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ARTICLE

Constructing Health Regions in Late Colonial French Africa

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Abstract

This article examines debates about the future of health coordination between French African colonies in the era of decolonisation. These debates illuminate tensions over the future of French doctors in Africa, the role of international organisations, and the meaning of colonial borders for public health. In the late 1950s, French officials sought to reformulate inter-territorial colonial medical structures in a way that could be sustained with African independence, resulting by the 1960s in the creation of new West and Central African regional health organisations. Newly appointed African health ministers supported these organisations for various reasons, including sharing costs of medical infrastructure and the idea of a French debt that could be addressed through technical assistance. Both French and African health officials in turn naturalised the idea of post-colonial health coordination between former French colonies, regardless of shared borders with other African states. Both French and African health officials used the rhetoric of "disease knows no borders" to engage in a process of health "region-making," although the outcome was health coordination rooted less in epidemiological realities than colonial histories. Late colonialism catalysed change in public health and medicine that mirrored broader political developments but also produced distinct discourses, agendas, and institutions.

Keywords: Africa; French empire; health; decolonisation; disease

In May 1961, officials from the former French colonies of West Africa gathered alongside French officials in Dakar, Senegal for a ministerial meeting of the newly formed regional health organisation—the Organisation for Coordination and Cooperation for the Fight Against Major Endemic Diseases, going by the acronym OCCGE (*Organisation de Coordination et de Coopération pour la Lutte Contre Les Grandes Endémies*). This organisation brought together seven of the eight newly independent states of the colonial federation of French West Africa and France as member states with the goal of inter-state health coordination. Speaking before the conference attendees, the Minister of Health of Togo, Dr. Kpotsra, asserted that diseases "are not concerned with political or territorial borders, nor with language borders that are imposed on us or that we have accepted."[1] In meetings of this organisation in the

[1] Archives Nationales, Pierrefitte-sur-Seine, France (hereafter, AN), 19940355/1. "Rapport Final de la Vème Conférence Ministérielle Inter-États de L'O.C.C.G.E." Dakar, les 3, 4, et 5 Mai 1961. Due to political developments of the late-1950s, Guinea did not originally join OCCGE as a member state. The formerly French-administered United Nations trusteeship of Togo attended this conference as an observer.

early 1960s, African officials repeatedly invoked the language of "disease knowing no borders," to on one hand affirm the necessity of the organisation as it was and on the other hand to call for its enlargement through the membership of "Anglophone" West African states.

Yet the fact remained that a bloc of francophone African states partnered with France served as the starting point for these discussions about the possibilities of regional health coordination. France provided fifty percent of the operating budget for OCCGE at its inception and a French military doctor, Pierre Richet, served as the Secretary General of the organisation until 1970.[2] A similar trajectory unfolded with former French colonies of Central Africa. In 1963, the African states that had formerly comprised the colonial federation of French Equatorial Africa, along with the former United Nations Trusteeship of Cameroon, formed a parallel regional health organisation also with a French military doctor as its technical head. OCEAC - *Organisation de Coordination et de Coopération pour la lutte contre les Grandes Endémies en Afrique Centrale* - cemented the reformulation of French African colonial geographies as a new institutional structure for public health after independence.

With a particular focus on OCCGE in West Africa, this article examines how these organisations arose out of debates in the late 1950s about the future of cross-territorial health coordination between French African colonies. These debates illuminate evolving tensions over the future of French medical officials in Africa, the role of international organisations, and the parameters of intra-African health coordination. This article shows that in response to political changes of the late 1950s, French medical officials sought to reconstruct inter-territorial colonial medical institutions, with particular attention to the colonial mobile health service, in a way that could be sustained with African independence.[3] French officials invested in these organisations as a way to sustain their own medical authority within Africa and to assert French-African relations as a framework for international health.

Newly appointed African health ministers generally backed the creation of these organisations, reflecting a political landscape of ongoing French power in former African colonies as well as the securing of authority by African leaders amenable to France. These African officials characterised their investment in sustaining inter-territorial health infrastructure as growing from a variety of agendas including support for a continuance of French medical institutions, concerns about funding at a national level for medical institutions that had been previously established to serve a broader region, the advantages to be gained through African coordination, and an ongoing debt owed by France that could be addressed through ongoing technical assistance with health.

While these organisations were shaped by the broader power dynamics of decolonisation, both French and African health officials helped to naturalise the idea of health coordination after political independence as proceeding primarily between former French African colonies. This framework for health coordination obscured or ignored the realities of shared borders with other African states and the way that disease operated across these geographies. Notably, however, these health officials did not only assert colonial ties as a justification for new postcolonial institutions. Rather, I argue that both French and African health officials in the late colonial period used the internationally-significant rhetoric of "disease knows no borders" to engage in a process of health "region-making," although the outcome was a form of health coordination rooted less in epidemiological realities

[2] AN 19940355/1. "Rapport Final de la Vème Conférence Ministérielle Inter-États de L'O.C.C.G.E." Dakar, les 3, 4, et 5 Mai 1961.

[3] On the reformulation of French-African ties through decolonisation in the field of science at a national level: Guillaume Lachenal, "Franco-African Familiarities. A History of the Pasteur Institute of Cameroun, 1945-2000," in *From Western Medicine to Global Medicine: The Hospital Beyond the West*, ed. Mark Harrison, Margaret Jones, and Helen Sweet (New Delhi: Orient BlackSwan, 2009), 411–444.

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than in colonial histories.[4] Thus, at a time when some Africans were exploring the possibilities of pan-African political structures and international health organisations were being newly reshaped by the membership of sovereign African nations, OCCGE and OCEAC entrenched colonial geographies for health coordination. The limitations of this regional framework in the face of disease and in the face of visions of broader intra-African coordination created fundamental tensions about the viability and suitability of these organisations in independent Africa.

In turn, this article highlights how "late" colonialism catalysed change in public health and medicine that at once mirrored political change but also produced distinct discourses, agendas, and institutions. Scholars have tended to focus on 1945 as marking a turn toward the late colonial period in Africa, defined by the weakening of European powers during World War II, rising political and economic demands by Africans, and a series of ensuing political and economic reforms to empire that shaped the decades ahead.[5] While situated within the changes of the postwar period, this article points to particular dynamics of 1956-1960 in French Africa as worthy of its own conception of late colonialism. 1956 brought significant structural political change to the French colonies of Africa and considering the ripple effects on medicine and public health opens different perspectives on questions of the cross-territorial politics of decolonisation. Recent scholarship on French West Africa has highlighted the political contingencies of the postwar period, showing that African leaders envisioned the possibility of securing independence through a variety of geographical scales, including federation both between African states and with France. The nation-state was not the only option on the table, and yet the nation-state is what Africans ended up with.[6] What was distinct about the period of 1956-1960 was the political and institutional dismantling of French colonial federations and discussion about what would come in their wake.

This article thus focuses on the late 1950s in the French African context as a period of ambiguity in which the institutional structures of some African autonomy from French rule were being built at the scale of the individual colony but the potential future connections between African territories and with France remained in question. French and African health officials did not conceive of their own choices during this time within the framework of "late colonialism," rather this retrospective periodisation can help historians to highlight particular dynamics of change. Seen through the lens of medicine, late colonialism laid the foundation for institutions that carried forward some of the possibilities, limitations, and tensions of imagining the politics of decolonisation through a geographical scale beyond the nation-state. In the era of decolonisation, other cross-territorial African institutions also emerged that enshrined both francophone African ties and ongoing dominance for France in Africa, such as *Union Africaine et Malagache* (UAM).

[4] The idea of "region-making" in this context builds on other scholarship that has analysed the constructed nature of borders or scales of representation in medical and public health work. For example, see Nadav Davidovitch and Rakefet Zalashik, "Medical Borders: Historical, Political and Cultural Analyses," *Science in Context* 19. 3 (2006): 309–316. Nicolas B. King, "The Scale Politics of Emerging Diseases," *Osiris* 19 (2004): 62–76, 63. King draws on the work of geographers Erik Swyngendouw and Niel Smith, "who argue that scale should not be regarded as an ontologically given geographic territory or a priori unit of analysis. Instead it is the outcome of a historically contingent political process, in which actors construct *scalar narratives* that invoke places and spaces at different geographic scales to explain events, enlist allies and attract attention and funding." King observes that the idea that "disease knows no borders" is a form of scalar narrative.

[5] Andrew W. M. Smith and Chris Jeppesen., "Introduction: development, contingency and entanglement: decolonization in the conditional." In *Britain, France and the Decolonization of Africa; Future Imperfect?* ed. Chris Jeppesen and Andrew W.M. Smith (UCL Press, 2017), 2.

[6] Frederick Cooper, *Citizenship between Empire and Nation* (Princeton: Princeton University Press, 2014).

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The leveraging of "borderless" ideals of medicine to create institutions that were in many ways emblematic of French neo-colonial power, however, marked a distinct logic of change. Examining how these health institutions emerged in French Africa shows how both French and African health officials used internationally-salient medical ideals to negotiate the fundamental tensions over territorial scale arising from this period of late colonialism. This negotiation ultimately cemented health cooperation through the scale of colonial geographies, thus blocking, at least temporarily, broader scales of African health cooperation. The article takes a critical approach to the use of these ideas of "borderless" medicine, seeking to highlight how this rhetoric worked to obscure reformulations of colonial power.

Inter-territorial health structures in French West Africa

The foundations for OCCGE and OCEAC lay in the inter-territorial structure of French mobile health services in Africa created during the colonial period. This history created a geographic model for health services that both French and African health officials pointed to as necessary to preserve in the late 1950s when political changes threatened its structure. Moreover, the particular career trajectories of French military doctors who ran these mobile health services and whose postings traversed the African colonies fostered a strong investment in retaining this inter-territorial structure during decolonisation. Through OCCGE and OCEAC, French doctors could maintain distinct positions of regional authority within Africa after independence. French health officials meanwhile asserted the value of the mobile health teams both as a hallmark of French colonial medicine and as representative of newly emerging postwar "borderless" ideals of international health.

French mobile teams were indeed representative of both colonial medicine and international health in terms of their structure of "top down" health campaigns, originally focused on addressing a single disease rather than on developing more comprehensive basic health services. The model in the French colonies in Africa originated from the work of Dr. Eugène Jamot in responding to sleeping sickness epidemics in the present-day Central African Republic in 1917.[7] French officials subsequently instituted this model across its African colonies and the work of the teams expanded after World War II to address a variety of communicable diseases such as smallpox and leprosy.[8] Mobile teams were meant to provide the basis for biomedical intervention in rural areas across French Africa, by sending teams directly to villages to diagnosis disease and perform vaccinations. These mobile health teams had a complicated history in terms of both their coercive methods and sometimes tragic outcomes, but they were often the pride and joy of French military doctors who worked for the service as well as some Africans that worked in them. French doctors asserted the value of the teams in part through their geographic reach.

The careers of French military doctors overseeing the mobile health service meanwhile bolstered their commitment to its inter-territorial structure. Dr. Pierre Richet, who would serve as the first technical head of OCCGE in 1960 previously held the position of the director of the mobile health service of the colonial federation of French Equatorial Africa beginning in 1953 and then as the director of the service for the federation of French West

[7] Rita Headrick, *Colonialism, Health and Illness in French Equatorial Africa, 1885-1935,* ed. Daniel R. Headrick (Atlanta: African Studies Association Press, 1994): 348–350.

[8] Jean-Henri Ricossé and Jean-Alain Husser, "Bilan et avenir de la lutte contre les grandes endémies en Afrique occidentale francophone," [Assessement and future of the fight against major endemic diseases in French-speaking Africa] *Cahiers d'études africaines* 22 no. 85-86 (1982): 145–168, 146. P. Richet, "La lutte contre les grandes endémies tropicales en Afrique noire francophone," [The fight against major tropical endemic diseases in French-speaking black Africa] *Afrique Contemporaine* Nov-Dec. (1980), 1–11.

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Africa (*directeur du service general d'hygiène mobile et de prophylaxie*) beginning in 1955.[9] With a federation-level director, the administration of the service cut across the boundaries of individual colonies and could thus, in theory, be coordinated across a vast geographical space. Fully implementing the plans for the mobile health service was, in practice, slow and uneven across territories, operating with a small group of medical staff.[10] For those working in the service, however, implementing the model across multiple colonies created a particular professional ethos and identity that shaped reactions to decolonisation and questions about the future of the service. French military doctors asserted themselves, and their militaristic operations, as uniquely capable of delivering medical interventions in rural Africa.[11] Moreover, as exemplified by careers such as Richet's that cut across colonies, part of this professional identity grew from the existence of a network of similarly-trained mobile health doctors across West and Central Africa.

Although the mobile teams were much celebrated by their leaders, they were not without their critics within the French colonial administration, who complained periodically about the financial and administrative autonomy of the service. Defenders of the mobile service in the 1950s turned to arguments not only about its medical successes but also about its structure as being in alignment with new postwar ideals of international health. In 1954, the director of the health service of overseas France defended the mobile health service, arguing that its work was only possible through an autonomy that included "freedom from administrative borders." He cast the service as a French model of worldwide trends toward more vastly coordinated action against disease, arguing that the "federal conception" of the service "is consistent with the evolution of world politics in the domain of health; the creation of international or intergovernmental organizations…is dictated by the more and more clear necessity of a coordinated action against disease; medical cooperation between countries is the order of the day, particularly in Africa."[12]

Postwar changes in international health meanwhile created a particular urgency among French officials about controlling health work on the ground in Africa. As recent scholarship has shown, French colonial officials pushed back against the incursion of programming in Africa by the newly created World Health Organization (WHO) and the creation of a WHO Regional Office for Africa, and sought to guard their position of medical authority over French West Africa.[13] In the 1950s, European colonial officials also established the inter-colonial Combined Commission for Technical Cooperation in Africa South of the Sahara (CCTA) as an attempted "institutional barrier" between United Nations specialised agencies, such as WHO, and colonial territories. CCTA, however, was both limited in its capacity to shape health programs in Africa and also represented a fleeting inter-imperial framework for health coordination.[14] French colonial officials thus saw a need to respond to the

[9] J. Languillon, "Le médecin général inspecteur Pierre Richet, 1904-1983" *International Journal of Leprosy*, (1984), 418. Jean-Paul Boutin and J-M Millelliri, "Pierre Richet (1904-1983), contre l'onchocercose et le totalitarisme," [Pierre Richet (1904-1983) against onchocerciasis and totalitarianism] *Médecine et Santé Tropicales* 29, no. 1 (janvier-février 2019), 17–19.

[10] W. Hailey, *An African Survey: A Study of Problems Arising in Africa South of the Sahara* (London, 1957), 1090.

[11] Sarah C. Runcie, "Decolonizing 'La Brousse': Rural Medicine and Colonial Authority in Cameroon," *French Politics, Culture & Society* 38, no. 2 (Summer 2020): 126–47.

[12] Service Historique de la Défense Archives, Toulon, France (hereafter, SHD), SHD 2013 ZK 005 115, 25 Oct. 1954, Le Médecin Général Inspecteur Robert, Directeur du Service de Santé de la France d'Outre-Mer. *Note sur le Service Général d'Hygiène et de Prophylaxie de l'AOF. Raisons pour lesquelles la déconcentration ne doit pas s'appliquer à ce service.*

[13] Jessica Lynne Pearson, *The Colonial Politics of Global Health: France and the United Nations in Postwar Africa* (Cambridge, Massachusetts: Harvard University Press, 2018).

[14] James A. Gillespie, "Europe, America, and the Space of International Health," in *Shifting Boundaries of Public Health: Europe in the Twentieth Century*, ed. Susan Gross Solomon, Lion Murard, and Patrick Zylberman (Rochester, NY: University of Rochester Press, 2008), 114–37. J. Pearson-Patel, 'Promoting health, protecting empire: inter-colonial medical cooperation in postwar Africa', *Monde(s)* 7:1 (2015), 213–230.

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changing contexts of international health and sought to both institutionalise and justify their own governance within this context. By the late 1950s, the ways French medical officials tried to secure their authority evolved, in response to the convergence of international health politics and important changes to French colonial governance in Africa.

Mobile health teams and the *Loi-Cadre*

While the initial postwar history of the mobile health teams represents new colonial development initiatives that scholars often point to as hallmarks of late colonialism, debates about the health service from 1956-1960 illustrate distinct negotiations about the future. As French law in the late 1950s reconfigured colonial governance to focus more on the scale of the individual colony rather than colonial federations, these broader political changes forced questions about the future of the inter-territorial mobile health services and set the stage for their institutionalisation after independence. As Tony Chafer argues, it was in the late 1950s that "the framework for French African policy in the post-colonial period was established" through a series of political and economic accords that would keep former African colonies "firmly in the French sphere of influence after independence."[15]

During this time, both French and African officials used the idea of an inherent good of inter-territorial health coordination, although various agendas motivated the commitment to this institutional structure. One of the specific ways that French officials sought to fortify their ongoing medical authority was through an appeal to the universal concerns of disease, essentially arguing that repurposed colonial structures could respond to the imperatives of international health. West African officials, meanwhile, faced broad questions about managing the ongoing dominance of French institutions and personnel while considering future health needs of individual African territories. Some, for example, had to newly contend with the possibility of carrying within African territorial budgets the cost of existing health programs and institutions established by the French to play a regional role. These final years of the 1950s thus brought forward questions about a tension between public health conceived of as an area of governance of the individual colony versus one that demanded a larger geographic conception.

The 1956 *loi-cadre,* or "framework law," which moved legislative and administrative authority away from the federation-level Government-General of French West Africa and French Equatorial Africa towards elected territorial assemblies, drove these debates about the future of the mobile health service. The law placed greater responsibility for the budgets of individual African territories in the hands of locally elected officials. While the French government maintained authority over areas such as foreign affairs and defence, individual "territorial services" would have responsibility over most public services, including health services.[16] Some prominent political leaders such as Léopold Senghor, future president of Senegal, had opposed the legislation due to a fear of the "Balkanisation" of French Africa, or the move towards more autonomy in the form of smaller political and geographic units as opposed to federations.[17]

For the federations of French West and Equatorial Africa, the *loi-cadre* thus catalysed the "territorialisation" of the general health service. While some structure for cross-territorial coordination in theory remained at first for the mobile health service, French observers characterised the law as producing fundamental changes. A decree from 16 December 1957 created a newly named coordinating structure for the mobile health service for French

[15] Tony Chafer, *The End of Empire in French West Africa: France's Successful Decolonization?* (Oxford; New York: Berg, 2002), 233.

[16] Chafer, 166–167.

[17] Cooper, *Citizenship between Empire and Nation.*

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West Africa (*Service Commun de lutte contre les Grandes Endémies* -S.C.L.G.E.).[18] Richet was serving as the federal director for French West Africa at the time and his role was downgraded to that of an "advisor" for this new coordinating body and his posting moved from Upper Volta to Senegal.[19] Each territory now also had an individual mobile service (*Services territoriaux d'hygiène mobile et de prophylaxie* - STHMP).[20] Writing retrospectively about this period, Richet pointed to the years 1957-1959 as the "division by territory" of the federal services.[21]

French medical officials critiqued the "territorialisation" of the mobile health services specifically through discourses about the superficiality of politically designated borders in the face of disease spread, but notably contained these concerns within the borders of French empire. Writing in 1958 about these changes, Dr. Louis-Paul Aujoulat noted that the mobile service maintained some structure at the inter-territorial level, he asked, "but for how long, and with what means of action?" He lamented the application of the *loi-cadre* in the realm of health, and suggested the new African governments acting in complete autonomy would be a threat to public health:

> Who can guarantee that the territories will always decide to harmonize and synchronize their efforts so that the sanitation undertaken by some is not thwarted by the inertia of others. What good, for example, to attempt to eradicate malaria in Togo if it remains in Dahomey?... It is on this plane that a harmonization, which cannot be imposed by law, must be organized and negotiated spontaneously between the territories. [22]

Aujoulat maintained his focus on the boundaries of French empire by using the illustrative example of the Togo/Dahomey (present day Benin) border, for example, but not the border between Togo and the newly independent Ghana, or between Dahomey and Nigeria. Aujoulat moreover took up the concept of disease eradication -an inherently global concept- and shrunk it to the scale of French territories. While emphasising ideals of cross-border coordination and "harmonization," he maintained these ideals as something that should continue to happen between the French-administered territories of Africa.

The *loi-cadre* also produced the first generation of African Ministers of Health to debate these matters. While African ministers voiced distinct and evolving concerns during this period, their interactions as a group and with France suggest some key dynamics. For one, West African political leadership during this time secured power because of their moderate stances toward France. Once in power, they faced limited options about how to secure budgets in areas such as health.[23] These officials thus largely supported the federation-level organisation of mobile health services as an enduring reference point for future health planning. Secondly, African ministers raised questions of how costs tied to both federation-wide medical institutions and to international health programs would operate

[18] SHD 2013 ZK 005 101 "Procès-verbal de la Commission consultative du Service de Lutte Contre les Grandes Endémies" Dakar, 7-10 Juillet 1958.

[19] P. Richet, "L'Histoire et l'Oeuvre de l'O.C.C.G.E. en Afrique Occidentale Francophone," [The history and work of the OCCGE in francophone West Africa] *Trans R Soc Trop Med Hyg* 59 (1965): 234–251, 236. Jean-Paul Bado, "La santé et la politique en AOF et à l'heure des indépendances (1939–1960)," [Health and politics in AOF at the time of independence] in *AOF: Réalités et héritages: Sociétés ouest-africaines et ordre colonial, 1895-1960. Tome 2,* ed. Charles Becker et al. (Dakar: Direction des Archives Nationales du Sénégal, 1997), 1242–1259, 1255.

[20] Bado "La santé et la politique",1254.

[21] P. Richet "L'Histoire" 236.

[22] Louis-Paul Aujoulat, "Médecine et Santé Publique dans les territoires d'Outre-Mer au lendemain de la Loi-Cadre," [Medicine and Public Health in Overseas Territories after the Framework Law] *Concours Médical* 80.14 (1958): 1729.

[23] Chafer, 234.

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going forward, with the concern that individual territories would now have the shoulder the cost of more expansive programming. Both of these areas of focus highlight the particular tensions of 1956-1960 around scales of medical services.

Meetings between health officials in both French West Africa and French Equatorial Africa took up these questions of what inter-territorial coordination would entail in the context of this ongoing political change. A commission of ministers of health of from West Africa met twice yearly between 1957-1959 to discuss the fate of the mobile health teams.[24] In July 1958, for example, Ministers of Health of the territories of West Africa met in Dakar for four days to examine the annual programs, campaign plans and budgets of the "territorialized" mobile health services.[25]

Attendees of these meetings raised not only the question of how they would interact among themselves going forward, but also how they would interact with international health organisations in light of the new administrative structure. These conversations at once highlighted how French officials were securing their ongoing role as intermediaries of international health, but also how individual African territories were now expected to carry the costs of health programming. Minister Eouanignon of Dahomey asked whether the territories should interact directly with these international organisations or pass through the mobile health service advisor, Dr. Pierre Richet? Richet responded that the relationships of territories with international organisations continued, for the time being to be established by *his* service (my italics), the *Service Commun.*[26] Minister Eouanignon also raised the hope, however, that the "local" costs of a malaria program, financed in part by WHO and UNICEF, would be taken under the umbrella of the *budget général,* rather than that of his territory, with the argument that the results of this program would benefit the entire group. A presiding French official replied that current legislation would not allow this; the malaria program was based on accords between Dahomey and international organisations, and if Dahomey was not able to uphold the part of the accords that called for responsibility for some local costs, it had the capacity to end the program.[27] These conversations highlighted new tensions and uncertainty over the delineation of financial responsibility and control between territorial African governments and French administration, with the questions of coordination focused not just on institutions of empire, but also the positioning of these institutions in the realm of international health.

In 1959, the structure of the mobile health service continued to evolve and became further entrenched in their individual territorial form through the creation of the French Community, which decisively brought an end to remnants of the federations of French West Africa and French Equatorial Africa. At this time, the teams became fully "national" in their orientation, thus dismantling the inter-territorial coordination that had existed since 1957. Each African state now had a *Service National des Grandes Endémies* (SGE) that fell under the authority of each national Minister of Public Health, with no institutionalised mechanism to coordinate their work.[28]

Concerns continued about the complexities of colonial institutions once conceived of as playing a regional role now being carried in African national budgets. In February 1959, Richet wrote that changes to the structuring of budgets and the political uncertainty of the former French West Africa raised "worrying questions concerning a historical service operating under very strict imperatives, structures and doctrines, the importance of which no

[24] Richet "L'Histoire", 236.

[25] SHD 2013 ZK 005 101 "Procès-verbal de la Commission consultative du Service de Lutte Contre les Grandes Endémies" Dakar, 7-10 Juillet 1958.

[26] SHD 2013 ZK 005 101, "Procès-verbal", 9. The meeting minutes are not presented as direct quotes; it was recorded that Richet referred to 'son service,' or his service as the intermediary for international organisations.

[27] SHD 2013 ZK 005 101, "Procès-Verbal", 19.

[28] Richet "L'Histoire", 236.

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longer needed to be demonstrated." He wrote that territories such as Upper Volta (present-day Burkina Faso) which had larger number of institutional resources and personnel related to the mobile health service were particularly faced with these worries. This structuring of personnel and resources had been designed under colonial rule to serve all the territories of French West Africa, but budgetary changes with the ending of the colonial federation had directed the full costs to Upper Volta alone.[29] In May of 1959, Upper Volta was not able to fund its mobile health service nor the research-focused *Centre Muraz*, and was seeking thirty-five million CFA in aid from France for both May and June 1959. These costs had previously fallen under the postwar French colonial development fund (FIDES), and Richet characterised the maintenance of funds of the former health service as a "question of life or death for the fight against major endemic diseases."[30]

French officials expressed both a rising uncertainty about their role in the mobile health service going forward and the need for future coordination efforts to at least appear to be African-driven. In February 1959, Richet raised questions about the future of "European" personnel working throughout the mobile health service in West Africa, hinting at brewing conflict due to "a trade unionist African staff politicized to the extreme" and those refusing "all collaboration and all discipline" in the name of immediate Africanisation.[31] In May 1959, Richet wrote to the Minister of Public Health for Upper Volta, Dr. Paul Lambin, calling for West African ministers of health to gather as soon as possible but that requests for "indispensable technical assistance" to replace colonial development funds must come directly from themselves (underlined). Richet's memo also suggested the need for a "conductor" to lead and main contact between the various ministers, and that Upper Volta play this "conductor" role for a variety of reasons including the location of the Muraz Centre within the state.[32]

In June of 1959, francophone West African ministers of health again met in Upper Volta, and both French and African health officials framed their work on cross-territorial health coordination as distinct from other realms of institutional change. A French report on the meeting noted that the fear that "the antagonisms that rendered so difficult the regulation" of certain ex-federal bodies did not occur in this meeting, but rather took a "an excellent atmosphere of constructive cooperation," even a familial feeling.[33] The Minister of Public Health of Upper Volta, Dr. Lambin, opened the conference paying "homage to this magnificent work" that is the mobile health service, and asserting that the "imperatives" of preventive medicine had not changed, thus setting up a contrast between political change and unchanging public health needs.[34] French and African health officials thus asserted the idea of the governance of health and medicine as somewhat "above" the politics of the moment. The meeting established an inter-state ministerial commission with a

[29] AN 19940355/1. "Fiche sur l'ex-SGHMP de l'AOF." Dakar, le 20 Février 1959, Le Médecin General P. Richet, Conseiller à la Lutte Contre Les Grandes Endémies.

[30] AN 19940355/1. Fiche à l'attention personnelle de Monsieur le Ministre de la Santé Publique de la Haute-Volta, Objet: Devenir de l'ex-SGHMP, Dakar le 13 Mai 1959. Le Médecin Général Richet.

[31] AN 19940355/1. "Fiche sur l'ex-SGHMP de l'AOF." Dakar, le 20 Février 1959, Le Médecin General P. Richet, Conseiller à la Lutte Contre Les Grandes Endémies.

[32] AN 19940355/1. Fiche à l'attention personnelle de Monsieur le Ministre de la Santé Publique de la Haute-Volta, Objet: Devenir de l'ex-SGHMP, Dakar le 13 Mai 1959. Le Médecin Général Richet.

[33] AN 19940355/1. 5 Juin 1959, Discours du Docteur Lambin, Ministre de la Sante Publique de la République de Haute Volta. On the idea of 'familiarity' in French-African medical institutions: Guillaume Lachenal, "Franco-African Familiarities. A History of the Pasteur Institute of Cameroun, 1945-2000," in *From Western Medicine to Global Medicine: The Hospital Beyond the West*, ed. Mark Harrison, Margaret Jones, and Helen Sweet (New Delhi: Orient BlackSwan, 2009), 411–444.

[34] AN 19940355/1. 5 Juin 1959, Discours du Docteur Lambin, Ministre de la Sante Publique de la République de Haute Volta.

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Secretary General at its head to direct this coordination, based in Bobo-Dioulasso.[35] Many questions remained, however, about the budget and how disagreements between member states would be handled.

By Autumn 1959, for example, the place of France in an emerging African regional health organisation remained in question. Initial statues for the organisation cast France in the role of observer, but French officials wanted to be ingrained in the organisation as a member state. Representatives from Mali in particular opposed this French role in the organisation. French officials complained about the unfortunate nature of "this discrimination" in light of the financial contributions expected by France to the organisation.[36] These discussions continued until Autumn 1959, as the Minister of Health of Mali called for France to take on a role only of observer and advisor, later "defending" himself against the charge of having tried to push France entirely out of the organisation.[37] Of course with no shared geographic borders to speak of, France's role in the organisation spoke to its emergence from colonial ties and the structures being established to continue French control in the region. The desire of French officials to make France an OCCGE member state demonstrates that securing ongoing French influence at an inter-territorial African scale, not just vis-a-vis emerging individual African nation-states, was a primary agenda crystallising during this period of late colonialism at the end of the 1950s.

Towards regional health organisations

As the example of OCCGE shows, negotiations of "late colonialism," here defined as 1956-1960, catalysed new institutional structures for African independence. In April 1960, health ministers of former French West Africa territories met in Abidjan, Côte d'Ivoire and officially formed the inter-state health organisation OCCGE, *l'Organistion de Coordination et de Coopération pour la Lutte contre les Grandes Endémies.* In addition to the seven original African member states, France prevailed in becoming a member state and contributed substantial funding and personnel to the organisation. The organisation would function through an administrative council and the office of the permanent Secretary General, and it would also serve as an umbrella for four scientific centres and institutes based in Upper Volta, Mali and Senegal.[38] Dr. Lambin of Upper Volta served as the first president of OCCGE.[39] Dr. Richet became the first Secretary General of the organisation, a position that he would hold until 1970, when Malian doctor Cheick Sow took over the position.

While OCCGE quickly formed a West African health block, African public health officials from across the former French colonies also gathered in larger groupings in coordination with French officials. These ongoing meetings both laid the groundwork for the establishment of an organisation in Central Africa parallel to that of OCCGE and explored the possibility of merging the two "regions" growing out of French West Africa and French Equatorial Africa into one. At a May 1961 meeting in Paris, comments from Central African health ministers highlighted the uneven French colonial investment in health services,

[35] AN 19940355/1. 12 Juin 1959. Le Haut-Commissaire Représentant le Président de la Communauté Chevalier de la Légion d'Honneur à Monsieur le Ministre d'Etat chargé de l'Aide et de la Coopération. Objet: Conférence des Ministres de la Santé Publique de Bobo-Dioulasso.

[36] AN 19940355/1. Le Haut-Commissaire représentant le Président de la Communauté auprès de la République de Haute Volta à Monsieur le Président de la Communauté. Ouagadougou, 5 novembre 1959.

[37] AN 19940355/1. 17 Novembre 1959, Paul Blondiaux, Le Chef de la Mission d'Aide et de Coopération auprès de la République Soudanaise à Monsieur le Gouverneur San Marco, Ministère d'Etat.

[38] Richet "L'Histoire", 237. The four institutes were the Centre Muraz and École Jamot in Bobo-Dioulasso, Haute Volta, the Institut Marchoux, Institute du Trachome (IOTA) in Bamakao and O.R.A.N.A. in Dakar.

[39] AN AG/5(F)/3391, Paris, le 18 octobre 1962, Note à l'attention de Monsieur le Président de la République, Président de la Communauté: Réunion du Conseil d'Administration de l'O.C.C.G.E.

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with some framing ongoing French health aid as a debt to be paid. While the minister of health from Cameroon commented that that country already had a "sufficiently robust infrastructure" for example, the Minister of Public Health of Congo Brazzaville, Raymond Mahouata, discussed the vast need for investment in health infrastructure and personnel in his territory, arguing that "it must be recognized that France left us with a meagre legacy, regarding medicine."[40] Mahouata stated that that delay in responding to the need for more medical personnel could only be considered "an infringement on human life and the future of our nation." It was up to France, he added "to do the impossible and make sacrifices."[41] The Minister of Public Works acting as representative for Chad similarly outlined the serious problem of personnel for this country and asked that France help with the need for doctors, nurses, and midwives, needs which he projected would only grow in the decades. He adopted a reprimanding tone towards France, observing that "France seems to have great difficulty responding to our growing needs..."[42] Turning to the interwoven histories of France with his country, he added that "each time that France has called our children to serve in it ranks for the defence of liberty and of fundamental freedoms, we have always been there. Today we call on France to help us protect the health of our fellow citizens and in particular that of our children."[43]

Beyond the national level, Central African ministers made calls for regional-level assistance from France, coordination between West and Central African states, and suggested this kind of coordination as a kind of counterweight to existing international health institutions. Etienne Boungougou, the Minister of Public Health of Gabon, called for aid and technical support from France at a regional level. In describing the service of mobile teams in his country, he reported that "the only difficulty concerns the lack of technical directives. There is WHO, of which the experts are very useful to us in the evaluation of needs and the elaboration of programs, but for the problems that arise daily, Gabon does not have sufficient qualified personnel to issue authoritative solutions."[44] The Minister from Chad also remarked on the need for coordination between states. He expressed his wish for a coordinating body for Central Africa to work closely with the West African OCCGE, hoping "to see these two organisations spread their field of action and become a true high commission of coordination of public health in Africa." He placed this vision in the context of his "disappointment" over the slowness and inefficiency of the specialised organisations of the United Nations in Africa.[45]

This kind of language about the inefficient nature of international organisations would reoccur in the early 1960s among both African and French doctors in their discussions about health coordination. International organisations embodied the ideal of transcending state borders in confronting disease, but French and African health officials critiqued them, particularly the World Health Organization, as not fully up to the task. In this meeting and others, health officials in this shared French-African space instead focused on the possibilities of cross-border coordination through the framework of colonial ties, which inherently set up barriers to other axes of coordination. These meetings thus mobilised the ideals of international health while valorising the structures of colonial medicine. At this particular moment in 1961, with the francophone West African health coordination newly institutionalised through OCCGE, and ongoing discussions about how the Central African states

[40] SHD 2013 ZK 005 224 "Conférence des Ministres de la Sante Publique des Etats d'Expression Française: Paris-Mai 1961, Fascicule 1-Les Problèmes Généraux".

[41] SHD 2013 ZK 005 224-Fasicule 1, 18.

[42] SHD 224, Fascicule II, 14-17.

[43] SHD 224, Fascicule 1, 43.

[44] SHD 2013 ZK 005 224, Fascicule 1, 23.

[45] SHD 2013 ZK 005 224-Fascicule 1, 44.

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might proceed, there was also a significant imagining going on of what bridging these two regional spheres, with the backing of France, might look like.

In August 1963, the states of the former French Equatorial Africa and Cameroon met in Yaoundé to pursue the creation of their own inter-state health organisation, OCEAC (*Organisation de Coordination et de Coopération pour la Lutte contre les Grandes Endémies en Afrique Centrale*). In his speech opening the conference, the Minister of Public Health of Cameroon, Dr. Simon-Pierre Tchoungui, emphasised the particular importance of cooperation in the realm of public health in which, "all isolated effort is irreparably doomed to failure"[46] Conversations about joining the two regional organisations of West and Central Africa arose but never moved forward, and so the organisations replicated the federal structure of French colonial rule, with the inclusion of the former United Nations Trusteeships of Togo and Cameroon.

Contested health regions in the early 1960s

In the early 1960s, the West African OCCGE moved forward as an organisation but its future membership, scale, and purpose remained in question and sometimes faced contestation, particularly around the issue of its connection to surrounding "Anglophone states." In 1962, the officially English-speaking states of Nigeria, Sierra Leone and the Gambia all sent representatives to an OCCGE meeting and Nigeria expressed interest in potentially joining the organisation as a member state.[47] English-speaking states of West Africa (Ghana, Nigeria, Liberia, Sierra Leone and Gambia) had created some mechanisms for health coordination through the West African Research Council and some discussions focused on creating ties between this organisation and OCCGE.[48] Creating regional institutions between francophone and anglophone West African states in the early 1960s, however, for the most part remained elusive.

Larger questions about the future of health coordination in relation to broader visions of Pan-African integration also remained. After facing political backlash from France in the late 1950s and not originally joining OCCGE, Guinea did join as a member state in March 1962.[49] In a ministerial conference of OCCGE in November 1963, President of Guinea, Sekou Touré, "insisted on the pan-African character of OCCGE" and urgency of its expansion to other African countries. He expressed his wish that the organisation create an affiliation with the Organization for African Unity (OAU), which had been created six months prior in May 1963. Later in the meeting, the Minister of Health of Guinea likewise turned the discussion to the creation of an organisation for public health coordination in the OAU, of which OCCGE could be the core. The discussion turned to how this adaptation of OCCGE would change the role of France, given that it was not a member state of the OAU. The official position of the French government was that it foresaw an eventual dwindling of its role and financial contribution in the organisation, thus making OCCGE a "strictly inter-African organization" but the timeline for these changes remained ambiguous.[50]

[46] World Health Organization Archives, Geneva, Switzerland (WHO) *Rapport Final de la Conférence des Ministres de la Santé des États Équatoriaux.* Yaoundé, les 21, 22, 23 août 1963.

[47] AN AG/5(F)/3391, Paris, le 18 octobre 1962, Note à l'attention de Monsieur le Président de la République, Président de la Communauté: Réunion du Conseil d'Administration de l'O.C.C.G.E.

[48] AN AG/5(F)/2588, Paris, le 17 Mars 1962, Note à l'attention de Monsieur le Président de la République, Président de la Communauté: Réunion du Conseil d'Administration de l'O.C.C.G.E.

[49] AN AG/5(F)/3391, Paris, le 18 octobre 1962, Note à l'attention de Monsieur le Président de la République, Président de la Communauté: Réunion du Conseil d'Administration de l'O.C.C.G.E.

[50] AN AG/5(F)/3391, Médecine Général Diagne. Rapport sur la 10^{e} Conférence Ministérielle Inter-Etats de l'O.C.C.G.E.

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By the time of organisation's 1964 technical conference, however, broader West African enthusiasm for the organisation appeared to have dwindled. Neither member states of Guinea or Togo sent representatives and, apart from Liberia, anglophone West African states were completely absent.[51] The French delegation described the atmosphere of the meeting as a sense of "malaise" weighing on the organisation and reported that it was being critiqued for being "too French, too military and not Africanized enough." It also reported critiques emanating from the Organization for African Unity, which was focused on creating institutions that were "strictly African."[52] The future structure and mandate of OCCGE was far from clear.

As it were, the structure of OCCGE as a heavily French influenced organisation focused on the former French colonies of West Africa endured for nearly 30 years. In this interim period, OCCGE played an intermediary role in major health campaigns such as the global smallpox eradication program in the late 1960s, and its origins in French colonial military medicine remained clear through this period.[53] In the 1970s, anglophone West African States formed their own regional association through the West African Health Community.[54] It was not until 1987 that West African states created an institutional infrastructure for broader health coordination across former colonial lines. In 1987, the West African Health Organization (WAHO) was created, bringing together both anglophone and francophone states, but having its headquarters at the OCCGE headquarters in Bobo-Dioulasso. WAHO still remains the specialised technical institution of health for the regional body the Economic Community of West African States (ECOWAS).[55]

Scholarship on the late colonial period in French West Africa has pointed to the "openings" and "closings" of political possibilities and political visions beyond those of the nation state.[56] Attention to these regional health organisations offers another dimension to understanding the contingencies of the late colonial period. As the nation-state became increasingly locked in as the territorial scale of African independence, French and African officials built new organisations across various realms of governance that would preserve French power and inter-territorial African ties. One of the "closings" of the late colonial period was thus also around limiting these inter-territorial ties to "francophone" states. Focusing on the period of 1956-1960 in which French colonial federations were broken down and planning began for how they might be institutionally reconceptualised through inter-governmental organisations underscores the particular contingencies of these years.

While OCCGE opened an institutional structure for health coordination across borders, it also limited the parameters of health coordination across the lines of colonial structures and languages. Late colonialism thus locked in inter-territorial structures along colonial lines, not just the form of the nation state, that created barriers to other forms of African regional integration. Questions about the scale of African coordination permeate the late 1950s and early 1960s and touch upon a variety of pressing political, economic, and social questions. In the realm of health, however, both African and French officials were using language about the specificity of health and epidemic disease to try to naturalise specific forms

[51] AN AG/5(F)/2588, Rapport de Mission: 3ème Conférence Technique de l'O.C.C.G.E, Rapport de la Délégation Française, Docteur L.P. Aujoulat and Docteur Coudreau.

[52] AN AG/5(F)/2588, Rapport de Mission: 3ème Conférence Technique de l'O.C.C.G.E, Rapport de la Délégation Française, Docteur L.P. Aujoulat and Docteur Coudreau.

[53] Horace Ogden, *CDC and the Smallpox Crusade* (Atlanta, GA: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control, 1987).

[54] Emmanuel Balogun, *Region-Building in West Africa: Convergence and Agency in ECOWAS* (Routledge, 2022), 81.

[55] West African Health Organization. https://www.wahooas.org/web-ooas/en/who-we-are. Accessed September 9, 2022.

[56] Cooper, *Citizenship between Empire and Nation.*

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of health coordination. The vision constructed in the late colonial period that endured institutionally for the early decades of independence was the naturalisation of health regions through the parameters of colonial history.

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