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Private Biomedical Practice in Black Africa before the French Colonial Occupation

Natéwindé Sawadogo*

Institut Universitaire de Formations Initiale et Continue, Université Thomas SANKARA, Ouagadougou, Burkina Faso

*Corresponding author: natewinde.sawadogo@yahoo.fr

Abstract

African medical historians have tended to focus their interest on colonial state organized medicine, at the expense of colonial private provision of medical services. This situation opens up the need for exploring the private practice as a contribution not only to shedding new light on the official account of French colonial medical assistance in Africa, but also to understanding the current challenges of health systems in former French colonies. In France, the movement for the occupational control of labor of professionalism in the area of health began in early nineteenth century, and was authorized around the end of the same century. This process could not ignore medical practice outside France, from the time of overseas territories up to the colonial occupation at the end of the nineteenth century. It is known from travelers' accounts, the literature on the French empire as well as from some incidental mentions in historical accounts on the development of health system in French overseas, that private practice initiated French medicine overseas, and that it was lucrative. It is also known that competition between different occupational groups for status in the area of health was fierce in France until the end of the nineteenth century, and even beyond. Surprisingly, archives on private medical practice in French African colonies are virtually unavailable.

African medical historians have therefore tended to focus their interest on the colonial state organized medicine about which archives have been made available. As for sociologists and anthropologists, they have remained largely silent about the topic. This paper sets out to explore, through the scanty available archives and secondary data, the situation of private medical practice in French African overseas at the end of the nineteenth century, when African territories fell under French colonial domination. This understanding, which draws on eliasian figuration analysis, is relevant for a better appreciation of the development of private medical practice during the following sixty years of colonial occupation, and even beyond.

Keywords: *French territories; Western Africa; medicine; private practice; colonial medicine*

1. Introduction

Until the 1980s, the topic of private health care in Sub-saharan Africa was virtually absent in both policy and academic discourses. It is from the early 1990s that policy-makers began to pay attention to the topic, with particular interest in two main issues. One of the issues of interest is developing countries governments' spending in health services [1-3]. The other interest is regarding the type of reform to be undertaken in order to reduce this spending [4-7]. Another corollary interest is how patients themselves could bear the cost, and how new providers could emerge as a response to the withdrawal of the state from financing and provision of health care services [8-12]. These policy issues resulted in a shoring of academic literature revolving around the same topics [13-16]. Despite of this increasing interest, a recent case study in South Africa still remark that "While much is known about how the public system operates, little work has been conducted on the private sector, perhaps not surprisingly in a profit-oriented, proprietary system"[17]. The situation is hardly different about most of Sub-Saharan countries [18-19], in particular when it comes to private biomedical practice in colonial time. This paper sets out to explore the following question: What evidence exist about private biomedical practice in French overseas settlements before 1900? How this development can be explained? The aim is of two folds, namely to: 1) identify evidence of private biomedical practice in the French overseas settlements, 2) analyze the process of integration of private biomedical practice in these settlements into the overall institutional framework of private biomedical practice in France.

The recent development of interests among policymakers and academics gives the impression that private biomedical care provision is a recent phenomenon in Africa, to the extent that all actors at the different levels of society would be called to engage in new socializations. A tradition of writing has so far unfortunately supported such a view. Indeed, for a long time, African medical historians have tended to focus their interest on the colonial state organized medicine. This literature has particularly focused on colonial medical policy [20-25], or as in [26], on the institutional development of the professions of colonial medicine. What is more, it has been produced from a traditional historical approach that makes medical Heros the topic of analysis. A few theses have consisted in case studies on the history of a particular health profession [27-29]. Although these studies are useful to pin down indirectly the development of private medical practice, this latter does not constitute an interest for them. In very rare cases, the interest in the impact of colonial health systems on African indigenous ones have led some, like [30], to address some moral questions that resonates with questions on the corporate interest of colonial health professionals. This is particularly the case with Lapeyssonie [31], whose book, entitled *La médecine coloniale. Mythes et réalités*, one of the earliest writings on French colonial medicine, studies the moral aims and performances of colonial doctors in the French colonial empire by demonstrating their altruism. Typically, this book is all about what the present paper tries to challenge, both in the scholarly as well as in the official account of colonial medicine -particularly the French one. Indeed, although the author rejects the use of the term, "Colonial Medicine" is a distinctly "colonialist" book. In fact, the author is one of the fervent players in the French colonial enterprise. Specialist in issues of Exotic Pathology and Tropical Hygiene, Dr. Lapeyssonie has served in Upper Volta, Dahomey and Vietnam. Also, in India, he held the Chair of Hygiene, as Director of the School of Medicine and Chief Physician of the General Hospital of Pondicherry. In addition, he was a physician-biologist of the Hospitals of France's Overseas, and member of the Society of Exotic Pathology of Paris, of the French Society of Microbiology, and Fellow of the Royal Society of Tropical Medicine and Hygiene of London. He was also a teacher at the Overseas Troops Health Service Application School. His involvement in such a relatively homogeneous social network helps to understand the position he defends in his work. The work, from our point of view, is also colonialist in that it sets out to magnify the work of colonial doctors and the administrative framework which served as its cog. Finally, the work appeared in a specific theoretical context unfavorable to a perspective different from that used by the author [32-33].

Chapters 4, 10, 11, and 12 of his book provide a clearer content of the altruistic "motivations" the author attributes to colonial physicians. The first describes the sanitary problems in the colonies which are the "pestilential diseases" such as Malaria, typhus, cholera and yellow fever, and especially the "fevers" which caused a very high mortality. Among these diseases, malaria and yellow fever in particular, "killed whites and bothered blacks" (p.40). Smallpox, plague, leprosy, and cholera were devastating especially among blacks. Colonial doctors would have intervened as liberators in this social chaos. In chapters 10 and 11, the author provides his proof of this "altruism" of the colonial doctors, who, like their contemporary representatives such as the agents of French humanitarian cooperation, treated whites and blacks. In Chapter 12, the author makes his recommendations based on his belief in the colonial experience. The author ignores the role of traditional practitioners, who nevertheless occupied a significant place [24]. Lapeyssonie does not mention either these so-called deaths by “accidents” which occurred during the treatment or experiments of colonial doctors [34]. It also does not assess deaths (especially due to acts of witchcraft) that the ban on traditional indigenous practitioners and the weakening of the powers of chiefs by the colonial administration would have favored [35-36]. The figures on health development provided by the author are the consequences of a process, but in themselves they do not inform us either about the motivations of the actors around whom the author builds his argument, nor about the means that these have used to achieve the results described. However, without these dimensions one cannot assess the "altruism" of colonial doctors. Yet, from our point of view, it appears possible to locate certain traces in the book to allow such an analysis.

The book opens with a methodological chapter (Chapter 1), where the author defines what he means by "colonial medicine". The term "colonial medicine", which he chooses to use, would be more appropriate for his purpose, despite the apparent contradiction between the two terms: "one perceived as noble and altruistic, medicine, the other imprinted with the dubious smell of Colonial times” (p.8). For him, what should rather be understood by “colonial medicine”, and not “colonialist”, “[it is] the set of technical procedures associated with the corresponding administrative actions which gave to the practice of medicine to the Colonies its very particular character” (p.8); it was born with the legal organization of the colonies, and disappeared with independence, between 1956 and 1960. Its birth met a need, and its disappearance the end of that need. So what was this need? The author agrees that it was to maintain the health of the military in preparation for the colonial conquest, to take care of the Europeans living in the subjugated territories. However, he rejects the view which maintains

that the care given to the natives was intended to provide labor. This idea is the most interesting, but also the least developed in the book, that is to say, the least exploited in the construction of the problem and in the analysis. Indeed, it reveals the restrictive nature of the use of colonial medical expertise by politicians. This constraining character of human interrelationships has, however, been neglected until now by the sociology of professions. The fact that the idea is not developed reflects a conceptual weakness, and makes it possible to understand the author's interpretations of the moral orientation of colonial doctors. The author tends to isolate the latter from the social structure that founds the utility of their expertise, as if, to take a similar field, one could understand the artistic field of the Ancien Régime Français without linking it to the social structure of the corresponding society [37-38].

The author's definition of colonial medicine has two dimensions: "technical procedures" and "administrative actions". What makes the colonial specialization of medicine, therefore, is not only a body of knowledge relating to a field of knowledge in the colonies, but also its social and economic organization through a specific administrative framework. It is particularly through Chapters 2, 3.7, and 9 that this administrative dimension is addressed. In these chapters it is the film of the establishment of the health administrative apparatus which is unrolled, going from the very first rather loose organizational forms in Canada, the Caribbean and around the trading posts on the African coasts, to the forms organization developed from the first decade of the 20th century, particularly with regard to Africa. The author refers to the particularity of the organizational dimension to qualify only the medicine that it organizes. Yet colonial administration as an organization is only the embodied structure of values of colonial power. Without more details on its foundations, means and goals, one cannot assess the benefit of health outcomes for colonized people, as well as the moral conduct of physicians.

It is interesting to examine how the author establishes the correlations between the technical and administrative apparatus and their beneficial effects through chapters 5, 6, and 8. The author makes the emergence of an esprit de corps of colonial doctors coincides with the creation of the School of Application of the Health Service of Colonial Troops (Pharo), which received its first students on February 1, 1907. For the author, with this school, "colonial autonomy is (finally) carried out. The tool is now forged "(p.93). It offers theoretical courses and practical work, adapted to the constraints of tropical colonies. These teachings are led by an experienced teaching staff, nourished by medical discoveries in the tropics. This would have resulted in the development of a technically and morally homogeneous body. According

to the author, the physicians from the Pharo are distinguished from the health personnel who dealt with the health of the colonists and the navy between 1664 and 1722. The latter had only received empirical skills from their corporations. Here the author makes a partisan selection. He reduces the group of which he speaks to only those leaving the Pharo. However, not only were doctors not the only practitioners, but also civilian doctors served in the colonies and these did not always go through the Pharo. It would therefore be methodologically inadequate to match the motivations of this composite group, but also, it would be inappropriate to claim to understand a professional segment without putting it in touch with its competitors. This is important in the sense that, outside of the colonial administration, the author ignores the regulatory organization. Even with regard to the colonial administration, it is not clear how the author understands its modes of regulation.

The recent literature on private medical practices in Southern Africa challenge this humanitarian discourse around medical practice during European colonization of Africa. By embracing the sociological concepts of professions, some African historians described the rivalries and tensions involving biomedical practitioners for market control during the colonial time. In their edited book [40], it is shown how the history of the biomedical profession was inseparably interwoven with the political history of the Cape in South Africa, the balance of power between practitioners, and the balance of power within the general social system. Beyond a binary distinction of indigenous healers and medical doctors, the book maps the ecology of healing services in the region and shows how medical doctors came to secure its monopoly. As Deacon has underlined it, although the authors admit that biomedicine offer therapeutic advantages compared to other therapies,they question the often-stated corollary that alternative therapies are unscientific, and that biomedicine is, almost by definition, more efficacious. As is stated, “What we wish to suggest in this volume is that the advancement of the biomedical profession at the Cape during the nineteenth century had less to do with therapeutic efficacy or preordained superiority than with political and socio-economic factors.” [39]. The healing market was disparate in terms of gender, class, race, and the competition was not only between African healers, and western, but within the biomedical occupation itself, there was strong rivalries around technical but also social identities (e.g. British occupation registration of foreign (non-British) medical doctors was severely restricted). According to Deacon, “until the last quarter of the nineteenth century western medicine had secured state support for the monopoly on legal practice as early as 1807, and it was this fact which allowed the profession to expand within both private practice and public

institutions in spite of the fact that most South Africans continued to consult traditional healers" [40]. The social history of the medical profession made by the authors goes beyond the traditional histories of a single powerful occupation, and tries to "understand the western doctor as only one group within a broader medical market" [40] with a legitimate use, though limited, of biographies. This resort to biographies, says Deacon, is "to enrich our analytical points rather than to provide a heroic history of the great doctors of the nineteenth century" [40]. Three unusual practices emerge from the book: a use of oral evidence, a social history of healing market, a social history of monopoly process and an explicit claim to break with great doctor histories. Xaba [41] has addressed in his thesis the demand, supply and regulation of indigenous medicines in Durban, South Africa from 1844-2002. In a context of limited technical arguments of competing healers, Seboko [42] has considered how segregation affected professionalization in South Africa 1900-1980. Flint [43], complementing her sources with oral history to explore the exchanges between healers in southeastern Africa from 1820s to 1940s. Her research "focuses on medicine as a site of power, contestation, and cultural exchange. Between the 1820s and 1940s, African healers transformed themselves from politically powerful women and men who threatened to undermine colonial rule and law into successful venture capitalists who competed for turf and patients with biomedical doctors and pharmacists in the major urban areas of Natal, Southern Africa" [43].

Based on these historical findings in Southern Africa, the present paper argues that in French West Africa private health care is constitutive of the health systems, and even predates public health care services. In fact, in France, the movement for the occupational control of labor of professionalism in the area of health began in early nineteenth century, and was authorized around the end of the same century. This process could not leave immune medical practice outside France, from the time of overseas territories up to the colonial occupation at the end of the nineteenth century. It is known from travellers' accounts, the literature on the French empire as well as from some incidental mentions in historical accounts on the development of health system in French overseas, that private practice initiated French medicine in overseas, and that it was lucrative. It is also known that competition between different occupational groups for status in the area of health was fierce in France until the end of the nineteenth century, and even beyond. This paper set out to examine, through archives and secondary data, the situation of private medical practice in French African overseas through to the end of the nineteenth century, when African territories fell under French colonial domination. This understanding, which draws on eliasian figuration analysis, is relevant for a better

appreciation of the development of private medical practice during the following sixty years of colonial occupation, and beyond. The paper is structured in the following. After this introduction, it addresses methodological aspects. Then, it analyses evidence and the conditions for the demand for private health care in, followed by the institutional set up for profit practice. The fourth section analyses the professional response to that demand. The paper ends with a discussion and concluding section.

2. Methods

This study adopts a qualitative approach, drawing on the conceptual framework of figurational sociology [44]. Figurational sociology builds on Elias innovative work on the European civilizing process from the Old regime to the Revolution. The institutional processes that the qualitative lens enable to understand are explored in accordance with a functional understand of social processes. In this regards, the first processes to be understood are those that are the basis of population movement beyond France. This resulted in the understanding that West African coats were among the most important French trading-posts from the seventeenth century up to the middle of the nineteenth century. It was in this context that in 1659 France established one trading-post at Saint-Louis (Senegal), and in 1977 it created another one at Gorée (Senegal). When the French was defeated in the hands of the British in 1815, its Senegalese trading posts of Saint-Louis was seized by the British, who returned it in 1817. In addition, between June and September 1843 France created three trading posts in Gabon (Equatorial Africa), Assinie and Grand Bassam in Ivory-Coast (West Africa). It occupied its old fort of Ouiddah (Benin) in 1863, which was abandoned following the abolition of the slave trade. Some of these trading-posts served first during the slave trade (e.g. Gorée, Saint-Louis, Ouiddah). After the abolition of slave trade, agricultural colonization was attempted in Senegal (Gorée and Saint-Louis) until the imperial colonization at the end of the nineteenth century. The itineraries to these locations as these locations themselves, become sites for inquiry. Setting out to trace doctors and the forms of transactions they interred during this processes require understanding the social, economic and political context of France. The study of this context is done through readings on French social and colonial history. Then, I will inquire into the security measures aboard ships and at the settlements, with the view to identify the role of health professionals in these and then examine the modalities of access to their services. This is done through reading on history of French colonial medicine, and on French medicine in general. This secondary literature

complemented an extensive and systematic archival search at the National Archives of Senegal, where most of the French colonial archives concerning West Africa are kept, covering the early seventeenth century to the end of the nineteenth century.

3. Results

3.1. The development of a Demand for Private Health care in French Western African Territories

The first forms of demand for private health care probably came from travelers and adventurers in search for new lands. The discovery of Western African coasts goes back to the middle of fifteenth century. Gorée is an Island of the North Atlantic Ocean on the bay of Dakar in Senegal, and was first known by the Portuguese thanks to the Portuguese navigator Dinis Dias, who reached Island in 1444, and named it “Palma”. Gorée was later taken hold by the Dutch France in 1617. Although based on voluntary decision, from the end of the century this demand was instituted by French political authorities. For instance, it was imposed a physician to Christopher Columbus during his first travel (1492). Then with the discovery of the new lands, the social and political transformations in France supported the development of overseas trade. Indeed, the sixteenth century constitutes a transitional period in the political centralization of the Old Regime of France. It witnessed the passage from a feudal society to an aristocratic society. The feudal society was characterized by exchanges in kind. The vassals chiefs of the king lived on incomes derived from their lands, which the king rewarded them for their services, especially military services. The hierarchies, headed by the king, were based on land property. In this social formation, the king was dependent on his vassal chiefs for his military enterprises. The form of economy reinforced this dependency as the vassals could develop their fiefs as to become relatively autonomous, and could even refuse to comply to the king’s request, unless forced. However, from the sixteenth century, the king made rank less and less dependent exclusively on the traditional rank of an estate. The rank constituted a royal distinction, generally as a reward for a military service, with less and less governmental functions.

By dissociating the title from the land, the king created new possibilities for recruiting warriors outside the landed nobility, creating thus a new larger of nobles. This process shows the increasing independence of the king from the old landed nobility. During this transitional phase, the nobility, including the king himself, remained essentially knights and warriors.

However, for the present purpose, the significance of the emergence of this aristocratic society in the sixteenth century is that the rewards in land were replaced by rewards in money. From the middle of the seventeenth century onward, the money economy was established, as a result of the development of commerce, urbanization, and centralization of the kingdom. The king thus witnessed the range of his source of income significantly extended. In addition to the produce of his lands, a large proportion of his income were made from raising taxes, selling offices, levy on the fortune of his wealthiest subjects through taxes, etc. As Elias put it, "Thus,from possessor and dispenser of lands, the king becomes gradually possessor and dispenser of money" [45]. While French kings' power increased in relation to the nobility because of the money economy, his relation to his source of income nevertheless became stronger. In other words the dominance of money as a mode of payment "considerably reduced their dependence on the feudal nobility but increased their dependence on money sources and the extensive network of which they were part" [46].

Two other corollaries resulted from this process which contributed to the increase of the king's power. On the one hand, the economic foundations of the feudal nobilities were undermined. The nobility was little involved in the commercial movement. They relied on their land rent. This rent was fixed. Unfortunately for them, as the mean of payment became larger, the value of money depreciated. This resulted in the raise of prices of commodities, including labor. The income from the product of their lands could not meet their expenses. Some nobility managed to enter the royal court's administration, but other lost their wealth in debt payments and fell into poverty. On the other hand the access to the title having become relatively open, the old low layer of the French society could then aspire to it through service to the kings, and those who had already the title of noble educated their descendent for the new positions they occupied. "Thus, the expansion of trade was impossible without an efficient protection of the trade routes by the State, without regulations providing security to traders, the one being dependent on the other. Without an army strong enough the kings could not operate the taxes levies, without tax revenues, they could not fund powerful armies." [45].

In 1659 France established one trading post at Saint-Louis (Senegal), and in 1677 it created another one at the Gorée (Senegal). The French settled in the Island in 1677, although deputed by the English. When the French was defeated in the hands of the British in 1815, during battle of Waterloo, its Senegal trading posts were seized by the British. They had been

returned in 1817, and France attempted an agricultural colonization to grow cotton and indigo. But the attempt failed, first (until 1821) because of the hostility of indigenous chiefs, and later because of unfavorable climatic conditions and soil problems. In addition, between June and September 1843 France created three trading posts in Gabon, in Equatorial Africa), Assinie and Grand Bassam in Ivory-Coast (West Africa). Besides, France occupied her old fort of Ouiddah (Benin) in the 1863, which was abandoned following the abolition of the slave trade in the 1840's. For further details on French presence in West Africa see [47-49].

In fact, before the abolition of slave trade (Denmark: 1802; Britain: 1807; France 1848; Brazil 1898) slaves were the only permanent commodity needed by European traders who settled on the African coasts. These traders provided slaves for the plantations of the Americas. The first recorded slave convoy to the French Antilles Islands forty Blacks from Senegal to Saint-Christopher in 1626 [50]. Other commodities such as ivory, gold, incense, animal for zoological gardens, plumes of ostrich, beeswax, honey, etc. were also shipped from African coasts; in particular gum Arabic was traded on the posts on the Senegal River, as "the gum was used in Europe to fix colors in the industry of painted canvases" [50]. This industry was booming in the eighteenth century. However as Crowder (1968:22) observed "[t]hese were but secondary to the main aim of trade with the West Coast: human cargo". However, as noted above, from the middle of the nineteenth century, slave trade was increasing losing its status as a legitimate trade. At the same time new commodities were receiving interest from both "legitimate" and slave traders. Palm oil was one of these. As Brunschwig [50] stated, "for the first time in his history, Black Africa became provider of an indispensable primary good, whose multiple uses did not stop increasing the demand in Europe.". Fat products were highly demanded in Europe because of the development of mechanization for use as lubricants. These products were first obtained from whale, fished at Australian seas. And towards 1823 extraction of vegetable oils became possible thanks to scientific researches. But compared to palm oil, these utilizations of these fat products were limited. With palm oil, scientific research identified different possibilities of utilization. For example it was used by to make soap, and before 1860, before the discovery of mineral oils, for lightening. Toward of the end of the century it was consumed as margarine. Around 1853, the French soap industry used oil extracted from the nuts of the palm oil tree and other vegetable oils, and later used the palm oil thanks to technological advances enabling its decoloring. Before this date, from 1845, peanut oil was also demanded. Nonetheless the English was the main consumers of palm oil

until 1870, as they imported about ten times more than the French. At the end of the nineteenth century rubber and other commodities such as cocoa, bananas, and mining products led Europeans to value Africa more. Scientific reports and travel reports of adventurers significantly contributed to heighten European interest in the interior of Africa. However, until the 1920s French trade involved mainly private companies.

Then in addition to the ships' crew, there were also the various passengers (merchants and others), who used health care services at calls of ports :

It is to be expected that the boats from the Dakar "L'Heraine" station in particular will more readily send their patients to the gorée ambulance where the daily fee for treatment for natives and non-officers is lower at the Dakar hospital [51]

As the settlements become more and more secure, this population increased, alongside the navy troops who were in charge of administrating these settlements. Only public health services (public hygiene, epidemic control, etc) were free of charge. Clinical services were paid even by navy officers. This is what I will later analyze as public privately managed health care services. These colonial administrators and some of the wealthiest colonist preferred sometimes even a private civilian doctor for more intimacy during sickness. Besides, until 1897 colonial navy officers' families were not received in navy medical facilities. They and the colonists who settled at the ports and later on the land, could only access medical treatment in private clinics. The Article 1 of a 1891's order states that "The wives and children of civil servants, officers and various agents of the State in service in the colony, will in the future be admitted to the maritime hospitals of St Louis and Gorée at the conditions of the tariffs applicable to the chief. of the family " [52]. Later this was extended to the African-french citizens and their families and the natives who could pay. A similar Order concerned the natives « The Directorate of Political Affairs informs the indigenous chiefs that those of their subjects who are ill will be received at the civil hospital in St Louis for the sum of 2 francs per day, the payment of which must be guaranteed by the chiefs. The Directorate of Political Affairs cannot urge sick natives too much to benefit from this favor which will enable them to find in all circumstances the care as skillful as they are devoted as their health requires " [53]

3.2. Institutionalizing private medical practice in French Western African territories

Before 1912, the year of the creation of the *Assistance Medical Indigène*, it was the provision of free health care that was an exception in French overseas territories and colonies. The common practice was that of fee for service. What appear as free public health care services was in fact paying state managed health care services. The institutionalization of this form of institutional paying health services goes back as far as the 1670s. Indeed, from 1673, one physician and one surgeon-major (chirurgien-major) were appointed to manage health issue, particularly public health issues, at the very first navy ports of Brest, Rochefort and Toulon have; in 1679 the measure was generalized to all ports, staffed by one First physician and one Second physician and six surgeons. Earlier on, this took the form of ships security measures. In the early fourteenth century, for example, Marseilles required that a barber be on board the passenger boats. The explorers were also the barbers' clients. For instance, Christopher Columbus was imposed one during his first travel (1492).

In January 1629, a code made obligatory the presence of a surgeon among the officers of every regiment of the Army; and in 1942, the code « instructed captains to take on board a very good surgeon for the care of the crew » [26]. In 1681, a further step was taken with Colbert's ordinance which stated that « any ocean-going ship of more than 36 people ought to take on board a surgeon (two if more than 50 people) whose competences will be controlled before boarding »[26]. In 1689, another ordinance went further than the 1681's and expand the functions, classes, relations of authority and fixe rates of payment per month for each category of health agent and according to the category of navy ships. The physicians sold his services on board before doing it on land, first in the metropolis, and then in all French settlements around the world. With the professionalization of navy medicine alongside increased colonial expansion, the institutionalization of for fee health care was then accomplished. From the early 1700s political authorities set up navy medical schools at the main navy port , such as Rochefort in 1722, Toulon in 1725, and Brest in 1731. This resulted in a significant increase in the number of permanent posts for surgeons and apothecary, although their numbers remained insufficient even in time of peace [26]. Before 1756, navy health officers appointed by the king represented 40% of the total ; between 1756 and 1763 this rate falls to 20%, and 11% between 1778 and 1783. At the beginning of the French Revolution of 1789, this rate was 20% of the total of the state funded navy health workers. Registration in naval medical schools were however high. This included also free attendant

students classed as « supernumerary » (surnuméraire), who would practice as civil surgeons in villages and towns. In Rochefort, for example, their number increased from 40, in 1740, to about 55 in 1756; and 120 around 1759, leading the authorities to reduce the number to 70, which was maintained until the Revolution of 1789. Pluchon [26] has shown that the low number of personnel despite the high registration at schools was due to desertion. The mean time of stay is five years, but a significant proportion, about one third, stayed less than a year. This provided a significant number of medical personnel for French overseas territories and colonies, that enable the setting up of a skeleton of public health organization. On the Senegalese settlements, for instance, before the 1880s, this organization comprised a Doctor in Chief, quartermaster, three councils (Health council, Health Commissions, Council of Hygiene and Public Safety).

The Art. 31 paragraph 2 of the Ordinance of September 7, 1840, states"Health officers and pharmacists not attached to the service can only practice in the colony by virtue of an authorization issued by the governor and after having completed the formalities prescribed by the ordinances and regulations" [54]. Until 1840, metropolitan laws applied to the colonies without modification or the need to be promulgated by an authority in the settlements territories or colonies. In this regard, in Senegal "the private practice of medicine and pharmacy was regulated by laws anterior to the Constitution of Year VIII [55], in accordance with the Ordinances of 1664 and 1696 of the Article 34 of the Ordinance of 28 may 1764 that prescribes that Ordinances legally published in France are enforceable in the colonies without requiring the need to be promulgated" [56] Interestingly, the Article 6 of the Constitution of Year III states that "the colonies are an integral part of the republic and subject to the same laws" [56]. Regarding the law on the organization of pharmacy and medical practice in the colonies, Art 38 states that "The laws rendered either in the civil or military administration or in the judicial order for the continental departments are applicable in the colonies". Thus ":The decree of the Parliament of Paris of July 22, 1748, the Royal ordinance of April 25, 1777, the letters patent of February 10, 1780, the decree of the National Assembly of April 14, 1791 therefore govern the practice of pharmacy in Senegal ; almost no act has repealed or modified them »[56].

In the early 1900s, the Governor of the colonies proposed a decree applying the 1892's decree concerning practice of medicine in the colonies. Writing to the Secretary of State, he said « I

have the honour to send you herewith a draft decree tending to authorize the pharmacists of the second class received by one of the schools of France, to practice in the colony without being subject to the obligation to pass a new examination. I do not think it necessary to insist at length on the importance of this reform, which will have the immediate result of facilitating the practice of pharmacy in the colony as a result of allowing the population to obtain more easily and more cheaply medication she needs. This measure will also have the advantage of giving current owners of pharmacies security they do not have »[57].

In Senegal, from the middle of the 1800s a number of regulations contributed to the extension of the demand for paid health care services. In 1876 an Order was issued by the governor of Senegal and Dependences defining conditions and the rate of deductions made in military hospitals for the wives and children of civil servants and army officers, 1876. Article 1 of the Order states that "The wives and children of civil servants, officers and various agents of the State in service in the colony, will in the future be admitted to the maritime hospitals of St Louis and Gorée at the conditions of the tariffs applicable to the chief of the family ”[52]. In 1891 this Order was issued. The Inspector General of the Colonies, Governor General of French West Africa, wrote to the Minister of the Colonies confirming that “The circular of August 30, 1895 relating to the circular of August 18, 1891 authorizes the families of officers and civil servants to enter the hospital at the same rates as their heads”. A similar Order concerned the natives “The Directorate of Political Affairs informs the indigenous chiefs that those of their subjects who are ill will be received at the civil hospital in St Louis for the sum of 2 francs per day, the payment of which must be guaranteed by the chiefs. The Directorate of Political Affairs cannot urge sick natives too much to benefit from this favor which will enable them to find in all circumstances the care as skillful as they are devoted as their health requires "[53].

3.3. Responding to Demand for Private Health care in French Western African Territories

Historically, it was on board of war ships that physicians appeared. They are found on the list of the Hellenic and Roman war ships’ crew and on funeral inscriptions [26]. Unlike their civilian counterparts practicing on land, the physicians boarding on Hellenic and Roman war ships belonged, through this function, to the upper class of their society. “Their role consists

essentially in the treatment of injuries caused by knifes and projectiles, and sometimes burns caused by the use of fire projectiles inaugurated during the Hellinic period" [26]. They were considered as part of the "technicians " of the crew. Then the physician became rare from the ship, only to reappear later for a short time in board ships in the fifteenth and sixteenth century, during the great naval discoveries. As Pluchon has put it, "Physicians do not appear in the colonies, with the exceptionof Canada, before the end of the reign of Louis XIV." [26]. Imbued with their privileged social rank and their university education, they practised at the ports in France or on land at some ports in the colonies, as king's commissioned physician or private practitioner.

In between times, the barber-surgeon filled this function. In the early fourteenth century, for example, Marseilles required that a barber be on board the passenger boats. The barber should "have an infirmary or thalar with an "apothecary shop containing herbs, spices and seasoning" [26]. The explorers were also the Barbers' clients. For instance, Christopher Columbus was imposed one during his first travel (1492). However, it is from the end of the fifteenth century, that the barber-surgeon's expertise was most demanded, not only from the adventurers, but also from political authorities and commercial actors. Indeed, in January 1629, a code made obligatory the presence of a surgeon among the officers of every regiment of the Army ; and in 1942, the code « instructed capitains to take on board a very good surgeon for the care of the crew » [26]. Like apothecaries, surgeons were from modest social origin. As a result, combined with their non-university education, they were less respected by physicians. According to the division of functions, " [p]hysicians are the word, surgeons and apothecaries, the hand. The former, who have the monopoly of internal pathology, analyze, diagnose, prescribe therapy. Surgeons and apothecaries execute" [26].

However, gradually, the problems of health became more related to other causes than to combats. The barber-surgeons' tasks were then not only to "shave chins and clip mops of hair" [31], "patch up a ;seaman fallen from the yard or open an absecess" [31], or treat injuries caused by knifes and projectiles, about which he has been recognized quite useful ; his main task became to prevent and treat also diseases (most of which were epidemics) contracted at sea or on the continent. In this respect, apothecaries and barber-surgeons faced the same criticisms at the beginning of the eighteenth century. As Pluchon has pointed out "in 1716, the navy Council was flooding of complaints underlying their mediocrity : most of them

do not have but " the outine of their art without any knowledge in anatomy or in surgery""[26]. Thus, from 1673, the navy ports of Brest, Rochefort and Toulon have one physician and one surgeon-major (chirurgien-major) ; in 1679 the measure was generalized to all ports, staffed by one First physician and one Second physician and six surgeons. In both cases, physicians and surgeons were "sponsored (*entretenus*), that is to say permanently appointed by the king" (Pluchon 1985 :70). In 1681, a further step was taken with Colbert's ordinance which stated that "any ocean-going ship of more than 36 people ought to take on board a surgeon (two if more than 50 people) whose competences will be controlled before baording"[26]. In 1689, another ordinance went further than the 1681's and expand the functions, classes, relations of authority and fixe rates of payment per month for each category of health agent and according to the category of navy ships. In addition to physicians and surgeons, there were then apothecaries, who were up to then confined to hospital ships (*navire-hôpitaux*) ; and "from 1718, the *entretenus* receive at the end of their career a partial pay, in a way to ensure them a descent end of life" [26].

The need for improving their professional competence led political authorities to include training duties for the First physician in the first instance, and then support projects for the creation of schools at the main navy port: Rochefort (1722), Toulon (1725), and Brest (1731). This resulted in a significant increase in the number of permanent posts for surgeons and apothecary, although their numbers remained insufficient even in time of peace [26]. Before 1756, navy health officers appointed by the king represented 40% of the total; between 1756 and 1763 this rate falls to 20%, and 11% between 1778 and 1783. At the beginning of the French Revolution of 1789, this rate was 20% of the total of the state funded navy health workers. Registration in naval medical schools were however high. This included also free attendant students classed as « supernumerary » (*surnuméraire*), who would practice as civil surgeons in villages and towns. In Rochefort, for example, their number increased from 40, in 1740, to about 55 in 1756; and 120 around 1759, leading the authorities to reduce the number to 70, which was maintained until the Revolution of 1789. Pluchon [26] has shown that the low number of personnel despite the high registration at schools was due to desertion. The mean time of stay is five years, but a significant proportion, about one third, stayed less than a year.

Table 1 : Health personnel in Senegal and Dependencies in 1829

Settlements Personel	St Louis	Gorée	Baquel	Total
Physician in chief	1			1
Health officer 1st class	1			1
Surgeon of 4th class	2			2
Pharmacist of 2nd class	1	1		1
Surgeon of 1st class		1		1
NI		1		1
Surgeon of 3rd class			1	1
Total	5	3	1	9

Source : H6 Questions Sanitaires : Organisation et fonctionnement de la santé 1829-1846

Initially, these health care facilities were created for the military and functionaries. The rates were as follow: in Dakar, army officers paid 14.14 francs whereas functionaries paid 9.43 francs. In St Louis, army officers paid 12.83 whereas functionaries paid 8.96 francs.

This selected practice and the low number of health public health personnel offered opportunities for private practices for individual practitioners in the settlements and colonies. These individuals are first found among public servants, either civilians or militaries. This group evolved from the *entretenus* (king's sponsored physicians) to the navy medical officers. The following definition, though from the from the 20th century is relevant for understand the status of the civil servant in the French imperial context: "are assimilated to civil servants, or chemists civil servants in view of the application of this decree, any pharmacists, or chemists, engaged by contract, or by decision, and receiving, as such, from one or more communities, offices, or public services, a remuneration greater than 1,200 f / month". In other words, civil servant refers to anyone practitioners receiving a monthly regular salary from the social entity. The regulations of health care services in the settlements and colonies as described above leave a large number of people (merchants, ships and boats crew, etc.) at the ports and on land unattended by a health professional. These civil servants formed the large number and powerful group of private practitioners in the French settlements and colonies in Western Africa. That this group of private practitioners exists is supported by the follow letter of the

Governor General of French Western Africa to a Governor of Senegal in 1904, stated as follow:

"Mr. Lieutenant Governor, The Minister of the Colonies has just ordered a detailed investigation into the way in which the doctors of the colonial troops practice civilian clients in the colonies. I have the honour to ask you to kindly let me know if you have personally learned that some of the doctors in service in your colony have given themselves up to the civilian clientele by claiming exaggerated fees from their patients, with a search for gain incompatible with the dignity of their official position or if the directors placed under your orders have received complaints of this nature." [58]

The second group is formed by individual health practitioners (medicine or pharmacy) who went in the settlements and colonies to set a trade around health services. They comprise designated civil servants, or health officers (coming from the corporation and not possessing a doctorate), some adventurers from the corporations, and later from medical schools and navy colonial medical school. They first received the king's sponsorship, then from the corporation once the regulation on medical practice was passed, and then administrative authorization from the health committee of the public medical police in the settlements and the colonies. The material interest of the medical civil servant were so entrenched that they used their administrative position to prevent individual civil practitioners setting up a practice in the settlements and the colonies. The do it by either continuing private practice even when a civil practitioner settle in the area or by prevent their access to administrative authorization for practice. The emblematic case is that opposing a navy medical officer to a civil pharmacist in the 1840s in Senegal.

3.4. Discussion and Conclusion

This paper set out to examine the situation of private medical practice in French African overseas at the end of the nineteenth century, when African territories fell under French colonial domination. This understanding is relevant for a better appreciation of the development of the practice during the following sixty years of colonial occupation, and even beyond. In France, the movement for the occupational control of labor of professionalism in the area of health began in early nineteenth century, and was authorized around the end of the

same century. This process could not ignore medical practice outside France, from the time of overseas territories up to the colonial occupation at the end of the nineteenth century. It is known from travelers' accounts, the literature on the French empire as well as from some incidental mentions in historical accounts on the development of health system in French overseas, that private practice initiated French medicine in overseas and that it was lucrative. It is also known that competition between different occupational groups for status in the area of health was fierce in France until the end of the nineteenth century, and even beyond.

So far African medical historians have tended to focus their interest on the colonial state organized medicine. Investigating privately organized practice can shed new light on the official account of French colonial medical assistance in its colonies of Africa. This official account, which has been largely made of works from historians, has been constrained by methodological standards of history as a discipline. This literature has particularly focused on colonial medical policy [20-25] or as in [26] where the focus is the institutional development the professions of colonial medicine, but is done from a traditional historical approach that makes medical heroes the topic of analysis. A few theses have consisted in case studies on the history of particular health professions such [27-29]. Although these studies are useful to pin down the development of private medical practice, this latter does not constitute an interest for them. In very rare cases the interest in the impact of colonial health systems on African indigenous ones have led some like [30], to address some moral questions that resonates with questions on the corporate interest of colonial health professionals. This is particularly the case with Lapeyssonie [31] whose book, entitled *La médecine coloniale. Mythes et réalités*, one of earliest on French colonial medicine, studies the moral aims and performances of colonial doctors in the French colonial empire by demonstrating their altruism.

This is partly consistent with the overall literature on colonial medicine in Africa. Indeed, the idea of profession as a body of knowledge appeared in early writings by some African medical missionaries. However, this occurred for a very short period, and was mostly concerned the writing of early Victorian doctors. The later disappearance of this idea occurred in favor of the label "witchdoctor" or other discrediting labels found in material such as dairies, biographies, and colonial officers' reports. This shaped early written material for professional historians. The emerging African medical history of the 1970s, which was mostly national history, overlooked the idea of profession that included competing healers; instead historians focused on the institutional analysis of biomedical establishment, that goes with

accounts about "great doctors". Doctors appear as causal element and consequently resulted in a biographical account of the history of western health services in Africa. As the postcolonial state established, by the late 1980s and the end of the 1990s the idea of profession shifted from its definition as a body of knowledge to the idea of collective, aided by an explicit push by Iliffe [59]. A critical historiography of medical systems in Africa that developed by the late 1980s, the recovery of oral history, and the emerging interest in social history of medicine helped to promote the use of ideas from the sociology of professions within African medical history. At this point, while mainstream medical history affirmed its emancipation, in the 2000s onwards there have been new developments so that professionalization is seen as jurisdictional control through competition and trade with political powers. This contributed to a significant move away from a linear and triumphal account of African medicine. The idea of profession refocuses on work as practitioners do it, and their political movement to draw boundaries through state support. The awakening of social history is of considerable value here. Yet what seems to retain academic attention is the idea of jurisdictional control and the conflict it implies. The frameworks which are used are mostly drawn from traditional sociology of professions and anthropological analysis. A rigorous application of the ecological approach to the professions, which gives a significant place to the ideological character of expertise, the role of competition, and the contribution of the State through the law, will probably boost the quality of African medical history. A really in-depth theorizing will lie, however, on a new sociology of the profession of African medical professionalization which draw from anthropology, history and sociology. As shown throughout this paper, sociology and history can mutually reinforce each other in the understanding of Africa's colonial experience.

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