

Experimental hubris and medical powerlessness: Notes from a colonial utopia, Cameroon, 1939-1949

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Turning the political command over to doctors — the utopia of ‘medical governance’ — has been a recurrent dream in the history of public health. This chapter examines an extraordinary attempt to materialize this dream. Between 1939 and 1948, the French administration of Cameroon handed over the direction of an entire province to doctors. For nearly a decade, the Haut-Nyong territory was placed under the responsibility of a handful of young colonial doctors, to the exclusion of any other administrative or military authority. The stated objective was to conduct experimentation in colonial administration, namely to set up a medical utopia where public health would blend into policy-making. Rediscovered thanks to the work of Peter Geschière (1982: 39; 1983) and the Cameroonian historian Wang Sonné (1998), this experimentation is worth studying for at least two reasons. First of all, this extreme case lets us glimpse colonial medicine’s political horizon in a pure state, we might say: a medical government turned toward population growth and the fight against epidemics, and guided solely by medical techniques, scientific knowledge and humanism. This case illustrates how colonial doctors envisioned in material terms the inaccessible ideal of European hygienists since the 19th century (Murard/Zylberman 1996) — the ideal of a ‘social medicine’ directly ruling and reforming society, as it applied verbatim Rudolf Virchow’s saying: “Politics is nothing other than medicine on a grand scale” (Virchow 1848; McNeely 2002).¹ Secondly, the Haut-Nyong utopia was designed as a literal experiment to be discussed and reproduced, but it was also a quite real place and a decisive episode in the history of colonial medicine. Despite the evidence, accepted by the doctors themselves, that this experiment was a nearly complete failure, it would inspire how health actions were imagined, planned and institutionalized after the end of the war in French Africa.

This empirical case will, herein, serve to reconsider how historians and anthropologists have approached the medical government of Africa and, in particular, how this issue has been frequently described with metaphors such as ‘experimentation’ and ‘living laboratory’. The purpose is not simply to object to these metaphors as being exaggerations or simplifications or to recall that a gap always exists between the intentions (experimental, humanitarian, disciplinary) voiced by doctors and actual realizations. That

¹ Virchow (1848): “die Politik ist weiter nichts als Medicin im Grossen.”

approach has become relatively classical nowadays and has even defined a research agenda in colonial studies (Stoler/Cooper 1997). Instead, this paper elaborates methodological propositions for moving beyond the alternative between a naive, literal description of biopolitical projects and a critical stance that amounts to showing that reality is more complicated or that big projects never work.

This paper proposes to reconsider the historiographical status of failure. It argues that hygienist or experimental utopias were productive in their failures, because they opened up a space of critique, reform or reaction. The paper begins with a review of the question of failure in the history of medical government, and suggests to avoid two historiographical pitfalls: forgetting the existence of failure (when we literally interpret doctors' claims about making Africa healthier, or about rationalizing the continent); and presenting the failure as the outcome of research by historians (when we concentrate exclusively on the contradictions and stalemates of colonial, experimental or medical 'governmentality'). After presenting a few theoretical points and the case of Haut-Nyong, I shall draw up a hypothesis about the *positivity* of this failure. How was the (systematic) failure of biopolitical utopias — instead of being a 'discovery' made by historians— a crucial factor in: their design, the rhetoric surrounding them, their implementation and their aftermath? By placing failure at the centre of analysis, this approach enables us to directly address the questions of medial powerlessness and hubris, not as retrospective assessments and *ex post facto* critiques of doctors' governmental ambitions but as positive and central aspects of the relationship between biomedicine and governance.

Revisiting the 'colonial laboratory'? A review of the literature

Experimentation has been a favourite theme in the history of colonial medicine. Even though experimental medicine in the colonies has not been the subject of many studies as such (exceptions being Pelis 1995 and Bonah 2007), the term 'experimentation' has met with success in historiography, where it serves as a loose metaphor for government interventions in the colonies. Bruno Latour's (1984) thoughts on the Pasteurian revolution have been influential in interpreting colonial medicine as a 'living experiment'. According to him, the Pasteurians saw the colonies as a field where they could give free reign to their

reformist ambitions (Dozon 1985). The “Solons of the tropics” were able, in these new lands, to come near to a “pasteurization of society” (which they had vainly sought to achieve in their homeland) by turning a whole society into a laboratory in the sense of a controlled, controllable place organized by scientific rationality and devoted to producing evidence and order.

Other authors, inspired by Michel Foucault’s (1997: 89) well-known proposal about the “reverse effects” on the European world of colonialism’s political techniques, have also described colonies as laboratories. For example, Paul Rabinow (2005: 289-317) has portrayed colonial Morocco (in particular, the Rif War) as a “laboratory of modernity” for French military officers, technocrats and planners. This phrase has even become a commonplace in the history of colonial sciences and techniques. Countless dissertations, articles, chapters and books have borrowed this figure of speech (e.g. Tilley 2001; Eckart 2002; de l’Estoile 2004; Braun/Hammonds 2008). Most of this research, though well documented, uses the word “laboratory” in a lax way (an exception being Anderson 2006). As a convenient metaphor, the word has had echoes in recent condemnations of using Africa or the “South” as fields for “delocalized” experiments (Shah 2006). Recent studies have precisely, yet problematically, described the colonial world (Africa, in particular) as the place of an “experimental governmentality” where political rationalities, though initially restricted to the domain of scientific research, were expanded to the scale of a whole society and population (Bonneuil 1999 and 2001), or even as the ultimate phase in a process of “experimentalization of the world” that had started in 18th-century Europe (Chamayou 2008).

There are several problems with adopting these ideas and metaphors. A general critique points to the confusion of intentions with realizations (Stoler/Cooper 1997: 6). Some studies, though excellent in other respects, treat the colonial doctors’ writings as self-fulfilling discourses (Dorlin 2006; Chamayou 2008). They fail to take into account the internal incoherence of such declarations, the criticisms levelled against them or the material factors restricting their application. This version of an experimental governmentality that was “ordering and disciplining the tropics” (Bonneuil 1997) should be qualified by taking seriously the study, as initiated by Mbembe (1996), of indiscipline and

disorder in the colonial context.² In like manner, Foucauldian interpretations of colonial health actions as a laboratory or “matrix of subjectivation” should be reassessed given that colonial medicine was, in most areas on the continent, satisfied with interventions quite limited in time and space, as Megan Vaughan (1991) has pointed out.

A second problem is more important. Simply put, the metaphor of experimentation was a favorite figure of speech used by colonial authorities themselves. For instance, the Pasteurian Charles Nicolle (1934: 142) referred to his medical surveys in Tunisia as “experimentation in action”; and Louis Tanon, the director of the Institute of Colonial Medicine at the Faculty of Medicine in Paris, wrote: “The hygiene of our lands [...] has every reason to draw inspiration from the experiments carried out in vast territories, where relatively primitive races dwell whom European civilization has not yet transformed.” (1930: ii) Commenting on colonialism’s life-size experimentation thus amounts to paraphrasing the writings of colonial science.³ This is not a problem in and of itself, but this calls for a careful discussion of the role of this metaphor in the colonial context. The question of experimental metaphors, in other words, must be tackled pragmatically (Sibeud 2002: 12-13), by analyzing their force in the negotiations conducted within the colonial administration; their appropriation by professional groups such as doctors; their function as a source of legitimacy in the eyes of French public opinion; and the critical, ironic or indifferent reactions to them.

Several strategies can help to renew the study of the colonial laboratory and of medical and experimental utopias in Africa without merely dismissing the metaphor as an abusive simplification of a much more ‘complicated’ reality.

To formulate the question differently, a first possibility is to discuss the actual function of colonial utopias in imperial societies, in particular: how were the colonies presented to public opinion back home as an ideal place for public health interventions? For instance,

² Mbembe: “In colonial disciplinary plans, as in what has been called native ‘responses’, there was always a proportion of ‘misses’, of the ‘unexpected’ and of ‘disorder’, which research has, till now, described with an incredible lack of precision. This proportion of ‘misses’, of the ‘unexpected’, of ‘disorder’, of the ‘unforeseen’ and of ‘aborted efforts’ or, in more positive terms, of the use of reason, is what we call ‘indiscipline’, especially in cases where it is consciously constructed, and without taking into account the results and effectiveness of the actions undertaken.” (1996: 33)

³ For examples of colonial doctors using this metaphor, see Anderson (2006: 113-114); and on Cameroon as a “field of experiments”, Martin (1921: v-vi).

campaigns against sleeping sickness or the experiments in social engineering conducted in leper-houses often had an inordinate impact on opinion in the colonizing country (Dozon 1985 and 1991; Lyons 1992; Edmond 2006; Lachenal/Taithe 2009). However these experiments, which usually went under that very name, had a ‘materiality’ as important for us as their ‘posterity’ back in Europe, where they were seen as ideals for public health interventions. Rather than being living laboratories or life-size experiments, the colonies were different and differentiated spaces that provided doctors with rhetorical resources. To pursue a classical analysis in line with Foucault (1994), the colonies would have to be seen as “heterotopias” or “counterspaces” rather than as a laboratory — as a constellation of projects both material and rhetorical, real and theatrical, that public health activists could use back in the homeland as a mirror, as a desired and idealized reflection.

What I would like to propose is a complementary but pragmatic approach to the idea of a laboratory. This approach should be limited neither to observing a gap between grandiloquent intentions and reality (Fassin 2001) nor to contriving variants on the theme of a “thwarted utopia” (Murard/Zylberman 1996). We might simply set the idea of a living experiment opposite the list of the thousand budgetary, theoretical and practical difficulties encountered by colonial health services and doctors. But this “analytics of failure”, to borrow from Gary Wilder’s (2005: 78) critique of colonial studies, is not satisfactory. It takes no notice of the fact that the gap between discourse and reality was, in part, positive. It is possible to move beyond the alternative between paraphrasing experimental metaphors and rejecting them as mere normative prescriptions that complicate understanding a much ‘truer’ everyday reality. How did the claim of conducting a living experiment weigh on daily actions? What effect did the publicity given to colonial experiments have on practices? How did the experimenters refer to, and interpret, the gap between plans and practices, especially when they depicted the failure in political, scientific or aesthetic terms? What we need to understand is this experimental governmentality’s materiality and performativity: what did it mean to govern and be governed in a place said to be a laboratory?

A last proposal: taking seriously colonial medicine’s experimental claims (in both their materiality and rhetorical effects) also implies accounting for the hubris rife in them. Since the 19th century, at least, the growth of experimental medicine had been associated with a

critique of mad scientists and the insanity of science (Bonah 2007). Likewise, a reflexive approach to the colonial laboratory entails acknowledging an immanent critique, omnipresent in colonial literature, of the megalomania underlying the very idea of a living experiment.⁴⁴ Understanding medicine or, more broadly, the colonial government as a thwarted or frustrated utopia spares the rationality of such plans even though they were — at the time — the target of criticisms ranging from ironical remarks on the ineptitude of “pilot projects” (Mazenot 1996: 21) to public scandals (Taithe 2009).

In a pioneering study, Warwick Anderson (2006: 9, 74-103) has shown that the first impediment to realizing the colonial doctors’ hygienist dreams was “colonial nerves”, i.e., cases of “neurasthenia”, “Congolitis” or “delusions of grandeur” among staff members, including doctors. Such cases were so frequent that, in the colonies and homeland, medical-psychiatric institutions — and many a publication — were devoted to them (Abatucci 1910; Martonne 1930: 109; Martin 1932; Jennings 2006; Dozon 2008: 50). Johannes Fabian (2000) has proposed an incisive reinterpretation of the history of the late 19th-century ethnology of Africa. According to him, the vast operation whereby anthropology was to put the continent “in order” was a task undertaken by explorers who were exhausted, alcoholic, addicted to morphine, madly in love or sick with malaria, and whose means of knowledge had more to do with ecstasy (to use a positive word) than cold rationality. This has opened the way for shifting the critique of colonialism “from the question of guilt to that of error” (Fabian 2000: 281). In the case treated in this chapter, it opens onto a hypothesis about the function — not just anecdotally in terms of blunders — of delusions, irrationality and nihilism in the biopolitical government of colonial Africa.

An initiation in hubris: The Haut-Nyong experiment, 1939-1948

“We are neglecting no measure capable of interesting natives and rousing them to pursue, despite themselves, their own well-being.” (David 1942)

The metaphor of the colonies as laboratories of modernity fits well to the history of

⁴ Colonial megalomania evidently makes us think of Rudyard Kipling’s short story, *The man who would be king* (1888), and Joseph Conrad’s *Heart of darkness* (1902). Louis-Ferdinand Céline’s *L’Église* (1932) includes a satire on colonial medicine.

medicine during World War II (Gaudillière 2002; Harrison 2004). Techniques used decisively in Europe, such as DDT or mass blood transfusions, were experimented through colonial Africa (Rabinow 1999: 84; Fintz 2004; Schneider/Drucker 2006). Furthermore, Allied campaigns in the tropics tapped new technologies — jeeps, jerry cans and bulldozers — that would come to symbolize international public health after the war (Amrith 2006). New forms of organization and governance also emerged during the war. Mark Harrison (1996) has cited as an example how a generation of British military doctors represented a new “culture of command” defined by its “managerial ethos” and a style of leadership freed from the code of military bravery.

Experimentation represented a key value in this new governance. In the army, a specifically colonial ethos set store on inventiveness and individual initiative. Colonial doctors — the majority of doctors in the Free French Forces — enjoyed talking about “their war” in Africa without gasoline, alcohol or drugs, and about the thousands of ways of making up for shortages (Lapeyssonnie 1982). Doctors thus had the opportunity to learn their trade. This was especially so for young specialists like Henri Laborit, who referred to colonial hospitals as “an absolutely astonishing field of experiments” for surgery (Laborit/Grenié 1997: 19; Keller 2007: 229-230). The situation led to seeing the empire as a world without limitations, where genuine experiments in policy-making could be carried out. Indeed, extreme tests in governing territories and peoples were conducted, as in Anchau, Nigeria, where British colonial doctors displaced populations, founded a town and tried to invent a new native society (Nash 1948; McKelvey 1975). Far from hamstringing the ambitions of colonial public health, WW II reinvigorated them. As Dominique Pestre (2004: 14) has argued, the war was often an initiation in hubris for scientists and statesmen. This is the angle from which I would like to tackle the case of Haut-Nyong.

Time for utopia

In early 1940, Richard Brunot, governor general of Cameroon, explained his approach to the governing council:

“I placed the Haut-Nyong region fully in the hands of medical authorities. By giving these doctors the leadership of this region, I wanted to signal my

determination to grant in all matters an absolute priority to all that is human. Before developing the land, it is necessary to produce people; and to this end, what better method than to confer the task on health technicians? Their policy will mainly center on developing bodies and families. They will, in a word, make a medical administration. Planning, breeding, feeding, healing, thus is defined their role.” (Journal Officiel du Cameroun 1940)

This project borrowed slogans from the improvement (*mise en valeur*) policies that, imagined since the 1920s, had sprung from the same mixture of colonial humanism, demographic obsessions, techno-scientific optimism and references to France’s generosity (Coquery-Vidrovitch 1979; Conklin 1997; Wilder 2005: 43-117). This was not the first attempt in French colonial medicine to create a sanctuary where public health would reign. In fact, the Haut-Nyong medical region had the same bounds as the “sector of prophylaxis of Haut-Nyong”, the principal area of activity during the 1920s of the Mission against Sleeping Sickness. The head of this Mission, Eugène Jamot (1935, quoted in Froment 1988), had demanded to be granted “in the infested zones [...] the authority of a surgeon in his operating room”. The “camp” at Ayos had become a “medical campus”, base of logistics and centre of research for the Mission. It even enjoyed an extraterritorial status, since it was placed directly under the authority of the governor of Cameroon with no interference from the local administration (Tantchou 2007). Owing to the emergency legislation in French Cameroon, everyday medical, administrative and police powers could be merged. Doctors in the countryside were granted “disciplinary powers” (CAOM 1924). Furthermore, the Indigenous Code on the legal status of colonized peoples contained a few ad hoc offences, such as the misdemeanour of “not executing prophylactic measures”.⁵ Whether the fight against sleeping sickness was an administrative or a medical question was a topic of discussion between the two World wars, both in French imperial circles (Martin 1931) and on the League of Nations’s Hygiene Committee, which officially recommended granting police powers to doctors (LNHO 1925).

⁵ “Infractions spéciales à l’indigénat”, order of 4 October 1924. Special offences were published in Gazette du Cameroun, 14, 15 November 1924.

Turning the whole area into a medical region in December 1939 signalled a change of scale. Dr. Jean-Joseph David, a colonial army doctor (alumnus of the Naval Health School of Bordeaux and of the School of Application at the Pharo in Marseille), was appointed to head the region, assisted by six other doctors in charge of the region's subdivisions. Marcel Vaucel, head of Cameroon's Health Service, summed up the situation: "The Haut-Nyong, worked for years now by doctor-prospectors familiar with all its nooks and crannies, was already a region of medicine. Thanks to Governor General Brunot, it is now a medical region where everything will be done for the sake of the native's health." (1940: 162)

The project was launched in a propitious political environment. In French Cameroon, doctors had, since the 1920s, managed to obtain a political and financial backing without parallel in Africa, usually by brandishing the threat of Germans coveting their former colony, which had been made a French and British mandate after WW I. The French administration's health policy in the former Kamerun was a favourite target of procolonial lobbies on the other bank of the Rhine. It was an international issue and a subject of long debates at the League of Nations (Eckart 1997; Callahan 1999/2004; Essomba 2004). Cleverly blown out of proportions by French colonial doctors, the German menace was used to justify health programs that had no equivalent in the French Empire (Headrick 1994: 405-406). The argument was never as plausible as in 1939, with the looming spectre of Germany coming back to Cameroon.

Besides, the ambitious, pragmatic formula of a medical region served to govern at a lower cost, since savings were made on assigning administrators to an enclave that was the historical centre of sleeping sickness in the colony and, too, an underpopulated area. Throughout the period between the two World wars, underpopulation was seen as an insurmountable obstacle to development (Geschière 1983). The idea of a medical region was not new: the German campaign against sleeping sickness, suspended by the Allied takeover in 1914, foresaw handing over to doctors administrative responsibilities for the most infested zones, the aim being to avoid frictions between administrators and the service in charge of the campaign (Kuhn 1914).

The war breaking out in 1939 did not change the situation, quite to the contrary. When Cameroon and French Equatorial Africa tipped to the side of Free France in 1940, colonial doctors stood in the front ranks (Sicé 1946). The director of the Institute of Hygiene in

Douala, the Pasteurian Jean Mauzé, and the head of Cameroon's Health Service, Marcel Vaucel, won renown by rallying Cameroon to the Free French cause in late August 1940; they then joined the French Resistance in the Sahara. In French Equatorial Africa, Colonel Adolphe Sicé, an army doctor and director of the Pasteur Institute in Brazzaville, was among General de Gaulle's first supporters. In 1941, de Gaulle appointed him *haut-commissaire* of Free French Africa, the name given to the new imperial territory encompassing Cameroon and French Equatorial Africa. For the colonial medical corps, the time had come for military heroism, administrative responsibilities and policy innovations. The Haut-Nyong experiment was a project where men could prove their mettle.

Dr. David drew up an action plan defined as a "social undertaking with demographic aims" (1942: 57). Haut-Nyong's medical administration was not intended to merely facilitate the work of doctors by leaving them to freely organize public health campaigns. The intent was — and this moored the experiment in a hygienist utopia — to give doctors as much freedom as possible including in matters of political and social organization. The project adhered to the "social medicine" ideals that the Rockefeller Foundation and League of Nations (Weindling 1995) had advocated during the interwar period, but without referring to them outright. When David warned in the first report, "No demographic recovery can be imagined without introducing thoroughgoing reforms in native society" (1942: 58), he was not trying to list the levers of actions beyond his control but, instead, to enumerate the priorities for his "direct medical administration". The head of the region was trying to administer a political medicine, not simply a public health program. He insisted:

"It would be vain to think that an isolated medical action suffices for re-establishing the demographic equilibrium if it is not completed with major works in hygiene, education and economic infrastructure. Cleaning up the country, building model villages, developing individual resources, in a word, improving the native's social situation are ultimately the most effective weapons. That is, on the administrative level, the task that falls on the medical region." (David 1942: 40)

This program stands out owing to its experimental ambitions. A twofold objective, political and cognitive, ran through it: lift the population but also meticulously describe this

lifting and thus test the worth of administration as a method for improving public health. The medical region was a test in scientific government: not only were enlightened technicians in charge but, even more, the government itself was an experiment (Murard/Zylberman 1984, Bonneuil 2001). This justified support for the project, in particular the large number of qualified persons assigned to it. According to Dr. David, this price had to be paid if the “Haut-Nyong region is to favourably pursue its destiny. This is the price for collecting what might be unique documents.” (1942: 109) But he worried lest, lacking the means for endowing the project with a scientific dimension, “this experiment loses most of its interest and its genuine significance”.

A telltale fact: the reports on Haut-Nyong not only circulated inside the local administrative pyramid but were also sent to specialized circles back in France. The Sleeping Sickness Committee in Paris, on which colonial doctors and the mandarins of Parisian parasitology sat, greeted the project in 1941 as “evidence showing the administration’s full interest in the native’s well-being”. For these experts, it was a trial run since “the creation of medical regions should multiply on a large scale” (Commission de la Maladie du Sommeil 1941: 14).

Actions were planned and assessed scientifically. An “action plan” was submitted to the governor and the Ministry of Colonies in February 1940 (David 1940) and again in 1942 as a four-year plan. The results were published. A new journal in Brazzaville, stamped with the Gaullist Lorraine Cross, *Revue des Sciences Médicales, Pharmaceutiques et Vétérinaires de l’Afrique Française Libre*, served as a forum for the Haut-Nyong doctors. An administrative routine changed: the yearly report was replaced with a “study on the direct medical administration of a distressed demographic [sic] region” (Médecin-Chef de Région 1944⁶). Besides the usual policy reports, doctors published their medical/sociological diagnoses and their reflections on the program and its results, which were quantified and discussed.

The medical administration was, indeed, an enterprise for producing documents and

⁶ The other existing report, which I have not consulted, bears the same title: Médecin-Capitaine Souhde, chef de la subdivision de Messamena, extrait d’étude médico-administrative de la subdivision de Messamena, 1940-1946, Archives de l’Institut de Recherches Scientifiques du Cameroun, Yaoundé, dossier H, Haut-Nyong. Geschière (1982: 161) has mentioned it.

records. Individual health records were systematized; “rounds of screening and inspection” (a medicoadministrative technology par excellence) were expanded beyond vaccination campaigns and the fight against sleeping sickness so as to count and follow up on pregnant women, syphilitics and infants or even inspect cacao plantations. By 1940, the Haut-Nyong medical region was routinely said to be an experiment or experimentation. This was much more than a metaphor. It shaped actions and made the utopia into something material, starting with all the paper used for documents and records.

The medical administration as social therapeutics

The documents produced by Haut-Nyong’s medical administration provide a clear-cut (indeed, astonishing) example of how a policy was implemented that not only focused on the population but also proposed subjecting all administrative actions to demographic requirements. Control and transform the bodies of persons, manage and reform the body of society, rationalize government actions: Dr. David and his colleagues were striving to design and apply what, in Foucauldian terms, can be called biopower: a combination of disciplinary institutions at the scale of the individual with biopolitical regulations at the scale of a territory (Foucault 1976: 177-191; Foucault 1997: 213-234). Let us review this total approach — as the doctors imagined and described it — to demographic recovery and, coincidentally, to the invention of a new society.

Child care with the goal of “fighting against denatality and forming a physically and morally healthy generation” (David 1940: 2) was proclaimed the priority. Maternity was to be medicalized. Pregnant women were systematically tested during doctors’ rounds in villages: each one examined, registered and summoned to go a month before the due date to a maternity centre. In the towns serving as subdivision seats, 36 new buildings were erected for creating maternity hospitals. Women were to be hospitalized for 45 days in order to spare them “the customary chores and [to receive] advice about elementary hygiene for the new-born” (David 1942: 7). A regional circular fixed their diet down to a gram of salt during this period “when they only eat and rest” (David 1942: 39). More than a thousand women in Haut-Nyong were following this regimen in 1940; and more than 2000, in 1943 as compared with fewer than 700 in 1939.

This medicalization of maternity was a classic objective in public health programs in colonial Africa (Hunt 1999, Hugon 2005); still, its experimental ambitions were especially striking in the Haut-Nyong. The program's success was to be judged by the fact that the "influx of women and children made it possible to gather information" (David 1942: 10). Besides records on pregnancies, an individual record was made for each infant and filled in during the "visits of control at home", which were part of the precisely planned monthly rounds. These rounds served to follow up on the survival and growth of infants and on their gradual infestation with helminthes and malaria. Infant mortalities were recorded with an accuracy seldom reached in Africa at the time (Bonnecase 2008). Graphs of weights were drawn for each administrative subdivision, and compared with European data. Even better, the program's effects were quantified: doctors assessed how the length of mothers' hospital stays affected the weight of infants at birth, and concluded the program had a "healthy influence" (Médecin-Chef de Région 1944: 3-4).

A second part of this program was education. Dr. David planned to fully reorganize schooling so as to serve the "genuine goals of educating adolescents and teaching them how to live" (1942: 43). To reach this "humanitarian goal", the program provided for weekly conferences on hygiene by doctors or their assistants, monthly visits for tests, the individual health files to be kept, work in fields and workshops, and meals in cafeterias where pupils "will learn to eat properly and healthily". The ultimate goal was to take "the native at the age when he is the most receptive" and, David imagined, prepare "a class of small farmers and ordinary village craftsmen, open to our ideas and trustful of our methods" (1940: 44). The region's nine schools were rebuilt; three more were opened in rural areas; and a new regional school was set up in a "nice building" in Abong-Mbang, the seat of the administration (David 1942: 48). More than a thousand pupils between seven and fifteen years old, wearing khaki shorts and shirts, were enrolled. David remarked that "nudity, rags and dirtiness are disappearing" (1942: 45).

Sports, which David defined as a "sanitary discipline", completed this program. Although this was not exceptional at the time (Bancel et al. 2003; Cantier 2004), the Haut-Nyong experiment even stood out in this respect owing to its clearly stated ambition to group "the totality of native youth under medical control" (David 1942: 2). The 1940 action plan announced: "The number of pupils being limited, many young people run the risk of

not escaping from their isolation. Sporting associations seem to us the organization best suited for subjecting youth to our medical and administrative surveillance.” (David 1940: 44) Every morning between 7:00 and 8:00, a lesson in physical fitness was given in all the medical region’s centres. A thousand young people were thus assembled every day. The practice of sports was compulsory in schools (Chef de Région 1942: 52). 26 soccer teams, wearing football shirts and shorts, played against each other for the title of regional champion. According to a circular, the year was to be punctuated by events leading up to the championship. At the end of a semester, qualifying matches involving all pupils were held in each subdivision’s village seat in the presence of David himself, who supervised a long series of events ranging from 100-meter races to javelin-throwing. The finals, organized every year at the time of delivery of the certificates marking the end of primary school, brought the best pupils to Abong-Mbang, where a big stadium had been built. This was a success, as David wrote: “The young natives keenly appreciate matches; they thus acquire health and the spirit of discipline wherein they are lacking.” (1942: 53)

To “some day give to the fertile land of Haut-Nyong the sturdy arms that it requires”, an equal effort — just as ambitious and planned — had to be devoted to adult health care. Proposed in 1940, this program included a “range of administrative and health measures inseparably dependent on each other” (David 1942: 58), most of which were applied by the end of 1942. It was based on a socioeconomic study that doctors had made of farmers in the region. Taking the Bulu area in southern Cameroon as an example to follow, this study saw the source of prosperity in the development of intensive cacao farming. More than five million cacao-trees were planted by late 1943. To improve the local food supply, soya seed was bought and distributed. In 1941, subdivision heads were asked for a report on livestock: doctors counted all livestock and bought hundreds of sheep for persons who did not own any. The head doctor drew up a plan for improving breeds by selecting rams. The 1940 action plan dwelled at length on “community hygiene”. The ideal village was described along with its model homes, field for sports, place for laundry and latrines (David 1942: 71). Major roadwork projects were launched; approximately thirty kilometres were opened in 1942 at Messamena, following an “impeccable layout evincing the qualities of endurance and initiative of Dr. Koch, the young subdivision head” (David 1942: 76).

The next point was demographic: “repatriating emigrants and driving out vagabonds”.

Once again based on a statistical study, the policy advocated by these administrator-doctors sought to put an end to emigration, which had been at the origin of the “continual losses affecting a population that has already borne the brunt of a reduction owing to major epidemics”. Dr. David (1942: 92) demanded the repatriation of at least two thousand persons from Haut-Nyong who were living in other areas in French Cameroon, and even of prisoners serving sentences elsewhere.

Medical actions as such were more or less secondary in this total conception of a population policy. The fight against sleeping sickness was, of course, to continue as it had “for long years now” (David 1942: 105). Thousands of syphilitics were recorded, treated, followed up on and studied. There were enough cases of leprosy to justify plans for an immense leprosarium near Abong-Mbang, which was to include a maternity, court, prison, centre of commerce and buildings for education (David 1942: 97). This literal utopia in a utopia, to be located at fifteen kilometres from the nearest dwellings, was to lodge two thousand patients.

The “emergency measure that is the medical region” (David 1942: 109) did not pursue the single objective of fighting against epidemics, nor even of sparing these efforts the usual frictions with other fields of government action. As Michel Foucault saw in the “plagued city [...] the utopia of the perfectly governed city” (1975: 232) in 17th-century Europe, we are tempted to see in the Haut-Nyong experiment an ideal form of biopolitical government. During a trip to London in September 1942 for a conference on the “postwar problems in Africa”, General Sicé appraised the medical region:

“We have tried [...] an experimentation. It has been done in a region particularly afflicted by sleeping sickness and malaria, the Haut-Nyong. The demographic situation there was so serious that this zone’s economic output had lost all value. The decision was made to confer the direction and administration to doctors from the colonial Health Corps. The results seem to overshoot all expectations. Death has stopped decimating villages; the treatment of sleeping sickness and malaria has put an end to sterility in households; maternal and child care have caused a sharp increase in the population in several villages. People, released from their obsession with death, have redeveloped confidence in themselves, and are lively and cheerful

once again. In this region, life has won; prosperity has come back; people have overcome the forces of destruction.” (1943: 32)

A Foucauldian interpretation of this medical administration falls short, as does an a posteriori discussion of the project’s progressivist aspects, as proposed by Wang Sonné, who sees in all this the starting point of the region’s development owing to the introduction of village cacao plantations. Let us make no mistake about the biopolitics of the Haut-Nyong experiment. It comes as no surprise that the implementation of the reforms imagined by David would meet with infinitely more impediments than suggested in Sicé’s daydreams. By insisting hereafter on the practical and political limits of this experimentation, the intention is not to discover a failed utopia (a point of little interest) but to show how both observers and the parties involved in the Haut-Nyong experiment diagnosed this failure and reacted to it, often by making the situation worse. The doctors themselves as well as missionaries present in the area spun other versions of the history of this medical region. These versions, in the documents and reports, suggest an other, disquieting image of the Haut-Nyong utopia.

Rubber for the Emperor: A counterhistory of Haut-Nyong

“Commandant David [...] has gone completely crazy”, according to the Archives of the Congrégation des Pères du Saint-Esprit (Mission de Lomié 1941b). In late 1941, the fathers of Catholic missions in Haut-Nyong could not stand it any longer: “The head of the region, David, [...] is certainly the biggest fake and nonbeliever we have ever had in Abong-Mbang. [...] What a sad situation, and dangerous too.” (Mission de Lomié 1942c)

For the missionaries, the hygienist utopia was turning into a bad dream, because Dr. David had a “horrible character” (Mission de Lomié 1942b: 104) and, above all, because his policy of experimentation was competing with the Catholic missions’ core activities: guiding bodies and souls through everyday life. The fathers in Lomié complained that when David did not convene the population on Ascension Day, he “chose on purpose Sunday to come see 600 people [a medical visit]: pregnant women, syphilitics and others. Obviously, anything that keeps them, Christians or catechists, from coming to mass.” (Mission de Lomié 1941a). When he came back in September 1942 for a control (Mission de Lomié

1942a), “It’s always Sunday!” In Messamena, the subdivision head, Dr. Henri Koch, was not appreciated either. He grabbed pupils from the mission to fill the benches in his own schools and made them work in the fields (Yaoundé/Divers 1942). He even arrested two local missionary instructors during their round of visits, whom he accused of “abandoning their village” (Mission de Messamena 1943) — the fight against vagabondage was taken rather seriously in the Medical Region.

The surveillance and confinement of pregnant women or syphilitics were competing with the missions’ *sixas*, disciplinary institutions for girls only, which were a mixture of a boarding school and a work camp where Christian girls spent long months before marriage (Laburthe-Tolra 1999). Doctors accused the *sixas* of sheltering persons carrying trypanosomes who were to be confined to their homes in villages (Yaoundé/Divers 1942). It was of no help that some missionaries felt sympathy with the cause of Pétain and the Vichy government. One of them, driven to despair, complained, “When will the reign of the Freemasons be swept away?” (Mission de Lomié 1941b) Called to the rescue, Graffin, the bishop of Yaoundé, recommended moderation: “We should not enter into the administrators’ private lives, as long as there is neither rape nor other acts of violence against our Christians.” (Mission de Doumé 1941) To put an end to these conflicts (among other reasons), he decided in 1942 to confer the eastern province, much of it part of the medical region, to Spiritan missionaries from Holland.

Skirmishes between the missions and colonial doctors were nothing exceptional (Daughton 2006), at least not in Cameroon. Mongo Beti’s novel *Le pauvre Christ de Bomba* (1956) contains a burlesque account of a “raid” that the service for fighting against venereal diseases made in a Catholic mission. Through such anecdotes, we see another account of the utopia emerging.

The picture in the reports filed by doctors was also painted in shades of gray. The tone of the very first report was disquieting: “The dwindling number of the European staff has reached a limit” and risked “irrevocably causing the Haut-Nyong experiment to collapse” (David 1942: 120). In fact, the whole medical staff counted initially but six permanent doctors (Vaucel 1940), helped by a few assistants: “poor whites” who learned medicine on the job and an unknown number of Cameroonian auxiliaries. In 1943, only three doctors, including the head of the region, still remained; and no relief was in sight (Médecin-Chef de

Région 1944: 5). Drugs were in short supply, in particular the arsenicals needed to treat syphilis. Guidelines were rewritten with the old prescriptions of mercury and bismuth.

Medical humanism had to make tough decisions during this time of shortages. The program planned, for instance, the compulsory confinement for a month of treatment of any syphilitic dwelling more than a day's walk away from a dispensary. How to apply this measure? It was not only severe (carrying sanctions for those who refused) but, even more, expensive (the cost of lodging and feeding hundreds of sick people). Dr. David proposed a radical solution to his assistants — turn the dispensary into a work camp:

“To be able to carry on with your tasks despite present difficulties, you will exceptionally be able to hire the male syphilitics in cure as administrative laborers [sic]. The regulatory withholding on their wages will enable you to feed them. As for the question of accommodations, it can be easily solved by quickly building a few additional huts with mats and bamboo.” (1942: 102)

Putting patients to work became widespread: persons afflicted with sleeping sickness or leprosy served as labourers for clearing water holes (an ‘agronomic prophylaxis’ for eliminating tsetse flies) and the site for the regional leprosarium. Another option was to put children to work on coffee plantations in order to free time for the mothers to devote to household chores.

The labour problem, particularly acute since 1930 following the expansion of big European plantations of cacao and coffee,⁷ complicated the doctors’ plans for social programs. The first action plan (David 1940) started by aggressively accusing European planters in the region of exploiting the population, fostering a native proletariat and flouting medical authorities. During a dinner, Dr. Koch sparked controversy by calling the mine owners “gangsters” (Yaoundé/Divers 1942). The labour shortage was widespread, and the

⁷ Geschière (1983) has shown that the development of big European plantations in Haut-Nyong was the official strategy for the “*mise en valeur*” (development policy) in the 1920s. Given the labor shortage during the 1930s, the growth of the plantations came to be seen as a threat to the region’s political and economic stability and to the operation of the administration itself, which had trouble recruiting personnel (including for medical campaigns). The colonial administration changed strategies in the 1930s, and tried to control work migration and foster small village plantations. This option was supported by doctors in the medical region and pursued, after 1945, by the population.

doctors had trouble finding for their “administrative work” able-bodied men, since the latter preferred wages from the planters. The cause, according to the doctors, could be traced back to a decree issued in 1937 after the French Popular Front ratified the International Labor Office’s convention on forced labour. According to it, “Labour is free in Cameroon.” For David, this “declaration complies with our principles [...] but is the worst of mistakes since — in the Haut-Nyong where hands are scarce — it has sown, owing to the interpretation made of it, confusion and disorder.” (1942: 84)

It was necessary to put an end to this “faltering principle of freedom of labour” (David 1942: 84) and to give the administration full control over the recruitment and movement of manpower. Forced labour, in other words, appeared as colonial humanism’s last resort. Although the phrase was not used, the context provided doctors with the opportunity in 1943 to tighten controls over the labour force, controls for which local administrators had been hoping for more than ten years (Geschière 1983: 96; Joseph 1986: 62-70).

Population statistics proved embarrassing, and even vanished from reports after 1942. The infant mortality rate definitely fell the first year, but was not calculated thereafter. The improvement in demographics was not discussed. To observe a real “rise in the social level of the natives”, the first report claimed it would be necessary to wait “a certain time”. Nothing was known about population trends; but fear was expressed in 1942 about a “poor demographic balance” (David 1942: 119). Pneumococcus — a disease never targeted by colonial medicine — was devastating whole villages (David 1942: 119). One out of two deaths of children from two weeks to two years old had been caused by “lung diseases”, a vast category beyond the doctors’ knowledge and power (Médecin-Chef de Région 1944: 4). At the end of 1942, “model villages” existed “nowhere” (David 1942: 71). A start, just barely, was made at building the leprosarium in 1944.

By 1942, the situation was distressing. The establishment of the medical region coincided with the switch to a war economy.

Latex was being harvested again, after having been nearly abandoned since 1915. World prices, at their lowest during the interwar period because of the expansion of hevea plantations in south-eastern Asia, exploded once Malaya, the Dutch Indies and French Indochina were lost. To deal with the expected shortage, the Allies were building up strategic stockpiles, intensifying research on synthetic rubber and lowering speed limits to

keep tires from wearing out so fast (Wendt 1947; Oyebade 1998). Despite its poor quality, African rubber, drawn by itinerant tappers from various species of vines and shrubs in the forest, was indispensable (Giles-Vernick 2002: 159-166). The forests in eastern Cameroon and the Belgian Congo were being tapped.

The doctor-administrators held an ambivalent opinion about this new economic situation. Given the price hike (from one franc per kilo before the war to twelve in 1944⁸), rubber truly occasioned a windfall, which locals (as well as European merchants) knew how to catch. Let us recall that, since the end of the 19th century, the history of rubber in eastern Cameroon, as elsewhere in Africa, was marked as much by acts of plundering and coercion as by a pragmatic adaptation of African peasants and traders to world price trends. This was evidence of an integration in the international economy that colonial authorities often simply followed in order to “tame” or “parasite” it with taxes (Dumett 1971; Harms 1975; Geschière forthcoming). The Haut-Nyong had been one of the first areas where a rubber rush had occurred at the turn of the century before coming to a halt when prices collapsed in 1913. German authorities had had difficulty controlling the trade and preventing violent incidents between tappers and traders, incidents that worsened as the locals who harvested latex acquired more wealth and weapons (Geschière forthcoming).

Thirty years later, the doctors in Haut-Nyong, whose economic policy sought to accelerate the acceptance and circulation of currency, understood that the harvesting of rubber and palm oil (with a comparable boom in prices) was the only way for natives to pay taxes while waiting for their own crops to ripen for the market. In pursuit of its regulatory ambitions, the medical administration devoted the whole subdivision of Lomié, the remotest area in the region, to rubber and conferred the harvesting on certain ethnic groups (David 1942: 63). The official objective was to limit the impact of the windfall, which would “not outlast the end of hostilities” (David 1942: 63), on the regional economy. Demand for rubber was “dangerously reviving the native’s taste for long treks in the woods” (David 1942: 63). To harvest wild latex, long trips were necessary, as well as a botanical knowledge and technical know-how beyond the control of colonial experts. This was the

⁸ These were the local prices practiced by European merchants (Mission de Doumé 1944: 129 and David 1942: 63).

exact opposite of the sensible peasantry that the doctors dreamed of seeing in model villages. David feared a “general return to nature” (1942: 119). As for the missionaries, they worried lest the free-flowing money “lead our people to their ruin”; a priest in Lomié wrote about the “fortune that rubber is leaving in the region and to say that it will be so poorly used” (Mission de Lomié 1943: 124).

Even though it represented an attempt to channel native agencies, the compromise chosen by the administration was rather brutal. To limit the impact of the boom on the regional economy, only a few tribes were mobilized for the harvest. Ever larger quantities of latex were required as of 1942, and force came to be systematically used. The missionaries in Lomié railed against this in their diaries: “A very low attendance at mass because the subdivision head made everyone leave for rubber.” In 1943, “all the men are in the forest [...] 62 tons [of rubber] on the market on 30 January. No one at mass.” In 1944, the subdivision head was even more severe following a poor harvest: “Everyone is out for rubber, because [he] has used a strong hand: all the chiefs [of cantons and villages are] in prison, the others are afraid.” (Mission de Lomié 1943 and 1944)

Doctors and missionaries were well-placed to observe the fallout from the region’s economic development. A missionary in Lomié noted in 1943, “the other event is the ravage wrought by sleeping sickness. Several cases have been detected by health officials. There were more than a dozen in Pohendoum alone.” (Mission de Lomié 1943: 124) The doctors confirmed in their annual health report the outbreak in Pohendoum, a village “providing shelter to forest rubber-tappers” (Farinaud 1944: 31). Harvesting latex and contracting sleeping sickness were known to be linked since the start of the century. This linkage figured in African accounts of the illness and had been an insolvable dilemma for colonial administrations (Lyons 1992). The latex-producing vines mostly grew along waterways and in swamps where tsetse flies proliferated. The ongoing search for new sources of latex meant long trips across infested areas; and the meeting of people, when taxes were collected or the latex was brought to market, facilitated transmission of the disease.

Colonial doctors in Haut-Nyong faced the most painful of paradoxes, which was never clearly formulated: the sleeping sickness epidemic — the very reason for the medical region and its founding myth — was proof that their project had failed. Worse yet, the epidemic partly resulted from their own actions. Statistics on sleeping sickness showed a sharp drop

in the region since 1935 at least. Between 1937 and 1939 (before the “medical command” was set up), the number of new cases in relation to the total population dropped nearly 50% a year. This trend continued more slowly between 1940 and 1942. But then the incidence of the disease shot back up, from 0,17% to 0,29% in 1943, 0,34% in 1944, 1,29% in 1945 and 4% in 1946 — a figure that had seldom been recorded, not even at the peak of the 1920 epidemics (Farinaud 1945, 1946 and 1947). Between 1940 and 1943, the rubber harvest in Haut-Nyong soared tenfold, overshooting 400 tons and probably even more in 1944 and 1945 (David 1942: 73; Médecin-Chef de Région 1944: 11), while American imports of African rubber reached 35.700 tons as compared with 7.300 in 1940 (Wendt 1947: 208).

The problems caused by the rubber boom were aggravated by an upsurge in world prices for minerals, a stimulus in Cameroon and all of central Africa to the mining economy and for mineral prospection (Dumett 1985). The Haut-Nyong was not spared. The alluvium of the Nyong River contained rutile, an oxide of titanium used in the paint for airplanes and automobiles. The rutile rush was a cause of despair for Dr. David, who saw his few remaining workers leave for open pit mines along the river — a location known to harbor tsetse flies. Production reached 2.000 tons in 1944.⁹ An irony of history: the discovery of the rutile deposit is still hailed as a contribution that the colonial Health Corps made to Cameroon’s development. In effect, two colonial pharmacists, Le Floch and Dufour, discovered the deposit during the war (Oudart 2005).

The recrudescence of sleeping sickness but two years after the enforcement of the emergency regime was made worse by the doctors’ own projects. In 1942, Dr. David decided to place the region’s future leprosarium in one of the last known strongholds of sleeping sickness, Madouma near Abong-Mbang. The laborers sent to work there in 1943 came down with the disease. Given the labor shortage, they were patients who had been sent there from leper-houses in the region. When they returned back to their leper-houses in 1945, they “caused a new, serious outbreak [of sleeping sickness] at the leper-house in Messamena” that spread to the neighbouring village and Catholic mission. The worst was yet to come however. When the leprosarium in Madouma finally opened its doors in 1946,

⁹ Statistic from the website on present-day plans for mining rutile in Haut-Nyong. <http://www.akonolinga.net> (accessed 14 July 2008).

the decision was made to (this time definitively) transfer there all leprosy patients in the region. According to the health service report, “several lepers who realized that contaminations had occurred the previous year in Madouma ran away: the outbreak in Messamena spread even farther, as new, small outbreaks occurred nearly everywhere at random depending on where the runaway lepers carrying the trypanosomes stopped for the night.” (Farinaud 1947: 167-168) Was there any surer proof of how lucid the leprosy patients were about the doctors’ generous intentions? The story would be a mere anecdote had the outbreak in Messamena not caused one of the severest epidemics in Cameroonian history.

The final results of this medical administration? Without any doubt: a failure, all the more painful insofar as it left the doctors speechless. As Vaucel wrote, the medical region was supposed to put an end to the “muted conflict that for a few years has set the administration and medicine at odds in the Haut-Nyong region: administrative officials half-heartedly applying regulations they claimed were incompatible with country life, and doctors persuaded of the futility of their purely technical efforts and demanding observance of the texts.” (1940: 162)

By conferring the command on doctors, the medical administration deprived them of their favourite enemy: the “narrow-minded bureaucrats” in the colonial administration. The doctors thus came face to face with their own powerlessness.

Conclusion

Following a gradual return to normalcy as the number of doctors assigned there decreased, the Haut-Nyong medical region was finally dissolved in 1948. Besides reminding us that Free France, like Vichy, had its share of biopolitical hubris,¹⁰ the short experiment in Haut-Nyong significantly influenced colonial policy. It was replicated in 1944 in Ubangi-Shari (Giles-Vernick 2002: 101-107), and would be cited as an example to follow in manuals of tropical medicine till the late 1950s. To quote from the chapter on sleeping sickness in the foremost textbook of the times: “In the areas afflicted by the epidemic, the

¹⁰ The importance given to a disciplinary control of women and youth in the Haut-Nyong experiment was very similar to the Vichy government’s colonial policies (Jennings 2001).

‘medical region’ formula, which conferred administrative powers on the health service, is especially to be recommended as achieving a maximal unity of medico-administrative goals.” (Vaucel 1952)

The Haut-Nyong experiment served as a reference point for the Brazzaville conference in early 1944, which organized health actions for French Africa (IMTSSA 1944). The convergence between the “reactionary utopianism” of the Brazzaville plan and the Haut-Nyong experiment cannot be ascribed to chance. There were only two doctors on the conference’s health committee: Marcel Vaucel, who headed the Cameroon Health Service when the medical region was created and then later became director of the Health Service in the Commissariat for the Colonies in Algiers; and Lt.Col. David, who had just been promoted to the top of the Health Service in Yaoundé. It comes, therefore, as no surprise that this health committee cited the medical region formula as an example and recommended it “for areas exceptionally afflicted by social plagues”. Without exaggerating, we can refer to Haut-Nyong as a laboratory and school of hubris, since this experiment foreshadowed the extraordinarily ambitious turn taken by colonial health policies after the war, policies lacking in neither daydreams nor disasters (Lachenal 2006).

Official accounts of the Haut-Nyong experiment should not be seen as mere propaganda that tried to cover up a posteriori the real situation, which has been described herein. On the contrary, this chapter should help us see the gap between reality and utopia not as a historian’s finding but as the grounds for critiques, actions and subjectivities. What is noteworthy is not so much the systematic failure of social medicine’s vast ambitions — in Haut-Nyong and in experiments conducted elsewhere at the same time (Marks 1997; Cueto 2004) — as the historical possibilities ensuing from this failure when it was recognized by the doctors themselves: an increasing reliance on coercion, the quest for technical solutions and, too, a sense of renunciation, which was the nihilistic counterpart to the utopias of social medicine (Roussin 2005).

Public health has constantly pondered this failure. As Didier Fassin has pointed out, the history of public health can be “described as [...] an endless denunciation of its shortcomings and failures” (2001: 54). What transformed certain major colonial doctors into heroes and models for the profession was, precisely, their failures, and the associated drama. The biographies of Eugène Jamot and Gaston Muraz, who had eliminated a disease

during the 1920s and 1930s that would loom again as a menace in 1948, read as a series of victory announcements followed by clashes and dismissals (Bado 1996). Inspired by these unfortunate but adored heroes, and rife with an ambivalent “desire for failure”, the ethics and aesthetics of colonial doctors harboured a nihilistic potential, which works of literature, ranging from Céline (Roussin 2005) to Sartre (2007), clearly portrayed. By placing immense hope in the ambiguous Africa (Balandier 1957) taking shape before their eyes, the doctors knew they ran the risk of being disappointed and losing their illusions. Historians reveal nothing by exposing these disappointments and lost illusions. On the contrary, the doctors found in them the very meaning and grandeur of their mission. In conclusion, we wonder whether this nihilistic and sometimes delirious — or rapturous — aesthetics was not the very grounds for breeding the political pretensions of these doctors and humanitarians, both of the colonial doctors of yore and of today’s heroes of “global health”.

A final question: did Commandant Dr. David actually “go crazy”, as the missionaries thought? It is hard to answer. He was promoted to head the Cameroonian Health Service in 1944 but passed away shortly after the war. He was buried near Abong-Mbang, where his grave apparently became a shrine.¹¹ One piece of evidence, reported in the oral accounts collected by Wang Sonné: Dr. David, a referee in pole-vaulting and foreman at construction sites, an obstetrician and demographer, a cacao-farmer and builder of schools, left behind the memory of a “very dreaded” man. He was known as “the Emperor of the East” (Sonné 1998).

Dr. Koch, his deputy and head of the Messamena subdivision, pursued his career after the war, drawing on the expertise he had acquired. Stationed in the early 1950s at the Federal Hygiene Service’s headquarters in Bobo-Dioulasso, he conducted demographic and statistical studies (Koch 1949, Le Rouzic/Koch 1949) before turning to the ethnology of “his” tribe, the Bidjoués of Messamena (whose language he spoke) and publishing a book on them in 1968. Faithful to the ambitions of the Haut-Nyong utopia, he penned, in 1967, an esoteric, meditative reflection on the “medicine of hope”. A quotation chosen by chance gives the tone of this book and lets us free to imagine what the medical rationality in power

¹¹ Fieldwork is needed to corroborate this point and confirm the grave’s location. In a private communication, Peter Geschière stated that, in the 1970s, locals said that pupils laid their workbooks on Col. David’s grave for luck in passing examinations.

in Haut-Nyong amounted to during the long years of war and the rubber trade: “No sick person and no doctor, no individual and no society, will ever be able to deny that the druid’s dolmen is alone in its place in reason on this earth.” (Koch 1967: 120)

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