CHAPTER SIX

COLONIAL HEALTH CARE

For the colonial doctors, there is no indigenous medicine, only that of ‘witch-doctors’ and ‘quacks’ exploiting the credulity of their fellows. Medical aid . . . is our duty. . . . But it is also, one might say, our most immediate and matter-of-fact interest. For the entire work of colonisation, all the need to create wealth, is dominated in the colonies by the question of ‘labour’.

Albert Sarraut, quoted by Jean Suret-Canale

Sarraut vividly illustrated the essential nature of colonial health care. His pronouncement was borne out in Suret-Canale’s analysis of health care delivery for the whole of French West Africa in French Colonialism in Tropical Africa. Their observations, along with those of others cited here bring us to the indisputable conclusion that French medical penetration was key to the entire process of colonization. In regard to the goal of colonization to generate wealth, Sarraut stated that health care in the colonial setting helped in promoting the “‘necessity, in a word, of conserving and increasing human capital to make financial capital work and bear fruit.’”¹ Sarraut’s was the “orchard” metaphor for French West Africa.

Bringing fruit to bear demarcated the distribution of resources in Senegal and reinforced the concept of what was “useful” and what was not in both the geographic and demographic senses. It also helped to crystallize a new set of class differences and antagonisms. It was along these lines that colonial health care policy was formed.

As mentioned, the distribution of health care services, aside from its geographic and demographic particularities, was hierarchical. Its initial distribution was based on lines of race and class. Those lines were replicated and to them were added issues of ethnicity and religious affiliation. The policy that led to the creation of the communes

¹ Suret-Canale, French Colonization, 403; 407.
introduced and exacerbated the differences between the communes and the interior, and between urban and rural populations. Yet, within the health care profession in the colonial arena, race certainly was the key determinant of access, post and status.

Colonization provided a model for health care among Africans that was characterized by at least three distinct elements. The cordon sanitaire was one operable dynamic. That was reinforced by a new consciousness among the new African elite that bound them even closer to France. This was complicated by the fact that even within the framework of French colonialism, the Senegambia was still a contested area: contested among the forces of Islam; and between Islam and the powers of indigenous institutions.

The Cordon Sanitaire

Colonial policy, through administrative design, emphasized the dichotomy between urban and rural. The city, in many ways, became synonymous with colonization. It separated the European and those who would be European from the rest of the population. In her discussion of the cordon sanitaire, Gwendolyn Wright speaks of “urban planning” as being of “central importance in consolidating political power.” For the French, she goes on, this was realized in Hubert Lyautey’s idea of the ‘dual city’. The “two cities” or two parts of the same city suggested “health precautions” with the designation of the ‘sanitary corridor.’ Within the French Empire, indigenous cities were routinely separated “for reasons of health” as well as for political and military control. For some colonial officials, “urban planning represented the essence of modern urban planning” where “health seemed to depend on the separation of populations”. This is exactly what medical officer Doublet and his colleagues had in mind in 1860.

2 Ibid.
3 Wright, “Architecture and Urbanism,” 299. There is little, if anything, original about Lyautey’s “dual city.” The concept in the Western Sudan goes back to the very first contacts between indigenous African polities and the agents of Islam. Muslims were segregated in separate enclaves that became the dual cities written of in the chronicles. One can argue, given the theocentric nature of both indigenous and Islamic communities, that this cordon sanitaire was also a barrier against ill health, politically, spiritually and physically. In Lyautey’s case, his designation may indicate that he was a shrewd observer of the African condition.