

Regional cooperation and health diplomacy in Africa: from intra-colonial exchanges to multilateral health institutions

Cooperação regional e diplomacia sanitária na África: dos intercâmbios intracoloniais às instituições multilaterais de saúde

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Abstract

Tracing the pathways of cooperation in health in sub-Saharan Africa from hesitant exchanges to institutionalized dimensions from the 1920s to the early 1960s, this article addresses regional dynamics in health diplomacy which have so far been under-researched. The evolution thereof from early beginnings with the League of Nations Health Organization to the Commission for Technical Assistance South of the Sahara and the World Health Organization's Regional Office for Africa, shows how bilateral dimensions were superseded by WHO's multilateral model of regional cooperation in health. Alignments, divergences, and outcomes are explored with respect to the strategies and policies pursued by colonial powers and independent African states regarding inter-regional relations, and their implications for public health and epidemiological interventions.

Keywords: international health; health diplomacy; regional cooperation; colonialism; sub-Saharan Africa.

Resumo

Trilhando os caminhos da cooperação sanitária na África subsaariana, de intercâmbios incertos a dimensões institucionalizadas dos anos 1920 até início dos anos 1960, este artigo aborda a dinâmica regional na diplomacia sanitária que, até o momento, carece de pesquisas. A evolução, desde os primórdios da Organização da Saúde da Liga das Nações até a Cooperação Técnica na África Subsaariana e o Escritório Regional da África da OMS, demonstra como dimensões bilaterais foram substituídas pelo modelo multilateral da OMS de cooperação sanitária regional. São analisados alinhamentos, divergências e resultados de estratégias e políticas empregados por potências coloniais e Estados africanos independentes em relações inter-regionais, bem como suas implicações em intervenções epidemiológicas e de saúde pública.

Palavras-chave: saúde internacional; diplomacia sanitária; cooperação regional; colonialismo; África subsaariana.



Over the last two decades, the increasing focus on international health diplomacy has provided new insights into global and regional interactions and the role of multilateral organizations within them. In the process, the League of Nations Health Organization (LNHO), the Office Internationale d'Hygiene Publique (OIHP) and the World Health Organization (WHO), as well as the Rockefeller Foundation's Health Division (RFHD), have all been singled out in published research (Cueto, Fee, Brown, 2019; Packard, 2016; Barona, 2015; Borowy, 2009; Farley, 2008, 2004; Weindling, 1995; Siddiqi, 1995). However, the impact of international and regional cooperation in health upon colonial contexts and vice versa has so far received far less attention (Havik, Monteiro, 2020; Bonoho, 2019; Pearson, 2018; Liu, 2018; Amrith, 2006). In various regions of the world, colonial overlords applied notions of sanitation and hygiene to the territories under their jurisdiction with a view to implementing public health and epidemiological interventions (Packard, 2016, p.32-49). International (scientific) cooperation was to have a marked impact upon advances in "medicine in the tropics," as tropical medical research invested in epidemiological and pharmaceutical innovation while using colonial territories as "living laboratories" (Neill, 2012; Tilley, 2011). In the process, public health and epidemiology gained a firm foothold in the tropics, while the internationalization of health resulted in the establishment of agencies coordinating the exchange and dissemination of data, programs, training and personnel (Packard, 2016, p.32-46).

In recent years, important strides have been made with the study of foreign relations, colonial health policies and international scientific networks in Africa (e.g. Pearson, 2018; Neill, 2012; Tilley, 2011). During the interwar years, proposals were tabled for an African Office in meetings organized under the auspices of the League of Nations Health Organization (LNHO) with the task of collecting epidemiological information, similar to the Far Eastern Bureau (FEB) in Singapore created in 1924. However, they were not implemented at the time owing to a lack of consensus on its location and mission (Sealey, 2011b, p.137-138; Borowy, 2009, p. 225-235). The historical dynamics of postwar cooperation in health in Africa and the role of the Regional Office for Africa (AFRO), the last of the WHO regional organizations to be set up in 1951, have only recently become the focus of research (Havik, Monteiro, 2020; Cueto, Fee, Brown, 2019, p.77-85; Bonoho, 2019;; Pearson, 2018). So far, limited forays have been made into the parallel health diplomacy conducted by colonial powers in AFRO and other regional organizations such as the Commission for Technical Cooperation South of the Sahara (CCTA) (Havik, Monteiro, 2020, p.305-309; Bonoho, 2019, p.40-45; Pearson, 2018; Pearson-Patel, 2015, p.82-84).

The present article proposes to relate proceedings of successive inter-African medical exchanges in the interwar years and after 1945 to developments in a broader public health perspective. The debates and outcomes of these meetings held between the 1920s and mid-1950s illustrate a pattern of parallel diplomacy and selective engagement conducted by colonial powers based upon a model of interaction derived from the International Sanitary Conventions. This approach, which centered on the (bilateral) exchange of epidemiological data, contrasted with the multilateral framework for cooperation practiced by LNHO in the interwar years and expanded by WHO-AFRO after 1945 in which disease control was embedded in a broader developmental perspective. These 'models' would clash in

the postwar era, when the stand-alone sanitary convention model applied by CCTA was shown to be outdated, slow to take effect, and of limited efficacy, as WHO-AFRO extended the multilateral global health model to the African region. Even before decolonization set in, parallel diplomacy which aimed to control regional development through CCTA had largely exhausted its purpose as member states failed to agree on the way forward. This colonial approach was modeled on a racialized understanding of epidemiology and the management of African populations in the context of vertical control programs, epitomized by the politics of controlling African sleeping sickness. By the mid-1950s, the colonial management of interlocking institutions and networks was being called into question for slowing the advance in regional development and cooperation in the sphere of public health. In addition, colonial medicine's hesitant engagement with rural public health issues beyond disease control became patent, along with its incapacity to coordinate and share improvements in the field via bilateral inter-territorial arrangements in the region. Based upon archival research in Portugal, Belgium, France, Britain and at the United Nations and WHO in Geneva, the present paper aims to fill existing knowledge gaps on the evolution of regional cooperation in health in a region that has so far been under-researched in this respect.

Interwar health diplomacy in Africa: hesitant approaches

From the early 1920s when the First Conference on Tropical Medicine in West Africa was held in Luanda (Angola) to the mid-1930s, a series of inter-colonial encounters served as the stage for an exchange of ideas between health officials and medical experts on regional cooperation in health in Africa. Organized by the head of the Angolan health services, the meeting set a precedent for the debate on health services, disease control programs, and the exchange of health information in sub-Saharan Africa. This encounter, attended by British, French, Belgian and Portuguese medical officers and experts, aimed to demonstrate the benefits of modern biomedical science to the African region and its populations (Castro, 2013, p.81-84; Nunes, 2012, p.303-305). Joining colonial officials based in South Africa, Nigeria, French West and Equatorial Africa (AOF and AEF, respectively), Cameroon, the Belgian Congo, Angola, Mozambique, São Tomé and Príncipe, as well as Goa, it drew comparisons between colonial territories, including Angola, the Belgian Congo, and the AOF and AEF. The main focus of debates was on disease control programs, such as those against sleeping sickness, malaria, yellow fever, kala azar, venereal diseases, and tuberculosis on a continent with high levels of morbidity and mortality. Public health, sanitation and social medicine were as yet incipient themes reflecting medical authorities' emerging concerns for "rural hygiene" (Primeiro Congresso..., 1923).

The meeting revealed a tentative *entente* in health diplomacy in Africa between France, Belgium and Portugal, which had covered common ground in preparatory meetings. Two distinct tracks for cooperation emerged here; the first was limited to the exchange of data on epi-endemic diseases (e.g. Vassal, 1923, p.131-132; Hesse, 1925; Trolli, 1928), while the second favored broader collaborations in the field of public health (Mora, 1923; Mitchell, 1923). The former would be the subject of bilateral agreements such as the Luso-

Belgian Sanitary Convention of 1927 which were based upon the International Sanitary Conventions of 1912 and 1926 (Sealey, 2011a). While focusing on sanitary border controls, a major concern of services on both sides was monitoring migratory fluxes for sleeping sickness. Other bilateral regional agreements were concluded in the interwar years between colonial powers, proposing joint organization of medical missions, monthly exchange of medical data, and issuance of medical passports (Ministère..., 1929).

However, progress on cooperation in the sphere of public health remained slow owing to a nation-centric approach, a protectionist attitude toward their respective colonies, and an overriding concern with the management of African populations (Lipphardt, Widmer, 2016, p.7). The International Sleeping Sickness Conferences held in London in 1925 and Paris in 1928, organized by the LNHO Expert Committee, illustrated this ambivalent attitude. While its recommendations favored joint efforts to combat a vector-borne disease by vertical means (Sealey, 2011b, p.193-196), the rules for engagement largely focused on controlling the movements of African populations and reordering settlements rather than considering improvements in medical care for affected populations (Kleine, Van Hoof, Duke, 1928, p.391-392). Given that a multilateral framework was rejected at the Paris meeting, cooperation remained limited to a step-by-step bilateral approach, as different vertical programs were put in place in imperial contexts (Mertens, Lachenal, 2012, p.1249-1271).

Regional medical interchanges: the Cape Town Conference

The first African medical interchange was held in West Africa in 1926, and involved high-ranking colonial medical officers from Britain, France, Belgium, Spain and Portugal (many of whom had attended the previous meeting), and a LNHO representative (Borowy, 2009, p.225-230). Held under the auspices of the LNHO and promoted by its medical director, Ludwik Rajchman, the interchange was the one of the LNHO's first forays into Africa. Having sponsored similar meetings in Europe and Asia, LNHO liaised with colonial governments, proposing study tours in West and Central Africa. Final conferences were to be held in Freetown and Luanda, revealed an emerging consensus on the combat against endemic diseases: "All speakers were agreed that the problems to be faced were the same for all the nations concerned and that the methods of tackling these problems were, allowing for small differences in detail due to racial characteristics, the same" (LNHO, 1926). The Cape Town and Johannesburg meetings reiterated this idea based on racial disease reservoirs, innate immunity to disease due to the "racial resistance" of Africans, while advocating sanitary segregation of residential areas between them and Europeans (LNHO, 1933, p.18, 24, 30; LNHO, 1936, p.18), although dissenting views on the supposed immunity of Africans surfaced during the latter (LNHO, 1936, p.70).

While the need to create cross-border mechanisms for data exchange was recognized, differences emerged on the best way forward. Whereas Belgian delegates favored limited bilateral exchanges which would be less time consuming, South African and Portuguese representatives proposed a pan-African bureau with a broad mandate (Mora, 1926; Thornton, 1926; Coghe, 2014, p.145). Besides the exchange of epidemiological data, it was also expected to "deal with all medical questions and to arrange frequent conferences"

(LNHO, 1926). Delegates suggested that one of the advantages of a regional bureau was “to allay unnecessary suspicion between the different governments and encourage those that are dilatory to notify the bureau quickly” (LNHO, 1926). The head of the French delegation suggested that the LNHO’s Far Eastern Bureau (FEB) could serve as an example for a West African office (Innes, 1927). Initially devised as a center funded by the Rockefeller Foundation, responsible for collecting and disseminating epidemiological intelligence, FEB soon extended its mandate to coordinating scientific research by expert committees on regional health issues, medical training, and promoting regional scientific conferences, while steadily increasing its geographical coverage (Akami, 2017; Barona, 2015, p.112-113; Sealey, 2011b, p.102-103; Borowy, 2009, p.143-154). By fostering a common sense of purpose among member countries (Manderson, 1995), it served as an example for health diplomacy in other regions.

The Portuguese delegate, António Damas Mora, a physician trained in Portugal who headed “native” health services in Angola, envisaged a pan-African Bureau aligned with the LNHO model, which entailed transferring the FEB in “adapted” form to Africa to ensure closer institutional cooperation between colonial health authorities. During his tour of West Africa, he found that little support was forthcoming in colonial circles for such a Bureau, which appeared more concerned with managing indigenous populations. His proposals subscribed to a regional organization held to promote regional public health initiatives including child and maternal health, adult health, rural hygiene, and sanitation (Mora, 1926). These concerns were not only shared by the LNHO medical director but also by the Rockefeller Foundation, which funded LNHO programs and would be present at subsequent interwar African exchanges. In a study requested by Rajchman on “native” health services in Africa, Damas Mora (1930) presented the first comprehensive, comparative analysis of rural facilities and care in British, French, Belgian, and Portuguese colonies.

When the LNHO’s medical director sounded out member governments to organize a follow-up to the 1926 meetings (Borowy, 2009, p.225-235), it was very much with these topics in mind (Rajchman, 1931). The envisaged “meeting of medical officers of African powers” eventually took place in Cape Town in 1932, at the invitation of the government of the South African Union (LNHO, 1933). Held in the immediate aftermath of the 1929 worldwide economic slump, it coincided with the LNHO’s attempts to assess its impact on public health and vulnerable populations in different regions of the globe (Borowy, 2008). However, public health data on Africa were scarce and unreliable, owing to low coverage of services (especially in rural areas where the bulk of African populations lived). The issue of rural medical services was the centerpiece of the European Conference on Rural Hygiene organized by LNHO in Geneva in 1931, which discussed states’ responsibility for organizing health services and rural sanitation and increasing the efficacy of medical assistance and health promotion in local communities. A follow-up meeting on rural hygiene in Bandung in 1937 extended the concept to colonial contexts in Asia (Borowy, 2009, p.335-343; 352-359). The Bandung meeting was preceded by a tour of countries in the region, which revealed serious shortcomings in services for rural populations (Borowy, 2009, p.352; Litsios, 2014, p.114-115; Amrith, 2006, p.36-37). Besides public health and community care, it also engaged with sanitation, education, and economic and social

development; its recommendations advocated the importance of preventive medicine and decentralizing health care to serve rural populations.

While initially envisaged as “a small conference,” it soon extended its range to encompass a large array of territories such as Southern and Northern Rhodesia, Mozambique, Belgian Congo, the AEF, and Uganda, and also included Kenya, Tanganyika, Nigeria, Angola, and the Gold Coast, as well as British India as an observer. French metropolitan officials and health officers from the Belgian Congo, however, contested the aims of the meeting. In their opinion, it diverged from the LNHO’s original recommendations (Boyé, 1932), illustrating colonial distrust in the LNHO’s intentions. The meeting was consequently renamed the Regional African Sanitary Conference, with a program circumscribed to combating yellow fever, air transport, smallpox vaccination, and rodent plague (Buchanan, 1932); rural hygiene was added belatedly, at the behest of the host country.

In the end, the meeting devoted most of its time to a technical discussion of yellow fever and other communicable diseases, paying little attention to medical cooperation and rural hygiene. Those who did underline the need for a common agenda for regional cooperation, including the South African delegate and his Portuguese counterpart, associated it with the need to prioritize rural hygiene. However, most delegations were more concerned with sanitary aspects of disease control such as the Sanitary Convention for Aerial Navigation (SCCAN) advocated by the OIHP (Abt, 1933, p.49-54), which failed to take “native health” seriously (Mora, 1932). Recommendations included undertaking health surveys on communicable diseases and recruiting “native” personnel for cooperation between government departments, as well as transnational collaboration between laboratories and exchange of health statistics. The delegates’ failure to agree on a common agenda for institutionalizing cooperation in the field of rural hygiene in the region was attributed to “great variations in the racial constitution and distribution of its population, its occupation and educational attainments” (LNHO, 1933, p.102).

Regional medical interchanges: the Johannesburg Conference

The next meeting, held in Johannesburg in 1935 (LNHO, 1936; Borowy, 2009, p.230-234), was once again hosted by South Africa, where the ongoing debate on rural hygiene and – segregated – “native” medical services was morphing into a health center movement to address the public health crisis (Harrison, 1993, p.682; Marks, 1997, p.453-454). The host country proposed focusing on “hygiene and medical services in rural areas, native health and provision of medical services for natives,” besides discussing the question of epidemiological controls and preventive measures against yellow fever, bubonic plague, typhus, and other diseases. Intent on avoiding a repeat of the Cape Town deliberations, both the LNHO and the host country wished to debate the question of public health while also being keen for the meeting to “really [be] a pan-African one” (Raijchman, 1934).

However, French and Belgian quarters showed little enthusiasm, owing to “a good deal of misunderstanding regarding our proposed conference” (Thornton, 1934). Their willingness to cooperate was conditional upon adherence to the OIHP “model,” which grew out of the International Sanitary Conferences and centered on the exchange of

information on control and surveillance of communicable diseases. Nevertheless, the South African delegation insisted on a sub-Committee (of LNHO) for Africa “with a knowledge of African conditions linked up with small regional sub-committees in Africa which could be convened regularly at intervals for the discussion of common problems” (Thornton, 1935). One of the new items added to the agenda was “the coordination of health work in Africa” and comparing experiences in different territories, while issues “other than medical could have a prominent place” (Stanton, 1934).

The meeting was attended by representatives from British, French, Belgian, and Portuguese colonies and protectorates including the AOF and AEF, Angola, Basutoland, Bechuanaland, Belgian Congo, the Gambia and Sierra Leone, Gold Coast, Kenya, Mozambique, Nigeria, Nyasaland, Northern and Southern Rhodesia, South Africa, South West Africa, Swaziland, Tanganyika territories, Uganda and Zanzibar, as well as British India. Its agenda included nine topics, covering the epidemiology of malaria (which was neglected in Cape Town), typhus, and sleeping sickness, as well as hygiene and medical services in rural areas and better coordination of health work in Africa. Debates on malaria covered the need for more research on child mortality and on the susceptibility “of the African man” to infection and its impact on “racial increase” (LNHO, 1936, p.111-112). South African delegates made a case for the “pooling of experience and an exchange of views at regular ... intervals [which] would lead to economy of effort and higher efficiency.” To that effect, the LNHO should set up a sub-committee on African problems, hold regular health sub-regional conferences and Pan-African Conferences every four years. These delegates linked improving the economic conditions of African populations to the success of measures towards “raising the physical and mental status of African races” (Thornton, Orenstein, 1936, p.207, 198). The meeting’s final recommendations embraced the idea (albeit vague) of an institution dedicated to research on rural hygiene and nutrition, a topic which was being promoted by the LNHO at the time (Packard, 2016, p.66-88; Borowy, 2009, p.379-393). While the linking of primary care, disease control, and rural welfare found tacit support among most delegations at the Johannesburg meeting, the idea of regional cooperation in the sphere of rural public health and establishing a special committee only elicited favorable responses from South Africa and the territories under British rule (Bloore, 1937).

By the late 1930s, when the follow-up meeting scheduled for Nairobi in 1940 was discussed, the Bandung conference had already set an important precedent by focusing on the well-being of rural populations. At the request of colonial authorities, the British Foreign Office proposed broadening its focus to include nutrition, rural hygiene and health education, and training African medical personnel, a matter which delegates at previous meetings had been hesitant to recommend. While these subjects were “of great interest at the present time,” they would also allow for discussions on colonial experiences and on devising practical, common procedures to tackle them “under the existing economic and general conditions obtaining in Africa” (Mackenzie, 11 Aug. 1939). To this end, study tours were organized to investigate methods of practice in European health services. However, plans for the Third Pan-African Health Conference were shelved due to the outbreak of Second World War (Mackenzie, 27 Nov. 1939). Nevertheless, some topics proposed for this conference would resurface in postwar CCTA and WHO-AFRO meetings.

Regional cooperation in health after 1945: institutional frameworks and dynamics

The period immediately following the Second World War was to lay the foundations for a new multilateral international system built upon the United Nations (UN) and its specialized agencies. The dominant perspective on technical assistance was characterized by a developmental and “welfarist” approach encompassing public health and epidemiology (Packard, 1997). The association between socio-economic and public health perspectives which the LNHO had embraced in the 1930s would become guiding principles for early postwar developmental inputs by UN agencies such as WHO and UNICEF under a broad definition of health and well-being. The establishment of WHO in 1948, which absorbed OIHP and LNHO and followed the recommendations of the first International Health Conference in New York in 1946, revived the process of international cooperation in health from a multilateral perspective (Cueto, Fee, Brown, 2019, p.34-61; Sealey, 2011b, p.272-298). WHO oversaw the creation of a network of six regional organizations, including SEARO (1948), EMRO (1949), WPRO (1951) and AFRO (1951), and WHO-Europe (1952); the already existing PAHO (formerly PASB) would retain its autonomy within the WHO system. The establishment of the WHO’s Regional Office for Africa (AFRO) in 1951, based in Brazzaville from 1952 onwards, was the first permanent regional organization exclusively centered on health in the region. Funded by WHO, it aimed to promote multilateral cooperation between its member countries (Britain, France, Belgium, Portugal, Spain, South Africa, and Liberia) and associated members (Southern Rhodesia) in the field of public health and epidemiology by providing technical and policy expertise, setting standards, providing training grants for (local) health personnel, and encouraging surveys and joint projects. Over time its membership would expand to include other associated members and independent African states. As a result, UN agencies and their regional offices were confronted with the colonial aspirations of its member countries and growing calls for decolonization in Asia and Africa (Pearson, 2017; Havik, Monteiro, 2020; Amrith, 2006).

AFRO was initially headed by a Dutch physician trained in the Netherlands, Britain, and South Africa, François Daubenton (1951-1954), who had professional experience in the African and the Eastern Mediterranean region. Acting as a medical consultant for mining companies in South Africa while supervising “native” hospitals and also working with WHO-funded public health programs in Ethiopia, he developed a keen interest in social medicine and sanitary engineering. Daubenton’s visits to colonial territories led him to be critical of inadequate health services, health coverage, and sanitary conditions (Carvalho, 1952). He advocated setting up three divisions within AFRO concerned with medical, technical-sanitary, and medico-sociological affairs (AFRO, 1952), and proposed conducting a critical study of public health administrations and future programs in Africa while advocating increased coordination between the different health systems in the region (Daubenton, 1953). In order to address the socio-cultural aspects of local health care, Jean-Paul Lebeuf, a well-known French anthropologist, was brought into AFRO during Daubenton’s mandate (Cueto, Fee, Brown, 2019, p.83; Lebeuf, 1957).

Unlike Daubenton, his successor, the Portuguese malaria expert Francisco Cambournac (1954-1964), was unanimously appointed due to a prior consensus reached between AFRO

and CCTA members (Lobo, Monteiro, 2016, p.135-137). Cambournac's appointment fit into a pattern regarding WHO and most of its regional WHO offices, which at the time were led by epidemiologists. Trained in Portugal, he was involved in projects for malaria eradication and control with the support of the Rockefeller Foundation during the interwar years and became a member of the WHO expert committee on malaria in 1948. He carried out a tour of African territories in 1950 to evaluate malaria policies and programs; while dominated by epidemiological considerations, these also addressed economic conditions, agriculture, nutrition, education, social well-being, and the raising of health standards (Cambournac, 1950). Favoring improved coordination of epidemiological interventions while working closely with colonial powers and governments, AFRO promoted inter-territorial collaborations, the first of which (a malaria pre-eradication program encompassing Mozambique, Northern Transvaal, the Bechuanaland protectorate, Natal, Swaziland, and Southern Rhodesia) was launched by WHO-AFRO in 1959.

Against the background of the Cold War era and driven by technological optimism, 'technical assistance' became the watchword for developmental inputs centered on selective transfers of technology and scientific expertise in an allegedly "depoliticized" framework (Cueto, Fee, Elizabeth, 2019, p.62-85; Amrith, 2006, p.85-87). Globally, the successful implementation of innovations in treatment and prevention was guided by a strong biotechnological optimism, which contrasted with a declining focus on social medicine on the multilateral international stage in the 1950s. Strong international pressures against WHO involvement in family planning projects were to circumscribe activities in the politically sensitive domain of reproductive health (Farley, Brock, 2008, p.111-123).

Parallel regional health diplomacy: the CCTA and AFRO

In 1950 South Africa – seconded by Liberia which was not a CCTA member – formally proposed the creation of AFRO after having been recommended at the first World Health Assembly in 1948 (held shortly after the general elections which brought the Nationalist Party to power), favouring a "cautious" approach to regionalization (Union of South Africa, 1950). Nevertheless, over the next decade, AFRO's program would come to include common technical services related to epidemiological and public health surveys and statistics, drug standardization, publications, and training fellowships and technical advisory services for malaria, tuberculosis, venereal diseases, environmental sanitation, nutrition, and maternal and child health. The introduction of new technologies for disease control and eradication, including antibiotics, vaccines, and diagnostic tests, helped shape the efficacy of services and mass medicine for African populations in a region with high child and adult morbidity and mortality rates. Innate or acquired infant or adult immunity among African populations was still the subject of heated debates (for example, in the case of malaria) and led some to doubt the need for control efforts, while others favored technological interventions for vector eradication (Webb, 2014, p.62-68, 74-78); these discussions posed serious challenges for rural public health interventions (AFRO, 31 Jan. 1951).

AFRO's mandate was broad, promoting preventive medicine as well as vertical control programs, harmonizing health standards, providing expertise and training programs, and

improving regional coordination of health services within a multilateral framework. The second report of the WHO Expert Committee on Public Health Administration, created in 1951, proposed implementing planning methods for integrated community health programs in rural areas, based upon community and family surveys to assess local health needs (WHO, 1954). While community development was agreed upon as a common goal, no working consensus was reached for polyvalent rural health centers in the region, given that applying a model for their organization was inadvisable: "There [was] no one answer for the whole of Africa" (AFRO, 1957, Annex III, p.4). The still embryonic science of health administration would only gain greater momentum in the 1960s following the failure of the global campaign to eradicate malaria. From its inception, AFRO was faced with daunting challenges to reduce the burden of endemic communicable and non-communicable diseases and their impact upon child and adult morbidity and mortality, while contributing to improvements in the overall well-being of African populations, most of whom were still living under colonial rule.

During the 1950s, in collaboration with other UN agencies such as UNICEF and FAO, AFRO promoted maternal and child health and nutrition surveys, improvements in rural and urban health services, environmental sanitation, provided grants for auxiliary medical training and nursing and expert services for tuberculosis, smallpox, malaria, yaws, onchocerciasis, schistosomiasis, and leprosy control. WHO-AFRO also funded (inter-) country programs for vertical disease control and eradication, including the training of local staff and educational programs (WHO-AFRO, 1951-1965). In providing expertise for national programs, WHO-AFRO recognized the need for greater coordination of research, planning, and implementation of joint projects in the region. However, progress was nevertheless slow and uneven owing to a lack of consensus on interventions (AFRO, 1951, 1956, 1962) and parallel diplomacy within AFRO and CCTA, while AFRO's planning capacity remained "extremely limited" until decolonization of the region set in (Manton, Gorsky, 2018, p.434-435; Webb, 2014, p.74-82).

The emergence of CCTA in 1950 with its secretariat in London led by the French diplomat Jean-Paul Henry, was inspired by the desire of the colonial powers (Britain, France, Belgium, Portugal, as well as South Africa) and associate member (Southern Rhodesia) to coordinate, control, and legitimate bilateral forms of technical cooperation and assistance in sub-Saharan Africa. Based on Anglo-French agreements signed from 1945 onwards and limited funding from colonial powers (Pearson, 2018, p.169), CCTA aimed to provide low-cost technical assistance in a variety of domains including health, while opposing "interference" from interests considered "foreign to the African continent," including UN organizations and Cold War protagonists (Henry, 1953, p.308). The Scientific Council for Africa South of the Sahara (CSA), which was established in 1950 in Bukavu (then Belgian Congo) and functioned as a liaison center for a network of expert panels and sentinel posts, advised CCTA on scientific matters and facilitated the exchange of epidemiological data (Ágoas, Castelo, 2019). Following pre-First World War and interwar initiatives to combat sleeping sickness, the "colonial disease" *par excellence* (Lyons, 1992), an International Conference on Tsetse and Trypanosomiasis was held in Brazzaville in 1948, with the participation of French and Belgian governments. This resulted in the establishment of new sub-agencies centered on research, such as the

Permanent African Bureau for TseTse and African Trypanosomiasis (ISCTR) in Léopoldville and the Permanent Inter-African Bureau for TseTse and African Trypanosomiasis (BPITT) in Brazzaville in 1949 (De Raadt, Janin, 1999). Rapid developments with regard to regional collaborations on sleeping sickness clearly set it apart from the approach to other diseases (Lachenal, 2017, p.55). The priority given to sleeping sickness in CCTA/CSA was an enduring legacy of empire which legitimated a regional view of “African” epidemiology, contrasting with WHO-AFRO’s global perspective.

The discussions held in CCTA on establishing a WHO Regional Office revived lingering differences of opinion which had already surfaced during interwar meetings. From the outset, colonial powers were well aware that CCTA was a “wholly white organization” and could be seen as “resentful to the entry of AFRO in its field of operations” (Pirie, 1950, p.2) Political changes on the continent accentuated divisions related to multilateral cooperation in the region, between the generally more favorable position of Britain and its associated members on the one hand and France and Belgium on the other. While generally siding with the latter “group,” Portugal sometimes played an ambivalent role, also owing to the presence of AFRO’s Portuguese director, Francisco Cambournac (Havik, Monteiro, 2020, p.307-308).

Colonial perspectives towards the role of WHO-AFRO in the region were associated with guaranteeing access to WHO funding for technical assistance while endeavoring to control or mediate disbursements through overlapping membership of AFRO and CCTA. While this position was largely consensual among member states, with the exception of Liberia, the attempt to use CCTA to partly supplant or replicate AFRO was not. In this respect, Britain, Southern Rhodesia, and South Africa favored a cooperative stance and avoiding duplication from the outset (Pirie, 1950), while France, Belgium, and Portugal preferred to carve out a parallel route for CCTA (Havik, Monteiro, 2020, p.304; Pearson, 2018, p.85-88). Portugal was supported by France in proposing that an African Sanitary Bureau (ASB) be established, “which might in due course enter into some kind of relationship with the WHO and take the place of a WHO African Regional Organization” (Reed, 1950; CCTA, 1951). These discussions laid bare “alternative conception[s] of medical cooperation” (Pearson-Patel, 2015, p.216) or different regionalisms (Bonoho, 2019) among colonial powers which were to play an important role in shaping parallel regional health diplomacy in the African region after 1945 (Pearson, 2018, p.67-88). Equipped with a limited mandate, the ASB was expected to facilitate collaborations between colonial powers on control of endemic diseases and exchanging epidemiological data and scientific studies. Operating in a bilateral format, its setup reflected an approach based upon regional sanitary conventions rather than the LNHO model originally proposed during interwar exchanges. Although the idea of creating the ASB was floated in different versions by Portugal, France, and Belgium at various CCTA meetings until the early 1960s and a working group was set up to discuss the issue (Henry, 6 Feb. 1955), the latter failed to produce a consensus.

Successive gentlemen’s agreements in 1951, 1954, and 1958 between different CCTA secretary generals and AFRO directors aimed to distribute tasks and topics in order to avoid duplication while agreeing on joint activities in certain areas. They established a tentative division of labor between CCTA and AFRO in the epidemiological sphere, which sought to legitimate CCTA expert networks on sleeping sickness, leprosy, treponematoses,

schistosomiasis and tuberculosis *vis-à-vis* WHO-AFRO. However, no clear agreement was reached for cooperation in the broader domain of public health or regional health projects, which allowed ample margin for duplication and maneuvering. Similar situations occurred with other UN agencies such as UNESCO, FAO, and ILO (Ágoas, Castelo, 2019, p.415-416). In the 1950s, inter-African meetings on medical cooperation promoted by the CCTA (which revived interwar encounters) therefore operated in a gray area, largely aligned with perceived national and colonial priorities (Mertens, Lachenal, 2012). Owing to parallel diplomacy, selective engagement and “inter-imperial hierarchies of prestige” (Coghe, 2014, p.137), progress in terms of inter-territorial collaborations remained largely limited to the exchange of epidemiological data and informal collaborations between health officers. By the late 1950s, this type of colonially inspired health diplomacy was overtaken by AFRO’s initiatives, which gained greater breadth, depth, and impact with decolonization and the adherence of newly independent states.

Inter-African conferences on medical cooperation

Efforts to relaunch the process of closer medical cooperation in Africa began with the Accra Conference in 1946 in which high-ranking medical officers from Britain, France, Belgium, and Portugal participated, as well as technical representatives from West African colonies. It recognized the need to organize study tours or “technical expert visits” and further exchange of information between territories and laboratories, reminiscent of collaborations during the interwar years, was reiterated at the meeting. It also recommended joint action on the control of infectious diseases, a topic which would serve as a thread for follow-up meetings (Henry, 17 Dec. 1955). An Anglo-Franco-Belgian meeting held in Paris in 1947 served to establish the *modus operandi* of regional medico-technical cooperation, proposing the coordination of regular meetings on African soil and inviting other concerned countries to join in. The first sub-regional meeting of directors of health services for East and Central Africa was held in Nairobi in 1949. Follow-up Inter-African Conferences on Medical Cooperation (IAMC) under the auspices of CCTA were held in Dakar (1951) and Léopoldville (1955). These meetings were prepared by high-ranking officials of the member countries’ foreign and colonial ministries to guarantee alignment with colonial political priorities. As a result, the more centralized approach followed by France, Belgium, and Portugal compared to the more delegational path pursued by Britain and its associated members came to the fore, eliciting contrasting contributions on local and regional dimensions.

The second Conference in Dakar in 1951 recommended continuing where Accra left off, while imposing a more rigorous schedule for cooperation, scientific exchanges, and studies on a variety of endemic diseases such as tuberculosis, polio, rabies, filariasis, and schistosomiasis. The Conference on Indigenous Medical Training focused on medical and paramedical auxiliaries and coincided with the IAMC, and was attended by representatives from territories administered by Britain, France, Belgium, and Portugal; it also included three African health officers from Sierra Leone and Nigeria. Liberia was absent from the Dakar meeting, although it included representatives from AOF, AEF, Belgian Congo,

Cameroon, Gold Coast, the Gambia, Nigeria, Portuguese Guinea, Sierra Leone, Togo and Uganda, and aimed to build upon the recommendations made at the Accra meeting. To this effect, it endeavored to extend the scope of periodical exchanges between health officers and synchronize and harmonize control and vaccination campaigns against infectious diseases, i.e. yellow fever, smallpox, rabies, tuberculosis, meningitis, syphilis, and yaws. Along the same lines, it also proposed funding medical training and internships on tropical diseases and nutrition, and research visits to neighboring territories, which had been proposed for the Nairobi meeting and would soon be promoted by AFRO. The British, French, Belgian, and Portuguese delegations reiterated that the medical and social problems in their respective territories were identical and that common approaches could be found, a statement reminiscent of those made during interwar meetings. Close relations between the different echelons of services and personal contacts between health officers were to be encouraged, along with sub-regional encounters (CCTA, 6 Oct. 1955), a possibility already considered at the second Cape Town meeting.

Discussions on cooperation were essentially circumscribed to ongoing technical interchanges between health services along common frontiers for prospection, control, and monitoring of populations to assess the prevalence and incidence of endemic diseases (Bolle, 1951). Presentations singled out successful Anglo-French (Gold Coast-AOF; Nigeria-Cameroon), Franco-Belgian (AEF-Belgian Congo), and Luso-Belgian (Angola-Belgian Congo) collaborations in frontier areas on mapping and combat against human African trypanosomiasis, as well as joint campaigns against smallpox, yellow fever, and BCG vaccinations (CCTA, 1954). Nutrition and diseases related to malnutrition (such as kwashiorkor) were also discussed, as were improvement of indigenous diets and diversification of food crops. The meeting, which essentially consisted of presenting “national” programs for disease control and surveillance, aroused particular interest given the presence of African health officers. One of the Nigerian delegates remarked upon the “historic date” in which “for the first time Africans participated [in a medical conference] on a totally equal footing” (Manuwa, 24 May 1951a, p.1). The director of Nigerian medical services at that time, Samuel Manuwa, was the first African to head a colonial delegation to an AFRO meeting (in Monrovia in 1952) while also serving as the only African member on the WHO Expert Committee on Public Health Administration. Manuwa obtained his medical training in Britain and was appointed head of the Nigerian health services in 1951, and was instrumental in establishing the Ibadan Medical School in 1957 while acting as a strong advocate for improvement of rural health planning to serve African populations. Accounting for half of the British delegation, such African contributions stood out for their critical assessment of health services and the limited cooperation with neighboring territories, while also casting a less favorable light on other services such as the French and Portuguese. Underscoring inadequate facilities, personnel, training, and funding in Nigeria, Manuwa lamented “the blind adoption of the curriculum taught at the University of London” in Nigeria’s medical schools, rather than a “local program based upon the real needs of the country” (Manuwa, 24 May 1951b, p.136).

The third meeting held in Léopoldville in 1955 included delegations from Britain, France, Belgium, Portugal, South Africa, the Federation of Rhodesia and Nyasaland (FRN),

the Gambia, Gold Coast, Nigeria, and Sierra Leone, then still under British jurisdiction; Spain, Italy, Liberia, Sudan, WHO, and UNICEF sent observers. It followed a meeting in Léopoldville attended by experts from Belgium, France, the UK, Portugal, South Africa, and the FRN, who (among others) discussed the French proposal for an Inter-African Health Bureau to exchange epidemiological intelligence, which met with strong opposition from Britain and the FRN (CCTA, 1954). Discussions were more compartmentalized than at the Dakar meeting, owing to the presence of numerous epidemiologists and colonial health officers based in the different territories. Although some progress had been achieved in the different territories in terms of health coverage, issues such as controlling inter-territorial migrations, synchronizing vaccination campaigns, and regionalizing inter-territorial medical cooperation needed to be addressed. Delegates voiced their disappointment with the lack of sustained progress in regional cooperation between health services, which largely depended on personal rather than institutional relationships; shortages and rotation of personnel tended to hamper these exchanges. To this end, sharing knowledge and resources to combat communicable diseases, joint disease control campaigns, preventive measures against smallpox and yellow fever, and joint prospecting in frontier areas were recommended, whereas common procedures were to be adopted for preparing and implementing joint projects. These surveys were expected to focus on neglected diseases such as hookworm, onchocerciasis, treponemal diseases (such as syphilis and yaws), leprosy, tuberculosis, and amoebiasis (CCTA, 6 Oct. 1955). Representatives from Nigeria, the Gold Coast, Sierra Leone, and the FRN observed that few bilateral agreements had been concluded or were operational with neighboring territories, and that collaborations were generally based upon “administrative arrangements” which were “non-official” in character. In the meantime, these territories had developed close ties with WHO and AFRO in terms of provision of external technical assistance while maintaining close inter-territorial ties (CCTA, 27 June 1955).

While the French delegation acknowledged that medical cooperation was still in an “embryonic stage” and that joint action was only facilitated in the case of epidemics, it was satisfied that decisive steps had been taken (CCTA, 15 July, 1955, 2 June 1955). Although this was acceptable to some, such as their Belgian counterparts, for others the lack of progress had become a sign of failure of CCTA-led conferences. The Portuguese delegates took an intermediate position, concluding that CCTA had “not lived up to expectations” and that “duplication with AFRO should be avoided” (Azevedo, 1955, p.13). British internal memos reveal that associated (Anglophone) members were not impressed by the Léopoldville meeting and preferred to work with UN agencies such as WHO and UNICEF. Indeed, there was a growing need to resolve practical issues (CCTA, 7 Feb. 1955), and territories such as the Gold Coast and Nigeria that were soon to gain self-determination, “much prefer to deal with WHO than with the CCTA” (Bourn, 1956). Hence, initiatives taken following the meeting, “could have been done equally well under aegis of WHO.” British officials attributed the lack of progress to French and Belgian “antipathy towards the international agencies” and “to build up CCTA into a large controlling body.” The idea to create an Inter-African Health Bureau “was put into cold storage” owing to the failure of the Léopoldville meeting (Bourn, 1956). Successive attempts to transform the BPITT into the aforesaid

Bureau – which were no coincidence given the exceptional regional status attributed to sleeping sickness by colonial regimes – were eventually abandoned (Cheysson, 1960).

While the CCTA welcomed closer cooperation with AFRO (despite ignoring the outcome of the Léopoldville meeting), subsequent meetings of this body acknowledged the lack of progress in inter-territorial medical cooperation (CCTA, 1957). By the time the Fourth Inter-African Conference on Medical Cooperation was set to be held in Luanda in 1961, the region was in the throes of decolonization. The conference, which was eventually cancelled (Soares, 1962), had been scheduled to coincide with the 13th meeting of the AFRO Regional Committee in Brazzaville, illustrating the attempt to synchronize agendas between AFRO and CCTA (CCTA/CSA, 1961). During the 1950s, joint CCTA-WHO/AFRO symposia were held on a variety of topics including communicable and non-communicable endemic diseases, public health, training, research, and standardization. The four inter-African meetings on nutrition held in Dschang (Cameroon, 1949), Fajara (The Gambia, 1952), Luanda (Angola, 1956), and Douala (Cameroon, 1961) were largely spearheaded by external experts from UN agencies such as FAO and WHO. Two Inter-African Conferences on Rural Welfare held under CCTA auspices in Lourenço Marques (Mozambique, 1953) and Tananarive (Madagascar, 1957) remained largely inconclusive, and while they focused on community development, only passing reference was made to “rural hygiene” (CCTA/CSA, 1957). By the early 1960s, multilateral cooperation in health in the region conducted via WHO and AFRO had greatly expanded, focusing on strengthening of public health services, health planning, education and training, joint vertical programs (e.g. malaria, leprosy, tuberculosis, smallpox, onchocerciasis, schistosomiasis, yaws and trypanosomiasis), environmental health, community development, and urbanization (Manton, Gorsky, 2018, p.437-440; WHO, 1962, 27 Dec. 1962).

Over the space of a few years, these organizations had become increasingly Africanized: by the early 1960s, 18 African states had joined CCTA and AFRO and formed the majority of members, thus radically altering the balance of power within them (WHO, 1968, p.3). One response to these changes was CCTA’s founding of the Foundation for Mutual Assistance in Africa (FAMA) in 1958, coinciding with the UN’s establishment of the Economic Commission for Africa, which had been delayed by colonial powers. FAMA’s health related activities centered on joint projects with European funding related to epizootics (e.g. rinderpest and trypanosomiasis), nutrition, training of laboratory staff, and mapping disease vectors (UNECA, 1958; CCTA/CSA, FAMA, 1961, p.10-11, 16, 38). While true to the CCTA’s philosophy, by proposing the funding “new bilateral forms of cooperation” to provide “technical assistance of an apolitical character offered without any [outside] interference” (CCTA, 1961, p.16), this constituted a belated effort to respond to developmental concerns from independent African states which had little relevance to cooperation in the sphere of public health.

The founding of the Organization of African Unity (OAU) in 1963 in Addis Ababa heralded a new era in inter-African political relations and a reassessment of inter-African institutions and relations. At the OAU’s first meeting, its members recommended greater cooperation in health, sanitation, and nutrition. The main items listed in the OAU’s program for future cooperation look remarkably familiar, and included exchange of

information on endemic and epidemic diseases and their control, exchange of medical, nursing, and technical personnel, and provision of reciprocal scholarships and training on health, sanitation, and nutrition. However, the overriding emphasis was now placed on human rights in line with the UN conventions, raising health standards among African populations and conducting research on how to improve them. The African states also declared that the CCTA's role would be reconsidered "within the overall context of Pan-African Co-operation" (OAU, 1963, IV). Eventually, after a complex and tense transition period, CCTA/CSA was formally integrated into the OAU as its Scientific, Technical and Research Commission in 1965, which played a limited role in the organization's affairs (Gruhn, 1971, p.467). An agreement was subsequently reached between WHO and OAU in 1969 to coordinate activities in the fields of public health, sanitation, and nutrition.

Final considerations

The debates on regional cooperation in health in sub-Saharan Africa were marked by four major cataclysms over the space of three decades: First World War, the Spanish Flu Epidemic of 1918, the 1929 economic crisis, and Second World War. Despite their implications for public health, sanitation, nutrition, health education, and social well-being, these issues were slow to translate into debates on African soil. Lacking an institutional framework, the LNHO's efforts to promote multilateral cooperation in health in Africa were notably less successful than in Asia, but to some it did appear to be a potential benchmark for cooperation *vis-à-vis* limited bilateral interactions. The foundations for post-1945 health diplomacy and cooperation in Africa were thus laid in the interwar years, giving rise to the different approaches to cooperation in health identified above, based upon bilateral Sanitary Conventions and the multilateral LNHO model. These would continue to operate in the region after 1945, albeit in adapted and sometimes hybrid versions.

Developmental and welfarist perspectives and the internationalization of health would impact their trajectories and underline the limitations of the CCTA's benchmark, i.e. colonial medicine. The CCTA experience illustrates a rather patchy progress in bilateral collaborations beyond the exchange of epidemiological data and informal interactions, owing to imperial and nation-centric approaches. The CCTA's selective engagement with certain pathologies represented areas of "colonial" expertise and existing vertical programs, reflecting the African territories' external dependence upon technical assistance. However, parallel diplomacy also affected the broadening and intensification of multilateral cooperation in public health in WHO-AFRO until new African states entered the fray in the 1960s. Crucially, disagreements on the way forward were not limited to "medical cooperation" but also related to scientific dimensions: while Portuguese, French, and Belgian delegates advocated the notion of African exceptionalism, their Anglophone counterparts argued for a global understanding of epidemiology. Fundamentally disagreeing with the "separation between a worldwide and an African point of view", the British delegate Wilson Rae emphasized that "there were no watertight compartments" (CCTA, 1953, p.3). The CCTA's attempt to keep UN agencies at bay and the colonial refusal to adopt a global health perspective were based upon notions of African specificity; without it, in the words

of its general secretary, Jean-Paul Henry, “our inter-African cooperation would be without meaning” (CCTA, 1953, p.3).

Far from merely acting as a body for “limited technical and scientific liaison and coordination” in the region (Gruhn, 1971, p.461), the CCTA challenged the global interconnectedness of health and disease. At the same time, it privileged vertical concepts of disease control tailored to African populations, epitomized by the sleeping sickness programs which had already been implemented in the interwar years and were based upon population management and control, to the detriment of rural public health and socio-medical interventions. As the “difference between gathering and disseminating health information and resolving problems on the ground” became increasingly patent in the 1950s (CCTA, 7 Feb. 1955, p.46), “inter-African” exchanges became superfluous (even before the decolonization process set in), while broad multilateral forms of cooperation gained momentum in a rapidly changing regional and international landscape.

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