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Medical Supervision in Mayotte During the Colonial Era (1843-1946)

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Abstract

From 1843 (when it actually took possession) to the end of the century, the colony's health system was based on the doctors of the Marine Medical Service. They were trained for two years in one of the three schools of naval medicine and surgery founded in the eighteenth century in Rochefort, Brest and Toulon. Their stay in Mayotte was only one stage in a career alternating assignment in maritime hospitals, the ships of the Fleet or other colonies. The Dzaoudzi Hospital, built from 1848 to 1851, was at the heart of their activity. It welcomes the soldiers of the garrison and the local population. Two to three doctors are permanently assigned to the colony. In addition to their service in the hospital, they had other duties such as visiting the infirmaries on the plantations or boarding ships. With the limited means at their disposal in terms of scientific knowledge and pharmacopoeia, they are confronted with known pathologies (leprosy, venereal diseases, respiratory diseases, etc.) but also with tropical diseases, including malaria, the great endemic disease of Mayotte. They are often the first victims and the continuity of service is weakened by convalescent leave in Reunion Island or mainland France. In 1886, France established its protectorate over the other islands of the Comoros, where it was now necessary to ensure a minimum medical presence, if only for the European settlers who lived there. However, the financial means are limited to cover the salaries of military doctors assigned to these territories and the shortage of personnel is accentuated despite the occasional use of civilian doctors under contract. At the same time, the reform of the training of naval doctors, with the establishment of a single school in Bordeaux in 1890, and the creation of a medical corps for colonial troops in 1901, laid the foundations for overseas health action with the autonomy of the colonial administration, which had a ministry in 1894. From 1908, the attachment of the Comoros to Madagascar, which became a province of the Big Island in 1914, integrated the archipelago into the structures of the Indigenous Medical Assistance (AMI) created by Gallieni in 1896. A hierarchical network of health facilities must provide the population with care but also promote prevention and hygiene measures. This organization is based on indigenous personnel trained at the medical school of Antananarivo or in the regional nursing schools. In residence in Dzaoudzi, a doctor from the colonial troops, placed in a non-executive position, managed the Comoros district, while Malagasy doctors, assisted by native auxiliaries, directed the health facilities, which partly solved the personnel problems of the previous period. Their action benefited from the fallout of the Pasteurian revolution (identification of pathogens and their vectors allowing prophylactic measures) and the use of new treatments such as synthetic antimalarials. In 1946, the Comoros became an overseas territory with increasing autonomy, a new stage in the history of its health services.

Keywords: mayotte; colonial era; pasteurian revolution; regional nursing schools

Introduction

We are going to talk here about the first steps of a health system on the European model in Mayotte during the colonial period. The latter really began with the taking possession of the territory by Commander Passot on 13 June 1843, almost two years after the signing of the cession treaty with Sultan Andriantsouli. Very sparsely populated (6,800 inhabitants in 1852, including about 200 Europeans including the garrison and civil servants), relatively isolated, this territory was not to be the priority of the administration. For several decades, medical facilities were very modest and their primary purpose was to provide care to civil servants and soldiers in the garrison. It was not until the beginning of the twentieth century that another evolution is taking shape. We are then more concerned with development and therefore with the health of the populations, providers of workers and taxes. In this context, doctors also exercise their humanitarian role and show dedication, while being aware, for some of them, of the magnificent field of experimentation and discovery that is open to them. It is these two major phases that we are going to describe.

Until the End of The Nineteenth Century: A Very Limited Medical Framework

Naval Doctors: Background, Training, Status and Role

The Context of Colonial Expansion

Until the end of the nineteenth century, it was the naval doctors who were in charge of the health service

in the colonies. Indeed, with the exception of brief periods under the Second Empire (in 1858-1860 with a Ministry of Algeria and the Colonies) and at the beginning of the Third Republic (November 1881-January 1882; March 1889-March 1892 and January 1893-March 1894 with the attachment to the Ministry of Commerce), the administration of the colonies depended on the Ministry of the Navy.

From the middle of the century, France's colonial expansion entered a new phase with the acquisition of new colonies in Oceania (Tahiti, New Caledonia) and Southeast Asia (Cochinchina). This expansion accelerated from the 1880s onwards. New territories that had to be administered but also to which a minimum of medical supervision had to be provided, if only for the troops stationed there, the civil servants and the European settlers who lived there. The number of active naval doctors (excluding senior officers and professors) rose from 296 in 1836 to 449 in 1844, 572 in 1870 and 624 in 1885. Those assigned to the colonies represented an average of 18% of the total number of soldiers (85 or 18.9% in 1844, 117 or 21.4% in 1867 and 122 or 19.5% in 1885) [1].

Training in The Schools of Naval Medicine and Surgery

How do you become a Navy doctor? Since the eighteenth century, three schools of naval medicine and surgery have been responsible for training surgeons embarked on warships. The first opened its doors in 1722 in Rochefort; two others followed in Brest in 1731-1734 and in Toulon in 1785.

Young people who wanted to enter these schools, like students in civil medical faculties, had to hold a baccalaureate of letters from 1821 (except for a brief period in 1831-1836) [2]. From 1865, they were also required to have a bachelor of science [3]. They therefore had a solid intellectual background when they entered school and enjoyed the prestige of a diploma that was then obtained each year by only a tiny minority (about 4000 in 1851, 7000 at the end of the century).

Pursuing medical studies in these schools is also an opportunity for many provincials of modest origins who could not cope with the expenses and cost of living in the cities of the great faculties of medicine of Paris, Strasbourg and Montpellier. Recruitment is therefore mainly regional. Alain Mounier-Kuhn, who worked on a sample of 142 doctors from the Navy and the Colonial Health Corps, notes that the areas of origin of two-thirds of them correspond to the three major war ports (39 doctors), Brittany (26), and the Atlantic and Mediterranean coasts (30) [4].

Until 1886, the studies lasted two years. The academic year runs from November 1 to August 25 of the following year. The end-of-year exams take place between August 25 and 31. The tests are oral, with each student being questioned for 15 minutes in each subject. The marks of the assessment during the year and those of the end of the year are taken into account in the overall mark of the competition at the end of the second year. There were two categories of students: those who wished to make a career in the Navy medical corps (intern students who would become "maintained" surgeons); They are barracked, wear uniforms and are subject to school discipline. Many of them receive scholarships. The other category, the "day students", who did not have this military status, attended classes and took exams, but the discipline was limited to driving. They will become "auxiliary" surgeons.

At the end of their schooling, the former takes the 3rd class competitive examination for maintained surgeons, the latter the 3rd class auxiliary surgeon examination. The latter will be recruited and therefore paid according to the needs of the service. The competition is also open to second-year medical students who meet the age criteria (between 18 and 23 years old).

Status, Career and Role

Naval surgeons have long been the poor relations of their administration in terms of status. Until the mid-1830s, they were considered only "employees" of the ministry and did not have the status of officers. They did not obtain it until 1834 [5] and the ordinance of 17 July 1835 [6] which reformed the organisation of the corps of naval medical officers established for each rank an equivalence with those of naval officers. For the first three grades of surgeons, this corresponds respectively to those of naval cadet 1st class, frigate lieutenant and lieutenant of a vessel.

Advancement is systematically made by competitive examination with seniority conditions up to and including the grade of surgeon professor.

Called "surgeons" and then "doctors" from 1865 onwards in the denomination of the degrees, they were not all doctors. The doctorate in medicine was not compulsory to access the first three grades of junior officers (3rd, 2nd and 1st class surgeons) according to the ordinance of 17 July 1835. He only became a member of the Colony to reach higher ranks and, in theory, to head the health service of a colony.

From 1865 onwards, health officers were required to take the doctorate within three years of passing the doctor's assistant competition (the first rank after passing the competition, a name that replaced that of 3rd class surgeon) in order to continue their career [7].
In 1886, training in naval medical schools was aligned with that of medical faculties. Students completed four years of study at the end of which they obtained the degree of doctor of medicine [8].
Many health officers wait years before taking the doctorate, due to a lack of time to prepare for it, taking advantage of a leave of absence to present the final exams and thesis. They had to ask the administration for an exemption from the compulsory baccalaureate of science from 1865 as well as the granting of 16 quarterly registrations (corresponding to the four years of medical studies) in order to be able to take the tests.
During their careers, naval doctors are required to carry out their duties in different situations:

- They can first be assigned to the maritime hospitals of the major ports of the fleet: Cherbourg, Brest, Lorient, Rochefort and Toulon. They treated sailors and soldiers of the Navy but also the civilian populations living in the vicinity. In the ports of Brest (until 1858), Lorient (until 1830), Rochefort (until 1852) and Toulon (until 1873), they were also in charge of the medical service of the prisons. They could also be used in the penal colonies opened under the Second Empire in Guyana (1854), Cochinchina (Poulo Condore, 1861) and New Caledonia (1864);
- Service at sea, on board the ships of the fleet, is also an essential part of their career;
- They may also be assigned to the Marine infantry regiments in mainland France or in the colonies and accompany them in times of war in their combat missions;
- Finally, they can obtain a post in the colonies where they work in the hospitals of our overseas possessions. Posting to the colonies is a choice. They apply to the Minister and take the open competitions to fill the vacant places.

Finally, these doctors advanced knowledge by contributing to major medical journals such as the Archives of Naval Medicine (1864-1889 and 1897-1910), the Bulletin de la société de pathologie exotique created in 1908, and others.

A Portrait of The Heads of The Health Service in Mayotte from 1844 to 1879

The First Heads of The Health Service: Their Career Path

Ten doctors succeeded each other from 1844 to 1879 at the head of the Health Service (see the table in Appendix 2).
They studied in one of the three schools of naval medicine and surgery: in Rochefort for Gustave VRIGNAU and Élie Myrtil LEBEAU, in Brest for Dominique DAULLÉ and Alfred GRENET and in Toulon for the other six. They were student surgeons there for two years before taking the 3rd year surgeon exam 3rd class at the end of the second year and thus begin their careers either as "maintained" or as "auxiliaries", the only one in the latter case being Dominique DAULLÉ. He is the only auxiliary surgeon on the list. Was his assignment to Mayotte explained by a lack of staff at that time? Or by the links he could have forged with the superior commander of Mayotte Morel, whose daughter he married on 5 October 1858, a few months after his arrival in Dzaoudzi? The documents consulted do not allow us to learn more.
These doctors began their studies between the ages of 16 and 20. Some were admitted to their school at a very young age: Charles GANTELME at the age of 16 in 1837 in Toulon, Gustave VRIGNAU at the age of 17 in Rochefort.
Of these ten health officers, five will defend a doctoral thesis in medicine, often at an advanced age, for lack of being able to find the time to prepare for the examinations and the defense. The youngest, Gustave VRIGNAU, defended his thesis in 1837 at the age of 30, the oldest, Jean-Antoine SANTELLI at the age of 52; the other three at 36 (Dominique DAULLÉ) and 41 years old (André EYSSAUTIER AND Alfred GRENET). The latter took advantage of a convalescent leave in 1866 to present it to the faculty of Montpellier "Medical memories of four years in Mayotte»). Only three of them (Gustave VRIGNAU, Dominique DAULLÉ and Jean-Antoine SANTELLI) held a doctorate when they arrived in Mayotte and thus complied with the regulations which stipulated that the heads of the health service in the colonies had to be doctors of medicine.
At the time of their arrival in Mayotte, they were experienced men with an average age of 40. (the youngest, Charles GANTELME, was 32 years old when he arrived in 1853; the oldest, Jean-Antoine SANTELLI, was 53 years old in 1878). Indeed, to reach the grade of surgeon or doctor of 1era class, the minimum required by regulation to head a colonial

health service, they had to first access the grades of surgeons or doctors of the 3rd class (at the end of their schooling at the medical school) and then the 2nd class. They had an average of 16 years of seniority in the Navy Medical Corps at the time of their assignment (At the two extremes, Charles Henri GANTELME and Alfred GRENET had 13 years of seniority, Marius GIRAUD, 20 years).

Their previous career has essentially alternated between stays in the seaports of mainland France and service at sea, on the ships of the fleet. For five of them (Gustave VRIGNAU, Charles GANTELME, Pierre MAIRE, Alfred GRENET and André EYSSAUTIER), the post of Mayotte was their only overseas assignment. Four served in Nossi-Bé or in Reunion in an earlier period: Dominique DAULLÉ (in Nossi-Bé from 1853 to 1856); Alphonse AUVELY (in Reunion in 1850-1854 and in Nossi-Bé in 1862-1865); Marius GIRAUD (in Reunion in 1852-1855 and 1859-1861 and Nossi-Bé in 1857-1859); Jean-Antoine SANTELLI (in Reunion Island in 1850-1851). Three of them had experience outside the Indian Ocean: Élie LEBEAU had spent two years in the French establishments in Oceania in 1843-1846, Marius GIRAUD had served in a Marine infantry regiment in Cochinchina in 1864-1866 and Jean-Antoine SANTELLI had stayed in Senegal in 1867-1868 and 1869-1871.

The duration of the statutory stay in Mayotte for the heads of the health service was normally four years, then three years at the end of the century, but in practice it varies considerably depending on the doctor. They remained in office for an average of about three years, the record belonging to Alfred Grenet who stayed more than eight years in Mayotte (from September 1861 to October 1869) but his marriage in July 1864 to a widow living in Dzaoudzi was probably not unrelated to the prolongation of his stay. Of the nine doctors for whom we have information in this area, only one, Marius GIRAUD, ended his statutory stay in 1876 without having invoked health reasons. All the others left Mayotte after an examination by the health council and were granted convalescent leave, two (Pierre Maire and Dominique Daullé) died in the line of duty. The first died of an attack of fever on his return from Nossi-Bé on 6 April 1857; the second, to the hospital of La Réunion where he had been sent on leave on January 9, 1861.

These elements confirm the importance of pathologies of tropical origin and the risks inherent in being assigned to the colonies. Alain Mounier-Kuhn believes that the possibility of dying before the end of the career "was close to 40% [9].

The Mayotte Health Service

Their main place of practice and habitual residence is the rock of Dzaoudzi where the hospital is located, which remained, until the beginning of the twentieth century, the only real medical structure in Mayotte. It was a Marine hospital until 1877, when it came under the local service and therefore the colony's budget.

The head of the health service is assisted in his task by one or two surgeons/doctors of the 2nd or 3rd class who are maintained or auxiliaries. Among them, we can mention the surgeon of the 2nd class Jean-Baptiste GÉLINEAU who was stationed in Mayotte between June 1851 and June 1852 and to whom we owe in 1858 a thesis entitled "Medical Overview of Mayotte Island and Louis Charles Émile MONESTIER, 2nd class auxiliary surgeon who stayed 11 years in Mayotte from 1858 to 1869 and who was the author of articles in the Archives of Naval Medicine.

The doctors were assisted by a nursing staff made up of nurses and hospital sisters from the Congregation of Saint-Joseph de Cluny (they were replaced by lay staff from 1904). In 1879, in addition to the two doctors, four hospital sisters, a nurse major and four ordinary nurses were included in the budget [10]. In 1898, Inspector General Picquié, noting the lack of activity in the hospital, found this hospital staff superabundant [11].

The functions of the doctors are not limited to their service at the Dzaoudzi hospital; they are also in charge of the sanitary police and therefore of the boarding of ships, the visit of the lazaretto of Bouzi and the leper colony of Mtsamboro; They also had to regularly visit the infirmaries of the island's plantations, for which they received a very lucrative subscription from the colonists.

In his thesis [12], Alfred GRENET indicates an average of 531 admissions per year to the hospital between 1 July 1861 and 30 June 1865. About 56% of the entries concern civil servants, soldiers from the garrison and the sick of ships docking in Mayotte. Settlers, housing workers and other inhabitants total 44%. The average number of hospital days is 19 days. Although the hospital enjoyed a high number of visitors until the end of the 1860s, it seems to have declined thereafter. There were 346 admissions in 1884. The Spiritan Fathers, present in Mayotte, noted in 1888-1889 that "The care of the hospital, we must say, is not very painful, for often there are no sick

people [13]. and in 1893-1895, they observed that "for four years, the hospital of Dzaoudzi has not given us much work; sometimes three months pass without a patient enteringand the author adds "Has Mayotte been cleaned up? [14]. How should we interpret this development? It probably cannot be attributed to the improvement in sanitary conditions. First of all, it seems that medical rounds have developed and patients therefore have less reason to travel. Administrator Mizon noted in August 1898 that the second doctor had to "to travel around the island of Mayotte and visit once or twice a week the infirmaries of the plantations, the police stations, to visit the villages where epidemics reign, to vaccinate the population [15]. The decrease in attendance at the hospital also seems to have coincided with the adoption in 1867, by the superior commander, of a new regulation establishing stricter admission procedures and imposing the reimbursement of days of hospitalization. Doctor Neiret confirmed this explanation in 1897: "Steamers carrying troops, warships sometimes leave soldiers or sailors in the hospital. Creoles do not like to enter the hospital; It is true that hospitalization costs are very high. The free natives never enter. The indentured servants show a rather great reluctance to enter it. The owners show an even greater reluctance to pay the two francs a day, the price of the hospitalization of the natives [16]. The same is true of the Spiritan fathers: "The hospital of Dzaoudzi gives us little work, but also little consolation; sometimes for three months, only a dozen Makoas, hired on the sugar estates, have entered it. As long as there was a man with a strong hand at the head of the colony, as the last administrator called himself, the poor, sick blacks had only to resign themselves to dying in a mean thatched hut: "no more room in the hospital," was his reply. There really should be a union that would pay the hospital fees for those who cannot do so [17].

Finally, in a context of staff shortages and absenteeism due to sick leave and convalescence, these doctors are sometimes required to work in jobs for which they were probably not prepared. Thus, in 1871-1872, Dr. Auvely was entrusted with the duties of acting judge for fourteen months [18].

Difficult Working Conditions: Isolation

Posting to Mayotte is not a sinecure. Like the civil servants, the soldiers of the garrison or the inhabitants of the small colony, they were confronted with isolation.

The doctors lived in the rock of Dzaoudzi where the garrison and the civil servants of the administration were concentrated. It's a closed world where they rub shoulders on a daily basis. In a letter of 1855 to the Minister, proposing the head of the Gantelme health service for the cross of the Legion of Honor, Superior Commander Vérand explained: "The officers and employees of our establishments in Madagascar have to contend not only against the diseases inherent in this frightful climate, but they are also deprived of what everywhere else, in our other colonies, makes life, if not pleasant, at least bearable. Here, of distraction of any kind, always left to himself, the officer or employee has only work to ward off boredom, and it requires a very great energy to control this terrible disease. I call it so because it is often the cause of many evils [19]. The superior commander did not specify these evils, but alcoholism must have figured prominently, as suggested by the decrees issued in 1846 regulating the opening of cabarets and the consumption of alcohol.

This isolation is accentuated by the slowness of communications and therefore of information. In 1855, Superior Commander Vérand complained that he had only one ship, "L'Indienne" and he observed that "nothing is more painful [...], than this isolation in which we find ourselves here, the lack of regular communication with Reunion Island, places us in an extremely critical situation. We are still wondering whether we will not run out of basic necessities, which has already happened [20].

It takes months to hear from the metropolis. To reach Mayotte or return to France, doctors board Navy ships or commercial ships. The journey, both outward and return, is very long, with all the risks that maritime transport entails. Gustave VRIGNAU, left Bordeaux on September 30, 1843. The ship carrying him, the three-masted "Le Bordeaux", arrived in Mauritius on 31 December to drop off passengers but was thrown ashore by a tidal wave and the doctor lost a large part of his luggage on this occasion. He arrived in Reunion Island on 13 January 1844 and stayed there for three weeks. He left for Mayotte on 4 February and was finally able to disembark there on 11 March 1844 after a journey that lasted a total of five and a half months. His successor, Élie Lebeau, took six months to reach his destination. The official and personal mail took the same routes, and news was received only from time to time.

The situation improved somewhat thereafter. From the beginning of the twentieth century, a Messageries

Maritimes liner provided a link with mainland France once a month on the outward and return journey. A steamer connects with the same frequency the islands of the archipelago except Moheli. The islands benefit from an optical telegraph communication system and a wireless radio station has been installed in Mayotte.

Difficult Working Conditions: Diseases

As we have seen above, doctors also pay their price for the climate and the endemic diseases of tropical countries. They are frequently ill, which is not without consequences for the functioning of the health service. If they are too affected by the disease, they must be examined by the Mayotte health council, which authorises them to take convalescent leave in Reunion Island, or even in the most serious cases, in mainland France. The inspection certificates give us an overview of the reasons why they have to interrupt or cease their duties. Thus Gustave VRIGNAU, authorized to leave Mayotte on July 27, 1848, landed in Reunion Island on September 2. The health commission that examined it in November noted that it was "who has been suffering for several years from a chronic disease of the abdominal viscera (chronic hepatitis and splenitis) occurring following intermittent febrile attacks [illegible] and also a carrier of a tuberculous skin disease [21]. His successor at the head of the health service, Elie Myrtil LEBEAU, who arrived in July 1848, asked the Minister of Marine to recall him to France for health reasons a year later. But it was not until November 1850 that the Mayotte health council examined it and concluded: "M. Lebeau has been suffering from intermittent fever since the month of April 1849, the attacks renewing themselves every fortnight have since become more frequent; The character of this fever presented for a long time nothing alarming except an increasing debility of the forces. [...] The strength is nil, the intelligence is seriously weakened, there is memory loss [22]. Sent to France, he was granted a six-month convalescent leave from 21 Nov. 1850. This renewed leave, he was finally placed in a position of non-activity due to disabilities and never returned to active service. Charles Honoré GANTELME, who succeeded him in 1853, was unable to complete his period of regular service in Mayotte and left his post on 20 August 1856.

We could thus multiply the examples. All doctors obtain, at one time or another (during their stay or on their return to France), a convalescent leave of at least three months, which is often renewed. This is not without problems for local authorities who are faced with absenteeism and have to juggle with limited medical staff. Thus, after the death of the head of the health service Pierre MAIRE in April 1857, the superior commander decided to keep the surgeon 2nd class PIETRI in Mayotte, instead of sending him on convalescent leave as planned, because he could not entrust the responsibility of the health service to a "young surgeon of the 3rd class". class, who enters the service and who has neither experience nor practice [23]. In 1869, the prospect of Dr. Grenet's departure worried the superior commander. He informed the Minister that "if M. Grenet leaves Mayotte, there is only M. Monestier, a doctor of the 2nd class, doctor of medicine, here to visit the inhabitants of Grande Terre and satisfy all the needs of military service and he adds that "M. Monestier, who is very ill at the moment, may still be so [24].

The Reforms of The Late Nineteenth and Early Twentieth Centuries and Their Consequences in Mayotte

Reforms at The Turn of The Twentieth Century

At the end of the nineteenth and the beginning of the twentieth century, reforms relating on the one hand to the training of doctors who had to practice in the colonies and, on the other hand, to the framework in which they carried out their action overseas were not without consequences for Mayotte.

Reforms Concerning Training

At the end of the 1880s, the training system of the Marine Medical Corps experienced a crisis that led to a reform of the organization of studies. Indeed, in 1886 [25], following a reform that can be described a posteriori as unfortunate, the body of medical professors was dissolved and one now became a professor by competition. The position is limited to five years. The doctors then returned to the frameworks of assignment of their rank (buildings, colonies). This prospect leads to a wave of resignations and a decline in the quality of studies (which have been extended to four years) because due to a lack of teaching staff, certain points of the curriculum are not addressed. In 1888, the Minister of Public Instruction's threat to no longer grant the equivalence of studies in the Navy schools with those of the faculties of medicine led to an overhaul of the system. Thus, in 1890, a school of the naval health service was created in Bordeaux, which became the main training school [26]. Studies in Bordeaux lasted three years. The students attended the city's medical school. The

three former schools of Brest, Rochefort and Toulon were transformed into annex schools. They served as preparatory schools where students followed the courses of the first year of medicine (they obtained the first four registrations) and prepared for the entrance exam to Bordeaux. They are also application schools where, after their doctorate, the laureates follow a few months (from 1 February to 1 September) of training in naval medicine. In 1895, Toulon became the only application school. Doctors were given tenure on leaving the navy or the colonial medical corps created in January 1890.

However, in the eyes of the Colonial Office, the program of the demonstration school, which was too focused on naval hygiene and war surgery, did not sufficiently meet the needs of doctors called upon to serve overseas. This is why the school for the application of the medical service of the colonial troops was created in 1905 [27]. It was established in Marseille in the Pharo district and inaugurated on September 27, 1907. The course takes place there from 1er February to October 1. Doctors of civilian medicine are accepted directly at the end of a competitive examination. On leaving school, a commitment to serve six years in the colonial health service had to be signed. The first class, which arrived on 1 February 1907, was composed of 42 doctors and 4 pharmacists [28].

A Changing Colonial Health Service

The extension of the French colonial empire favoured the autonomy of the colonial administration and the establishment of a new framework for the health service in the colonies. The main steps are:

- The creation by the decree of 7 January 1890 [29] of the "health corps of the colonies and protectorate countries". It was formed on an autonomous basis and was therefore seconded from the Marine Medical Corps. All the colonial health services, with the exception of the medical service of the marine troops, are placed under the authority of the Minister in charge of the colonies. For recruitment, navy doctors and pharmacists can opt for this new corps (120 navy doctors will join it). It is also planned to recruit civilian doctors who have graduated from a faculty, under the age of 28;
- The creation of colonial troops by the law of 7 July 1900: the regiments of the Marine troops were withdrawn from the Ministry of the Navy and transferred to the Ministry of War. The medical corps of the colonies was given the task of providing the medical service of the colonial troops, the organization of which was specified by the decree of 11 June 1901 [30].
- The decree of 4 November 1903 [31] organised the colonial health services. It provided that some of the doctors of the colonial health corps could be placed outside the cadre when they carried out functions in structures (health police, hygiene, etc.) of which the civil part formed the essential. They are placed in this position for a maximum period of four years. "In 1911, 200 colonial doctors and 16 pharmacists were in a non-executive position, i.e., 40% of the workforce of the health corps [32].

The consequences for Mayotte: medical supervision and the health service until 1946

From the end of the nineteenth century, a new era began for the health system of Mayotte. It suffered the repercussions of the successive reforms of the colonial health service, the new responsibilities resulting from the protectorate over the other islands of the Comoros in 1886 and its incorporation into the general government of Madagascar from 1908.

A Context of Budgetary Difficulties and Staff Shortages at The Turn of The Nineteenth and Twentieth Centuries

The first challenge for the health service from the end of the nineteenth century was to meet the needs of the three protectorates created in 1886 in addition to those of Mayotte. However, to assume this new responsibility, the financial and human resources are sorely lacking. The local budget is insufficient. In 1893, for budgetary reasons, the governor of Mayotte decided to transfer the 2nd class doctor Brochet to the Comoros with residence in Anjouan. This obviously meets a need, but it is also a way of eliminating a post in Mayotte and making savings, because its pay will be borne by the protectorates' budgets. The head of the health service therefore found himself alone in Dzaoudzi for a few years. In 1898, the Ministry of the Colonies proposed the installation of a civilian doctor who would also be a colonist. But the administrator Mizon was quick to point out the incompatibility of exercising the two functions and therefore the inanity of this project, which never saw the light of day [33]. At the beginning of the twentieth century, to meet the needs, European colonization doctors were called upon to be recruited in metropolitan France or to doctors from the colonial troops' medical corps who were placed in a non-executive position. The

experiment does not seem to have been very conclusive with regard to civilian doctors, since the documents give only two names: Doctor Candé in Anjouan and Doctor Duché in Grande Comore. They were then replaced by doctors from the colonial health service. In a 1906 report, the inspector of the colonies Norès criticized the lack of clear regulations concerning them and more generally the absence of a regulatory framework for the colony's health service [34].

At the beginning of the twentieth century, in addition to the hospital in Dzaoudzi, an infirmary functioned in Hombo (Mutsamudu, Anjouan) and a rudimentary straw hut in Moroni (Grande Comore). The latter was replaced in August 1910 by a new construction. In Mohéli, a room to be used as a hospital was delivered to the local service on 1er May 1914. This shows the modesty of the means deployed.

The CEI Brings New Human Resources

The attachment of Mayotte and the protectorates to the General Government of Madagascar from 1908 (decree of 9 April, but the archipelago retained its financial and administrative autonomy) was a turning point for the Comoros archipelago, which became one of the provinces of the General Government in 1914 [35] after the annexation of the protectorates of Anjouan, Mohéli and Grande Comore, which had become colonies in 1912 [36]. Now included in the orbit of the Big Island, it will depend in the organization of its health system on the directives of Antananarivo and will be part of the system set up from 1896-1904 by General Gallieni, that of the Indigenous Medical Assistance (AMI). But it was not until 1915 [37] that the regulations concerning the MAI were officially applicable in the Comoros archipelago.

This organization, which was gradually imitated in the other territories of the French Empire, reflected the desire of the colonial authorities to give new impetus to the action of the health services with the indigenous populations. It will be characterised by the densification of the healthcare offer and a more systematic prevention policy against endemic diseases. The massive use of indigenous auxiliaries (doctors, nurses, midwives) makes it possible to meet this ambition. It is a system run from Antananarivo by the Director of the Health Service who is also the Director of the AMI. Each province has an autonomous budget financed by a special tax and the reimbursement of the days of hospitalization of paying patients.

The difficult question of the shortage of personnel, which applied to Mayotte but also to the other colonies, was partly resolved by the use of indigenous auxiliaries. This is how the triptych of colonial troop doctors; European colonization doctors and indigenous colonization doctors was formed to provide medical supervision. The indigenous colonization doctors, the most numerous, were largely trained at the Antananarivo medical school, which was created in 1896 where medical studies lasted five years. A corps of "indigenous colonization doctors" was created in 1900 [38]. they are recruited by competitive examination and provide managers for hospitals and medical posts in Madagascar and the Comoros. A corps of indigenous nurses and midwives will also be created. They allow the administration to make substantial savings since their pay is much lower than that of the Europeans. We can get an idea of the importance of indigenous auxiliaries through the figures given by Albert Sarraut in the early 1920s on the AMI in Madagascar: "Medical services are provided by 12 civilian medical assistance doctors, 12 military doctors from the colonial troops, 182 indigenous auxiliary doctors recruited from among the students of the Antananarivo medical school, 124 indigenous midwives trained at the Antananarivo medical school and in the regional midwifery schools, and finally by 481 vaccinating nurses and indigenous nurses [39].

It was these doctors who were found in Mayotte and the Comoros in the interwar period under the direction of a European medical inspector belonging to the medical corps of the colonial troops. In 1921, the doctor in Dzaoudzi was even assisted by two Malagasy doctors who had belonged to the nationalist organization VVS and were probably under house arrest by the authorities in Antananarivo. One of them "provides the service of the medical post of Mamoudzou" and "Three indigenous doctors headed the health facilities of Mohéli, Anjouan and Grande Comore [40].

An Improvement in The Health Situation?

What assessment can be drawn from the evolution of medical supervision from 1844 to 1946 from the health point of view? Has there been an improvement? And which one? In the absence of a more in-depth study and sufficiently precise data, the conclusions can only be partial.

A Region Reputed to be Unhealthy and with Dominant Ailments

What is certain is that during a large part of this period, Mayotte had the reputation of being particularly unhealthy. In 1852, Commander Bonfils had dramatic accents to describe the situation: "From what I can observe on the spot, any individual who has spent five consecutive years in the locality is completely worn out. The men who have arrived here strong and vigorous, the men who are hard to die, are after this lapse of time reduced to the state of infirm old men. This metamorphosis usually manifests itself by catarrhs, deafness, asthma, dry colic, and swelling of the legs. There are very few subjects on which this kind of decrepitude can be observed, many have died here, many have also gone to die elsewhere. Each year spent in this country deprives at least two of them from existence, dries up all the sources of life, withers and withers the future. The last three quarters that I have just gone through have been very happy, they say, I am pleased about it: 567 admissions to the hospital, 5698 days and 8 deaths! At the moment, the inhabitants are covered in boils, they say it's a good sign [41]. In the 1920s, an administrator still spoke of a climate "hard, depressing [42].

These are the same conditions that are found throughout the colonial period. In his thesis defended in 1866, Alfred Grenet took stock of the hospital's activity from 1 July 1861 to 30 June 1865. The main conditions motivating admission to hospital are "malarial fevers" in various forms (44%), dysentery (7%), bruises and wounds (6%), and finally "contagious Mozambican ulcers" (4.4%). In 1912, the annual report indicated that "The most common diseases are yaws or cankered wound, malarial fever, venereal diseases, hydrocele and elephantiasis [43]. In 1931, the five most widespread diseases were, in order of frequency and importance: "yaws, malaria, tropical ulcers, elephantiasis, leprosy [44]. In 1947, the main ailments that led to admission to the Dzaoudzi hospital (405 in total) were yaws (107), malaria (54), syphilis (52) and phagedenic ulcer (46) [45].

Medicine, which had been powerless for a long time, benefited from new means from the beginning of the twentieth century.

An Improvement in Some Areas

Despite the weakness of human and material resources during most of our period, the health situation seems to have improved from the interwar period onwards. Indeed, Western medicine in the colonies became more effective because it benefited first of all from the fallout of the Pasteurian revolution. We will now be able to put a name to the causative agent of certain diseases and possibly its vectors, the identification of which makes it possible to take prophylactic measures. The discoveries will follow one another. Discovery of the causative agent of filariasis in its microfilarialized form by Demarquay in 1863 and macrofilarialism by Bancroft in 1876, of the bacillus responsible for leprosy by Hansen in 1873, of the dysenteric amoeba by Lösch in 1875, of the haematozo an responsible for malaria in 1880 by Alphonse Laveran, of the bacillus responsible for tuberculosis by Robert Koch in 1882 and of the cholera vibrio by the same researcher in 1883. In 1894, Alexandre Yersin, a doctor in the colonial health corps, discovered the plague bacillus. In 1902, the trypanosome responsible for sleeping sickness was identified. In 1905, the agent of syphilis, pale treponema, was discovered by Fritz Schaudinn and Erich Hoffmann.

Although effective treatments were not always available, the discovery of the role of mosquitoes as vectors for lymphatic filariasis (in 1877, by Patrick Manson), yellow fever (in 1881 by Carlos Finlay), malaria (in 1897-1898 by the Englishman Ronald Ross and the Italian Giovanni Grassi), and rat fleas for the plague, in 1898 by Paul Simond) made it possible to take prophylactic measures (mosquito net, destruction of larval sites, hygiene rules, etc.). Smallpox, which had wreaked havoc in the nineteenth century (epidemics of 1875, 1886 and 1898 in Mayotte) was less present thereafter if we except for Grande Comore in 1922 where the epidemic claimed nearly 200 victims [46]. This is the result of an improvement in vaccination coverage thanks to vaccination rounds and a better quality of the vaccine produced in Madagascar since the beginning of the century.

From the first half of the twentieth century, doctors also had access to more effective drugs resulting from advances in research. Salvarsan (arsphenamine) was discovered in 1908 and marketed in 1910; Stovarsol (acetarsol) was synthesized in 1921. They are used against syphilis and parasitic diseases (trypanosomiasis). Against malaria, in addition to quinine used since the nineteenth century, synthetic antimalarials were developed by the Bayer company, such as plasmoquin (1926) and quinacrine (1932), the use of which was attested in Mayotte in the 1930s for the former [47] and 1940 for the second [48]. At the beginning of the thirties, the medical inspector Bouillat, who contracted amoebic dysentery during a round, reported that she had been "quickly curbed by

amiphene [an iodinated antidiarrheal] With the help of opium, stovarsol and emetine [49].

Despite these Improvements, Problems that Persist

The first problem mentioned by the administrators is always that of communications. The relative isolation of Mayotte has consequences for the health of the population. The first is that if one or more doctors are unavailable, it is necessary to wait a long time for a replacement from mainland France, even if this issue will be partly resolved with the use of European or indigenous doctors from Madagascar. The supply of medicines is also made difficult. The absence of more frequent relations between the islands of the archipelago can also have dramatic consequences, as in July 1931: "the native doctor of Anjouan having had to treat a European, Mr. Mac Luckye, for tetanus, asked Dzaoudzi for anti-tetanus serum. A dhow was immediately armed. Although the season was propitious, this dhow was lost, carried by the currents, in South Africa, after twenty days of navigation [...] Mr. Mac Luckye died [50].

The location of the hospital in Dzaoudzi, which could be understood at the beginning of the colonial period, is less and less relevant as the population of Grande Terre increases and it is still difficult to travel to receive care. In his 1932 report, the administrator called for the creation of a vaccination station in Mamoudzou and justified his request: "The difficulties of communication between this locality and Dzaoudzi prevent the interested parties, and many of them go to the capital. Apart from the fact that the price of the round trip is 3 francs, the natives under treatment or observation do not know where to go to take their meals and to stay in a locality that offers no facilities of this kind [51].

Another example, Inspector Frezouls observed in 1909 that the leper colony of Mtsamboro was difficult to access and that "the lepers of Mayotte are too abandoned [52]. There is always talk of moving it to the interwar period, proof of the administrative slowness, because it is too far from the doctor in Dzaoudzi and because "the supply of food and drinking water was uncertain [53].

For the administrators, who after the First World War were imbued with the challenges of improving the health situation and the role of the MAI, the prejudices of the population constituted an obstacle to progress and to France's civilizing mission. The culture and religion of the natives would be an obstacle that would have to be removed. They complain of religious prejudices which result in the reluctance of women to be examined by European or Malagasy doctors and have recourse to matrons for their childbirth. In the 1920s and 1930s, the problem of the absence of midwives was regularly raised by administrators. In order to improve maternal and child protection, they are calling for the recruitment and training of indigenous midwives. But this solution is hampered by the lack of schooling for young girls. Traditional medicine is also criticized, sometimes violently. Thus, in his 1916 report, the chief of the province did not have harsh enough words against these healers, whom he described as follows: "All these doctors, all these soothsayers, all these oracles, all these magicians, all these swindlers provided with herb and knowledge by the Indian shopkeepers, hinder progress, check the evolution of intelligence, lock down minds, sow distrust, spread error and terror, disturb the public tranquility as well as individual beliefs. Their number is a function of their power and our prestige». Then follows the list of the 34 "Wizards" of Mayotte [54]. Thirty years later, the administrator notes that "The danger they represent is considerable, if we want to remember that a phagedenic ulcer is cured by the application to the wound of a plaster made of mud, straw, lemongrass, cow dung and he indicates that these " found is [...] have been warned that they could be brought before the courts for illegal practice of medicine [55].

Conclusion

At the end of this quick survey, what should we remember? First of all, it should be noted that the history of medical supervision and, more broadly, of health during the colonial era in Mayotte has yet to be written. I have just outlined it and I do not want to end with an overly pessimistic note which would be in a way a manifestation of anachronism, that of projecting our conception of public health into a time when conditions were different. If the administration was the first to criticize the delays and problems of the health system in its colony of Mayotte, is the balance so negative? Can we even speak in terms of balance sheet? And in relation to what other elements of comparison? Let us not forget, first of all, that European medicine has gradually established itself on an almost virgin field from a medical point of view with very limited financial and human resources at the outset because the local population was not the privileged target. Everything changed with the implementation of the AMI with mass medicine

thought out in all its dimensions (prevention, hygiene, care) and of which there was not even an equivalent in mainland France at the same time when the challenges were undoubtedly less. Was our countryside, our villages, better equipped? Consulting a doctor was often, until the middle of the twentieth century, a rare and costly approach. The use of bonesetters, healers, grandmothers' remedies were commonplace. Something to think about if we really want to judge France's achievements in its colonies!

Abbreviations

ANOM: National Overseas Archives (Aix-en-Provence)
SHD-V: Historical Service of the Defense (Vincennes)

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Appendix 1: The distribution of Navy doctors (1st, 2nd & 3rd class surgeons) in the colonies at different times (source: General State of the Navy and the Colonies for 1844; Annuaire de la Marine et des colonies pour 1867 et 1885).

	1844				1867				1885			
	Ch 1st cl	Ch 2nd cl	Ch 3rd cl	Total	Ch 1st cl	Ch 2nd cl	Ch 3rd cl	Total	Ch 1st cl	Ch 2nd cl	Ch 3rd cl	Total
Guadeloupe	3	10	6	19	4	7	5	16	2	8	-	10
Martinique	3	10	3	16	3	7	4	14	3	6	-	9
Guyane	1	5	3	9	4	9	10	23	3	5	-	8
Sénégal	2	8	5	15	4	16	4	24	4	9	-	13
La Réunion	1	7	2	10	2	9	2	13	6	6	-	12
Mayotte	1	-	-	1	1	-	-	1	1	-	-	1
Nossi Bé	-	-	-	-	1	-	-	1	1	-	-	1
Inde	1	3	-	4	1	3	-	4	1	2	-	3
Océanie	1	5	2	8	1	-	1	2	2	2	-	4
Nouvelle-Calédonie	-	-	-	-	1	3	1	5	5	10	-	15
Cochinchine	-	-	-	-	3	6	3	12	9+14(1)	6+15(1)	2(1)	15+29(1)
Saint-Pierre et M.	1	1	1	3	-	1	1	2	1	1	-	2
Total Head Count	91	200	158	449	150	260	136	546	224	252	148	624
Numbers in the Colonies	14	49	22	85 (18,9%)	25	61	31	117 (21,4%)	52	70	2	122 (19,5%)

The Franco-Chinese war of 1884-1885 explains the large number of doctors in Indochina and its region (10 1st class doctors in Tonkin, 3 in Formosa and 1 in Cambodia; 13 2nd class doctors in Tonkin and 2 in Formosa)

Appendix 2: The first heads of the health service in Mayotte (1844-1879). Sources: Archives of the Historical Service of the Defense in Vincennes (SHD-V) and Rochefort (SHD-R).

Surname Given Names	Sources	Date & Place of Birth	Career	Assignment to Mayotte	End of career/ Death
VRIGNAU Gustave	SHD-V: MV CC7 Alpha 2489 SHD-R: - 179-180 4F2/15	Born on 10.9.1807 in Pessines (Charente Maritime)	Admitted to Rochefort on 10.10.1823, Pupil at Rochefort: 16.4.1825, Surgeon 3rd class: 1.8.1827, 2nd class: 25.12.1836, Ch 1st class: 4.6.1843, Doctor of Medicine in 1837	12.3.1844-26.7.1848	Died on 28.10.1852 in Rochefort

	- 59-60 3E 1724				
LEO Elijah, Myrtil	SHD-V: MV CC7 Alpha 1414 SHD-R: - 129 3E 1724 - 63-64 4F2/14	Born on 27.12.1808 in Rochefort (Charente Maritime)	Pupil at Rochefort: 16.6.1828, Surgeon 3rd class: 2.11.1832, 2nd class: 11.11.1837, 1st class: 16.11.1847	19/7/1848-5/12/1850	Died on 23.12.1854 in Saintes
GANTELME Charles, Honoré	SHD-V: MV CC7 Alpha 955	Born on 22.12.1820 in La Seyne (Var)	Pupil in Toulon: 28.8.1837, Ch 3rd class: 13.11.1839, 2nd class room: 2.6.1844, 1st class: 7.6.1852, Main Bedroom: 16.1.1861	16/3/1853-20/8/1856	Retired on 31.5.1865 Death on 16.1 .1890
MAYOR Pierre, Hyppolite, Constant	SHD-V: MV CC7 Alpha 1646	Born on 9.10.1811 in La Spezia (Italy)	3rd class auxiliary: 24.1.1832, 3rd class-maintained room: 12.7.1841, 2nd class: 1.1.1848, 1st class: 7.5.1856	12/10/1856-6 /4/1857	Died on 6.4.1857 on the way from Nossi-Bé to Mayotte
DAULLÉ Dominique, Isaac	SHD-V: MV CC7 Alpha 609	Born on 14 December 1821 in Brest (Finistère)	3rd class auxiliary: 7.3.1841, 2nd class auxiliary: 7.10.1846, Doctor of Medicine in 1857	18/3/1858-20/12/1860	Death on 9.1.1861 in Saint-Denis (Reunion Island)
GILL Alfred, Louis, Zacharie	SHD-V: MV CC7 Alpha 1078	Born on 30.4.1825 in Carhaix (Finistère)	Pupil in Brest (?): 26.9.1845, 3rd class: 1.1.1848, 2nd class: 15.12.1853, 1st class: 25.5.1861, Doctor of Medicine in 1866	24/9/1861-5/10/1869	Death on 10.1.1878
AUVELY Alphonse, Léopold	SHD-V: MV CC7 Alpha 74	Born on 17.9.1828 in Le Luc (Var)	Pupil in Toulon: 1.1.1849, 3rd class: 16.1.1850, 2nd class: 2.5.1855, 1st class: 5.12.1861, Principal physician: 20.10.1872	1869/1872	Death on 29.8.1877
GIRAUD Marius, Étienne, Antoine	SHD-V: MV CC7 Alpha 1027	Born on 4.7.1830 in Six-Fours (Var)	Pupil in Toulon: 18.4.1850. 3rd class: 7.6.1852, 2nd class: 7.5.1856, Doctor 1st class: 24.10.1868, Principal physician: 17.11.1884	7/2/1873-28/3/1876	Retired on 12.10.1886
EYSSAUTIER André, Alexandre	SHD-V: MV CC7 Alpha 838	Born on 28.10.1839 in Pierrefeu (Var)	Pupil in Toulon: 25.5.1859, 3rd class: 25.5.1861, 2nd class: 3.6.1865, Doctor 1st class: 20.11.1875, Doctor of Medicine in 1880	30/1/1876-6/5/1878	Retired on 25.6.1884
SANTELLI Jean, Antoine	SHD-V: MV CC7 Alpha 2256	Born on 7.5.1825 in Bastia (Corsica)	Pupil in Toulon: 3.11.1845, 3rd class: 1.1.1849, 2nd class: 4.5.1854, Med. 1st class: 23.5.1866, Principal Med: 6.9.1879, Doctor of Medicine in 1877	11/3/1878-23/12/1879	Admitted to compulsory retirement on 8.10.1880

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