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'Traditional Birth Attendants' and Reproductive Expertise in Postcolonial Mali

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ABSTRACT

Over the twentieth century, Malian families turned to older women reproductive specialists like excisers (who initiated young women into adulthood), nuptial counsellors (who educated women for sex within marriage) and popular midwives. Their work reflected an expansive understanding of health and fertility. In the 1970s, Mali's government sought to incorporate 'traditional medicine' into the health system. State health workers trained popular midwives as 'Traditional Birth Attendants' (TBA). The same health workers defined nuptial counselling and excision as un-therapeutic and outdated cultural practices. Comparing these responses reveals the role of gender and social status in the making of an African health system.

In 1977, El Hadj Oumar Koné, director of the Malian Red Cross, co-founded an association to promote 'traditional medicine'. The association critiqued the fact that Mali and other developing countries had 'imitated the models proposed by so-called modern medicine … [which are] overwrought, impersonal, and extremely expensive …'. The group proposed that 'African countries … [should] create a new model integrating modern medicine and traditional medicine better adapted to their traditions and their financial realities'.[1] Koné was not alone. In the 1970s, some West African journalists and intellectuals argued that the development and use of indigenous knowledge systems could serve postcolonial needs.[2] At Mali's Ministry of Health and *École Nationale de Médecine et de Pharmacie* (ENMP), doctors, pharmacists and medical students looked to local practitioners and practices. Under the tutelage of Dr Mamadou Koumaré, who was head of a national institute for research on traditional medicine, pharmacy students researched herbal medicines.[3] Medical students like Lalla Haidara proposed using popular healers to staff the national health system, given Mali's lack of sufficient biomedical infrastructure and personnel.[4] Other students, like Moussa Maiga, noted that such a model would formalise the reality that Malian patients 'trusted local healers' and often turned to them before seeking biomedical care.[5] These calls were amplified in the early 1980s, in a series of national conferences which proposed that the state health system turn to 'traditional healers' to resolve staffing issues.[6]

When they considered which Malian specialists to incorporate into the health system, Malian policy makers could have turned to any number of practitioners, from herbalists to women who provided sexual education. But in spite of the existence of

a range of male and female therapeutic specialists, only one kind of local healer was ever systematically employed in Mali's national health system: the popular midwife as a 'Traditional Birth Attendant' (TBA). Why was the popular midwife/TBA brought into the national health system, when other therapeutic actors were not? Drawing on medical student theses, oral histories and the records of rural health projects, this article focuses on debates about three female reproductive specialists to demonstrate how international health norms combined with certain Malian conceptions of proper maternity, healing and social status to include some practitioners and reproductive practices in postcolonial definitions of 'traditional medicine' while excluding others.

Throughout the twentieth century, Malian families had relied on older women reproductive specialists to help women become socially recognised mothers. Excisers (Bamanakan: *bolokolikelaw*) transformed a person into an adult, through genital surgery and initiation.[7] Nuptial counsellors (*màŋɔmagaw)* provided vital knowledge about wifehood via sexual and marital education and spiritual protection before and after the wedding. Popular midwives (*timinimusow*) worked to ensure safe childbearing over the extended period of pregnancy, birth and infancy, and confirmed the legitimacy of the newborn. Initiation, marriage and childbirth all intertwined moral evaluation with therapeutic interventions.[8]

Although different women served as popular midwives, excisers and nuptial counsellors, there were important similarities in their work. All three specialists were older women, who apprenticed with a family member, in-law or neighbour, first assisting with ancillary caretaking tasks (like washing laundry) and over time learning expert interventions.[9] Each specialist provided education about normative behaviour, along with somatic interventions (such as massage during childbirth or the excision surgery). All three mastered the identification, collection, preparation and dosages of plant medicines to improve sexual health, heal surgical wounds and speed labour. They also protected their vulnerable charges against invisible forces and spirits, using tools like amulets and healing prayers (*kilisi*) which drew from the Islamic esoteric sciences that observed and engaged with the unseen world. Their varied interventions reflected an expansive understanding of health – including well-being and fertility – at risk from both physical and invisible forces. For their work, these specialists were paid in-kind.

It is important to note that this work varied between different Malian regions and communities. Historically, some women in Mali gave birth alone and the attendant only arrived after delivery, while in other cases, midwifery knowledge was diffuse, with several older women attending a birth as opposed to a single person.[10] Excision and nuptial counselling were more common in some communities than others. These practices also changed over time, responding to new technologies (such as razor blades and condoms) and to changing social worlds (such as the widespread conversion of Malians to Islam in the mid-twentieth century).

Additionally, these specialists came from different social groups. Schematically, in southern Mali, each person was a member of a distinct social community, which included 'noble' freeborn individuals (*hɔrɔnw*), people defined socially as 'slaves' (including the descendants of enslaved people) and *nyamakalaw* – semi-endogamous professional groups which included blacksmith/potters (*numuw*), griots (*jeliw*), leatherworkers (*garankew* and *sɛkiw*) and several others. In theory, each of these groups married internally and held a monopoly over certain skills and social roles,

although lived social practices were invariably more complex.[11] Nuptial counsellors inherited their work as *garankew* and *sɛkiw*, although a small number self-identified or were identified as being of enslaved descent.[12] Excisers were *numuw*. In addition to their ritual control of initiation, men from *numu* families often smelted and forged iron, while women worked as potters, controlling the transformation of clay into pots, iron into knives and children into adults.[13] Midwives, on the other hand, could come from any social group and were not necessarily of *nyamakalaw* descent.

As the Ministry of Health began in the late 1970s to develop and implement policies to formally incorporate 'traditional healers' into the health system, government health workers responded in very different ways to these three specialists, seeking to professionalise popular midwives as TBAs while identifying nuptial counsellors and excisers as outdated cultural actors. The same health workers who supervised TBAs also drew national attention to the problem of pre-marital pregnancy and to critiques of excision, in ways which were critical of the work and social role of *nyamakalaw* specialists. Through their responses to these reproductive specialists, government health workers shaped the meaning of Malian 'traditional medicine'. Scholars have demonstrated how the twentieth-century development of the conceptual category of 'traditional medicine' in Africa was produced *in contrast* to biomedicine. In spite of quotidian realities, colonial biomedical professionals framed their work as the inverse of 'traditional medicine' – an amalgamation of diverse local and regional therapeutic practices – even as legislation such as anti-witchcraft ordinances reshaped the socio-political uses of individual and communal healing.[14] Following independence, countries like Tanzania, through engagements with other non-Western countries, most notably China, solidified a postcolonial vision of 'traditional medicine' as an alternative to biomedicine.[15] In Mali, the process of creating useable 'traditional medicine' led biomedical actors to distinguish between the physical, social and esoteric interventions performed by reproductive specialists, excluding many practices and practitioners from 'traditional medicine'.

Village health workers to serve rural Malians

Mali's postcolonial governments faced a challenge: how to provide health care to the country's predominately rural population. As of 1980, the population density was under twenty people/square mile. There was an average of one doctor for every 26,000 rural Malians.[16] Over the 1970s and 1980s, building on the concepts of the Primary Health Care movement (see below), the Ministry of Health sought to expand its personnel by training rural health workers drawn from two groups: young literate rural residents and existing therapeutic specialists. Their aim was to train new staff without increasing the national health budget, the bulk of which was consumed by the salaries and equipment for tertiary hospital facilities located in Bamako and regional capitals.[17]

Biomedical health services had been introduced into colonial Mali (then termed Soudan Français) by the French state, which began to invest in maternal and child health in the 1920s. The colonial government built maternity wards and trained young African women as *sage-femmes* (nurse-midwives) and visiting nurses. These women were assigned throughout French West Africa to provide infant health services and obstetric care.[18] In stark contrast to popular midwives, *sage-femmes* were usually

younger than the women they served. They also offered a very different setting for childbirth, which was attractive to some, although not all: birth occurred in a bed in a clinical space, instead of at home, kneeling on a mat.[19] However, biomedical maternal and infant health services were not widely accessible and were largely defined by the absence of infrastructure, personnel and materials.[20] When Mali gained independence from France in 1960, the new country of over four million people had only thirty-six maternity wards.[21]

Under President Modibo Keita, Mali's socialist government concentrated on the development of secondary health services, including those for maternal and child health. The state built dispensaries in county and district capitals and established a school to train mid-level health personnel like *sage-femmes*.[22] Concurrently, some high-ranking members of the Ministry of Health evinced scepticism for local therapeutic practices. According to one interviewee, in 1968, the then-Cabinet Director suggested that traditional practitioners should be 'thrown in prison'.[23] In rural areas, some district officers and village councillors penalised homebirth by popular midwives, fining couples 2,000 to 6,000 Malian francs for not giving birth in maternity wards.[24] Some officials may have targeted popular midwives rather than the parturient's family – midwives in Sikasso Region described their fear of being jailed for performing homebirths.[25]

After ousting the Keita government in 1968, a military junta led by Moussa Traoré ruled Mali until 1991. Under the Traoré government, the Ministry of Health emphasised rural health services, specifically encouraging community construction projects and programmes to train village-based health workers.[26] These strategies were central to the growing international movement for Primary Health Care (PHC). PHC emphasised the social and economic origins of disease and called for health systems to prioritise universal health care in resource-poor communities via investments in infrastructure and sanitation, and the employment of large numbers of health workers with basic training, including indigenous practitioners. PHC entailed a somewhat idealistic vision of community investment in community health. [27] In Mali, PHC involved rural healthcare provision, preventive health measures like public sanitation projects, community financial participation and the use of community-based health workers.[28] In defining their own PHC programmes, Malian health policy makers drew inspiration from other African countries like Niger and Tanzania, and from projects in Bangladesh, Costa Rica and China, as well as from the World Health Organization (WHO), which became a champion of PHC under the leadership of Halfden Mahler.[29]

The PHC movement formally culminated in the 1978 Alma Ata Conference, prompting a swift backlash from a cadre of powerful institutions, including the Rockefeller Foundation, the World Bank and UNICEF. They championed 'Selective Primary Health Care' which turned away from structural investments to emphasise the use of specific low-cost interventions like oral rehydration solution and breastfeeding.[30] However, in Mali, well into the 1980s, political leaders continued to reference the language and model of PHC – including the use of village health workers.[31]

The first village health worker projects in Mali had been launched in the early 1970s in Koulikoro and Sikasso Regions. These projects trained literate young women as rural auxiliary midwives, or *matrones*.[32] *Matrones* were in theory from the community where they worked and were assigned to a rural maternity ward once the building

had been constructed and equipped by community residents.[33] These *matrone* projects did increase rural health infrastructure – by 1977 Sikasso and Koulikoro Regions each had around 110 rural maternities.[34] However, the decision to rely on community resources (unpaid labour, time and money) meant that this new health infrastructure was distributed unevenly, reflecting each community's pre-existing wealth, especially because these projects came on the heels of a six-year drought culminating in the 1972–74 Sahelian famine.[35] At the turn of the decade, still only fifteen to twenty percent of all registered births in Mali occurred in the presence of biomedically trained personnel.[36] Most *matrones* assisted just ten to twenty births each month.[37] To expand maternal health services, medical students and doctors began to amend their vision of the *matrone* as a village health worker – suggesting that popular midwives could also play this role.

The international 'TBA'

The 1970s witnessed a rapid shift in Malian biomedical discourse about popular midwives. Medical student theses from the early part of the decade identified popular midwives as the cause of maternal and neo-natal mortality; at best, some proposed that they could serve as peer educators but should not attend births.[38] But by 1980, the Malian Ministry of Health authorised several projects to train popular midwives in biomedical techniques and to rename them 'TBAs'. They would attend births in their community of origin, or work as subsidiary personnel in rural maternity wards.[39]

Programmes to train TBAs occurred in tandem with the development of programmes to research the biomedical efficacy of indigenous techniques.[40] At the *Institut National de Recherche sur la Pharmacopée et la Médecine Traditionnelle* (INRPMT), opened in 1973, the pharmacological efficacy of herbal medicines was assessed through chemical analyses and the standardisation of dosages.[41] The *Institut* also served as the clearing-house for state-sanctioned knowledge about Malian therapeutic practitioners; *matrones* were instructed to 'collaborate with the INRPMT-recognised female traditional healer (*thérapeutre traditionnelle*)'.[42] This is of course not to suggest that Malian practitioners were unknown to anyone involved in this process. Many government medical workers already collaborated with local practitioners, for example.[43] But research at the INRPMT and ENMP formalised the identification of non-biomedical practitioners and practices that might serve the goals of the state health system.

All MD students at the ENMP completed a thesis on a clinical, pharmacological or public health topic, a requirement which reflected their expected role as leaders of the country's health system, not simply clinicians. Some of the medical student research on 'traditional medicine' eerily echoed the conceptual categories enumerated by colonial ethnologists.[44] Specifically, students delineated conceptions of 'natural' and 'supernatural' diseases, and biological and magical treatment (including witchcraft), and developed lists of practitioners that used these same demarcations: herbalists, religious healers (*marabouts*) and 'psycho–therapists who responded to social issues'.[45] The research process was also strongly gendered. Information and samples of *materia medica*, the basis of pharmacological research, were primarily drawn from male healers. One representative thesis – based on ten months of research and over 500

interviews – included surveys of 283 male healers and 16 women healers.[46] Several medical students proposed engaging male healers in the national health system.[47] However, to my knowledge, male healers were not formally brought into the health system in this period. Instead, only women therapeutic actors – specifically popular midwives retrained as TBAs – were used as village health workers. Neither form of healing was adopted wholesale. Malian biomedical actors engaged with men's knowledge and women's labour. While medical knowledge was 'objectified' via the planting of test plots for herbs and scientific tests of dosages, the TBA model appropriated therapeutic practices that could be remade as care labour; the labour of birth work was transformed into feminised care work.

Malian policy makers focused on TBAs over male healers in part due to the global interest in this figure. Within the institutional networks of the PHC movement, the TBA was imagined to be a figure common to all rural communities in the Second and Third Worlds, regardless of political or cultural context. Beginning in 1972, the WHO convened meetings and produced standardised training manuals for TBAs.[48] Malian programmes to train popular midwives as TBAs were rooted intellectually, financially and practically in these international networks. The definition of the TBA in Malian training manuals drew on that proposed by the WHO.[49] Malian TBA training projects were funded by UNICEF and employed trainers from neighbouring Haute–Volta.[50]

TBA programmes also responded to the limitations of *matrones*. Malian doctors attributed the small number of births performed by *matrones* to 'absenteeism' as these women married or went back to school and to the fact that some parturient women were uncomfortable giving birth with young *matrones*, a practice that contravened social norms that proscribed younger women seeing older women nude.[51] As older women, it seemed that popular midwives would resolve both concerns. Additionally, TBAs were appealing because they were designated as volunteers and were not paid from the state health budget. Instead, each community improvised its own payment model, usually encouraging the parturient's family to offer gifts, a model which replicated historical payment systems for popular midwives.[52]

Malian policy makers also drew on their own institutional history for inspiration. In the 1960s, a doctor working in Dogo (Bougouni *cercle*) had trained popular midwives in biomedical norms.[53] In the colonial period, the French state too turned to popular midwives to fill gaps in staffing. Although colonial doctors disparaged Soudanese midwifery, because maternal and child health services were consistently under-resourced in Soudan Français, the colonial state relied on popular midwives, reconciling these two positions through the language of safe birthing practice. Most maternity wards in smaller towns in Soudan Français had employed at least one popular midwife, under the supervision of a *sage-femme*.[54] Additionally, from 1925 until the 1950s, the state paid a bonus (*prime*) to popular midwives who performed homebirths, three to ten francs for each healthy birth.[55] Although not all births were registered, records of registered births show that, in 1946, 46 *per cent* of registered births were attended by popular midwives and in 1951, they attended 31 *per cent* of registered births.[56]

The TBA projects of the 1970s seemed to echo those of the colonial period, but there were important differences. First, while colonial projects were fundamentally pronatalist (paying midwives upon the presentation of the infant to a colonial registrar), those of the 1970s also emphasised maternal mortality. One primary concern of

postcolonial TBA trainings was that TBAs refer cases of dystocia (problems during labour, including obstructed labour and uterine inertia) to biomedical facilities. Additionally, although in both eras the state health services rhetorically promoted the use of older women as TBAs, in the postcolonial period some younger women were recruited to serve as TBAs. Around the world, programmes to train TBAs created a developmentalist category that restructured the work of women who participated in childbirth, sometimes even inventing this position when none existed.[57] In Mali, TBA training projects sought to recruit *literate* popular midwives.[58] Only roughly 25 *per cent* of Malians were educated in French schools in this decade, and even fewer older women in rural Mali knew how to read and write in French.[59] Some villages strategically chose to send young literate women, who had never attended childbirth, to be 're-trained' as TBAs, shifting the very people to whom this term referred.[60] However, TBA projects did also recruit older women. They also acknowledged, at least partially, that midwifery was a form of Malian 'traditional medicine'; this was not the case with other Malian reproductive specialists.

The therapeutic exclusion of nuptial counselling

The doctors, nurses, *sage-femmes* and *matrones* who trained, supervised and worked with TBAs were well aware of the existence of other Malian reproductive specialists, such as nuptial counsellors and excisers. Indeed, nuptial counselling and excision were the subject of vocal public debate in the 1970s and 1980s, especially within the *Union Nationale des Femmes du Mali* (UNFM). As the women's branch of the single legal political party, the UNFM's membership included most French-educated Malian women, like health workers and civil servants.

Much of the UNFM's activism centred on the *fille–mère*, or unwed teenage mother. This category was more about marital status than age at pregnancy. As Barbara Cooper has pointed out, a married fifteen-year old was a wife and mother, an unmarried fifteen-year old was a *fille–mère*.[61] The UNFM's 1974 charter included a section on 'the acute problem which the *fille–mère* poses to our society'.[62] Over the following decades, the group conducted surveys and held national conferences on the *fille–mère*.[63] By virtue of their professional engagement with pregnant women, *sage–femmes*, *matrones* and other health workers were some of the first to call attention to the issue of unwed motherhood, beginning with reports from the Social Services department, a sub-unit of the Ministry of Health.[64] Health workers like Mme. Fadima Ba, a *sage-femme* working in Segou, and Mopti-based Dr Mountage Coulibaly served as 'expert witnesses' about the life experiences of *fille–mère* at meetings and national conferences.[65] These activists came from the same social circles as the health workers who defined TBA policy and supervised TBAs on a daily basis (in some cases, they were the same people). But, in sharp contrast to the narrative around popular midwives/TBAs, there was no call to integrate or re-train Malian specialists involved in sexual education – such as nuptial counsellors.

When a young woman married, her family could employ a nuptial counsellor, selected and paid by the bride's mother and aunts, to provide education and care during a ten-day period of seclusion before and after the wedding.[66] Brides often had lifelong relationships with their counsellors, returning for advice, conflict–resolution, and aphrodisiac products.[67] At the same time, the counsellor supported social

norms – advising the bride to be submissive, obedient and respectful towards her husband and in-laws and sometimes confirming the bride's virginity through examination of the bedsheet. During seclusion periods, the counsellor used blessings (*kilisi*), amulets and surveillance to protect the bride from any acts of witchcraft aimed at sabotaging the marriage.[68] She provided advice about sex, legitimating sex *within* marriage specifically, according to sociologist Assitan Diallo.[69] In Muslim families, this included information about the ablutions to perform after sex.[70]

Nuptial counsellors used plant medicines to prepare the brides' bodies for sex. They instructed brides about the use of aphrodisiac products like incense, and herbal teas that perfumed sweat.[71] They made infusions of various plant medicines, like *babi*, to increase vaginal secretions, making sex more pleasurable.[72] Other aphrodisiac herbs were inserted as vaginal suppositories or placed in the groom's food.[73] Historically, counsellors had prepared intense purgatives from *diangara* and *balibali* to weaken the bride before having sex; by the 1970s, these herbs were less commonly used although counsellors still limited the bride's diet to porridge.[74] Counsellors provided other plant medicines to promote fertility and conception, including medicines to treat STIs and yeast infections – which were understood to be a source of infertility.[75]

In spite of the fact that nuptial counsellors used herbal products that modified women's bodies for reproductive ends, Malian biomedical personnel did not define them as therapeutic actors. This exclusion is interesting in part because counsellors socialised young women about marital sexuality at a moment when this was of utmost concern to Malians. But neither health workers nor UNFM members sought to repurpose nuptial counselling for new ends, as was the case with popular midwifery. Instead, they suggested that the state should take on the task of ensuring moral education, proposing that middle and high schools offer courses on sexual health and home economics (*éducation à la vie*).[76] Indeed, one of the keynote speakers at the 1986 *National Seminar on Fille–mères*, Mme Algiman Hiri Alice N'doure, posed the question – 'is the nuptial counsellor still necessary?'[77]

UNFM's different engagement with nuptial counsellors and popular midwives may have been because its members – and perhaps other Malians whose views are not so well-archived – attributed the existence of *fille–mères* to the failure of 'traditional' forms of social control, including a decline in pre-marital abstinence and 'family surveillance' over young women.[78] They may have also been resistant to work with nuptial counsellors because of twenty years of rhetoric naming *nyamakalaw* specialists as the cause of the runaway cost of events like weddings, initiation ceremonies and naming ceremonies. From the first years of independence and through the Traoré military regime, there were regular complaints about the high cost of such social events that included calls to restrict the gifts made to *nyamakalaw* specialists like griots, nuptial counsellors and excisers. These demands were ostensibly an attack on the rich, who displayed their wealth through lavish gifting to *nyamakalaw* attendees at social events. But they also targeted *nyamakalaw* themselves for deriving income from such gifts, sometimes terming them 'parasites'.[79] In 1963, the socialist government had (rather unsuccessfully) sought to restrict the payments made to nuptial counsellors at weddings, and to excisers during initiation events.[80] Concern about the high cost of weddings were repeated under the Traoré regime as well.[81] The repeated critique of *nyamakalaw* as avaricious, and indeed as undermining the body politic, likely made

it harder for government policy makers to identify the work of *nyamakalaw* nuptial counsellors as a form of therapeutic practice or care. Additionally, the omission of nuptial counselling from 'traditional medicine' reflected the ways that biomedical framings separated social and esoteric knowledge from something called medicine. This process of differentiation was also evident in the protocols for retraining popular midwives as TBAs.

Midwives without midwifery

Retraining popular midwives as TBAs involved separating their social and spiritual interventions from physical ones. Indeed, biomedical policy makers and personnel seemed to have primarily desired midwives' labour, rather than any specific knowledge or skills. In the 1970s and 1980s, Malian popular midwives used a variety of somatic, medicinal and esoteric techniques. They offered prenatal advice and used plant medicines to prevent miscarriage. During labour, the popular midwife came to the parturient's home and identified active labour by external embodied signs; when the woman's 'neck swelled up' the midwife instructed her to push.[82] To resolve dystocia, midwives used back and abdominal massage, usually accompanied by the recitation of *kilisi* blessings.[83] They could also deploy medicinal baths and drinks made from herbs like the oxytocic *ngoloninje* (*securinega virosa*) for dystocia, and other plant medicines for haemorrhage and placental retention.[84] Once the infant was delivered, the midwife would cut the umbilical cord and aid the infant's father in burying the placenta with millet and other ritual objects.[85]

Popular midwifery operated beyond the bounds of biomedical logic, linking social and physical processes. For example, popular midwives were involved in determining the legitimacy of the infant, policing the linkages between proper reproduction and women's actions; since extramarital sex was understood to be one cause of prolonged labour, midwives could decide when dystocia might be caused by the parturient's social transgression and compel an adultery confession believed to allow labour to proceed safely.[86] Additionally, midwifery interventions responded to risk from invisible forces, across time. Popular midwives took care in burying the placenta, because mistreating the placenta could compromise the baby's health or the mother's fertility, in the future.[87] They also protected against common childhood illness caused by malevolent actors. Dating back to at least the 1930s, popular midwives were specialists in diagnosing and treating *kono*, a convulsive illness in young children attributed to exposure to the nightjar bird (*dabi*) in utero or after birth. They treated *kono* by preparing amulets and preventive and curative medicinal baths.[88]

Whereas popular midwifery responded to physical, social *and* invisible risks, the process of training TBAs generally sought to reframe popular midwifery as a set of specific physical interventions, and to funnel a range of therapeutic actions into a narrower practice of care work. For those TBAs who worked in rural maternity wards, *matrones* assigned TBAs to perform care labour, rather than therapeutic interventions. While the *matrone* would supervise childbirth, the TBA was tasked with bathing the newborn and cleaning the ward. The latter task inverted age-based hierarchies in Malian homes, where cleaning was usually done by young people.[89] Many *matrones* challenged popular midwifery practices that moved beyond physical caretaking to address social transgressions or invisible agents. Some banned TBAs from using

anti-witchcraft medicine, or using adultery confessions to resolve problems in labour, on the grounds that they were immoral or dangerous.[90] Of course, such restrictions were unevenly enforced. *Matrone* Oumou D. described how the TBAs she supervised would continue to surreptitiously perform banned actions. Additionally, she recognised that midwives had unique knowledge to protect infants and mothers from witchcraft at the vulnerable moment of birth; her own child was washed in anti-witchcraft medicines by her TBA colleagues.[91]

Trainings for popular midwives-as-TBAs were based around the adjudication of efficacy and harm. Most trainings began with a survey of common midwifery practices, which were then designated as 'beneficial' or 'harmful'.[92] Then, a health worker would lecture on subjects like anatomy, STI-linked infertility, the civil registry and the importance of prenatal consultations.[93] Most trainings also sought to replace existing aetiologies, often rooted in the actions of invisible agents or spirits, with biomedical concepts of disease, a process which also served to move control over treatment away from popular midwives and towards practitioners with biomedical education.[94] TBA trainings from the 1970s and 1980s sought to convince popular midwives that *kono* was cerebral malaria or malarial convulsions (*accès pernicieux*).[95] This was a new translation – in the colonial period, *kono* had been firmly identified as a Bamanakan term for tetanus.[96] In both instances, however, identifying *kono* as a translation of a biomedical disease category was also an attempt to move the malady into a biomedical framework. The repetition of this pattern in TBA trainings effectively sought to transform midwives' multi-faceted work of diagnosis, treatment and care labour into primarily care work.

TBA trainings also emphasised the importance of sterile tools and aseptic environments for the health of the mother and infant. 'Hygiene and cleanliness are indispensable rules for a good birth attendant … She must cut her nails and keep them clean. She must wash her hands with clean water and soap, dried with a clean cloth'.[97] TBA trainings introduced the concept of microbes, as well as practical demonstrations on how to sterilize razor blades and scissors with alcohol, by flame, or by boiling.[98] While the concern about sterile instruments was related to many forms of infection including puerperal fever in the mother, only one was commonly named: neo-natal tetanus.[99] Because of the link between asepsis and tetanus, trainings involved an implicit, and sometimes explicit, rejection of the ritual protections of *nyamakalaw*. Many midwives had historically cut the umbilical cord with an iron knife forged by a *numu* ironworker; replacing this knife with a razor blade necessitated a different prioritisation of risk, in which bacterial threats supplanted those of spirits or invisible agents.[100]

Discussions of asepsis undergirded a critique of both popular midwifery and excision. An undated *sage-femme* reference manual written sometime after 1977 listed two causes of tetanus related to midwifery practices: 'cutting the umbilical cord without sterile tools' and 'traditional practices such as putting shea butter on the umbilical wound'. It also linked tetanus to 'the excision of young girls during the neo-natal period'. (By the 1970s, as explained below, many had begun excising daughters at a much earlier age.) To prevent tetanus, the *sage-femme* was to offer anti-tetanus treatment to pregnant women and babies born at home and also '[train] TBAs on the basic ideas of asepsis and antisepsis, and [educate] mothers on the danger of traditional practices concerning the umbilical cord and excision'.[101]

Asepsis and excision

In the 1970s, the vast majority of women in southern Mali experienced genital excision, primarily clitoridectomy.[102] Historically, excision had mainly occurred within a communal initiation process that paralleled group initiation and circumcision for boys. Through these processes, young people expressed their bravery and self-discipline in preparation for adulthood. In Dioila in the 1960s, initiation took place when girls were about thirteen or fourteen. Girls demonstrated their self-control through a series of tests, beginning by eating a plate of scalding porridge (*cɛfarinto*) by hand without betraying any pain and culminating in excision itself. Through song, young women were exhorted to act courageously and honoured for their bravery after the surgery. After three to four months of education focused on how to be a proper wife and adult, women re-joined their community through a huge celebration.[103] To prepare girls to be excised, excisers and other older women caretakers limited certain food that inhibited healing such as shea butter, peanuts and tomatoes; after surgery, they used spiritual tools (*kilisi*) and herbal medicines to staunch bleeding and promote cicatrisation.[104]

The explicit meaning of excision differed between Malian communities – in interviews with scholars, people variously described it as a mechanism to fully gender a person's body (by removing a masculine element of the woman's body, the clitoris, and a feminine element of the male body, the prepuce) or a religious obligation, a way to facilitate childbirth, or a means to ensure chastity and prevent infidelity. What was constant was the idea that to be uncut was to be a child.[105] The gender-neutral term for an un-excised or un-circumcised child, *bilakoro*, was an extremely serious insult when lobbed at an adult.[106] Because excision marked adulthood, it was often demanded by young people, who sought to prove themselves and claim their place within adult society. Sometimes young people informed their parents that they were ready for excision.[107]

By the 1970s, the close links between excision and initiation had begun to dissipate. The parents of children enrolled in school often moved the initiation process from the cool, dry season of January/February to July/August to coincide with the school's summer vacation.[108] July/August fell within the rainy season which preceded the harvest, a period of increased food insecurity and greater labour demands; the temporal period for initiation thus became shorter. Additionally, the age for circumcision and excision began to fall. Excision was increasingly performed on infants or toddlers, rather than adolescent girls.[109] Performing the surgery on young children appealed to families for various reasons. It removed the social pressure for the initiate to behave courageously, and it cost less than months-long initiation events. For the numerous Malian communities that had only converted to Islam in the mid-twentieth century, performing the surgery at a younger age also allowed it to be decoupled from non-Muslim initiatory practices.[110]

As early as the 1950s, but especially by the early 1970s, biomedical personnel like *sage-femmes*, *matrones* and nurses began to speak publicly and privately against excision, citing their professional exposure to problems during childbirth.[111] Their professional medical experiences made them receptive to the burgeoning international anti-'female circumcision' discourse in the 1970s and 1980s.[112] However, for Malian health workers in the 1970s, the dominant concern was the risk to the girl undergoing the excision surgery, especially the risk of infection and haemorrhage, problems

attributed to the exciser's lack of knowledge of asepsis and anatomy.[113] For some *sage-femmes* and doctors, these concerns called into question all forms of female genital cutting.[114]

However, other women health workers, especially *matrones* and nurse's aides (*aides-soignantes*), responded to concerns about haemorrhage and infection by performing excisions themselves in quasi-biomedical settings.[115] Almost none of these women were *numumusow* (blacksmith/potter-family women). Most excised infants and toddlers, rather than older girls. Many performed the surgery before or after their shifts in rural maternity wards, while others performed the surgery at home using biomedical tools like razor blades and enamel surgical trays. These 'off-the-books' procedures were a small source of income, given instable state salaries.[116] The presence of this alternative form of excision did not end the practice, nor its importance as a marker of adulthood, although it did shift its location for some families. In a 1997 survey, anthropologist Claudie Gosselin found about a quarter of excised women had been excised by a biomedical professional rather than a *numumuso*.[117] These numbers suggest that in the 1970s and 1980s, while many parents still sought out *numumusow*, an increasing number relied on health workers to perform excision. To challenge the secret esoteric knowledge of *numumusow*, health workers defended their own excision practice on the basis of their biomedically rooted ability to prevent infection and haemorrhage. Such initiatives and arguments worked to exclude excision from the category of 'traditional medicine'.

Conclusion

As the Malian state sought to expand health services 1970s and 1980s, a variety of people – doctors, journalists, activists and *matrones* – raised the question of how 'traditional healers' could serve the goals of the state. This broad question ultimately narrowed to focus on TBAs. Looking specifically at three reproductive specialists: popular midwives, nuptial counsellors and excisers this article has examined why and how this contraction occurred.

One important factor in this process was the ongoing focus on women as mothers by Mali's postcolonial governments. State officials in both the socialist and military regime highlighted investments in maternal health programmes to demonstrate the state's commitment to Malian women and their vociferous demands to improve the lives of girls and women.[118] Statistics around maternal and child mortality were also increasingly used as international markers of state legitimacy. From the perspective of Malian civil servants, the importance of maternal and child health to national and international claims led to a focus on expanding maternal and infant health services. This partially explains why popular midwives were incorporated into the national health system while other male and female healers were not.

Additionally, the institutionalisation of the TBA in Mali was inseparable from contemporary international health trends. According to Stacy Leigh Pigg, the development of the figure of the TBA responded to an 'institutional need to narrow the gap between the myriad local practices and the international world of health services management'.[119] Malian health policy makers were intellectually and financially connected to global medical networks as they created national concepts of traditional

medicine. Faculty from France, Senegal, the USSR and China taught alongside Malian professors at the ENMP, and international donors and trainers supported rural health projects, including projects to train TBAs.[120] Thus, the decision to retrain *popular midwives* as TBAs built on international assumptions about women's expertise, as well as the existence of women birth workers in Mali and the state's engagement with these specialists since colonial times.

However, we should not only examine why the popular midwife was re-imagined as a TBA, but why other reproductive specialists – most notably, nuptial counsellors and excisers – were *not* re-imagined as auxiliary agents for state projects. For many Malians, regulation of sexuality and conception through practices like nuptial counselling and excision was central to 'proper' reproduction. These concerns led UNFM members to repeatedly condemn unwed motherhood and encouraged health workers to take on the work of excision. One reason why excisers and nuptial counsellors were not professionalised, I have suggested, was due to ongoing debates about *nyamakalaw* work in postcolonial Malian society. Since Mali's independence, concern about the cost of weddings, childbirth and initiation had often coalesced around the cost of payments made to *nyamakalaw* specialists, including payments to nuptial counsellors at weddings and to excisers during initiation. These ongoing critiques foreclosed the possibility of formally identifying the knowledge and skills held by *nyamakalaw* nuptial counsellors and excisers as forms of caregiving.

Additionally, and more crucially, their work fell outside of the limits of 'traditional medicine' as defined by Malian health workers and civil servants. Not all forms of medicinal knowledge, like an exciser's ability to heal surgical wounds or a nuptial counsellor's fertility medicines, became encompassed within 'traditional medicine'. Nor were all midwifery interventions identified as therapeutic within a biomedical framework. Yet postcolonial Malian definitions of 'traditional medicine' did not simply replicate opposing categories of biomedicine and 'traditional medicine'. Instead, against the backdrop of the idea of biomedical efficacy, Malian policy makers, civil servants and health workers defined local practices in dichotomous ways: empirical versus esoteric, therapeutic versus cultural and beneficial versus harmful.[121] These dichotomies mapped on to different categories of specialists *and* specific practices.

The exclusion of certain forms of bodywork, caregiving and reproductive interventions from medicine also pivoted on who had authority over young women's reproductive capacity. Interestingly, and in contrast to other historical contexts, these contestations did not occur between men and women specialists.[122] In Mali, inside and outside of the biomedical system, reproductive expertise was women's expertise. Instead, the debates were about *which* women, and the relative importance of age, social status and education in establishing authority over reproduction. As suggested above, one fault line was about social group – between women whose authority was based on their *nyamakalaw* status, and others who claimed authority from other sources whether or not they were *nyamakalaw*. Additionally, tensions over legitimate authority occurred between generations – emphasising age or, inversely, education.

Within the Malian national health system, the desire for literate health workers was in constant tension with, and generally took precedence over, other recruitment criteria. Given schooling patterns, education was generally a proxy for age. Thus, in the 1970s and 1980s, literate young(er) women challenged the social authority of

older women reproductive specialists. Younger *sage-femmes* and *matrones* critiqued the work of older popular midwives. Medical personnel began to perform excision, displacing *numuw* practitioners. This dynamic echoed longer histories of reproduction in Africa, which have been so thoughtfully explored by historians of other colonial contexts.[123] In postcolonial Mali, a larger group of literate women claimed reproductive authority. But they were never totally successful. Although this article has focused on the elaboration of state policy regarding 'traditional medicine', popular midwives, excisers and nuptial counsellors have remained important. Today, many Malians value all three groups of reproductive specialists who, through evolving therapeutic practices, continue to claim authority over young people's fertility and sexuality.

Notes

1. Centre des Archives Diplomatiques de Nantes, Nantes, France (CADN) 62PO/1/66 Association Malienne pour la réhabilitation de la médicine traditionnelle N. 30/AMRMT. Circulaire 28 novembre 1977.
2. For example, *Famille et développement* n. 28 (octobre–décembre 1981), p. 24. One common subject was, *n'ko*, a Mandé-language alphabet linked to medicinal knowledge. See Joseph Hellweg, 'Reading Urbanity: Trans-Urban Assemblages in the N'ko Literacy and Healing Movement', in Brigit Obrist, Veit Arlt and Elisio Macamo (eds), *Living the City in Africa: Processes of Invention and Intervention* (Zurich: Lit Verlag, 2013), pp. 271–89. On similar processes in relation to psychiatry in Senegal, see Katie Kilroy-Marac, *An Impossible Inheritance* (Oakland: University of California Press, 2019).
3. On Koumaré, see Mamadou Koumaré, *Pour mieux comprendre et mieux se soigner* (Bamako: La Sahélienne, 2006).
4. Bibliothèque de la Faculté de Médecine, Pharmacie, et Ondo-stomologie, Bamako (FMPOS) 78M04 Lalla Haidara 'Prévention et control des endemies majeurs par les praticiens traditionnels', (1978), pp. 8, 61–2; Mamadou Koumaré, interview by the author, Bamako, 10 July 2015.
5. FMPOS 76M05 Moussa Maiga, 'Promotion des soins de santé primaires au Mali' (1976), p. 3.
6. CADN 62PO/1/66 Isack Diarra, 'Conférence sur la médecine traditionnel' *L'Essor* (8 septembre 1982).
7. In this article, I use the term excision, the common French-language term used in Mali. Bamanakan terms include *boloko* and *seliji*. I acknowledge that exciser's work involves what is understood by many people today as a form of violence. But working within historical Malian concepts requires us to see that this was a reproductive practice, that is, a practice which served to ensure socially recognised reproduction.
8. Barbara Cooper has termed this an 'ethical probation … in terms of reproduction'. Barbara Cooper, *Countless Blessings: A History of Childbirth and Reproduction in the Sahel* (Bloomington: Indiana University Press, 2019), pp. 5–6.
9. Madian D. (Popular midwife), interview by the author and Lucie Bello, Bamako, 20 July 2015.
10. Aoua Keita, *Femme d'Afrique* (Paris: Présence Africaine, 1975), p. 268.
11. See David Conrad and Barbara Frank (eds), *Status and Identity in West Africa: Nyamakalaw of Mande* (Bloomington: Indiana University Press, 1995).
12. Sarah Brett-Smith, *The Silence of Women: Bamana Mud Cloths* (Milan: 5 Continents Editions, 2014), pp. 219–20; Hawa B. (Nuptial counsellor), interview by the author, Koulikoro, 31 January 2017. On leatherworkers generally, see Barbara Frank, *Mande Potters & Leatherworkers* (Washington, D.C.: Smithsonian Press, 1998).
13. See Patrick McNaughton, *The Mande Blacksmiths: Knowledge, Power, and Art in West Africa* (Bloomington: Indiana University Press, 1988).
14. Stacey Ann Langwick, *Bodies, Politics, and African Healing* (Bloomington: Indiana University Press, 2011), pp. 52–4; Karen Flint, *Healing Traditions: African Medicine, Cultural Exchange, and Competition in South Africa, 1820–1948* (Athens: Ohio University Press, 2008). Scholars have also explored the means by which 'traditional' medical practitioners adapted to biomedicine. See Projit Mukharji, *Doctoring Traditions: Ayurveda, Small Technologies, and Braided Sciences* (Chicago: University of Chicago Press, 2016).
15. Langwick, *Bodies*, pp. 61–2.
16. CADN 62PO/1/66 Rose Bastide 'La Situation sanitaire du Mali: Une Interview du Dr. Ngolo Traoré', *L'Essor*, 5 août 1980.

17. CADN 62PO/1/66 Bastide 'La Situation sanitaire'. This was the case in several African countries, see Randall Packard, *A History of Global Health* (Baltimore: Johns Hopkins University Press, 2019), pp. 232–3.
18. Pascale Barthélémy, *Africaines et diplômées à l'époque coloniale (1918–1957)* (Rennes: Presses universitaires de Rennes, 2010). See also Nancy Rose Hunt, *A Colonial Lexicon of Birth Ritual, Medicalization, and Mobility in the Congo* (Durham: Duke University Press, 1999); Lynn Thomas, *Politics of the Womb: Women, Reproduction, and the State in Kenya* (Berkeley: University of California Press, 2003).
19. Jane Turrittin, 'Colonial Midwives and Modernizing Childbirth in French West Africa', in Jean Allman, Susan Geiger and Nakanyike Musisi (eds), *Women in African Colonial Histories* (Bloomington: Indiana Univeristy Press, 2002), pp. 71–91, here pp. 76, 78–9.
20. For example, Keita, *Femme*, pp. 50, 64–9, 92–3. This was true for most of French West Africa according to Cooper, *Countless*, pp. 125–7.
21. Bibliothèque de la Direction Nationale de la Santé, Division de la Santé de la Reproduction, Bamako, Mali (DNS SR) Ministère de la Santé 'Infrastructure Sanitaire du Mali' (1970), p. 3.
22. Sanoussi Konaté, *Cinquante ans de développement au Mali* (Bamako, 2013); Devon Golaszewski, 'Reproductive Labors: Women's Expertise and Biomedical Authority, Mali, 1935–1999' (unpublished doctoral thesis, Columbia University, 2020), pp. 194–221. On nationalism and health projects, see Sunil Amrith, *Decolonizing International Health* (New York: Palgrave Macmillan, 2006).
23. Mamadou Koumaré, interview.
24. FMPOS 77M19 Fodé Coulibaly, 'À la recherche d'une stratégie d'éducation pour la santé en milieu rurale au Mali' (ENMP 1977), pp. 61, 73; Archives Nationales de France, Pierrefitte (ANF) 19940744/19 Bintou Sangaré, 'Santé et développement communautaire' (1978), p. 51.
25. ANF 19940744/19 'Compte-rendu de l'évaluation', pp. 16–17, 24.
26. Golaszewski, 'Reproductive', pp. 229–40.
27. Marcos Cueto, Theodore Brown and Elizabeth Fee, *The World Health Organization: A History* (Cambridge: Cambridge University Press, 2019), pp. 170–71, 176–7; Packard, *A History*, pp. 242–3.
28. ANF 19940744/19 Sangaré, 'Santé', p. 66.
29. For example, FMPOS 76M05 Maiga, 'Promotion', pp. 12–14.
30. Marcos Cueto, 'The Origins of Primary Health Care and Selective Primary Health Care', *American Journal of Public Health* 94 (2004), pp. 1864–74, here pp. 1868–9.
31. CADN 62PO/1/66 Isack Diarra 'Séminaires régionales sur la sante', *L'Essor* (n.d.); Archive of Assan Bagayoko (AAB), Cissé et al., 'Manuel pour les matrones et les aides-soignantes, dans le cadre des soins de santé primaire' (Dioila Centre de Santé, août 1983), p. 1.
32. FMPOS 75M10 Inna Dicko 'Contribution à l'organisation et à l'administration des services de Santé Maternelle et Infantile dans la région de Bamako' (1975), pp. 62, 68–9. On *matrones* in contemporary Mali, see Nicole Warren et al., 'Matroniya: The Lived Experiences of Rural Auxiliary Midwives in Koutiala, Mali', *Health Care for Women International* 34 (2013), pp. 482–98.
33. One description of this process is ANF 19940355/27 'Infrastructure sanitaire du Mali 1974 – Section Statistique Sanitaire', p. 48.
34. FMPOS 77M07 Mariam Maiga, 'Contribution des activités de planification familiale' (1977), p. 10.
35. See Vincent Bonnecase, *La Pauvreté au Sahel: Du Savoir colonial à la mesure internationale* (Paris: Éditions Karthala, 2011).
36. CADN 62PO/1/66 'Synthèse 4/79-n 6/DAM' (30 avril 1979).
37. ANF 19940744/19 'Compte-rendu de l'évaluation', pp.7–9.
38. For the former, FMPOS 75M10 Dicko 'Contribution', p. 67. For the latter, FMPOS 77M07 Maiga, 'Contribution', p. 28; FMPOS 77M19 Coulibaly, 'Stratégie', pp. 65–8.
39. CADN 24PO/1/617 Dr Hubert Balique 'Rapport d'évaluation du CFRSR de l'ENMP dans l'arrondissement de Djidian, cercle de Kita' (février 1980), pp. 43–4; ANF 19940744/19 DRSP Région de Sikasso, 'Deuxième session de formation à l'animation des matrones rurales de Bougouni' (22–31 octobre 1980), pp. 5–6, 10.
40. FMPOS 76M05 Maiga, 'Promotion', p. 8.
41. ANF 19940355/27 'Infrastructure', pp. 9–10. On similar process in other African countries, see Abena Osseo-Asare, *Bitter Roots: The Search for Healing Plants in Africa* (Chicago: University of Chicago Press, 2014).
42. Bibliothèque Nationale du Mali (BNM), MSPAS Division de la Santé Familiale 'Le guide de la matrone rurale' (1978), p. 28.
43. For example, Boubakari M. (former aide-soignant), interview by the author, Koulikoro, 17 April 2017.

44. 'Médecine et pharmacopée indigènes en Afrique noire française', *Bulletin du comité d'études historiques et scientifiques de l'AOF*, (1938), pp. 581–93. See also Kwasi Konadu, 'Medicine and Anthropology in Twentieth Century Africa: Akan Medicine and Encounters with (Medical) Anthropology', *African Studies Quarterly* 10 (2008), pp. 45–69.
45. FMPOS 77M19 Coulibaly, 'Stratégie', p. 27; FMPOS 78M04 Haidara, Prévention', pp. 36–7.
46. FMPOS 80P10 Niananka Koné, 'Plantes médicinales du cercle du Kolokani' (1980), pp. 31.
47. FMPOS 78M04 Haidara, Prévention', pp. 62–5, 73.
48. Stacey Langwick, 'The Choreography of Global Subjection: The Traditional Birth Attendant in Contemporary Configurations of World Health', in Hansjörg Dilger, Abdoulaye Kane and Stacey Ann Langwick (eds), *Medicine, Mobility, and Power in Global Africa* (Bloomington: Indiana University Press, 2012).
49. AAB Cissé, 'Manuel', p. 51.
50. ANF 19940744/19 'Compte-rendu', p. 25.
51. For example, FMPOS 77M13 Mahamadou Coulibaly, 'Accouchement en milieu urbain et rural au Mali' (1977), p. l.
52. On the range of payment options, see Hamady D. (retired nurse), interview by the author and Marianne Khassogue, Kita, 19 July 2017; ANF 19940744/19 'Deuxième session – Annexe', p. 10.
53. Konaté, *Cinquante ans*, p. 53.
54. For example, Archives Nationales du Mali, Bamako (ANM) FR 1H14 'Rapport statistique médicale – Koulikoro, février 1936'.
55. Archives Nationales du Sénégal, Dakar (ANS) 2G43.13 Rapport sanitaire – Soudan 1943, pp. 119–20.
56. Service Historique de la Défense, Toulon (SHD) 2013 ZK 005 – 040 Médecin–Colonel Vernier, Service de Santé 'Rapport annuel Soudan Français, Partie Statistique' (1946), p. 10; SHD 2013 ZK 005 – 041 Médecin–Colonel Vernier, Service de Santé 'Rapport annuel Soudan Français, Partie Statistique' (1951), p. 349.
57. See Sarah Pinto, *Where There Is No Midwife* (New York: Berghahn Books, 2008); Stacy Pigg, 'Authority in Translation: Finding, Knowing, Naming and Training "Traditional Birth Attendants" in Nepal', in Robbie Davis-Floyd and Carolyn Sargent (eds), *Childbirth and Authoritative Knowledge* (Berkeley: University of California Press, 1997), pp. 233–62.
58. Hamady D., interview.
59. Jaimie Bleck, *Education and Empowered Citizenship in Mali* (Baltimore: Johns Hopkins University Press, 2015), pp. 77–82.
60. S.K. (former TBA, matrone, and exciser), interview by the author and Marianne Khassogue, Kita, 19 July 2017.
61. Cooper, *Countless*, p. 244.
62. Centre Nationale d'Information sur la Femme et l'Enfant, Bamako (CNDIFE) Mme. Semego Mariam Doucouré 'UNFM: Réalisations et objectifs' (Mémoire, ENSUP, 1987), 'Annexe I: Résolutions', pp. 28–30.
63. For example, CNDIFE Kadia Traoré Collection (C-KT), File 0154-007 'Procès-verbal du séminaire régional sur l'excision – l'avortement – l'infanticide et les filles–mères, Séance du 19 novembre 1984' (Tombouctou, 19–21 novembre 1984).
64. For example, ANF 19940744-19 Nene Sy 'Rapport d'activité 1969 – Service sociale de l'INPS' (12 janvier 1970).
65. Archives of the Association Malienne pour la Promotion et la Protection de la Famille, Bamako Mali (AMPPF) Box 2574 Mme Ba Fatima 'Les problèmes des filles–mères' (1982); AMPPF Box 2574 Dr Mountage Coulibaly, 'Le problème des filles–mères à Mopti', *Séminaire sur le planning familial*, (Mopti, 9–12 mars 1981). See also AMPPF Box 2574 Dr Gaoussou Traoré « Le problème des filles–mères » (DNS, 1986).
66. For example, Hawa G. (nuptial counsellor), interview by the author and Marianne Khassogue, Bamako, 26 October 2016.
67. Ami L. (nuptial counsellor), interview by the author and Marianne Khassogue, Kita, 18 July 2017.
68. On witchcraft, see Peter Geschiere, *Witchcraft, Intimacy, and Trust: Africa in Comparison* (Chicago: University of Chicago Press, 2013).
69. Assitan Diallo, 'Paradoxes of Female Sexuality in Mali: On the Practices of Magonmaka and Bolokoli-Kela', in Signe Arnfred (ed.), *Re-Thinking Sexualities in Africa* (Uppsala: Nordiska Afrikainstitutet, 2004), pp. 173–89.
70. See Hawa B., interview.
71. On incense, see Adam Ba Konaré, *Parfums du Mali* (Paris: Cauris, 2007).
72. *Babi* is *Chrysopogon nigritanus*, a sandalwood-scented root related to vetiver.

73. Ami L., interview.
74. Hawa G., interview with the author and Marianne Khassogue, Bamako, 15 November 2016. Niakale D. (nuptial counsellor), interview with the author and Marianne Khassogue, 14 August 2017. See also, Golaszewski, 'Reproductive'.
75. Fatoumata K. (nuptial counsellor), interview with the author and Marianne Khassogue, Bamako, 23 September 2016.
76. DNS SR 'Séminaire sur la fille–mère', pp. 8–9; AMPPF Box 2574 Coulibaly 'Le problème des filles mères', pp. 1–3.
77. DNS SR 'Séminaire sur la fille–mère', p. 24.
78. For example, AMPPF Box 2574 Coulibaly, 'Le problème des filles–mères', p. 1.
79. 'La Commission Sociale des Femmes de l'US-RDA prend des mesures sociales révolutionnaires', *L'Essor quotidien*, n. 4211, samedi 14 septembre 1963, p. 1.
80. 'La Commission Sociale', p. 1; ANM US-RDA BPN 55d144 Délégation spécial des femmes du Djenne, n. 3, Djenne, 16 août 1968.
81. CNDIFE Doucouré, 'Annexe I: Résolutions'; DNS SR 'Séminaire sur la fille–mère', pp. 8–9.
82. ANF 19940744/19 DRSP, Région de Sikasso 'Deuxième session de formation – Annexe, Example d'une enquête avec les AT du Kola', p. 9.
83. Fanta D. (Popular midwife), interview by the author and Marianne Khassogue, Kita Talako, 20 July 2017.
84. FMPOS 80P10 Koné, 'Plantes', pp. 29, 39, 58, 69. See also, Madian D., interview; FMPOS 78M04 Haidara 'Prévention', pp. 65–7.
85. FMPOS 77M07, Maiga 'Contribution', p. 54.
86. Pregnant women sought to avoid such accusations by not telling anyone they had gone into labour and using oxytocic herbs, with the help of popular midwives. Oumou D. (former *matrone*), interview by the author, Koulikoro, 1 February 2017.
87. ANF 19940744/19 'Deuxième Session – Annexe', pp. 9–13; Fanta D., interview. On midwifery and the placenta, see Barbara Cooper 'Traveling Companions: The Burial of the Placenta in Niger', *African Studies Review* 62 (2019), pp. 127–48.
88. FMPOS 76M05 Maiga 'Promotion', pp. 58–9. On treatment for *kono* in the colonial period, see Institut Fondamental d'Afrique Noire, Cahiers William Ponty, Dakar (IFAN) Babacar Tiemoko Coulibaly, 'L'éducation de l'enfant Ouassalounké' (École Normale William Ponty, c. 1937), pp. 25–6. On the 1970s, see FMPOS 78M04 Haidara 'Prévention', pp. 31, 36; ANF 19940744/19 DRSP 'Deuxième session – Annexe', p. 9; Brett-Smith, *Silence*, p. 222.
89. S.K., interview.
90. Oumou D., interview.
91. Oumou D., interview. On popular midwives' cultivation of spiritual skills, see also Langwick, *Bodies*.
92. ANF 19940744/19 DRSP 'Deuxième Session – Annexe' pp. 13–14; CADN 24PO/1/617 Balique 'Rapport', p. 46.
93. CADN 24PO/1/617 Balique 'Rapport', p. 46; AAB Cissé, 'Manuel', pp. 53–4.
94. On contestations over authority in childbirth, see Robbie Davis-Floyd and Carolyn Sargent (eds), *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives* (Berkeley: University of California Press, 1997).
95. FMPOS 77M19 Coulibaly, 'Stratégie', pp. 16–17, 28; 'Sortir le village de la maladie', *Famille et développement* n. 28, pp. 37–8.
96. IFAN C11 Coulibaly, 'L'éducation', pp. 25–6.
97. AAB Cissé, 'Manuel', p. 52.
98. AAB Cissé, 'Manuel', pp. 53–4.
99. AAB Cissé, 'Manuel', pp. 53–4; FMPOS 77M19 Coulibaly 'Stratégie', p. 18.
100. BNM 'Le guide'.
101. DNS-SR Ministère de la Sante Publique 'Manuel de travail en santé familiale' (Undated, post 1977), p. 97. See also Mme Fatoumata Touré (activist) interview by the author and Marianne Khassogue with Dr Ousmane Touré, Bamako, 1 March 2017.
102. On excision in Mali, see amongst others, Sarah Brett-Smith, 'Symbolic Blood: Cloths for Excised Women', *RES* 3 (1982), pp. 15–31; C. S. Arnal Soumaré, *Culture traditionnelle africaine et marquage du corps féminin. L'excision chez les Bamana du Bédélougou* (Université Toulouse Le Mirail, 1996); Claudie Gosselin, 'Feminism, Anthropology and the Politics of Excision in Mali', *Anthropologica* 42 (2000), pp. 43–60; Claudie Gosselin, 'Handing over the Knife: Numu Women and the Campaign against Excision in Mali', in Bettina Shell-Duncan and Ylva Hernlund (eds), *Female 'Circumcision' in Africa*

(Boulder: Lynne Rienner Publishers, 2000); Ibrahim Camara, *Le Cadre rituel de l'éducation au Mali* (Paris: L'Harmattan, 2002); Aurélie Latourès, 'Saisir l'état en action en Afrique subsaharienne: Action publique et appropriation de la cause des mutilations génitales féminines au Mali et au Kenya' (unpublished doctoral thesis, Institut d'études politiques de Bordeaux, 2008).

103. René Luneau, 'Les Chemins de la noce: La Femme et le mariage dans la société rurale au Mali', (unpublished doctoral thesis, Université de Paris V, 1974), pp. 379–419.
104. Luneau, 'Les Chemins', p. 381; D. C. (exciser), interview by the author and Marianne Khassogue, Kita, 18 July 2017.
105. See Latourès, 'Saisir', pp. 157, 204–5; Diallo, 'Paradoxes', pp. 174-5.
106. D.C., Interview.
107. Luneau, 'Les Chemins', pp. 423–5. On excision as claiming entrance into one's community, see also Thomas, *Politics*; Tabitha Kanogo, *African Womanhood in Colonial Kenya 1900–50* (Athens: Ohio University Press, 2005).
108. ANF 19940744/19 Kadissabou Diagne 'Monographie du Sanankoroba' (avril–mai 1967), p. 23.
109. This was already common in Soninké communities in western Mali, but it became increasingly widespread. Josephine Traoré (activist), interview by the author, Bamako, 3 November 2016.
110. Gosselin, 'Feminism', pp. 53–4. On Islamization, see Brian Peterson, *Islamization from Below* (New Haven: Yale University Press, 2011).
111. On West African sage-femmes' critiques in the 1950s–1960s, see Barthélemy, *Africaines*, p. 215. For 1970s, see Josephine Traoré, interview; Fatoumata Touré, interview. Nurses (and women doctors) were also at the forefront of movements against cutting in Ghana and Egypt. Saida Hodžić, *The Twilight of Cutting: African Activism and Life after NGOs* (Oakland: University of California Press, 2017), p. 95.
112. Some of the critiques of this movement include Bettina Shell-Duncan and Ylva Hernlund (eds), *Female 'Circumcision' in Africa* (Boulder: Lynne Rienner Publishers, 2000); Obioma Nnaemeka (ed.), *Female Circumcision and the Politics of Knowledge* (Westport: Praeger, 2005); Ellen Gruenbaum, *The Female Circumcision Controversy* (Philadelphia: University of Pennsylvania Press, 2001); Miroslava Prazak, *Making the Mark: Gender, Identity, and Genital Cutting* (Athens: Ohio University Press, 2016). Historical accounts include Thomas, *Politics*; Janice Boddy, *Civilizing Women: British Crusades in Colonial Sudan* (Princeton: Princeton University Press, 2007); Heather Bell, 'Midwifery Training and Female Circumcision in the Inter-War Anglo–Egyptian Sudan', *Journal of African History* 39 (1998) pp. 293–312.
113. Latourès, 'Saisir', p. 195; Fatoumata Touré, interview.
114. DNS-SR Maiga Lalla Mint Bah 'Recherche: Conséquences gynéco–obstétrical de l'excision chez la femme malienne' (Faculté de médicine, Dakar, 1984).
115. Anaye S. (employee of the PNLE), interview by author and Marianne Khassogue, Bamako, 13 December 2016.
116. Ami K. (incense maker), interview by the author and Marianne Khassogue, Bamako, 2 November 2016; S.K., interview.
117. This rate varied by region and focused on women living in regional capitals. Gosselin, 'Handing', p. 195.
118. Golaszewski, 'Reproductive', p. 204–5.
119. Stacy Pigg, '"Found in Most Traditional Societies": Traditional Medical Practitioners between Culture and Development', in Frederick Cooper and Randall Packard (eds), *International Development and the Social Sciences* (Berkeley: University of California Press, 1997) pp. 259–90, here p. 262. See also Langwick, 'Choreography'.
120. For example, FMPOS 75M10 Dicko, 'Contribution', pp. iii–v.
121. Konadu, 'Medicine'.
122. One example is Hibba Abugideiri, *Gender and the Making of Modern Medicine in Colonial Egypt*, (Farnham: Ashgate Publishing Group, 2010).
123. Thomas, *Politics*; Hunt, *Colonial*; Cooper, *Countless*.

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