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'I Am a Nurse': Oral Histories of African Nurses

Participants' stories offer insight into how African nurses adapted European models and ideas to meet their needs.

"I felt good, I felt really proud, and I said to myself, 'I am a nurse.' I have chosen this profession and nobody can take it away from me," said study participant Sophie Makwangwala, a retired nurse from Malawi, during an oral history interview, explaining the pride she felt when she first put on her nursing uniform and cap. To her, the uniform was a powerful symbol of professional nursing. Not only did it convey considerable authority,[1] but it also served to prove her worth as a nurse to a society unaccustomed to black women in professional roles.

Most documentary sources of African history have been written by colonial "masters" and are skewed by cultural bias.[2] African voices have long been obscured from Western academic disciplines. Oral history studies offer a way to access such voices. In this article, we report on a study that broke new ground through its sampling of African informants whose stories have yet to be heard. Through oral history interviews, Ms. Makwangwala and 12 other African men and women described what nursing practice and education meant to them during and after periods of colonization, and how they interpreted such meaning to meet their own needs. Their stories provide rich texts that offer alternative concepts of nursing identity formation and professionalism. They also provide evidence of African nurses' value systems and help to clarify why they did their work.

PURPOSE

We wanted to better understand the local history of nursing from the perspectives of indigenous people, drawing particularly upon the accumulated reflections of older nurses. To that end, we sought to collect and share the oral histories of a sample of African nurse leaders who studied and practiced nursing during the late colonial era (the 1950s) and subsequent periods of decolonization and independence (the 1960s and 1970s).

It must be kept in mind that the word "Africa" refers to the entire continent, which is home to more than 50 nations; history varies from one country to another and even from one part of a country to another. One cannot assume a total African continental experience. With this in mind, we focused on three sub-Saharan countries: Togo, a former French colony; and the former British colonies of Malawi and Mauritius. Each of these countries has a distinct history of colonization, which in turn shaped its educational system.

BACKGROUND

Using oral sources. Africans have a long commitment to oral history. Lee has argued that "the practice of oral history has been a foundational component of the discipline of African history," with storytelling being a crucial element.[3] Tuhiwai Smith asserts that within this genre, oral histories that tell "the

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ABSTRACT

Background: Much of African history has been written by colonial "masters" and is skewed by cultural bias. The voices of indigenous peoples have largely been ignored.

Purpose: The purpose of this study was to collect the oral histories of African nursing leaders who studied and practiced nursing from the late colonial era (1950s) through decolonization and independence (1960s–70s), in order to better understand their experiences and perspectives.

Methods: This study relied on historical methodology, grounded specifically within the context of decolonization and independence. The method used was oral history.

Results: Oral histories were collected from 13 retired nurses from Mauritius, Malawi, and Togo. Participants' educational and work histories bore the distinct imprint of European educational and medical norms. Nursing education provided a means of earning a living and offered professional advancement and affirmation. Participants were reluctant to discuss the influence of race, but several recalled difficulties in working with both expatriate and indigenous physicians and matrons. Differences in African nurses' experiences were evident at the local level, particularly with regard to language barriers, gender-related divisions, and educational and practice opportunities.

Conclusion: The data show that although institutional models and ideas were transported from colonial nursing leaders to African nursing students, the African nurses in this study adapted those models and ideas to meet their own needs. The findings also support the use of storytelling as a culturally appropriate research method. Participants' stories provide a better understanding of how time, place, and social and cultural forces influenced and affected local nursing practices. Their stories also reveal that nursing has held various meanings for participants, including as a means to personal and professional opportunities and as a way to help their countries' citizens.

Keywords: African nurses, nursing history, oral history

perspectives of elders and of women have become an integral part of all [i]ndigenous research."[4] And as Cooper has noted, "Africanists . . . still rely on oral interviews for access to 'facts' of a variety of kinds. Oral interviews are important ways of valorizing and making more widely accessible the rich local knowledge of Africans about their own worlds and environments."[5]

According to professional convention, historians must support oral findings with written evidence. But for much of Africa, written documentation of the history of nursing is scarce.[6] This raises numerous questions for researchers. What should be done when few written records exist? Does the paucity of documentation mean that we don't examine the history? If we fail to examine it, are we privileging only voices from the global North? When considering the history of colonized countries, one has to ask: whose history was recorded? From whose perspective? When the voices of the silenced—be they minority populations, the poor, or others excluded from power—aren't studied, gaping holes are left in the knowledge base.[7]

Especially when there are no or few written documents available, oral histories can serve as a rich resource. In his pioneering work, *Oral Tradition as History*, Vansina argued that storytelling was a culturally appropriate research method, although he had to convince the historical establishment that it was respectable.[8] We also examined the work of Henige and other historians, focusing on oral history with an African-centered emphasis.[9-12] Until more written sources emerge, historians must turn to the oral record. It's worth noting that as time passes, the number of older nurses who studied and worked during and after colonization and might provide their histories is diminishing.

Our project began during the summer of 2009 at the International Council of Nurses (ICN) Quadrennial Congress in Durban, South Africa, at the inaugural meeting of the Nursing History Section. One of the section's goals is to work together on joint history projects across national and cultural borders.[13] At that meeting, several sub-Saharan African leaders of professional nursing associations approached the meeting's two academic leaders regarding the history of nursing in their countries. They reported that their own expert knowledge had long gone unrecognized, and they wanted the stories of that history told, proposing interviews with retired nurse leaders. After the ICN conference, one of the academic leaders and three of the African nurse leaders began to collaborate

on what would become this study. Ideally, as Braun has stated, "indigenous research should be led, designed, controlled, and reported by indigenous people."[14, 15] For this to happen, certain resources were needed. A research grant from the University of Pennsylvania School of Nursing allowed the academic leader (one of us, BMW) to travel to Addis Ababa, Ethiopia, to train the three nurse leaders from Mauritius, Malawi, and Togo (KD, BEP, and BL, respectively) in the oral history method. The grant supported all travel and hotel expenses and the procurement of computers and digital tape recorders.

Contextual background. Colonial medical and nursing services in sub-Saharan Africa emerged in the late 19th century as a means to care for the health of whites who lived in large cities. But after World War II, European colonial powers' rule over African countries began to weaken, and Africans mobilized to organize new governments, health care institutions, and schools. For this to be accomplished, a healthy, skilled, and educated populace was needed, and colonial leaders began working with African health officials to educate African women and men as nurses.[2, 16, 17]

'I have chosen this profession and nobody can take it away from me.'

Mauritius, an island nation in the Indian Ocean, was first colonized by the Dutch in the 17th century. It was subsequently under French and then British rule, the last from 1810 until it gained independence as the Republic of Mauritius in 1968. Its geographical location had made Mauritius an important connection point for trade routes. During the early 20th century, owners of large sugar plantations began providing health care to their workers in order to maintain a healthy workforce. A large multiethnic population soon developed, composed largely of Indians, Chinese, and Pakistanis. This population was also religiously diverse. Under the predominantly Christian British, most nurses had been women. But because the Hindu and Muslim faiths require sex segregation in health care (caregivers and nurses must be of the same sex), a relatively high percentage of Muslim and Hindu men entered nursing in Mauritius. (They were not compelled to take midwifery courses, as male nurses were not allowed to work in gynecologic and obstetric wards.)

As Rafferty and Solano have noted, the creation of Britain's Colonial Nursing Service (CNS) in 1940 "established a British nursing 'empire,' with nursing sisters leading education and training" and influencing "nursing practice and professionalism internationally."[6] An early focus was the exporting of British ideas and nursing practices "to indigenous populations abroad,"[6] including those of both Mauritius and Malawi. In the 1950s British nurses introduced "modern" nursing education to Mauritius: this included three years' training at school as a "general nurse" or two years' training in midwifery.[18] (A British nurse known as Matron Davies trained many of the nurses interviewed for this study.) The language of instruction also changed from French to English, and by 1958, in keeping with British standards, nursing students were required to hold a Cambridge School Certificate or a London General Certificate of Secondary Education.[18]

Malawi was made a British protectorate in the late 19th century, and was known as Nyasaland. In 1964, the country gained its independence as the Republic of Malawi. Hastings Kamuzu Banda, an American-educated physician, became its first prime minister, and high on his list of priorities was expanding health care, including the education of nurses and midwives.

Togo. Initially colonized by Germany in the late 19th century, after World War I Togo became a French colony. In keeping with France's assimilation policies, its citizens were required to learn the French language and adopt French cuisine and styles of dress. After World War II, opportunities increased for many French-speaking Africans, particularly men who wanted to become nurses.[19] Togo has a large Muslim population, and as in Mauritius, Muslim segregation patterns meant that more men were needed in nursing. In 1960, Togo gained its independence as the Togolese Republic.

As decolonization progressed, colonial agents were pulled out of African countries, and many took their nurses and other resources with them. When French colonial authorities left Africa, they stopped economic assistance and removed even their equipment,[20] which left few resources for local nurses to draw upon. And Rafferty and Solano have argued that, in effect, Britain's CNS "laid the foundations for the postcolonial international migration of nursing services."[6] When the British left Mauritius and Malawi, they took their expertise with them, including many African nurses who emigrated to England.[21] What remained was a foundation of nursing education based on the European model that African nurses adapted to meet their own needs.

METHODS

Historical methodology. This study relied on historical methodology, grounded specifically within the context of decolonization and independence. The method used was oral history, which was defined as personal reminiscences about events and situations occurring during the participants' lifetimes. (Such histories are distinguished from oral traditions, which involve the recounting of events that occurred before a person's lifetime.) The histories in this study involved career

histories, not life histories, and covered a narrower range of memories. Data analysis included the examination and interpretation of professional, racial, religious, and gender-related issues to enhance our understanding. Cultural historical methods were also used to facilitate understanding of the meanings that participants ascribed to the events they had experienced. (See *How Oral History and Qualitative Research Methods Differ*.[22-24])

Sample. A purposive sample was used, with researchers approaching specific nurses whom they personally knew to be leaders. The inclusion criteria were that participants had been leaders in national professional associations in their countries and had studied during the colonial and decolonization periods. Thirteen retired African nurses who had studied nursing during the colonial and decolonization periods participated. They included six men and two women from Mauritius (Samuel Antonio, Virindramansing Juwaheer, Dominique Bacosse, Jagdeo Abeelack, Mahmoob Ramjaun, Deoparsadsingh Seetohul; Josee Clementine Serret, Lisette Janine Poule); three women from Malawi (Sophie Makwangwala, Anna-Marie Ziba, Molly Jere); and two men from Togo (Roger Ehlan, Sossa Joseph Aholou). None had yet been represented in current historical writings. All were African nursing leaders and had mentored the African researchers (KD, BL, and BEP). As Tuhiwai Smith has noted, in obtaining the stories of people silenced in the past, it's not unusual for older community members, including those who have mentored younger ones, to be approached "as the first point of contact."[4]

Procedure. Following the guidelines of the Oral History Association, the African researchers gained the participants' informed consent and collected the oral histories through audiotaped interviews. The African researchers brought to the study their knowledge of local culture, nursing education programs and standards, and language. Interviews were conducted in the local language. The Malawian researcher conducted interviews in the Nyanja (*chinyanja*) language (also known as Chewa [*chicheŵa*]). The Mauritian researcher reported that six of the eight participants used the Mauritian "Creole" dialect and two used English. The Togolese interviews were conducted in French, which is still the official language of Togo. All written transcriptions were done afterward by the local researchers, and were then translated into English by either the local researcher or a bilingual transcriber from Same Day Transcription Services in Philadelphia.

Although the American researcher lacked an African perspective, she shared her knowledge about historical nursing research and the oral history method with the African researchers, and met with each African researcher via Skype to analyze and interpret the data together. Because of language differences, all of the researchers didn't review all the recordings; rather, each researcher restricted her or his interpretations to her or his interviews.

The University of Pennsylvania's institutional review board approved the study. Yet there remains much uncertainty about ethical procedures for research in resource-poor countries. All of the African researchers and participants were members of their countries' professional organizations but were not associated with academic institutions. In Mauritius, Malawi, and Togo, those professional organizations do not have institutional review boards.

The African researchers did play major roles in designing and approving the interview questions, conducting and transcribing the interviews, interpreting the data, and writing up the findings. The semistructured, open-ended questions focused on the professional aims, education, relationships, and successes and struggles of the participants. Interviews were conducted one-on-one and face-to-face. Each participant

How Oral History and Qualitative Research Methods Differ

The oral history method is similar to those methods used in some types of qualitative nursing research (such as phenomenological or ethnographic studies) in that each tries to "give voice to the voiceless."[22] In so doing, researchers strive to decrease the power differentials between themselves and the people they study.[22, 23] Yet the methods differ in many ways.

First, history is a discipline, not just a methodology, and as such it precedes modern nursing. Second, oral histories involve an interaction between two people, an interviewer and an interviewee, whereas qualitative research methods often involve working with larger numbers of people. Oral historians don't aim for a certain number of interviews before saturation is reached; rather, in focusing on an individual or individuals, they seek to "invoke a set of shared understandings and histories."[24] Third, in most forms of qualitative research, participants' names are usually protected; in research based on oral histories, participants often want their names documented for the historical record (although they may choose anonymity if they wish). Fourth, qualitative research tends to emphasize the present, whereas oral histories emphasize the past. Thus oral histories must be analyzed within their cultural context, the milieu in which the events described took place. Fifth, data analysis and interpretation of data differ. Qualitative nursing researchers often use content analysis; historians use methods that involve comparing and evaluating data points against each other and against competing explanations. The concepts of saturation, thematic content analysis, consensus, cross-checking, and reconstruction are common in qualitative nursing research but are not used by oral history researchers. Lastly, historical analysis invites interpretation; there is no one correct interpretation. This differs significantly from content analysis, which involves coding the data until themes or categories emerge and consensus is reached.

was interviewed once, with each interview lasting about 45 minutes. The local researchers began the interviews by asking participants why they had entered nursing, whether they'd had outside support, and what their work trajectories had been (for more details, see Table 1). Then the researchers explored how participants understood their work, created new professional identities, and developed practice models within the context of decolonization and independence.

RESULTS

Education. Participants' educational and work histories bore the distinct imprint of educational and medical norms that were based on European standards. Thus, there were many similarities in the nursing education that participants had received.

> there were also midwives who were trained in vernacular languages. . . . And there were also enrolled nurses [who] were a bit higher in rank and were trained by government. . . . These attracted me to nursing when I saw them.

Her self-esteem and status were enhanced when, in 1969, she became the senior sister in the labor ward. She also had the support of a chief matron and medical superintendent, and reported that she "really felt valued."

The participants' responses suggested that they embraced European education in many ways. For all of them, education provided a means of advancement and a way to make ends meet. According to Togolese participant Mr. Ehlan, the nurse "has authority in the village or in the city; he is in his place, so people want to be like me." Also, many of the nurses in this study were critical of "modern" nurses; in this they were not unlike older nurses in many countries who may be critical of their younger counterparts.

When the voices of the silenced aren't studied, gaping holes are left in the knowledge base.

In Mauritius and Malawi, the British-based educational system was hospital oriented, with African students performing tasks in the wards under the supervision of white British nurses. As in England, students had to satisfy the demands for service in hospitals. As Mr. Juwaheer noted, "Even as a student, we worked night and day. All these holidays they have today, at that time we did not have these." Students learned how to do tasks such as testing urine, making beds, giving baths, bandaging wounds, and giving medications. By the third year, students had charge of the wards. Students also had to balance work with study time. The curriculum consisted of medical and surgical nursing, anatomy, and pharmacology. In Togo, in addition to science and nursing courses, students learned about sanitation, hygiene, wound care, and practical matters pertaining to the diseases most seen in Togo (such as malaria, pertussis, and trypanosomiasis). Mr. Ehlan reported that, as in France, student learning often involved making bedside rounds with physicians and nurses and mastering material that had immediate relevance to their practice.

Malawian participant Ms. Jere described the variety of nursing training available during the 1960s and why she chose to meet the British qualifications:

> People in villages were being taken care of by traditional healers and traditional birth attendants. But in the hospitals we had hospital attendants; we used to call them HAs and these were really like doctors. . . . They were locally trained, mainly by the missionaries. And then

Nursing education also afforded several participants a way to gain respect in their local communities. For example, Malawian participant Ms. Ziba became a midwife whom people listened to because she had the courage to stand up for what she knew to be correct knowledge and practice:

> I had one patient that I said should not go for vacuum extraction, but people pleaded with me saying, "Please, the husband is pleading that she shouldn't go through a [cesarean] section," but I said "No". . . . This one is a successful story because I was able to stand up to people and say that this person could not deliver because I knew what I was doing.

Racial issues. To counteract participants' tendency to gloss over any unpleasantness, the local researchers probed gently with regard to racial issues. Participants reported difficulties in working with both expatriate and indigenous physicians and matrons during the 1950s and 1960s. It wasn't until the 1960s that indigenous nurses began to hold administrative positions. For example, according to Mr. Seetohul, in 1963 a Mauritian nurse, a Ms. Raoul, became a nursing educator.

Although most instructors were white, it appears that, regardless of race or nationality, relations between

students and instructors were often tense because of the instructors' strict expectations. Such rigorous training was similar to what nurses in Europe and other countries reported during the same time period.[25,26] Mr. Seetohul recalled that Ms. Raoul was known as "The Iron Lady." And another Mauritian participant, Mr. Juwaheer, described a strict hierarchy based on rank: "It was difficult to please them. Even the matron . . . It was very difficult to please her." Indeed, the Mauritian researcher noted that because Mauritian instructors followed British standards, many of the indigenous teachers were considered "more British than the British."

Similarly, Togolese participant Mr. Ehlan remembered that bonding based on race was lacking:

> In fact, we who were new, when you see the older nurses, they were imitating the whites, the manner of directing that whites had; so they gave orders sternly like the whites did. It was rare to see a black nurse manager who treated you like a black brother.

In other parts of Africa, as well, indigenous instructors and managers often acted like colonialists in failing to bond with their fellow Africans.[27] Many had likely attained an educational level closer to that of their white counterparts and learned to project the dominant culture's expectations on their colleagues. This was a major complaint of Wangari Maathai, a Kenyan environmentalist and political activist who was awarded the 2004 Nobel Peace Prize; she described some Africans as "collaborators" with regard to colonial authorities.[28]

Professional identity. Like many nurses worldwide, the study participants found nursing to be an affirmative experience. As Ms. Poule, a Mauritian nurse, commented, "I was lucky. I chose my work and it was a success." Ms. Ziba, a Malawian participant, stated,

> Nursing is not a mere profession, it is a calling. . . . I have enjoyed nursing. . . . Even in my coffin, I will be a nurse. . . . All this is because I have nursing at heart and my patients are my priority. And as for what I would like to be remembered for, it is being a good nurse and midwife and a professional who respects her profession as her bread and butter among other things. You know, sometimes my family has complained because I spend most of my time at the hospital. [Laughs] When I have something to do I will not leave until it is done. My profession comes first.

Others responded in similar ways. In 1991, Ms. Serret helped to open the new Jawaharlal Nehru Cancer Hospital and Research Centre in Mauritius and served as matron until she retired in 1994. "My head is still there," she noted. It was important to Mr. Seetohul that he felt himself to be "on equal footing" with both his African and British counterparts. When asked to describe a memorable experience, all of the participants told stories about patients they had cared for and whose healing they had facilitated. They had worked in nursing between 30 and 40 years, and many had come back after retirement either to paying jobs or as volunteers. For Mauritian participant Mr. Antonio, nursing was an "all-time success story." He is still volunteering as a nurse.

Differences in African nursing experiences were evident at the local level, as follows.

Language barriers. Most nurses in this study had to overcome language barriers, which made their studies harder. Mr. Abeelack noted that in Mauritius, "It was not easy. It was not easy." But Mr. Bacosse, another Mauritian participant, had no problems with the English language, as he'd been taught by British expatriates in secondary school. Other participants developed creative responses to the language issue, such as fusing English and additional languages to form Mauritian Creole, a French-based language. In Mauritius, Indians are in the majority, and they took up Mauritian Creole as their main language to distance themselves from the English- and French-speaking white elite. Still, to matriculate into nursing school, potential students had to pass the Cambridge School Certificate or London General Certificate of Secondary Education examinations.

'Nursing is not a mere profession, it is a calling.'

Different goals. A sense of vocation and a commitment to serving others were important to the African nurses in this study, as they are for many nurses worldwide. Some, like Mauritian participant Mr. Ramjaun, had chosen nursing over other jobs such as teaching. But the study participants were distinctive in their desire to serve their countries. Ms. Makwangwala wanted to be a nurse "so that I could be an ambassador for [Malawi]." Another Malawian participant, Ms. Ziba, reported feeling she had received unfair treatment regarding her salary, but had "worked on for the sake of my people." It was very important to her that other Malawians join the profession so that "we will have locally produced nurses."

Study-abroad opportunities. After World War II, the changing economic and political environment in sub-Saharan Africa gave several participants the opportunity either to study abroad or to take additional

Table 1. Responses from Mauritian, Malawian, and Togolese Participants

	Mauritius								Malawi			Togo	
	Antonio	Juwaheer	Bacosse	Abeelack	Serret	Poule	Ramjaun	Seetohul	Jere	Makwang-wala	Ziba	Ehlan	Aholou
When entered nursing school													
Year(s)	1950s	1956	1950s	1957	1954	1956	1957	1963	1964	1964	1970	1950	1960
Reason for entering nursing													
Vocation/ service to country		•		•					•	•	•	•	•
Parent/ other encouraged	•	•	•		•		•		• (impressed with nurses)	• (impressed with nurses)	• (impressed with a nurse)		
Personal experience with caretaking				• (friends)									
Job opportunity				•		•						•	•
Status								•	•	• Nursing uniform a powerful symbol	•	• Author-ity in village	
Outside support			• British Ministry of Overseas Develop-ment						• Minister of Education (studied in UK)	• Prime Min-ister Banda's govern-ment (studied in Germany)		• Support to study in France	• Support to study in France

Positions held after graduation													
Midwife						•			•	•	•		
Matron/ head of floor or unit/ administrator		•			•	•	•	•	•	•	•		
Part-time after retirement	•									•	•		
Health education												•	•
Chief of nursing service											Head of regional program	Chief of National Service for Health Education	General supervisor and consultant for National Service of Nursing Care and World Health Organization
Hospital	•	•		• Surgery, burns, trauma	• Orthopedics, burns	• Surgery, pediatrics	•	•	•	•	•		
Clinic										• (rural)		• (village)	
Prison	•												
Public health											•	•	•

classes at the colonial government's expense. In Mauritius, Mr. Bacosse received a scholarship from the British Ministry of Overseas Development to train as a tutor. In Togo, a shortage of nurses and especially of physicians became acute during the decolonization period, and the government began sponsoring specialty training. The two Togolese participants were thus able to further their university education. For example, Mr. Aholou studied public health in France and also in Dakar, Senegal, a leading educational hub in what was then French West Africa. Afterward, he worked for the National Service of Nursing Care to ensure workforce capacity of nursing and auxiliaries in the field. He also worked with the World Health Organization.

During the same period, more female nurses were specializing as midwives. In Malawi, Ms. Makwangwala benefited less from her country's former colonial ties than from newer international connections that developed during the Cold War. She related how, in 1964, Prime Minister Banda "had a vision to build big hospitals in Lilongwe and Blantyre," and "decided to send the nurses who were in the mission hospitals abroad for training." Banda was a leader of the pro-Western bloc in Africa, and many Western countries, including Germany, supported him. Ms. Makwangwala profited from that support in being given an opportunity to study in Germany. Such international links helped many Malawian nurses to learn what nursing practice was like in other countries.

The gender-related distinctions in the nursing profession in the three countries are striking. One such distinction was the aforementioned segregation by sex among caretakers and patients in Mauritius and Togo, resulting from the influence of Muslim and Hindu faiths. For example, in Mauritius, all the government hospitals—which made up most of the hospitals in the country—had separate male and female wards, affording men more opportunities to practice than they might have had otherwise. Educational distinctions also had great influence. In the 1950s in colonized Togo, women weren't encouraged to pursue higher education; rather, they were expected to stay home and care for the family. After decolonization, as the "nuclear family" model gained influence, this pattern only became more entrenched. Thus, as study opportunities for Africans expanded both throughout Africa and abroad,[29] these also favored men. Indeed, Mr. Ehlan's career reflects this: he received government support to study nursing in France and later went on to become chief of Togo's National Service for Health Education, developing and administering its health education programs.

Practice opportunities also reflected gender-related divisions. Particularly in rural areas, distances to clinics were typically great and few physicians practiced; thus nurses often had expanded roles, and this tended to benefit men. In both Togo and Mauritius, male nurses informally became assistant physicians or community physicians in remote dispensaries and were called "Doctor" by the community. It was also cheaper and easier for patients to see a male nurse than a physician. And once qualified as nurses, some found work in pharmacies; Mauritian participant Mr. Bacosse remembered compounding medicines. Mr. Ehlan summarized the situation in Togo:

> You are the nurse, the physician, the obstetrician. . . . He who was in the village, there was no difference. He acted like a resident doctor and at the same time a nurse because he did consultations and wrote prescriptions, and he gave care and did births also.

In Togo, because of a dearth of surgical specialists, during the 1950s and early 1960s, experienced nurses opened the first surgery units outside of Lomé. Mr. Aholou decried the colonial physicians' perceptions that nurses were merely their helpers, noting that many free clinics in villages were managed by male nurses. In the hospitals, male nurses often worked in an expanded role that involved consulting with patients. Only the sickest patients were referred to physicians.

Female nurses' roles usually included traditional gender-based tasks. Mauritian participant Ms. Poule stated that "everything was the nurse's job," noting that in addition to midwifery, she cooked for and served as a counselor to families. In Malawi, as in Togo, in the 1950s men were generally expected to provide for their families while women were expected to meet domestic needs. When, following decolonization, women began to enter nursing and to work outside the home, their husbands often felt threatened. As Ms. Jere recalled,

> This one nurse told me that her husband had wrong ideas especially when it came to her coming on night duty. The husband thought that maybe there was something going on between her and the doctors at the hospital. This happened a lot, especially for the young couples so I would talk to them, including their husbands.

Ms. Jere further explained that she considered the welfare of her junior nurses to be of paramount importance. She recognized that work performance issues often had less to do with the hospital than with family situations. She often acted as a de facto family counselor, knowing that if she could help relieve some of their domestic problems, their performance would improve.

DISCUSSION

The nurses who participated in this study took the practical step of gaining knowledge, including

European expertise, knowing this could benefit them and their fellow countrymen and countrywomen. Thus this research shows how important education was to the professional development of African men and women; indeed, as one historian has stated, colonial and postcolonial gains in literacy and skilled human resources were "impressive."[30] Participants in this study chose to remember many positive aspects of nursing that led to intrinsic rewards. For them, as for nurses in other countries, becoming a nurse had required discipline and hard work. It also meant an opportunity to carry out their sense of having a calling.

Their oral histories also served to refine ideas about African nurses and their work. As noted earlier, in some countries, sex-segregated health care policies based on religious beliefs meant that more male nurses were needed to serve the population, and this encouraged more men to become nurses. Mauritius, in particular, continues to have a large number of male nurses in its nursing workforce. That said, the absence of male midwives in Mauritius is striking, and the failure to accept men as midwives continues to have consequences. For example, before a female nurse can be promoted to charge nurse, she must take a posteducation basic midwifery course; her male counterparts are promoted without such training. (Paradoxically, only nurses are so affected. Mauritius allows male obstetricians and gynecologists to care for its female population.)

The preference for separation by sex also created opportunities for women to hold managerial positions within their allotted areas. Each of the study participants carved out her or his pathway, recognizing that both men and women were responsible for fulfilling caregiver roles. Furthermore, because of tremendous shortages of health care professionals, nurses working in rural areas in Togo and Mauritius took on more extensive roles that mimicked those of physicians. They worked with limited resources under conditions of poverty and a high incidence of disease. There was no malpractice insurance; then again, almost no one could afford to sue.

The African nurses in this study were also distinctive in their desire to help their countries heal from the effects of years of colonialism. This likely reflects the fact that, at the height of the African independence movement, a strong national pride emerged in many countries, along with a collective will to improve the lives of their citizens. When the study participants spoke, they emphasized their nationalistic perspectives and demonstrated their loyalty to their countries.

Limitations. Because of the small sample size, the study findings can't be generalized to larger areas and populations, especially since each African country is distinct. Nor should the data gathered be taken to represent a comprehensive history of nursing in sub-Saharan Africa. Furthermore, oral histories are situated in time and place, and are inherently subjective in nature. The participants' histories may reflect how participants wanted to be remembered by others; or they may involve inadvertent errors in recall, since participants were reporting what they now believe their past actions were. They may have created a self-consciously "progressive" narrative by emphasizing confidence and pride in their accomplishments. The participants were reluctant to talk about race, and the significance of their silence in this regard must be considered. Some of the women may not have been comfortable speaking about their feelings to male researchers. Lastly, although the local researchers knew the participants they interviewed, and in this way were fellow "insiders," they also held current prestigious positions in their professional organizations, and the participants may have seen them as "outsiders." There may have been some things that participants withheld in order to resist what, as one historian has put it, the "prying eyes of researchers."[4]

Participants were reluctant to talk about race.

Nursing implications. Nurses from resource-rich countries in practice around the world today need to consider the views of local nurses, who want to be involved in decision making about policies that affect their countries and communities. This study's findings indicate that African nurses often expanded their scope of practice in ways that advanced practice nurses did only decades later in the global North. We can learn from African nurses as they share their stories about the former and current locally prescribed roles of men and women, the ways such roles affect the nursing profession, and the obligations countries have to provide care for their citizens. In particular, male nurses in sub-Saharan Africa tend to have an unusually high status in their local communities; they can serve as examples to international policymakers trying to develop strategies aimed at attracting more men to nursing. Lastly, understanding the minds and spirits of Mauritian, Malawian, and Togolese nurses can help other nurses to relate more effectively to nurses and patients from these countries.

CONCLUSION

During the colonial era, nurse educators from Britain brought their ideas about nursing to Mauritius and Malawi; and French ideas similarly influenced Togolese nurses. The study participants' words give a central place back to the people who experienced this history,[31] and provide insights we can get in no other way. We learned about how the "colonized" received

their education, and about the distinct appeal that nursing held for both women and men. As in other countries, nursing became an important route for the development of professional skills and status. African men and women engaged with colonial instructors and institutions and, through diverse interactions and with conscious intent, often transformed their education in order to better meet their own objectives. After colonization ended, many African nurses had to face depleted workforces and resource-poor work environments. Despite such barriers, they worked diligently to strengthen their countries' health care systems and thereby serve their people.

Through this study, we have tried to ensure that African nurses' voices become part of the record, instead of assuming that existing written archival materials speak for them. Many historians call for the validation of oral histories by written records,[8, 32, 33] but it does not negate their importance when no written records are available. Furthermore, all oral historical research is inherently work in progress, because we can never tap the entire memory of any group of informants. Most important, we hope these data will inspire the creation of African nursing archives and broaden our knowledge of nursing history. These oral histories offer a starting point from which to engage other scholars and to further the restoration of Africans to their rightful place as the main actors in their histories. We want to continue this important conversation. ▼

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