflect the hospital's deeply situated past; in re-appropriating colonial technologies of rule to fit Sierra Leonean frameworks, they have begun decolonize the locus of biomedical power.<sup>264</sup>

### **“A matter of morals”**

As we learned in chapter four, being seen and recognized as a nurse in Freetown (in a cap, an apron, or a belt with a scrollwork buckle) was in part to display adherence to a moral framework located in an early Cottage iteration of the hospital, which was itself linked to an imaginary of Florence Nightingale. During my ethnographic fieldwork in Freetown maternity centers, I observed that the ideals of educational texts and the frequent sartorial references to Florence Nightingale with lamp were at great odds with everyday practical training and exigencies in the maternity ward. As one nursing student told me while she practiced the art of folding paper to make an emergency cap in case she ever forgot to bring hers: “It is a matter of morals to wear the cap. The cap and the apron, they tell people you are a nurse.” However, the student was folding the cap while actively ignoring her assigned patient who was burning with fever. This dissonance suggested that the student had adopted the ideals of Florence Nightingale selectively, as symbolic of social propriety rather than clinical excellence. The morals signaled at

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<sup>264</sup> Brian Larkin's (2009) analysis of contemporary Nigerian uses of colonial technologies is helpful here, as is Ann Stoler's (2008) discussion of ruination and Nancy Hunt's (2013) work on the afterlives of colonial debris.

this visual register seemed at odds with some of the practices I witnessed on the wards. This chapter argues that the moral realm of PCMH, where death and birth hovered together in the shadows of the wards, must be understood on its own, situated terms.

I could not enter the hospital to begin conducting research until my application for approval from the Sierra Leone Ethics Board was approved – a process which took months and many trips to Connaught Hospital to deliver revisions of my application (each revision requiring the production and circulation of seven hard copies). I was allowed into the hospital compound, just not the hospital buildings, and so I used this time to observe comings and goings, becoming familiar with the gate guards and the hospital grounds. As I sat on a bench in the courtyard outside the main hospital building one morning a woman came to sit beside me. After exchanging greetings, I inquired as to her business there that day. She was alone and appeared to be beyond childbearing age, and she was bursting with joy. Her daughter in law had just given birth to her first grandchild, a healthy boy. She had apparently been laboring for a long time somewhere else, and when the baby was born he “had some distress. His color was not good.” Worried, they brought her and the baby to PCMH, where the baby was taken to the nursery for monitoring. Earlier that morning he had been released to his mother.

The woman was visibly radiant with relief and joy and pride. Congratulations and hugs ensued, and we struck up a conversation about the hospital. Noting my complexion, she told me she had thought I was one of the Cuban healthcare workers who circulated in and out of the hospital as part of a Cuban exchange program. I learned that her son was, in fact, in Cuba at the time, training to be a doctor. He would get a ‘good education’ there, she assured me. Cuban doctors were well-trained, and her son would do well there. He might even stay there. After learning my own reasons for being there that day (since I was clearly not a Cuban physician), she

told a story of three generations of birth experiences at PCMH, a story which began with a hearty assessment, punctuated by a hand clap: “These nurses today, they are *strict-o!*”<sup>265</sup> They are *good!* The place is *clean!*” She told me that when her mother had given birth to her “the place was fine! good!” but when she had given birth to her son there in the 1980s “the nurses were bad. The place was terrible. Mess everywhere, here and here and here, toilet everywhere, just dirty, here, there.” She gestured to memory, pointing out these places as they materialized in her speech. She finished this middle section with a teeth-sucking dismissal: “It was terrible, a terrible place!” This most recent birth seemed to have revised her opinion. Even though she was here in the courtyard, she was happy. The baby was healthy and her daughter-in-law’s mother was with her, taking precedence as the first visitor over this grandmother by marriage. She was perfectly content to wait her turn there in the court yard. In this narrative and in the woman’s demeanor, “strict-o” equated to maintaining a clean environment and enforcing visiting rules, but also seemed to relate to their ability to help her ensure the well-being of her new grandson transition, securing his status among the living.

### **Parsing violence**

"WY! Wy! Wy" Cries the woman on the bed. She 17 years old, it is her first baby, and she has been pushing for over an hour. As she tries to get comfortable, sitting up on the thin rubber mattress, a nursing student tells her to lie back down. Back down on the bed, writhing in pain. 15 minutes pass: "Wy! Wy!" A midwife enters the room and yells at the woman, furious that she is not doing as she has been told: "Wetin you de do? Yu

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<sup>265</sup> The –o suffix in Krio is used either for emphasis or to soften a hard word. My cousins describe my Auntie YoYo, as “hard-o” with a similar hand clapping punctuation. YoYo is generally soft-spoken, tremendously good-natured, and generous to a fault. She once quietly loaned me her entire week’s salary of 90,000 *leones* when I forgot my wallet and was stuck, unable to purchase fuel for the drive back from my grandmother’s house in Bo. However, if she wished to assert dominance over my cousins, to keep their behavior in line as teenagers, she could flip a switch and eviscerate and wither with look and an economy of precise, sharp words. Strict-o signals a similarly hard-soft nature.



wan kill yu pickin?" – she warns the woman, whose name is Musu, that if she doesn't do as she is told she will cause the baby's death. The midwife checks Musu's progress, announcing that a caput succedaneum has formed on the baby's head. She tells Musu to lie on her side and push, and to "lock her feet" together at the ankles. Musu complies as best she can.

The hour drags on. The four students lining the walls chat amongst themselves and occasionally tell Musu "yu geh fo biah" (you must bear it). Finally, when Musu unlocks her feet and attempts to sit up in bed, a student yells in her face "Yu hate yu pickin?! Wha, you nor like yu pickin?!" and directs her to lie back down. "Wy! Wy! Wy!"

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This chapter attempts to make sense of the scene above which played out with degrees of repetition and variation during my observation on the labor ward. Yelling at parturients, pregnant women in the process of giving birth, was common practice at this hospital, as were slapping, verbally threatening, clamping hands over mouths, and enforcing body postures. I do not attempt to justify the actions of those I studied amongst and worked alongside, nor do I intend to pass ethical judgment from a place of privilege and safety. Instead, I use these findings to ask: Was this violence? If so, what was this violence *doing*? Finally, what was it doing in Freetown in 2011-12? I suggest that "clinical violence" may be a useful analytic, framing such practices within the multiple intersecting worlds of this West African hospital.

A review of current literature on violence in African maternity wards yields a curious range of results.<sup>266</sup> There are dozens of articles concerning violence perpetrated by patients on

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<sup>266</sup> See for example Kathryn Anderson, "WORKPLACE AGGRESSION AND VIOLENCE: Nurses and Midwives Say NO," *Australian Nursing Journal* 19, no. 1 (July 2011): 26–29; A. Björkdahl, D. Olsson, and T. Palmstierna, "Nurses' Short-Term Prediction of Violence in Acute Psychiatric Intensive Care," *Acta Psychiatrica Scandinavica* 113, no. 3 (March 1, 2006): 224–29, doi:10.1111/j.1600-0447.2005.00679.x; M. Michelle Rowe and Holly Sherlock, "Stress and Verbal Abuse in Nursing: Do Burned out Nurses Eat Their Young?," *Journal of Nursing Management* 13, no. 3 (May 1, 2005): 242–48, doi:10.1111/j.1365-2834.2004.00533.x.

care providers, nurses in particular and a large body of literature discussing the problems those who work in mental health face when weighing the potential of their patients to perpetrate violent acts in the future. The nursing literature has appropriated the terms 'horizontal' and 'lateral' violence to describe the tendency of senior nurses to 'eat their young.' Practices akin to clinical hazing are widely acknowledged within this literature. Yet none of the results point to violence perpetrated by care providers against patients.

As the 2015 deadline for the Millennium Development Goals grew closer, a wave of literature linked to human rights discourse emerged around the concepts of 'abuse' and 'disrespect.' This literature considered women's uptake of medical maternity services, identifying them as major barriers to seeking professional supervision aimed at decreasing infant and maternal mortality. In a landmark study fundamental to the policy interventions which have sprung up around this literature, Bowser and Hill argued that "disrespect may act as a deterrent to skilled care utilization" having "direct implications on the global strategy for increasing skilled maternal care coverage to achieve Millennium Development Goal #5" to decrease maternal mortality by 3/4."<sup>267</sup> The publication propelled a new wave of literature, contributing to the White Ribbon Alliance's 2011 "Respectful Maternity Care: the Universal Rights of Childbearing Women."<sup>268</sup> This literature offered a new analytic, combining shifts in global health rhetoric with a focus on intervention. Bowser and Hill identified seven categories of disrespect: physical abuse, lack of informed consent confidentiality or dignity (including verbal abuse), discrimination, abandonment, and detention for inability to pay fees. Moyer et.al. called these

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<sup>267</sup> Bowser, D., & Hill, K. (2010). Exploring evidence for disrespect and abuse in facility-based childbirth. *USAID-TRAction Project, Harvard School of Public Health*. p. 49

<sup>268</sup> "Respectful Maternity Care," *White Ribbon Alliance*, accessed May 5, 2014, <http://whiteribbonalliance.org/campaigns2/respectful-maternity-care/>.

practices "maltreatment," further subdividing a subset of clinical practices into targets for specific outcome-oriented intervention.

This decontextualized approach is of little aid for those in the qualitative social sciences who seek to frame the issue with nuance and sensitivity. Moreover, this globalizing rhetoric essentializes the African continent, where more than half of all maternal deaths occur, as a "region." I suggest that a different approach may be needed. Is this maltreatment? Disrespect? Violence? Hannah Arendt provides a useful differential diagnosis, outlining key factors dividing violence from terms with which it is often conflated: power, strength, force, and authority. Power, she suggests, can only rest within a group and can only persist as long as the group remains a group. Strength is akin to power, only in singular form. Force, she suggests, should connote movement and the release of energy. Authority is characterized by unquestioning obedience. Violence, on the other hand, is instrumental. It *does* things in the world.

If nurses routinely slapping women in a maternity ward was violence, what was it *doing*? Perhaps there is a simple answer. Rachel Jewkes, who works in South Africa, argues: "In many developing countries, nurses in the public sector are working long hours in harsh conditions, and there are extreme power differentials between them and their predominantly poor, illiterate patients...In these situations nurses have been reported to employ humiliation, verbal coercion, and even physical violence to assert their authority and *control patient behavior*."<sup>269</sup> Why might a nurse want to control parturient behavior? A common clinical justification for silencing women at PCMH was that crying out – distress in general – could result in raised blood pressure. Nurses would admonish women for loudness, claiming: "When you holla, holla, holla like that you

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<sup>269</sup> R Jewkes, N Abrahams, and Z Mvo, "Why Do Nurses Abuse Patients? Reflections from South African Obstetric Services.," *Social Science & Medicine* 47, no. 11 (December 1998): 1781–95., p.1781. emphasis added

pressure de go up. Dis holla gi yu more trouble." Raised blood pressure is an indicator of trouble in pregnancy, predominantly as the symptom of an underlying chronic pathology called pre-eclampsia, usually accompanied by other symptoms such as headache and vision changes. Thus the mobilization of fear based on a nurse's clinical knowledge could be mobilized to silencing a loud parturient.

Musu was told that lying down would "help her contractions," and that locking her feet at the ankles and pushing while on her side would prevent her from causing her infant's death. The staff in this situation did not provide further clinical justification, but used fear based on an imagined adverse clinical outcome as the key motivator. However, the condition on which this advice was based (evidence of a caput succedaneum and of prolonged labor) would only be exacerbated by Musu's lateral position and crossed ankles. A lateral position is not indicated for prolonged second stage labor, and the upright position she sought would likely have sped up the delivery.<sup>270</sup> The nurse in charge was busy with two other patients and did not have time to attend to Musu. Thus, her crossed ankles and side-lying position made it possible for her to have a birth attended by skilled personnel in the form of the oncoming shift. Upon assuming charge of her at shift change, the midwife who assumed Musu's care performed a cervical check and immediately instructed her to grab her ankles and push. This opened her pelvic outlet and the infant was born within a matter of minutes.

## **Emplacing violence**

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<sup>270</sup> Annemarie Lawrence et al., "Maternal Positions and Mobility during First Stage Labour," in *Cochrane Database of Systematic Reviews* (John Wiley & Sons, Ltd, 2013), <http://onlinelibrary.wiley.com.proxy.lib.umich.edu/doi/10.1002/14651858.CD003934.pub4/abstract>; Seong-Hi Park et al., "Effect of Postpartum Outcomes in Mother's Upright Position During the Second Stage of Labor: Systematic Review," *Korean Journal of Women Health Nursing* 18, no. 3 (September 2012): 209–222 14p, doi:10.4069/kjwhn.2012.18.3.209; Yinon Gilboa et al., "Caput Succedaneum Thickness in Prolonged Second Stage of Labour: A Clinical Evaluation," *Australian and New Zealand Journal of Obstetrics and Gynaecology* 53, no. 5 (October 1, 2013): 459–63, doi:10.1111/ajo.12104.

Episodes of violence at PCMH must be placed within the framework of a hospital as a social and gendered institution that exists in a storied, concrete place. Attempting to grasp the ‘particularness’ of this institution as one of multiple overlapping registers of significance, I draw on Aaron Cicourel’s work on the notion of clinical contexts.<sup>271</sup> Through his analyses of conversations among medical professionals, Cicourel suggests a dual notion of context, which:

Includes an institutionalized framing of activities or ways that group-derived prescriptive norms pressure and/or channel people with designated titles, presumed competencies, duties or responsibilities into certain physical spaces at certain times in order to engage in a finite number of specifiable activities. Within this institutionalized context or framing of activities, emergent processes of talk appear that create a more narrow view of "context" in the sense of locally organized and negotiated interaction.<sup>272</sup>

Appropriating Cicourel’s approach may help place the multiple forms of “interpenetrating...systematically codified”<sup>273</sup> practice emerging in the intensely plural context of this Freetown hospital in the 20<sup>th</sup> century.

### **Touch and distance**

The labor ward was a space of invisible boundaries dividing groups of people from one another and students seemed to understand this instinctively. Yet in the outpatient department there was simply not enough room for them to occupy space separately and the room was negotiated in a wiggling shimmying shifting manner with students, staff, supervisors, and observers such as myself weaving in and out, often touching one another inadvertently or

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<sup>271</sup> Aaron V. Cicourel, “The Interpenetration of Communicative Contexts: Examples from Medical Encounters,” *Social Psychology Quarterly* 50, no. 2 (June 1987): 217–26.

<sup>272</sup> *Ibid.*, 218

<sup>273</sup> *Ibid.*, 224

purposefully. Prior to the Ebola outbreak, casual touch was part of the social fabric. A greeting was a full body embrace. Friends, male and female, often walked along streets and sidewalks with hands or fingers gently touching. When my friend Isatu needed to bring her young son to work with her, as she often did, he would lay his body across both of ours on the gurney in the OPD and nap. It is difficult to emphasize the extent to which touch and physical contact permeated social interactions prior to Ebola, but necessary to factor it in when considering gestures of aggression or violence – perhaps even more so when noting the complete absence of touching women in labor. The first time a woman in labor was touched was often at the point of delivery. For the nurse, attending a woman in labor entailed looking through the doorway occasionally watching for changes or signs of progress. For students it entailed staying in the room throughout the labor, carrying on private conversations about unrelated things. Occasionally a student would laugh and say “yu geh fo biah” in a woman’s direction.

Violence focuses attention on the body. Violence usually entails the deliberate exercise of physical force and involves sensory effect. In terms of sensory effect, the absence of comforting touch could often seem as violent as the slap of a hand. Violence causes harm to the body or psyche, an outcome which terms such as 'maltreatment' or 'abuse' might elide. Above all, as Hannah Arendt reminds us, violence is about the exercise of power. By framing violence within the contextual logic of clinical expediency, we have seen one way such practices might be interpreted. Still, we need a different language to describe practice in some African maternity wards.

Clinical violence suggests a path to another analytic. The word *clinical* *replaces* the violence. Clinic, the root word, comes from the Greek and Latin: of or pertaining to a bed. *Clinical* adds the elements of care and instruction, pertaining to the sick bed, specifically the

space of indoor hospitals, in connection with medical training.<sup>274</sup> Insisting on the clinical emplaces violence within institutional and ethical frameworks. Scott Stonington, who writes about "ethics that sit in places" in Thailand, cautions against the unintended consequences of "erasing the fractal-like landscape of place-ethics" he argues:

[anthropologists] advocating for a universal ethics to protect emerging global subjects make a strong case, motivated by compassion and solidarity in the face of exploitation. But...there will be repercussions from this approach. An awareness of this tension will be vital to global efforts to find the best way to interact ethically across time and place, across different *ethical locations*.<sup>275</sup>

I suggest that we bring together the clinical and social science literatures around the notion of clinical violence. Clinical violence was a quotidian part of accomplishing medical and social functions of the hospital, as fundamental to practice on the wards of PCMH as (the often uneven) collection of vital statistics or charting hourly observations. This plainer language of clinical violence opens conversations about the hospital as a site for social reproduction.

Rosalind Shaw's work on memory amongst Temne-speakers in Sierra Leone reveals a theory of practice: "a different way of 'remembering' the past, one in which "violently dislocating transregional processes (conquest, colonialism, migration, war, wage labor) are rendered internal...(literally) incorporated into people and their social and cultural practice."<sup>276</sup> I suggest

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<sup>274</sup> ("Clinical, Adj." 2014) "Clinical, Adj.," *OED Online* (Oxford University Press), accessed November 21, 2014, <http://www.oed.com.proxy.lib.umich.edu/view/Entry/34381>.

<sup>275</sup> Scott Stonington's work is heavily influenced by Paul Farmer's vision of "pragmatic solidarity," which implies a sort of co-location. See also Kleinman, Arthur. 1999. "Moral Experience and Ethical Reflection: Can Ethnography Reconcile Them? A Quandary for "the New Bioethics"". *Daedalus* 128 (4). The MIT Press: 69–97.

<sup>276</sup> Rosalind Shaw, *Memories of the Slave Trade: Ritual and the Historical Imagination in Sierra Leone*, 1st ed. (University of Chicago Press, 2002:5).

that examining violence as integral to the clinical at PCMH suggests its own theory of practice. This practice, like any other clinical practice, must be understood on its own terms.<sup>277</sup>

Catherine Bolten, who studied changes the war wrought in the Sierra Leonean social fabric, argues: "Nothing, not even violence, exists without reference to the 'parent culture' of fundamental cultural practices."<sup>278</sup> Working in the mid-2000s, she found that a system of patronage and allegiance informing relationships of all kinds – which she called love – had been fundamentally altered in the years of scarcity during and after the war. "The imbalance [in the love relationship] is created when individuals with multiple relationships shed the less nourishing ones because they are unnecessary. This loosens the bonds of the system itself, creating and enhancing social inequalities."<sup>279</sup>

Bolten's formulation is useful here. Many of the tensions apparent on hospital wards mapped on to social dynamics and gendered tensions between age sets within Sierra Leonean households. Seniors dominate juniors, insiders dominate strangers.<sup>280</sup> This domination often takes the form of forced labor and of verbal and physical abuse. Men have long been part of the nursing profession in Sierra Leone, but women have always controlled the field of childbirth. At PCMH, physicians only attend surgical births; all the rest are attended by nurses and midwives.

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<sup>277</sup> This does not mean one must agree with or practice it oneself. I struggled with how to react to instances of violence while continuing to collect ethnographic observations. Denise Roth Allen, as a trained doula, writes of a similar difficulty in encountering ethically complex situations in *Managing Motherhood, Managing Risk: Fertility and Danger in West Central Tanzania* (University of Michigan Press, 2002).

<sup>278</sup> Catherine E. Bolten, *I Did It to Save My Life: Love and Survival in Sierra Leone* (Berkeley: University of California Press, 2012:3).

<sup>279</sup> *Ibid.*, p. 9

<sup>280</sup> During a debriefing of hospital staff that followed the screening of the scathing documentary depicting the hospital in a terrible light, an administrator deployed this very language, chiding "Juniors" for granting interviews to the British documentary film makers when "seniors" were not around.



These distinctions between place and space and distal and proximal modes of nursing resonate with the gendered, hierarchical social and institutional contexts at PCMH.<sup>281</sup>

The nursing profession in Sierra Leone is deeply fragmented, and within this hospital, multiple intersecting hierarchies were at play. Students of midwifery and basic nursing were a constant presence on the ward and, as the most junior, performed the most basic and menial tasks. Senior nurses barked orders at them: “Nurse! Take the vitals!” or “Nurse! Clean this blood!” These were the same sorts of orders I heard my aunties bark at my younger cousins during family gatherings. “Fatmata! Fetch the water!” “Fatmata! Start the fire.” The difference was that senior nurses, by using the student’s title (nurse) asserted absolute dominance and stripped agency from their juniors but simultaneously reified their incorporation into the hierarchy: even from the bottom, students could lay claim to being a part of the structure of power. Unlike a multigenerational family household, where the youngest and least powerful will remain the least powerful until someone younger comes along, successful student nurses will advance in the ranks, earning one blue stripe on their cap for each year of training they endure.

The hospital functions much like a multigenerational female household, albeit one that provides maternity care to destitute, desperate strangers. Michel Foucault argued in *The Birth of the Clinic*: “The most important moral problem raised by the clinic is the following: by what right can one transform into an object of clinical observation a patient whose poverty has compelled him to seek assistance at the hospital?”<sup>282</sup> My findings suggest that the distance created and maintained between laboring women and staff at PCMH assists in performing this

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<sup>281</sup> For more on the differences between space and place see Edward S. Casey, “From Space to Place in Contemporary Health Care,” *Social Science & Medicine*, Vulnerable Places: Contextualizing Health Practices, 56, no. 11 (June 2003): 2245–47. The entire special volume is helpful.

<sup>282</sup> Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception* (Vintage, 1994): 83.

transformation of human patient into clinical object, with a strict edge: "*Yu geh fo biah*." "You must tolerate. You must bear this." These words were often spoken from the bottom of the clinical pyramid, from nursing students to laboring, birthing patients whose social positions were even more marginal than theirs.

## **Conclusion**

Thomas Hughes has argued: "one of the primary characteristics of a system builder is the ability to construct or to force unity from diversity, centralization in the face of pluralism, and coherence from chaos. This construction often involves the destruction of alternative systems."<sup>283</sup> At PCMH, the biomedicine of the global North with its protocols and paper trails, was an alternative system; rather than destroying it in favor of coherence, nurses maintained it, reinterpreting both system and non-system into a language of practice in which the dominant biomedical model chattered in constant dialogue with West African ways of doing, seeing, knowing. I observed over the months that much like spoken Krio, there was a language of practice specific to PCMH. It had to be learned (and was not taught), but it could also be changed, modified, and improvised when necessary.

This chapter has investigated troubling clinical practices and the appearance of violence at PCMH. Perhaps we may conclude that the difficulties of functioning within a clinical non-system, the space of neglect and disrepair that is a colonial maternity hospital building on the edge of a city in which little can be predicted or controlled, may be mitigated by tapping into systems of power, hierarchy, and authority that are more firmly established. If, as Bolten suggests, the war frayed the "parent culture" of Sierra Leone beyond repair, must ask how, and

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<sup>283</sup> Wiebe Bijker, Thomas P. Hughes, and Trevor Pinch, eds., *The Social Construction of Technological Systems: New Directions in the Sociology and History of Technology* (The MIT Press, 1989), 52.

through what practices, a new fabric might emerge from the threads. We must, Brian Larkin wrote: "keep in mind the disrepair of everyday life but insist on the imaginative force that overruns that breakdown."<sup>284</sup>

The violence I witnessed on the wards reasserted power, authority, hierarchy based on clinical knowledge in an overwhelmingly gendered institution. It also drew on pre-existing modes of sociality, family and interpersonal dynamics that filtered in from life in the city and were amplified within the small concrete walled spaces of the labor ward. When slapping, yelling, restraining, and admonitions such as "You must bear this" were met with little or no resistance, social distance was reinforced, the ethical framework located and placed in a hospital where the powerless and the disempowered together accomplished the work of physical reproduction. Perhaps in joining together and reasserting the "parent cultures," the dual hierarchies of British colonial nursing and Sierra Leonean family structures, these practices may be understood as part of the work of social reproduction at PCMH.

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<sup>284</sup> Larkin, *Signal and Noise*. p.127

## Chapter 7

### Knowing about Not Seeing in a Freetown Hospital

#### Introduction

The title of this chapter alludes to Murray Last's piece "The Importance of Knowing about not Knowing," in which he examines a 'non-system' of medicine flourishing in 1970s northern Nigeria. Noting the anthropologist's reluctance to collect "negative evidence" in favor of "explaining a system" or "unraveling the complexities of knowledge," Last encourages us to critically examine practices of institutionalized not-knowing.<sup>285</sup> While this chapter does engage in some system-explaining, it does so in order to frame institutionalized knowledge as a product of embodied, enacted, situated clinical practice, that which "involves juxtaposition of multiple semiotic fields...lodged within a larger hierarchy of displays being performed by the body."<sup>286</sup>

Scholars have previously drawn attention to the links among mobility, knowledge, and power in African medical contexts, from Nancy Hunt's nurses on bicycles to the circulation of entire medical systems across the continent and beyond.<sup>287</sup> As I demonstrated in chapter one, the

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<sup>285</sup> Murray Last, "The Importance of Knowing about Not Knowing: Observations from Hausaland" in Steven Feierman, John M. Janzen, and Joint Committee on African Studies, *The Social Basis of Health and Healing in Africa* (University of California Press, 1992).

<sup>286</sup> Sotaro Kita, *Pointing: Where Language, Culture, and Cognition Meet* (Psychology Press, 2003), 221–22.

<sup>287</sup> Hunt, *A Colonial Lexicon*; Hansjörg Dilger, Abdoulaye Kane, and Stacey A. Langwick, eds., *Medicine, Mobility, and Power in Global Africa: Transnational Health and Healing*, 1 edition (Bloomington ; Indianapolis: Indiana

Freetown of 2011-12 was riddled with visible and invisible historical and contemporary shapeshifting hazards. Memories suddenly materialized, unbidden, like the potholes in the middle of the road to disrupt the experiences of my informants as they moved through the city. Knowing how to not see or how to hide knowledge facilitated their ability to move past sites of traumatic memories. Mariane Ferme writes of the dangers of a shape-shifting trickster figure attacking those walking by ruins or hidden graves in Kpuawala, rural eastern Sierra Leone where she worked for decades. This Ndɔgbɔsui's (malevolent spirit's) intent to control victims through deadly question and answer games can only be thwarted by processes of dissimulation. Potential victims can find safety by hiding their real intentions and knowledge behind absurd answers. Deliberately concealing knowledge beneath the absurd becomes 'an effective weapon for unmaking the world as we know it...but also for surviving this act of destruction'<sup>288</sup> Deliberate deception, in this example, is a useful survival strategy that holds the power to “unmake” a dangerous world.

This chapter focuses on the productive tensions between mobility and blockage and between seeing and not seeing. If mobility in the city is mediated by knowledge and visibility, what might an examination of mobility and blockage, seeing and not seeing at PCMH reveal about the nature of these tensions? How might examining these tensions in a single hospital contribute to understanding how local factors interact with the kinds of knowledge both demanded and generated by global health initiatives?

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University Press, 2012); Tracy J. Luedke and Harry G. West, eds., *Borders and Healers: Brokering Therapeutic Resources in Southeast Africa* (Indiana University Press, 2006).

<sup>288</sup> Ferme, 2001, p.31

## Witnessing as technology.

A body of nursing literature has grown up around the end-of-shift report or the "hand-off."<sup>289</sup> Much of this clinical literature foregrounds the ritualistic elements and social functions of the practice.<sup>290</sup> As an anthropologist anticipating ritual, I quickly discovered that the shift report in the labor ward at PCMH consisted of a departing nurse following an oncoming nurse from room to room, checking names off a list. The goal of this practice was simply to show the next shift which name went with which patient. Ritual was the last thing on the mind of one staff member when I asked her why she was taking report for the entire ward. "This one is not prepared, and this one had gone up to sign, and this one is changing." When I probed about the nature of shift report, she replied: "In this country our names are all so similar. If you don't see the patient, you might get confused. There are too many Isatu Kamaras!"

Witnessing was often a source of authoritative knowledge in the particularly fraught case of a 'runaway' patient, a young woman who had been in labor for several days. Someone noted "attempted home delivery!!!!" in her chart. Her amniotic membranes were ruptured and there was evidence that her cervix was dilating but the baby was in a breech position. Though I had seen breech deliveries performed successfully without surgical intervention previously, this woman and her family were advised that she required a caesarean section or else, as the staff advised, "the baby would have a bad life." The word on the ward was that the doctors and "even

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<sup>289</sup> D. Dowding, "Examining the Effects That Manipulating Information given in the Change of Shift Report Has on Nurses' Care Planning Ability," *Journal of Advanced Nursing* 33, no. 6 (2001): 836–46; D. Lamond, "The Information Content of the Nurse Change of Shift Report: A Comparative Study," *Journal of Advanced Nursing* 31, no. 4 (2000): 794–804;

<sup>290</sup> See, for example, I. Ekman and K. Segesten, "Deputed Power of Medical Control: The Hidden Message in the Ritual of Oral Shift Reports," *Journal of Advanced Nursing* 22, no. 5 (1995): 1006–11; Mary M Hays and Clarann Weinert, "A Dramaturgical Analysis of Shift Report Patterns with Cost Implications: A Case Study," *Nursing Economics* 24, no. 5 (September 2006): 253; O. Yonge, "Shift Report: A Ritual Play on a Residential Adolescent Psychiatric Unit," *Journal of Psychiatric and Mental Health Nursing* 15,1(2008): 45–51.

the matron" had come to try to convince her to stay. She left against medical advice but before she left signed a witnessed document releasing the hospital of liability.

Witnessing was also important in the production of sex, as the genitals of newborn infants were displayed to their mothers immediately upon cutting the umbilical cord. When relatives came to the ward, the visit usually included a staff member unwrapping the *lappa* cloth to display the neonate's genitals. Understanding witnessing in Sierra Leone helps contextualize the logic informing this visual production of sex. A basic social requirement is that there should be as many witnesses as possible when gifts are given or received. One reason is to guard both parties against claims of wrongdoing. Thus the practice of displaying genitals both satisfied curiosity and guarded against accusations of baby-switching. The announcement of "boy" or "girl" was insufficient and could later be rendered invalid if not accompanied by visual evidence. Clinical knowledge was visually and socially achieved. That which was known was known by acknowledgement: knowing together by seeing together.



Figure 19: Student nurses tend to neonates on display at the Resuscitaire

### **Contingent technologies**

In the United States, technologies used to detect antepartum and intrapartum death are readily available. Unless such a death has obviously occurred during or prior to birth, if a neonate is born with few or no signs of life in the U.S, the standard of care is immediate transport to a purpose-built portable Infant Care Center where nationally standardized protocols for neonatal resuscitation are implemented. The fewer signs of life, the more aggressive the intervention. Technologies available in the United States quickly produce authoritative knowledge guiding resuscitation protocol.



At PCMH in 2011-12, when a neonate was born not breathing there were few ways to know if and when its heart had stopped beating. With limited and intermittently available diagnostic technologies, the labor ward's Infant Care Center took on a different nature. I observed that fetal scalp monitors, lights bright enough to reveal fine degrees of pallor, external cardiac monitors (all requiring a reliable, steady supply of electricity), and high-quality pediatric stethoscopes sensitive enough to detect the faintest heartbeat were not available. Instead, years of clinical experience combined with fingers palpating for an umbilical pulse proved authoritative.

The Infant Care Center at PCMH provides an example of how one group of nurses in one post colonial West African hospital have woven their own ways of doing and knowing into the many forms of (post) colonial infrastructure and technology. While a bag-valve mask ventilator hung on the Infant Care Center in the labor ward, there were no oxygen canisters on the ward, and little care to be provided beyond wrapping and labeling the corpse. At PCMH, this technology was used primarily to display infants. Though not fulfilling its intended function as a portable, fully equipped resuscitation station (as denoted by its proprietary name, the Resuscitaire), the Infant Care Center did perform a critical role. In rendering infant bodies visible for the inspection and social acknowledgment, this biomedical technology at PCMH assisted in a different set of clinical practices necessary to fully transition a neonate into the world of the living.

### **Contingent inscriptions**

At PCMH, as in many other hospitals, the patient register is a fetishized knowledge object, a grid rendering essential information about each patient visible to the system. During my time at the hospital, I watched as the admission grid was scrupulously maintained, often to the detriment of the parturient. Women in active labor, with a potentially imminent birth, were

required to produce demographic data such as address and phone number while trying not to give birth on the floor of the outpatient department. The register was a point of institutional pride, an indicator of effective management. Yet I often witnessed the inscription of data that was speculative or based on approximation.

If a woman arrived wearing a veil, she would be inscribed in the record as "Fula," despite the fact that Sierra Leone's polyethnic population is 60% Muslim and only 30% of citizens self-identify as Fula. Women from the border regions who are not fluent in English or Krio often arrive with no one available to translate for them. In such cases, data is produced through pantomime, with nodding of heads or guessing used to fill in as many blanks in as possible in the register. Thus what was made visible in the system was not always accurate.

### **The Stakes of Not Knowing**

Information recorded on the register in Freetown had consequences far beyond institutional pride. In many senses, the rest of the world was watching. Maternal and infant mortality have been the subject of alarm, speculation, consternation, and blame since at least 1897, when William Prout first reported rates of death he found shocking. The stakes involved in knowing where, how, and to what extent perinatal deaths are occurring have only increased in the 21<sup>st</sup> century. Sierra Leone's maternal/child health indicators have hovered at or near the bottom of global rankings for decades. In 2008 Amnesty International conducted an investigation and in 2009 published a report entitled 'Out of Reach: The Cost of Maternal Health in Sierra Leone.' The report cited a 1 in 8 maternal mortality rate and proclaimed the situation a "human rights emergency." Through what it termed "A Catalogue of Failures," it placed the blame on the broken healthcare system and "the highest out of pocket expenditure in sub-Saharan Africa for

healthcare".<sup>291</sup> In 2010, in response to this bad press and in response to donor agendas, president Ernest Bai Koroma introduced a program to provide free medical care for pregnant and lactating women and children up to age five. In 2011, when I began research PCMH, the Millennium Development Goal deadline was looming, the "Free Health Care" was fully implemented, and all eyes were on the country's maternal mortality statistics – mostly from a distance.

Susan Erikson has argued that the primary purpose of collecting and disseminating health statistics in and about Sierra Leone is to enable health system analysts to conduct their work from a distance.<sup>292</sup> These statistics eventually become health indicators integral to what she calls the "forecasting and farcasting" work of global health initiatives such as the Millennium Development Goals. Sierra Leone's health sector depends heavily on donor funding and, not surprisingly, recordkeeping thus largely reflects efforts to promote practices that further donor agendas. Medical records are thus often assembled in an ad-hoc fashion to comply with the most recent round of state-mandated institutional benchmarks and standards. My fieldwork examined the social production of clinical data out of which such statistics are generated.

I found that while the admission register was clearly a site for rendering knowledge visible, another register served as a site for rendering knowledge invisible. This was the delivery register, into which details of each delivery were supposed to be accurately inscribed. Maternal death was also to be inscribed in the register, as reducing maternal mortality was key to keeping donor money flowing. As I learned, this was very grey territory.

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<sup>291</sup> Amnesty International Secretariat, *Sierra Leone: Out of Reach: The cost of maternal health in Sierra Leone*, 22 September 2009, Index number: AFR 51/005/2009 :28

<sup>292</sup> Susan L. Erikson, "Global Health Business: The Production and Performativity of Statistics in Sierra Leone and Germany," *Medical Anthropology* 31, no. 4 (October 6, 2011): 367–84.

## **Not seeing and the production of ignorance**

The Outpatient Department at PCMH is a room with one window, approximately 100 square feet of floor space, usually two but sometimes three chairs, often up to eight staff members, and always a number of cockroaches. They climbed up the blood pressure machine to burrow in folds of the cuff. They scurried across the countertop used for everything from urine testing to hand-washing to cleaning instruments to eating lunch from a communal bowl. They jumped from the shelves where records are kept. They climbed up and down the wall dividing the Outpatient Department from the waiting area, stopping to wiggle their antennae before disappearing behind the door trim. I once saw a cockroach blocking the numbers flashing on the scale used to weigh newborns, before crawling into its lappa

The nurse in me was horrified. I could not fathom the notion of using a blood pressure machine with a roach crawling up the edge toward my hand. As a person with a serious aversion to insects of any kind, I subdued the visceral urge to run screaming from the room. Roaches may be common in this dense tropical environment, but they are not welcome, if the booming business of street vendors dealing in various traps and poisons provides any evidence. In this clinical environment, with its one bottle of hand sanitizer prominently placed on the charge nurse's desk, the appearance of cleanliness and the maintenance of order over an often unpredictable environment seemed very important. Yet not once did I observe anyone brushing away or squashing one of these roaches, as one would certainly do at home in the kitchen. Indeed, no one, in my experience, commented or voiced acknowledging their presence. Did no one else see the roaches? When days of observing these crawling, climbing, jumping creatures co-existing alongside medical instruments in the Outpatient Department turned into weeks and months, it appeared the answer was no.

That something I considered fundamentally, unquestionably 'matter out of place' in the clinic could be so invisible prompted me to think about what else was not seen.<sup>293</sup> The apparently invisible dead rats I passed in the hallway while accompanying the matron on her rounds, the tiny corpses wrapped in bright lappa cloth, hidden out of sight in the sluice room most mornings; these were other things not-seen. The staff's silent agreement as to the invisibility of certain things suggested that not-seeing is indicative of more extensive patterns of "knowing about not knowing."

This is where the problem of place and the contingency of the local brushes up against the "global" of global health. Epidemiologists link rats and roaches to the spread of diseases such as pseudomonas, typhus, and staph.<sup>294</sup> Several studies have pointed to such vermin as the source of nosocomial or hospital acquired infections<sup>295</sup> A maternity unit in the United Kingdom was closed as recently as 2007 on account of a cockroach infestation<sup>296</sup> That vermin are a problem to be solved in the context of public health has been evident since the rat-extermination campaigns of the early 20<sup>th</sup> century. In fact, the practice of setting aside the first half of the first Saturday of every month as a 'cleaning day' stems from this era and remains in widespread practice in Sierra Leonean businesses and homes.

Thus, it is not that there have never been roaches or rats in hospitals or that such creatures are unique to African hospitals, but hospitals are not supposed to be infested with vermin.

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<sup>293</sup> Mary Douglas, *Purity and Danger: An Analysis of the Concepts of Pollution and Taboo*, 1st ed. (TAYLOR, 2002).

<sup>294</sup> A. Salehzadeh, P. Tavacol, and H. Mahjub, "Bacterial, Fungal and Parasitic Contamination of Cockroaches in Public Hospitals of Hamadan, Iran," *Journal of Vector Borne Diseases* 44, no. 2 (June 2007): 105–10; Y. M. Tatfeng et al., "Mechanical Transmission of Pathogenic Organisms: The Role of Cockroaches," *Journal of Vector Borne Diseases* 42, no. 4 (December 2005): 129–34.

<sup>295</sup> R. Fotedar and U. Banerjee, "Nosocomial Fungal Infections--Study of the Possible Role of Cockroaches (*Blattella Germanica*) as Vectors," *Acta Tropica* 50, no. 4 (April 1992): 339–43.

<sup>296</sup> "Cockroaches Close Maternity Ward," *BBC*, September 26, 2007, sec. Manchester, [http://news.bbc.co.uk/2/hi/uk\\_news/england/manchester/7014001.stm](http://news.bbc.co.uk/2/hi/uk_news/england/manchester/7014001.stm).

Vermin signal dirt, uncleanness. The nurses who run PCMH and the students who learn here hold Florence Nightingale, an original champion of the benefits of clinical cleanliness, to be the ideal nurse.<sup>297</sup> Her actions during the Crimean war and subsequent arguments about environmental cleanliness are fundamental to the curriculum at Sierra Leone's National School of Nursing. As we learned in chapter four, her lamp serves as the emblem for the Sierra Leone Nurse's Association. A young nurse with the name Florence was jokingly referred to as "lady with the lamp" whenever she passed by the outpatient department. The ideal of Florence mattered in some way here, and vermin had no place in Florence's wards; it is interesting to come to terms with their lack of place in the clinical nursing imagination at PCMH. They do not fit into the schema. Swatting or shooing would be to acknowledge sight and acknowledging sight would be to acknowledge presence. I concluded that a reality without vermin at PCMH could only be realized if it was collectively, tacitly agreed that they did not exist. In the same way that seeing together creates knowledge, collective not-seeing may be part of the clinical habitus of this hospital.<sup>298</sup>

Historians of the visual such as Isabelle De Rezende, Drew Thompson, Patricia Hayes, and Elizabeth Edwards have done much to broaden understanding of seeing – the dynamics of power involved in seeing, the role of technology in mediating sight, the problematic truth claims of the image in African contexts.<sup>299</sup> Attention to the margins (as emphasized by David William

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<sup>297</sup> In fact, in her *Notes on Nursing*, Nightingale wrote: "It cannot be necessary to tell a nurse that she should be clean, or that she should keep her patient clean, seeing that the greater part of nursing consists in preserving cleanliness" [1860]1969:87

<sup>298</sup> Susanne Buckley-Zistel, "Remembering to Forget: Chosen Amnesia as a Strategy for Local Coexistence in Post-Genocide Rwanda," *Africa: Journal of the International African Institute* 76, no. 2 (2006): 131–50. Siri Suh, "Rewriting Abortion: Deploying Medical Records in Jurisdictional Negotiation over a Forbidden Practice in Senegal," *Social Science & Medicine* 108 (2014): 20–33; Pierre Bourdieu, *Outline of a Theory of Practice* (Cambridge University Press, 1977).

<sup>299</sup> De Rezende and Isabelle M, "Visuality and Colonialism in the Congo: From the 'Arab War' to Patrice Lumumba, 1880s to 1961.," 2012; Drew Thompson, "(Re-)Exposing Old 'Negatives': New Discourses and Methodologies in Photographic Studies on Africa," *African Studies Review* 57, no. 3 (2014): 175– 85; Elizabeth Edwards, Raw

Cohen) is important, but historians and anthropologists should also consider the elided. The sociality involved in naming and recording the clinical is key to situating kinds of statistical knowledge about bodies. Such exploration should cause actively searching for the unseen. Foregrounding invisibility and hiding may help locate the production of clinical knowledge about bodies within practices of anti-inscription such as the erasure of medical data.

If the clinical gaze is to know, what possibilities inhere in visually not-knowing? Like ubiquitous roaches, maternal and neonatal death may be "disappeared," elided from the record and collectively not-seen. Perhaps, as with movement through the city, collective tacit knowledge and not-knowing facilitate the 'getting things done' of clinical practice, negotiating the hallways, memories, and potential dangers of the hospital ward.

### **Practice makes perfect**

As I worked alongside those practicing in the labor wards and admitting department, the regularity with which I witnessed clinically questionable practices suggests that such practices were less antithetical to clinical propriety in this hospital but constitutive of it. After providing a brief bit of historical context I will examine two of these practices in greater detail, and discuss their potential contributions to the study of medicine in Africa.

In North America and Western Europe, the clinical record is a quasi-sacred object. Falsifying data on a patient chart is grounds for dismissal; depending on the gravity of the situation, it may result in revocation of a professional license.<sup>300</sup> Patient charts are commonly

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Histories: Photographs, Anthropology and Museums, (Oxford: Bloomsbury Academic, 2001); Patricia Hayes in Wolfram Hartmann, Patricia Hayes, and Jeremy Silvester, *Colonising Camera: Photographs In Making Of Namibian History* (Ohio University Press, 1999).

<sup>300</sup> Rachel C. Cartwright-Vanzant, "Medical Record Documentation: Legal Aspects in Neonatal Nursing," *Newborn and Infant Nursing Reviews*, Legal Issues, 10, no. 3 (September 2010): 134–37, doi:10.1053/j.nainr.2010.06.008;

subpoenaed in malpractice suits. Accurately keeping a record of events as they happen can protect clinical staff from legal liabilities. The common nursing school mantra repeated in nursing schools throughout the U.S., "not charted, not done," underscores the extent to which patient records are a means of accounting for everyday activity on the ward. In this system, now gone digital, charting in pencil would be incomprehensible.

During my time in Freetown, I learned that clinical records did not serve similar functions.<sup>301</sup> In May, 2012, a family claimed that the nurses on duty had switched their male infant for a girl baby while the family wasn't looking. In the aftermath of these accusations, the nursing staff in question were 'invited' to the nearest police station to give statements. The hospital administration's response was to fire the security staff and instruct the matrons to tell their staff not to talk to anybody without administrative permission. During a staff meeting, a senior hospital administrator apologized to the head of the labor ward for her embarrassment. Medical records never entered this case. Whether it was because Sierra Leone knows a legal system that privileges oral testimony or not, clinical documents were incidental, absent.<sup>302</sup>

However, paper records did serve other functions. One was to satisfy the benchmark requirements instituted along with the 2010 Free Health Care initiative. Civil employees tasked with monitoring the implementation of this program conducted intermittent reviews at PCMH. They did not observe practice on the wards, but instead counted things like the number of caesarean operations performed, immediate life or death outcomes, and the use of the partograph – a chart designed to monitor the progress of labor (which, I observed, was often filled out long

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Abbey Hyde et al., "Social Regulation, Medicalisation and the Nurse's Role: Insights from an Analysis of Nursing Documentation," *International Journal of Nursing Studies* 43, no. 6 (August 2006): 735–44

<sup>301</sup> They often serve multiple purposes, in fact. See Matthew S. Hull, "Documents and Bureaucracy," *Annual Review of Anthropology* 41, no. 1 (2012): 251–67, doi:10.1146/annurev.anthro.012809.104953.

<sup>302</sup> There are numerous examples of the importance of eyewitness testimony in contemporary Freetown.



after a woman had given birth). A maternity center showing an increase in the use of partographs would be 'in compliance' within the stipulations of Free Health Care, yet regardless of when the data on the partograph was actually recorded.

The admitting department at PCMH received patients referred from all over the country. Some of these were questionable referrals, in admitting staff's eyes, to say the least. Staff at outlying maternity centers knew the criteria for referral (such as elevated blood pressure or arrest of labor). Occasionally – rather more than occasionally – women who did not meet the criteria would appear by ambulance, with the appropriate diagnostic criteria indicated on the papers in hand, and need to be admitted.

Another common use of paper was antenatal clinic attendance records; these provided access to the hospital. I observed that the penny slips of the 1930s had been transformed over time into an even more valuable form of currency. If a patient could not produce a paper record but had attended the antenatal clinic at PCMH, a search for her name in the pile of pink antenatal slips stacked in a designated cupboard in the Outpatient Department would begin. If she had attended elsewhere, she would be expected to have carried the slip with her. If a woman did not have a slip and it was also not urgent, she was turned away or shamed. If it was urgent – for example amniotic fluid leaking on the floor or intense labor pains – every attempt would be made via mobile phone or via calling out in the courtyard and waiting area, to contact someone who knew something about her before she was touched. Even in extremely urgent cases, if a nurse transferring a woman to the labor ward had neglected to bring or create a paper record, a staff member would be dispatched to fetch the record before the patient would be attended.

Donors are fond of sending size small latex gloves as charity gifts. The problem is that these don't fit many people, and so the few, prized, size large gloves are washed and reused.

Washing and reusing exam gloves would be incomprehensible, unconscionable, perhaps actionable in the well-stocked hospitals of the global north. This practice is incomprehensible only within a system in which the gloves are worn to protect patient and provider from the transmission of infectious disease. In placing such practices, it is important to ask: What is this nurse or that midwife using the glove for? What is its purpose? What does it do in his or her world? In what ways might it express clinical norms of this institution in this place? If gloves are the first line of defense in an infectious disease protocol meant to protect everyone, as in North American, the Freetown practice at first makes little sense to an outsider. If their purpose is, rather, to prevent the nurse's hands from coming into contact with the bodily fluids of a laboring woman, or to reconcile an imaginary of a clinical practice in which nurses wear gloves with the reality of too many size small gloves, it does.<sup>303</sup>

Similarly, hospital records are not only for record-keeping. At PCMH, what was written in medical records was rarely a reflection of an abstract reality or a claim to truth. What was written often served the function of intentionally MIS-informing, or of deliberately obscuring the truth. However, hospital records and patient charts did perform critical work of permitting and denying passage into and through this hospital. As such, they were fully functional elements in this clinical milieu.

### **Space, Place, and Authority**

Regulating space, permitting or denying passage through hospital through the hospital wards was another way the nurses at PCMH practiced authority. Ruth Malone, who studies

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<sup>303</sup> There is also research demonstrating that washing and re-using gloves puts both the patient and the one wearing the gloves at risk. See C. Glang-Yetter, M. Torabinejad, and A. Torabinejad, "An Investigation on the Safety of Rewashed Gloves," *Journal of Dental Hygiene: JDH / American Dental Hygienists' Association* 63, no. 8 (October 1989): 358–59, 362, 388–89; R. J. Olsen et al., "Examination Gloves as Barriers to Hand Contamination in Clinical Practice," *JAMA* 270, no. 3 (July 21, 1993): 350–53.

nursing in the United States, argues that the digitization of hospital processes and the corresponding increase in physical distance between patients and nurses, a situation she terms "distal nursing," is a major threat to a nurse's physical, narrative, and moral proximity to patients. "Nursing as a human practice also has spatial aspects," she argues: "Since relationship with the patient is considered central to nursing practice, nursing depends at least in part upon sustaining some meaningful *proximity* to patients."<sup>304</sup> Yet at PCMH I found that the enforcement of *spatial* distance – between parturients and kin between staff and parturients, between grades of staff and students – worked in tandem with enforcing *social* distance. I observed profound differences between Malone's assumptions about nursing as an ideally 'proximal' practice and the practices of social and spatial distancing on the labor ward.

Senior nurses governed use of space to suit their needs. One morning in the Outpatient Department I realized that the sister in charge was absent. One of two ward sisters was always in attendance, and today it should have been Salimatu. She was signed in on the ledger and was usually a fixture presiding over the room with her quick wit and startling clinical acumen. When I began to ask about her my queries were met with sideways glances. It was not unusual for staff members to be signed in while not actually present. I personally witnessed staff from other wards signing in for multiple people on more than one occasion, and often saw staff inscribe their presence in the book and then disappear for hours. Some went to mosque. Some went to meetings. Some left for other facilities to train as nurse anesthetists. As long as these staff were signed in to the register, though, they were officially present and compensated accordingly. But

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<sup>304</sup> Ruth E Malone, "Distal Nursing," *Social Science & Medicine*, Vulnerable Places: Contextualizing Health Practices, 56, no. 11 (June 2003): 2317–26, doi:10.1016/S0277-9536(02)00230-7.

Sister Salimatu was a woman of the highest integrity. If she was signed in she should have been there.

Finally, laughter came from the supply closet. “Tai-ra, Tai-ra!” I heard, my name shouted with a Krio lilt from behind the door. Puzzled, I peeked through the crack that had been pried open by a bare foot with an elaborate pedicure: “I am in here!” There Sister Salimatu sat on a stool, her short, natural hair combed out in a halo around her head, her white uniform neatly folded and placed on a box behind her. In her lap were three plastic bags containing lengths of hair matching her own color: hair extensions. Another woman who was not wearing a uniform stood behind her, carefully sectioning off areas to be plaited in with the purchased hair. “Today we are having a salon!” Sister laughed and clapped her hands, amused by my surprised face. And I was definitely surprised. Braiding was expensive and time consuming, not the sort of thing to be squeezed in to a spare moment in the middle of the day. Additionally, I would never have guessed that the utility closet in the outpatient department could be transformed into an ad-hoc hair salon. The fact that it was, at the direction of this senior staff member and for her own personal benefit, and that the rest of the staff would cover for her, evading questions about her whereabouts was testament to the ability of a nurse with status and authority to commandeer space within the hospital in a way that a lesser ranked staff member may not have been able to.

Hospital space was also appropriated for informal community activities. The main labor ward had a receiving room where laboring women were either routed into one of the two holding areas to the left of the receiving room or to the active labor rooms that lined the hallway to the right. None of the labor or triage rooms had doors. Beyond the anteroom was another room that was used for deliveries when the smaller rooms were occupied or when more space was required, such as a twin delivery necessitating two nurses. Twin deliveries were spectacular events and this

room would fill as students crowded around to watch. This room was also used for the immediate recovery period, and mothers might linger for an hour or two following a birth before being transferred to the post-natal wards.

The only room on the ward with a door was the nurse's room. This space, with one window and roughly 15 square feet of floor, was where staff members changed into and out of their uniforms, where they kept handbags and charged mobile phones. This is where many of my informal interviews took place, as staff would quietly beckon "lets come into the nurse's room." This was the nurse's space: Physicians, male and female, wandered onto the labor ward but the nurse's room was off limits for all but nurses. Food service came around during the day and communal meals took place as nurses of all grades crowded into the nurse's room to eat rice from the same bowl with their hands, drinking from a communal jug of water. This was also a space for commerce, as nurses from other wards would come to sell bolts of dyed cloth, frozen ginger beer, dresses purchased at markets downtown. The nurse's room was a space of community and commerce within the labor ward but entirely separate from it. I imagine it had once been a closet, but it had become so much more. The exclusivity of this space and the way in which entry was regulated reaffirm my observations about the power of nurses to influence mobility and block passage within the hospital.

Laboring patients were isolated from kin and this isolation was rigidly enforced. In one instance, the successful birth of twins had a newly-minted granny hopping up and down, dancing with joy in the hallway outside the labor ward where her daughter lay after the birth. She was permitted to see the newborns, *lappas* were unwrapped so that sex could be confirmed, and she was permitted perhaps 30 seconds at the doorway of her daughter's room. Laughing, dancing, she clapped and sang "I de tell God tenki!" over and over. However, a second attempt to enter

the labor ward prompted a scolding from a midwife sitting on the bench adjacent the labor ward doorway. Though there was no physical door, she flatly forbade the granny from entering a second time. When I asked why, she cried "She has been! I don't want people going in and out of the labor ward." Although male construction workers installing a door on one of the delivery rooms had been freely entering and leaving all day, and although cleaners in plainclothes came in and out at will, the imaginary boundary was firm. Pointing to the threshold of the 70-year old doorway, she proclaimed "*This is the line.*" Through paying attention to the movements of people within and through the wards, I learned the extent to which nurses could exercise their authority to either facilitate or block mobility within the hospital.

### **A death of that hospital? The stakes of not seeing**

Perhaps the most basic thing to be known about bodies is whether they are alive or dead. The dead or dying body presents a particular kind of problem for a system of global accountability and remuneration predicated on reducing mortality. I observed that the occurrence of infant mortality could be blurred out of the medical record, especially given the lack of basic life-saving resuscitation equipment and medication. As a daily witness on the wards, I suggest that the extent of infant mortality can only be estimated based on the fluidity of categories available. Each morning on the ward after greeting my friends I would engage in a morbid ritual: the body count. The sluice room where instruments were rinsed and where mops and cleaning equipment were stored was also the place where infant corpses from the night shift were laid in a row, tagged with a note detailing the sex, date and time of birth, and the mother's name. Usually they were gone by mid-day, silently collected for burial by family, swaddled in colorful *lappas* brought by laboring mothers intending to bring home a living child.

It was common practice for resident physicians on night duty to simply turn off their phones, and so obstetric emergency cases admitted after the physicians were gone for the night were left to the nurses to manage. While the physicians only handled operative or emergent cases (day or night) it was be the exceptionally rare operative case admitted at 2 a.m. that would make it through until the morning.<sup>305</sup> Intra-uterine fetal demise, stillbirth, asphyxia due to cephalopelvic disproportion, arrest of labor: the categorization of these deaths rang as hollow to me as Dr. William Prout's over a century ago. The only time I ever heard someone acknowledge the existence of these corpses was when a night shift nurse forgot to attach an identifying tag. While infant mortality could be hidden around a corner out of sight, the crux of this problem for Freetown's death actuaries was that the dead or dying body of a mother could not be denied.

At the end of 2011, a year after the implementation of "Free Health Care," the Ministry of Health and Sanitation held a meeting of all 'in charges' (supervisors of reproductive health facilities from Freetown and surrounding areas) to discuss "A Guide for the Implementation of Norms and Standards for Improved Quality of Integrated Maternal Newborn and Child Health Interventions."<sup>306</sup> The goal was to review maternal child health statistics from the previous year and allow the 'in charges' to review the guide before it was completed. The ten-page document was designed to track compliance with benchmarks in focus areas such as 'Family Planning' and 'Infection Prevention.' The most extensively benchmarked area was EmONC, or Emergency Obstetric and Newborn Care, with 12 separate measures. Up to this point the group had been providing suggestions about additional categories to include or different ways to determine if the

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<sup>305</sup> A British documentary film-maker who was in Freetown during the winter of 2011 spent a day filming at PCMH. Among the things she documented was the inability of nurses to contact resident physicians who had turned off their phones. In follow up, I have asked for a copy or transcript of the film, which I saw during a screening, but she has still not replied and the film was never released.

<sup>306</sup> Government of Sierra Leone, Ministry of Health, 2011

benchmarks were being met. When the group got to the EmONC section the discussion turned to documentation. The section detailing the skills to be demonstrated scaled up from first-line interventions, such as the administration of oxytocin (a basic medication used to contract uterine muscle and stem bleeding), to documenting referral, performing a caesarean section, and finally to meetings of the maternal death review board.

Through the discussion, it became clear to me that not everyone was compliant with the standards. The doctor coordinating the meeting admonished the group not to "hide" records when a woman was dying: "The reason for not hiding records when a death is occurring is not to *prove* anything, it is to *improve*." A representative from PCMH asked "What if the mother is brought in dead or dying? Do we have to record it? It is not a death of that hospital!" The doctor replied that the catchment area for PCMH was "the whole country," a fact confirmed when I interviewed nurses and midwives at other maternity centers. When I asked about maternal mortality the answer was almost always a variant of "We do not have maternal death. Women do not die here because if they are dying, we refer!"<sup>307</sup> Throughout my research at different clinical sites in Freetown I heard this refrain multiple times: "We do not allow women to die here."

The pregnant or laboring body is in a state of existential limbo, but maternal death is an absolute category: all that remains is to place blame. If the statistics recorded all the miles between a living woman at home and "a death of that hospital," perhaps a sense of community death might emerge. But in the age of global health, where do the boundaries of community responsibility end? If dead bodies can be deliberately elided from the record and the place of

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<sup>307</sup> Physicians tended to discuss this more directly. One, anticipating a rotation to the Ola During Children's Hospital across the car park from PCMH, waved from her chair in the Outpatient department, that patients there "Just die. They die and die and die."



death shifted statistically and overwhelmingly to one institution, we must the role of negative evidence in global health statistics further statistics.<sup>308</sup>

Electronic medical records are not yet the standard practice in Freetown. The systematic nature of altering medical records became clear to me at the meeting when a representative from a prominent global health organization stressed the need to document in pen rather than pencil. "Let's be honest with ourselves" she asked, "why do we write in pencil?" Several members of the group chuckled: "So you can go back and change it!" While the first speaker suggested that admitting a dying would not render the receiving hospital responsible for the death, the subsequent discussion of documenting in pencil indicated that such a death would indeed be considered "a death of that hospital," but also that the paper trail creating the knowledge linking a death to individuals and practices could be deliberately rendered visible in such a way that it could also literally be erased: not seen.<sup>309</sup> More often than not "that hospital" was PCMH. It is this hospital where more women died in childbirth than anywhere else in the country, the receiving staff had no control over the factors that sent them there. Late presentation to the

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<sup>308</sup> The importance of addressing gaps these was brought home for me through Elizabeth Nansubuga's work, specifically the presentation "Prevalence and Risk Factors of Maternal Near Miss in Central Uganda: a Community Based Study" at the Population Studies Center, University of Michigan, September 21, 2015. Nansuuga's work examines the cascade of factors leading to "near miss" events in rural Uganda. While what constitutes a "near miss" varies, Kaye et.al. (2003) estimate the rate of the "near miss" events to be six times the rate of maternal mortality. A longitudinal study in Nigeria successfully correlated decreasing near-miss maternal morbidity with rates of maternal mortality.

Pattinson et al (2003) did not find a direct correlation, but suggest that tracing the antecedents of near-misses can serve as a broader measure of "inadequacies in the health care system." See D. Kaye et al., "Maternal Mortality and Associated near-Misses among Emergency Intrapartum Obstetric Referrals in Mulago Hospital, Kampala, Uganda," *East African Medical Journal* 80, no. 3 (2004): 144-49; see Oladapo et al. "Near-miss" obstetric events and maternal deaths in Sagamu, Nigeria: a retrospective study." *Reproductive Health* 2, no. 9 (2005): 1-9; R.C. Pattinson et al., "Can Enquiries into Severe Acute Maternal Morbidity Act as a Surrogate for Maternal Death Enquiries?," *BJOG: An International Journal of Obstetrics & Gynaecology* 110, no. 10 (October 1, 2003): 890.

<sup>309</sup> I followed the process of documentation in nursing notes to the extent that I could. In one instance while I was looking at them they changed. First the record said no membranes felt. When I came back to check again just before I left it said membranes felt.: the NO had been crossed off.

hospital, lack of facilities and skill in outlying areas, distance and difficult of transport were elided from final statistics.



*Figure 20 A friend showing off in the Outpatient Department, 2011*

### **Precarity and knowledge at PCMH**

The nursing profession in Sierra Leone is fundamentally unstable. This instability is only slightly mitigated by specializing in midwifery and being assigned to PCMH. While the increased demand for skilled maternity nurses since 2010 means that those assigned to PCMH are rarely 'transferred out' to posts in the country, the Nylander model of rotation is hard-wired

into the rhythm of hospital life nonetheless. Nurses rotate wards every few months. Rotating to a different ward may also involve rotating to a different shift. In practice, this might mean that a nurse who has been working on the day shift in the outpatient department for 12 weeks could arrive one morning to learn that she would be working on the midnight shift in the postoperative ward as of the next day. Nurses had limited power over this constant unpredictability.

The practice of obstetrics is often unpredictable. Pregnancy, labor, and delivery are fundamentally precarious, liminal states. The parturient's body is inherently off balance, occupied by another life form, undergoing constant, often odd physical changes and ever-shifting physical and emotional needs, with the rupture of the amniotic sac and the beginning of labor always hovering on an invisible horizon. The transition from fetus to neonate, from an unborn, potential life encased in a womb to a separate body with squalling lungs and flailing limbs, is physiologically and spiritually one of the most profound and precarious phenomena to accompany human existence.

The difficulty in managing even a well-equipped labor and delivery ward receiving healthy parturients on a quotidian basis can be summed up in the words of a resident I worked with at a large urban hospital in Michigan. Justifying the use of an oxytocin drip to speed up the labor of a woman who was not 'progressing' at a satisfactory pace, he argued: "We have to manage these women actively because you never know what's going to walk through the door." Labor and delivery wards are often trickle and torrent rather than rather than ebb and flow. In Freetown, at the only facility equipped to handle obstetric emergencies, what 'walks through the door' could rarely be anticipated.

While there are 12 government-run hospitals and 65 community health centers providing some degree of obstetric care, PCMH was and is the country's only fully equipped tertiary care

maternity facility. Ending the vermin infestation may be beyond the power of the nurses and midwives. Eliminating maternal death similarly was beyond the power of the nurses and midwives. As the national referral center for obstetric emergencies, PCMH received the worst of worst case scenarios on a regular basis. The outcome for these cases might be contingent on something as simple as what time of day they arrived.

During my months of participant observation, I arrived to find that there were no physicians available in the hospital on three separate occasions. Twice they went on strike to protest the lack of sleeping quarters and inadequate funding for tea provisions and top-up cards for their mobile phones.<sup>310</sup> One morning I walked in to chat with Melvina, the sister in charge of the outpatient department that week. When I asked how the day was shaping up she replied "We have some bleeding cases today in the OPD. We have some patients in labor." Melvina, with her immaculate white dress, quick smile and even quicker wit, often kept me on my toes. Flashing her dimples as she whisked out of the room she called over her shoulder "No doctor in outpatient today. They have a meeting." The sangfroid with which she dealt with predictable unpredictability was astonishing.

Another morning I found Binta rushing to take my hand and lead me to excited the 'little person' who had miraculously delivered overnight. The woman suffered from a form of dwarfism: her pelvis was misshapen and her stature dramatically shorter than an average adult female. She had been scheduled for months to have a Caesarean operation, the date booked as soon as the pregnancy was diagnosed, but she happened to go into labor during one of the physician's strikes. The midwives were able to facilitate a vaginal delivery and save them both,

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<sup>310</sup> While the concerns may seem trivial, the strike must be placed within the context of Sierra Leone's long history of organized labor strikes.

and Binta eagerly dragged me up to the postnatal ward to show off the wonder of this woman and her healthy baby. Lack of equipment, facilities, and skilled providers in outlying areas, combined with distance from the hospital and the difficulty of transport meant that women referred here often arrived beyond help. For many, PCMH was death's door.

## **Conclusion**

Considering documentary technologies in relation to practices of concealing (whether of live, sick, or dead bodies) and erasure (such as purposefully documenting the progression of labor in pencil) may provide insight into how things beyond nursing jurisdiction were often ignored, elided from the record, collectively un-seen, or forgotten: collectively unknown. We need to think not only about what nursing as an embodied practice does, what kinds of knowledge might be called into being, but also about what embodied nursing practice undoes, what it erases, and the forms of knowledge suggested by negative evidence. Collective seeing, acknowledging (knowing together), is a key means by which knowledge is produced in this hospital. To see the roaches and rats collectively would be to acknowledge their presence - like genitals, like laboring patients. Collectively seeing them would entail naming them –Isatu Kamara, male, female, roach, rat. Collective ignorance, or not verbally (and thus socially) acknowledging sight is one of the key ways in which actors in this field, this sphere of practice, this place, maintained relational networks of power.

Judith Butler asks us to think of bodies not only as matter but as materializing.<sup>311</sup> I consider embodied practice among techniques of the body, habits of movement that materialize knowledge and from which they are derived. The act of seeing both creates and embodies clinical knowledge. It gives form to knowledge within a material body that is seeing – or not-

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<sup>311</sup> Judith Butler, *Bodies That Matter: On the Discursive Limits of "Sex"* (New York: Routledge, 1993)

seeing – *from* somewhere.<sup>312</sup> I wish to suggest here that perhaps the precarity inherent in being a nurse at PCMH may be offset by the embodied nature of nursing knowledge itself. Embodied knowledge, the palpating fingers, the carefully trained ear that are the tools of the trade, are in part constituted of muscle memory: learned habits, passed down in practice from generations of predecessors in a corpus of knowing how to do with hands and ears, how to see and not see, but also knowing socially what to speak into existence and what to leave unstated and invisible.

The clinical space is a 'field,' in Bourdieu's sense, structured through relations of power.<sup>313</sup> A focus on the knowledge produced by embodied practice reveals how actors in resource poor clinical settings fill gaps in the globalizing 'health for all' narrative while sustaining local power relations.<sup>314</sup> In mathematics,  $i = \sqrt{-1}$ , represents the definition of the imaginary unit, the number that does not exist. Although intuitively difficult for non-mathematicians such as myself to grasp, the  $i$  can be a necessary element of a fully logical equation. The number that doesn't exist must be factored in in order to find answers about other things. Not knowing needs to be part of the equation, and yet the globalizing logic of clinical inscription does not account for negative evidence. In the examples I have provided, knowing about not-seeing is key to situating the kinds of statistical knowledge deployed in the service of global health agendas. The visual is a key ethnographic mode for locating authoritative knowledge, but the authority it indexes is different than the power/knowledge nexus signaled by an ultrasound. The authority invoked in

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<sup>312</sup> Donna Haraway, "Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective," *Feminist Studies* 14, no. 3 (Autumn 1988): 575–99; Jessica Dubow, "'From A View On the World To A Point Of View In It': Rethinking Sight, Space and the Colonial Subject," *Interventions: International Journal of Postcolonial Studies* 2, no. 1 (2000)

<sup>313</sup> Pierre Bourdieu, *The Field of Cultural Production* (Columbia University Press, 1993).

<sup>314</sup> Alice Street, *Biomedicine in an Unstable Place: Infrastructure and Personhood in a Papua New Guinean Hospital* (Durham: Duke University Press Books, 2014).

choosing not to see is rooted in histories of power structures and in the status of clinical professionals.

## Conclusion

In a 46-second YouTube video entitled "Infectious Disease Control at PCMH,"<sup>315</sup> Sierra Leonean medical student Sinusi Jalloh stands in front of a painted wooden sign outside a hospital in Freetown, Sierra Leone in September, 2014. Dressed in blue hospital scrubs, Jalloh briefly describes "an infectious disease control program we are doing in collaboration with West African Medical Mission at the PCMH Maternal...Maternity Hospital...ehm, cottage, we are training staffs on disease and infection prevention methods in the isolation unit and also at other wards in the hospital." Directly behind Jalloh is a painted wooden sign bearing the name of the institution to which he refers: PCMH. The transposition of Maternity into Maternal in speech is easily understood, but why does the word "cottage" appear suddenly, anachronistically, in the midst of this otherwise uncomplicated sentence?

Throughout this dissertation, I have used PCMH to refer to Princess Christian Maternity Hospital. This makes sense for several reasons. First, because medical professionals have a tendency to use acronyms whenever possible and "Princess Christian Maternity Hospital" is a mouthful begging for an acronym. PCMH is the acronym chosen by Freetonians and recognized by the many international agencies circulating through Sierra Leone. In Freetown, "PCMH" will get you where you need to go. It stands for something, performing an instrumental function in

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<sup>315</sup> <http://www.youtube.com/watch?v=dIvY1p0vsOs&list=UU9FIWrDnizdqpnIflGBTqw>, accessed 11/8/2014



everyday speech. But PCMH has another name: Cottage Hospital, or — as above — often just “Cottage.”

“Cottage” does different work, signifying at the register of tacit collective knowledge. There is only one “Cottage” hospital in Sierra Leone, and it is remembered and re-invoked in present-day speech in a way that recognizes and names the storied, hybrid compound on the edge of town as both a microcosm of Freetown’s creole history and as a site for processes of social reproduction in which the future remains open to new inflection and reinterpretation. “Cottage” predates the Sierra Leonean civil war and two world wars. It predates the Ebola outbreak, decades of political corruption, the West African Medical Staff, even Sister Mary Ward. Memories of the Cottage hospital are embodied in generations of Freetonians who became parents, whose children first drew breath in the beds and on the wards, and whose grandparents and great grandparents proudly displayed newborn families in photos taken on its iconic stairway.

Today the view of the stairway is obscured: it can no longer be seen from the road and one must travel through the squat building housing the outpatient department and out the other side to see it, but it is still there. The stones commemorating the many contributions of Freetown residents are still there, names of British and Sierra Leonean families, the congregations of churches and mosques who collected on behalf of Mrs. Ingham’s endeavor remain etched in blocks lining the hallways, marking a time when the city came together to rebuild what had been destroyed in a form even stronger than the original. The use of the term “cottage” creolizes space and place, invoking the past in the present, and locating the hospital in a historical imagination of Mrs. Ingham’s time. “Cottage” helps us make sense of other creole elements of this institution.

In order to answer my original research questions, I have reconstructed a historical record that allows the reader to see how historical elements were mobilized and reinterpreted in 2011-12. This history connects the nursing caps and buckles I observed to a particular 'Cottage' era in the hospital's colonial history. Material and symbolic links to this era were consciously re-invoked and polished or creased with pride, remembered, and maintained at PCMH. This dissertation provides examples of moments in which anachronism and dissonance may be read as aspects of a clinical imaginary, and in which normative biomedical notions of 'best practices' must be placed within the context of Freetown's complex and unique past.

The spatial and visual orientations presented here – conceptually and practically – reflect complex processes of "suturing" past to present in non-linear fashion. Nancy Hunt speaks of suturing both in a filmic sense, as frames joined unevenly connote "split subjects, subject positioning, and identification" and in the sense of quilt making in which bits of cloth are "patches, scattered pieces of cloth with jagged edges, gaps, and holes" arranged to constitute an "almost bedspread," each bit of cloth holding its own story, regularly, perhaps daily, reconstituted by its owner into the semblance of a bedspread.<sup>316</sup> The rough edges of past and present are continually brought together, often re-fashioned along old seams, as the city is constituted and re-constituted through patterns of movement and memory. Evisceration stories and memories of violence surface like sloppy B-movie edits, interrupting travel and sometimes blocking it altogether.

The ability to effectively mobilize affinities and negotiate competing alliances determined access to resources and spaces within the hospital, much as it did in the city. I found that elements of compositional wealth, secrecy, ordeal, ways of facilitating and blocking passage,

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<sup>316</sup> Nancy Rose Hunt, *Suturing New Medical Histories of Africa* (Zürich: LIT Verlag, 2013).

networks of kinship and obligation, and the politics of knowledge that I observed in Freetown and in my experience as a member of a Sierra Leonean family were interwoven with the social and biomedical framework of the hospital so that they became indistinguishable, quotidian. Much like the revising, overwriting, and inventing that have shaped the city of Freetown, social processes in the hospital should be understood and capitalized upon for their generative potential. At the Cottage Hospital in 2011-12, the poles of life were often temporally and spatially concentrated. The hospital could be a route to death, a transition of bodily states, a thin place between this world and the parallel world of the ancestors.<sup>317</sup> Yet it could be and more often than not was, a site of joy — successful birth, the passage of new life into the arms of waiting kin, and “I de tell God tenki!”

In this hybrid hospital, lifesaving obstetric surgery could be performed (when enough physicians were present), but social wounds and memories could also be laid bare. As nurses reshaped British colonial frameworks to fit within the Freetown context, reinforcing locally salient social hierarchies, I observed clinical and social practices performed with an overwhelming vernacular resonance. While history was constantly, often consciously present, it was also subject to revision, its most basic terms redefined. Caps and buckles were both artifact and embellishment, but perhaps most importantly indices of an embodied tacit collective knowledge that permitted drawing on multiple sources simultaneously in order to achieve some degree of mastery over the unknown, the unpredictable, the ambient precarity, and the 'regular irregularity' that permeated everyday practice in the maternity wards.

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<sup>317</sup> Sorrell, Jeanne Merkle. "Listening in thin places: Ethics in the care of persons with Alzheimer's disease." *Advances in Nursing Science* 29, no. 2 (2006): 152-160.

This dissertation's analysis of a particular hospital in a particular place is meant to encourage more questions than answers, prompting us to consider how biomedical technologies might be more mobile than immutable, and to consider how *all* medicine is contingent on located concepts of the body, personhood, the nebulous border between life and death.<sup>318</sup> It has aimed to show how ethnographic detail, nested within a frame that embraces moral and historical imaginations alongside medical technologies, may invite debate about the weight of the past in Africa's clinical spaces. Encouraging an ethnographically-grounded consideration of the terms of debate, the dissertation demonstrates that what a hospital is or does depends on *where*, *when*, and *whom* is posing the question.

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<sup>318</sup> While examples of African "difference" abound, STS work continues to show how "the scientific" is equally contingent and constructed in well-resourced urban centers of the global North.

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