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Crafting sanitary diplomacy: Morocco and Tunisia in the World Health Organization and the struggle against infectious eye diseases (1956–1960)

Martina Biondi[a,b]

[a]Department of Philosophy and Cultural Heritage, Ca' Foscari University of Venice, Venice, Italy; [b]Department of History, University of Maryland, College Park, MD, USA

ABSTRACT

This article examines the making of sanitary diplomacy within the World Health Organization (WHO) by newly independent Morocco and Tunisia (1956–1960). Drawing on archival sources, official documents, the press, and audiovisual materials, this article sheds light on the proactive role of Morocco and Tunisia in the international health arena, particularly through their efforts to decolonise the WHO and decentralise its Regional Office for Europe. It argues that Moroccan and Tunisian sanitary diplomacy primarily aimed to secure international health assistance programmes to address pressing national public health emergencies inherited from colonial rule and reshape the severely inadequate health workforce system. Attention is given to efforts to combat infectious eye diseases, in particular trachoma, against which mass campaigns achieved significant results in the short term. The article demonstrates that the first WHO-sponsored international health conferences in the Maghreb – on trachoma and vaccination held respectively in Tunis and Rabat in October 1959 – not only fostered transregional recognition of Morocco and Tunisia's commitment to public health but also highlighted their roles in the international circulation of medical knowledge. Finally, the article traces the subsequent efforts to combat trachoma in the region, which ultimately led to the elimination of the disease in Morocco.

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KEYWORDS Sanitary diplomacy; World Health Organization; Morocco; Tunisia; trachoma; post-independence

Introduction

This article examines the making of sanitary diplomacy within the World Health Organization (WHO) by newly independent Morocco and Tunisia

CONTACT Martina Biondi martina.biondi@unive.it; martina.biondi91@gmail.com Department of Philosophy and Cultural Heritage, Ca' Foscari University of Venice, Malcanton Marcorà Dorsoduro 3484/D, Calle Contarini 30123 Venice, Italy

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during the early years of Mohammed V's reign and Habib Bourguiba's leadership (1956–1960). It argues that the early post-independence years in the two Maghreb countries served as a laboratory for sanitary diplomacy and new approaches to public health policy. Drawing on official documentation produced by the World Health Assemblies (WHAs), WHO Regional Offices, and national documentary institutions, as well as on archival materials from the WHO Project Files on trachoma, press sources in Arabic and French, and audiovisual material, the article explores how Morocco and Tunisia carved out diplomatic space to rebalance power relations within the WHO while benefiting from funding programmes and technical assistance as part of global efforts to eradicate major infectious diseases. Through their participation in WHO bodies, the two countries sought to channel resources and expertise toward nationally defined priorities, advocate for greater institutional decentralisation and representation, and turn Rabat and Tunis into sites for the production and circulation of international health knowledge. In this sense, Morocco and Tunisia's influence should be understood not as the capacity to impose hegemonic medical models on the WHO, but rather as their growing ability to negotiate the terms of international health cooperation and pursue their own sanitary diplomacy.

Studies on sanitary cooperation have tended to examine the Global South primarily as a recipient of international health initiatives (Manton and Gorsky 2018; Pearson 2018; Staples 2006). Much of the available literature has indeed adopted the history of the WHO or that of global superpowers as its main analytical framework, often overlooking the emergence of regional actors and local forms of agency, as well as the dynamics of sanitary diplomacy from the perspectives of countries in the Global South. At the same time, public health and sanitary cooperation in the post-independence Maghreb countries remain largely under-researched. One of the few analyses of the topic, dating back to the seventies (Paul 1977, 3–12), emphasised the neocolonial character of post-independence medicine, highlighting the compromises made to ensure continued cooperation with France. While patterns of dependency and asymmetry between newly independent countries and former colonial powers undoubtedly persisted and continued to shape bilateral relations, acknowledging their persistence should not obscure the processes of claim-making that unfolded within multilateral arenas.

To this end, this article conceptualises vaccination initiatives, as well as the treatment of infectious eye diseases such as trachoma, as a key arena in which relations between the two Maghreb countries and the WHO were forged. Caused by *Chlamydia trachomatis*, trachoma is an infectious disease that damages the inner lining of the eyelids, leading to eye irritation and corneal injury. If left untreated, repeated infections can cause the eyelids to turn inward, resulting in irreversible blindness. From the nineteen thirties, when orally administered medicines and topical ointments proved effective

in treating trachoma, the disease became potentially eradicable, provided that large-scale intervention campaigns were implemented worldwide in endemic areas.[1]

From the fifties, a new focus on child welfare and health care made trachoma – a disease primarily affecting children – a matter of particular attention and common intervention for both the WHO, which established the Expert Committee on Trachoma, and the United Nations Children's Fund (UNICEF). Such concern was also widely shared across independent Maghreb countries. As part of a broader recognition of youth as a cornerstone of national development, growing emphasis was placed on reducing infant mortality, providing child health care and nutrition, and expanding vaccination programmes to children and newborns. The heightened attention to immunizations strengthened Morocco and Tunisia's involvement in international health initiatives aimed at controlling infectious diseases.

Accordingly, this article explores this process through two landmark WHO events held in Tunis and Rabat in 1959: the Trachoma Conference and the Conference on the Control of Infectious Diseases through Vaccination Programmes. As the first international health meetings hosted in the Maghreb region, these events not only recognised the two countries' commitment to combating infectious diseases but also positioned them as increasingly active participants in international health debates and exchanges. Finally, the article traces the subsequent efforts to combat trachoma in the region, which ultimately led to the elimination of the disease in Morocco.

Situating sanitary diplomacy

Within the broader field of international health, sanitary diplomacy has come to play an increasingly important role over time. The notion of sanitary, or health, diplomacy has served to describe power and cooperation dynamics among countries and international organisations in the domains of public hygiene and global health (Fairman et al. 2012; Fidler 2013; Novotny, Ilona, and Michaela 2013). The concept of sanitary diplomacy has also been employed from a historical perspective. Scholarship has shown that from the late eighteenth century onward, sanitary diplomacy was institutionalised through the establishment of Sanitary Councils operating across and beyond the Mediterranean, as well as through the convening of International Sanitary Conferences (Chiffoleau 2012, 155–186; Harrison 2006; Martínez 2016). These interventions aimed to adopt and enforce common sanitary and quarantine regulations to curb the spread of infectious diseases, particularly cholera, which threatened trade routes and endangered community safety (Baron 2022; Huber 2020; Speziale 1994).

In the Maghreb region, international sanitary policies resulted in restrictions on mobility – especially travel to Mecca during the *ḥajj* – through

port cities to protect Mediterranean trade and Europe from contagion (Bazzaz (al-) 2000; Speziale 1997). These practices reflected a broader tendency to frame local populations as potential vectors of disease and to employ sanitary regulations as instruments of imperial power (Baldwin 1999; Bashford 2004; Chircop 2018; Dubin 1995).

During the first half of the twentieth century, new dynamics emerged within sanitary internationalism. After the establishment of the first international health organisations in the early twentieth century,[2] the creation of the Geneva-based League of Nations Health Organization in 1923 marked the emergence of a major organisation dedicated to the preservation of global public health. The League adopted an innovative approach to supporting the development of national health systems, taking into account the socioeconomic conditions that shaped population health, including housing, hygiene, and nutrition (Borowy 2009, 301–420).

Following the Second World War, the prospect of unifying pre-existing health organisations and establishing a body capable of addressing and coordinating global health challenges faced several obstacles. In particular, the U.S. was reluctant to support the creation of an organisation that might operate beyond its direct control or interfere with domestic health policy. The eventual compromise involved the creation of an international institution that largely set aside the broader socioeconomic dimensions of health and focused primarily on providing technical assistance to health programmes, thereby embodying the technocratic biomedical perspective strongly favoured by the U.S. (Packard 2016, 119–125). It was on the basis of this compromise that, in 1948, the WHO was established as a specialised agency of the United Nations (Cueto, Brown, and Fee 2019, 34–61).[3]

Since its inception, the WHO has been guided by a strong belief in the capacity of medical science not only to control or eliminate infectious diseases in certain regions, but ultimately to eradicate the burden of major infectious diseases worldwide.[4] The so-called 'era of eradication' (Packard 2016, 133–179) encompassed interventions targeting a wide range of infectious diseases, with particular emphasis on malaria and smallpox. However, the WHO proved to be fully successful only in the case of smallpox, which was officially declared eradicated worldwide in 1980. Smallpox eradication was made possible by unprecedented U.S.-Soviet technical cooperation within the WHO in the context of the Cold War, with the U.S.S.R., in this exceptional instance, playing a leading role in sponsoring the campaign (Cueto, Brown, and Fee 2019, 115–145).

While global health initiatives were deeply shaped by Cold War dynamics, with the WHO generally aligning with U.S. priorities, the process of decolonisation also exerted considerable influence on the organisation. Decolonisation brought new actors from the Global South into the WHO (Cueto, Brown, and Fee 2019, 2), many of whom were close to the principles of the Bandung Conference of 1955 and the Non-Aligned Movement established

in 1961 (Dinkel 2018; Lüthi 2020, 97–109). In this context, Global South countries challenged the bipolar order and advocated for greater access to the WHO's funds to mitigate the effects of health emergencies and the chronic deficiencies affecting their health care systems.

The capacity of newly independent states to engage effectively in sanitary internationalism has already received attention in the historiography, which has thus offered more nuanced accounts of Cold War dynamics beyond bloc confrontation (Amrith 2006). According to Jennifer Johnson (2018, 678), 'actors in the Global South were not mere beneficiaries of international health initiatives following decolonization; they were active participants and negotiators of their implementation at home'. Johnson (2018, 2020) has indeed pioneered the analysis of how, with regard to family planning projects, newly independent Morocco and Tunisia actively engaged with international organisations to advance national development and expand their health and social care services.

The two Maghreb countries displayed a marked degree of convergence in their ascent within the international health arena. This shared trajectory was not limited to the post-independence period. Under French colonial rule, both Morocco and Tunisia were granted WHO associate member status at the Fifth WHA in May 1952 (WHO 1955, 21). Although this status did not allow them voting rights at the WHAs, it enabled the French colonial administration's initial implementation of WHO-sponsored activities in their territories. The campaigns against infectious diseases that took shape within this context, however, reflected the intertwining of colonial and international medicine (Packard 2016, 14). They reproduced a distinctly top-down biopolitical model that prioritised economically productive areas while largely neglecting marginal regions. Conversely, after these initial, circumscribed sanitary interventions, independent Morocco and Tunisia sought to extend health policies across the entire national territory, in accordance with the rights of citizenship to which former colonial subjects were now entitled. Significantly, this contributed, on the one hand, to challenging the colonial approach that continued to permeate international medicine and, on the other, to opening up previously unexplored avenues for sanitary diplomacy.

Moroccan and Tunisian delegates in the WHO: attempts at decentralisation and decolonisation

In May 1956, two months after independence, Morocco and Tunisia were admitted as full WHO members.[5] Operating at the intersection of medicine, administration, and nationalist politics, the heads of delegation at official WHO meetings were leading figures in the post-independence state apparatus who translated domestic health priorities into claims within the international sanitary arena. The Moroccan delegation was led by the Minister

of Public Health, Abdelmalik Faraj. A French-trained physician and prominent nationalist close to Istiqlal leaders Mohamed El Fassi and Ahmed Balafrej, Faraj retained his position under the Bekkai and Balafrej governments, until 1958, when he was named director of the National Institute of Hygiene. He had specialised in the treatment of typhus and smallpox within the Moroccan hospital system and was serving as an inspector in the Health Directorate when he was included in the Moroccan delegation to the WHO at a time when the country held associate membership. As for Tunisia, during its first participation in the WHAs as an independent country, the delegation was led by Mahmoud El Materi, appointed Secretary of State for Public Health in the first government formed by Habib Bourguiba. A physician and a leading nationalist, El Materi was one of the founding members of the Neo-Destour Party and served as its first president in the thirties.

In a first notable step, the Moroccan delegation led by Faraj advocated for the establishment of a Western Mediterranean sub-regional office based in the country, with the aim of better aligning WHO initiatives with Morocco's specific health challenges (WHO Regional Committee for Europe 1957, 10–12). Despite resistance to sub-regionalization, particularly from Scandinavian countries, Moroccan diplomatic efforts resulted in the creation of two *bureaux des zones*, one in Rabat and the other in Istanbul. Staffed by additional specialised WHO officers working on long-term projects and supported by increased dedicated budget allocations, these offices contributed to the decentralisation of the Regional Office for Europe's activities (WHO Comité régional de l'Europe 1958, 11–15).

Significantly, in May 1957, El Materi was elected vice president of the Tenth WHA held in Geneva (WHO 1957, 121), reflecting Tunisia's rapid integration into the international health arena. More broadly, Bourguiba's diplomats adopted a proactive and decolonial stance and rapidly gained visibility within the WHO bodies. At a 1956 EMRO session, delegate M. Slim, Head of the Social Hygiene Section at the Secretariat of State for Public Health, called for the abolition of associate membership, arguing that Tunisia 'had long been humiliated by the limitations on the rights of associate members' (WHO Regional Office for the Eastern Mediterranean 1956, 16). At the plenary session of the Tenth WHA in 1957, Tunisia warmly welcomed Ghana's admission to the WHO as a full member (WHO 1957, 82–83) and later supported the inclusion of other newly independent African countries.

The following year, at the Eleventh WHA held in Minneapolis, Tunisia was elected to one of the six seats on the WHO Executive Board with unanimous support, replacing Syria, which had become part of the United Arab Republic (WHO 1958a, 91–92 and 133–134). On this occasion, during discussions on international cooperation in medical research, Slim advocated for a more equitable distribution of research laboratories between Western and Global South countries (WHO 1958a, 216). At the Twelfth WHA in 1959, in response

to a proposal to expand the membership of the WHO Executive Board, Tunisia emphasised that any enlargement should ensure equitable geographical representation. In contrast to the Belgian delegation, which maintained that Europe's greater experience and administrative efficiency in sanitary matters justified broader representation, the Tunisian delegate, A. Cherif, a hospital administrator, argued that newly independent states were fully entitled to participate in the WHO's decision-making processes and that the organisation would benefit more from the direct involvement of health professionals from countries most in need of medical assistance (WHO 1959a, 391–395).

Taken together, these interventions show that Moroccan and Tunisian sanitary diplomacy extended beyond the acquisition of technical assistance. Tunisian representatives used health institutions to contest hierarchies of political status inherited from colonial rule and to press for a redistribution of representation within the WHO. Decolonising and decentralising international health, from this perspective, meant renegotiating who was entitled to participate in defining institutional structures and shaping their global distribution. In addition to promoting a diplomatic approach favouring greater decentralisation and decolonisation within the WHO, the Moroccan and Tunisian delegations placed considerable emphasis on the urgent need for medical supplies, health care infrastructure, and the training of health professionals in their countries. At the Sixth Session of the WHO Regional Committee for Europe, Faraj highlighted Morocco's pressing need for enhanced basic training of paramedical personnel and requested the assignment of a WHO expert to support such programmes. He accordingly proposed amendments to the 1957–1958 Committee budget to accommodate Morocco's demands (WHO Regional Committee for Europe 1956b, 8). Morocco subsequently secured both technical and financial assistance for health care training and for the establishment of new nursing schools (WHO Regional Office for Europe 1959, 13). Similarly, at the request of the Tunisian government, the WHO expanded its support for the development of nursing and midwifery education in the country (WHO Regional Office for the Eastern Mediterranean 1958, 55). These requests reflected both countries' efforts to strengthen their national health systems through WHO assistance, revealing the concrete impact of their sanitary diplomacy. In this sense, participation in the WHO enabled Morocco and Tunisia to translate diplomatic representation into tangible resources, professional expertise, and institutional support for the consolidation of their postcolonial health systems.

In particular, the Moroccan and Tunisian delegations at the WHO increasingly prioritised the fight against infectious diseases affecting children. As Faraj aptly summarised, independent Morocco was called upon to 'save the younger generation from death, combat social scourges, enact social legislation, and train qualified personnel' (WHO 1956, 130). Accordingly, and in

line with the WHO's broader mission to contain the global spread of infectious diseases, the most extensive technical assistance and training programmes implemented in Morocco and Tunisia during these years focused on tuberculosis, malaria, venereal diseases, and infectious eye diseases.

The place of the struggle against trachoma

Infectious eye diseases were endemic in numerous areas of Morocco and Tunisia. It was estimated that in the early fifties, out of a population of 3.5 million people, more than one million Tunisians had an acute eye infection, and more than 80% of those affected were children under the age of 15, with particularly high rates of endemicity in the southern part of the country (WHO Regional Office for the Eastern Mediterranean 1957, 20). Similarly, in Morocco, in the second half of the fifties, the most prevalent infectious diseases in the country were conjunctivitis, ophthalmia, and trachoma.[6] Official documentation from the Ministry of Health described trachoma as one of the most serious 'social' diseases affecting Morocco, alongside malaria and tuberculosis. In particular, it was reported that beyond the Saharan slopes of the Atlas Mountains the disease affected almost everyone from early infancy (Empire Chérifien, Ministère de la Santé 1956, 1–5, 16).

Following the two countries' entry into the WHO as associate members, pilot projects against trachoma had been introduced in Morocco and Tunisia. Although they had the merit of finally targeting the most affected Muslim and Jewish populations, such projects were, by their very nature, experimental initiatives, limited in duration and spatial scope. For instance, one of the earliest anti-trachoma pilot projects involved the treatment of children in schools across Marrakesh (Reinhards 1955). Conversely, interventions promoted by newly independent states reflected a shift toward recognising the control of infectious eye diseases as a national public health priority, laying the groundwork for substantial interventions aimed at reducing their impact nationwide.

In both Morocco and Tunisia, the importance of addressing infectious eye diseases became particularly evident at the first national meetings dedicated to health care. During the first *Conférence nationale de la santé,* held at the Faculty of Sciences in Rabat from April 18–20, 1959, under King Mohammed V's direct initiative, a subcommittee within the Prevention Committee discussed key public health strategies against infectious eye diseases.[7] Three years earlier, on June 2, 1956, the *Premières journées médico-sociales tunisiennes* were inaugurated in Tunis by the Secretary of State for Public Health Mahmoud El Materi and Prime Minister Habib Bourguiba. The initiative identified, among the social consequences of ocular infections, blindness as a national emergency, estimating that at the time there were approximately 18,000 blind individuals in the country. The meeting took stock of existing

infrastructure and emphasised the need to intensify efforts to combat eye diseases, as well as to strengthen related research and training. To this end, the *Service central de la lutte contre les ophtalmies transmissibles* was inaugurated at the Secretariat of State for Public Health and Social Affairs.[8]

Trachoma's high prevalence made it a pressing domestic problem, while its concentration among children linked disease control to broader postcolonial projects of social development. At the same time, from the perspective of international health, the availability of relatively inexpensive mass treatments made measurable results possible within a relatively short period. The trachoma public health emergency could therefore serve simultaneously as an opportunity for the newly independent Maghreb countries to demonstrate their capacity to implement effective health interventions and as a field of action for international organisations, setting a precedent for broader interventions against the disease.

In 1957, Tunisia relaunched the campaign against infectious eye diseases with technical and financial support from the WHO and UNICEF, alongside contributions from the government in the form of personnel and logistical assistance. Inaugurated by Bourguiba himself, the campaign initially concentrated on the highly endemic southern and central-southern regions (Zone 1 and Zone 2), and progressively moved northward, with the objective of covering the entire national territory (see Figure 1).[9]

This geographical progression can also be read in political terms. By moving from the highly endemic south toward nationwide coverage, the campaign extended public-health provision into areas that had been unevenly served under colonial rule. In schools across the central-southern areas of Gafsa, Gabès, El Hamma, and the island of Djerba, the percentage of children affected by trachoma was indeed remarkably high, ranging from 47% to 79% (Health and Sanitation in Tunisia 1958, 8). In addition to the systematic trachoma group treatment programme for schoolchildren, the campaign included a mass field action to contain seasonal conjunctivitis, which, when contracted alongside trachoma, exacerbated the severity of the disease.

The polyvalent dispensaries in Gabès and Sfax served as central coordinating units for a network of subsidiary dispensaries operating in more peripheral and rural areas of Zone 1 and Zone 2. Their activities included mass screenings and the treatment of trachoma and conjunctivitis carried out by nursing and dispensary staff using mobile units.[10] Beginning in 1959, the progressive extension of interventions to the central and northern regions of the country was facilitated by the higher concentration of local dispensaries and the increasing integration of personnel within the national health system. Activities included a pilot anti-trachoma project in the Djebel Lahmar suburb of Tunis, which also provided epidemiological data for research into the disease (WHO 1960, 87–88).



Figure 1. Map reproduced with the permission of the WHO from: Campaign against contagious eye diseases, Tunisia/WHO/UNICEF, Troisième avenant au plan d'opérations de lutte contre le trachome et les conjonctivites aiguës en Tunisie pour la période allant du 1er janvier au 31 décembre 1957, 22/EMRO/TUN/43, DHS.4/5 Tunisie 3, WHOA.

In this sense, the campaign also prompted an acceleration in research on trachoma and other eye diseases in the country. A research programme was conducted at the *Centre d'ophtalmologie et de trachomatologie* in Tunis, where a virology laboratory was established with WHO support for the isolation and identification of trachoma strains.[11] This facility complemented

the work of the *Institut Pasteur de Tunis*, whose epidemiological research on trachoma encompassed not only pathogen isolation but also the development of diagnostic techniques and studies on antibiotic efficacy and resistance ('Rapport sur le fonctionnement de l'Institut Pasteur de Tunis pendant l'année 1959. Trachome et conjonctivites aiguës bactériennes' 1960, 244).

In Morocco, the mass campaign against trachoma and acute conjunctivitis began with large-scale treatment in highly endemic regions, supplemented by targeted school-based interventions in the most severely affected urban areas. Each year, new schools were added to the campaign, while antibiotic treatments were repeated in those previously covered. By 1958, the initiative had reached approximately 230,000 children and successfully treated approximately 10,000 cases of trachoma.[12] Following a pilot project in the rural area of Tiznit, in the south of the country, where approximately 1,000 children were treated, the government decided to extend the programme to rural and underserved areas across the country. It is important to note that, due to a shortage of medical personnel, interventions involved the direct treatment of all schoolchildren without prior screening (Iskander 1989, 18). Despite the severe shortage of health care personnel, which represented one of the most pressing problems of the immediate post-independence period, in Morocco the principal objective was to ensure that, by 1960, all school-age children affected by trachoma would receive treatment upon returning to school (WHO 1958b, 31).

At the same time, the campaign placed Morocco at the forefront of international experimentation in the fight against trachoma. Notably, the campaign generated evidence that contributed to the adoption of new approaches to trachoma control, first at the national level and subsequently at the international level. The pilot projects conducted in Marrakesh, Tiznit, and Meknes were based on experimental trials that tested antibiotics administered on an intermittent schedule (Reinhards, Weber, and Maxwell-Lyons 1959). Evaluations carried out in collaboration with the *Centre d'ophtalmologie et de trachomatologie expérimentale de Salé-Rabat* found no clinical evidence of antibiotic resistance in trachoma: even under the harsh environmental conditions of southern Morocco, the disease appeared to remain responsive to intermittent treatment. Building on this evidence, the subsequent part of the campaign adopted intermittent antibiotic administration and introduced phases of self-treatment, facilitated by the monthly distribution of ointments. Within a relatively short period, this prophylaxis made it possible to contain seasonal conjunctivitis epidemics, treat a substantial number of trachoma cases, and significantly reduce the risk of blinding corneal complications.[13]

Nevertheless, the mass campaigns against trachoma and acute conjunctivitis in Morocco faced significant challenges, particularly in relation to logistical constraints and gender-related issues. Operational difficulties arose in

the Agadir region in 1956 and, the following year, in Sidi Bennour, where activities were suspended due to administrative obstacles and personnel shortages. In addition, between 1957 and 1958, delays were reported in the northern regions, reportedly linked to socio-political unrest in the Rif and the repression by the regime.[14] Moreover, at times, inadequate health education and the irregular provision of ointments led to families' inconsistent adherence to self-treatment procedures for children, resulting in interruptions in the continuity of therapy.[15]

Finally, the low level of female school enrolment, particularly in rural areas, constituted an obstacle to the effective outreach and treatment of trachoma among girls. This was a serious concern, as disease prevalence was higher among female subjects. A similar setback also occurred in the Tunisian governorate of Gafsa, where initiatives to combat trachoma were hampered by the lack of community-based eye health education programmes targeting women.[16] These shortcomings reveal the limits of international support for public health, as the effectiveness of mass campaigns ultimately depended on domestic infrastructure and on the capacity of national health systems to sustain treatment at the local level.

Despite logistical limitations and insufficient attention to gender issues, the WHO regarded the ongoing campaigns against infectious eye diseases in Morocco and Tunisia as largely effective and, as such, worthy of recognition. As early as 1957, Prince Mohan Kaul, Assistant Director-General of the WHO Department of Advisory Services, cited both countries as exemplary cases for large-scale mass-treatment campaigns and praised the gradual integration of specialised services into the regular public health infrastructure (WHO 1957, 184).

In this framework, the Moroccan case became a vehicle for WHO public health propaganda. In a letter sent in October 1957 to the Minister of Health, Abdelmalik Faraj, WHO Director-General Marcolino Gomes Candau announced the appointment of film director Gunther von Fritsch to work in the country. Von Fritsch was tasked with capturing key moments of the campaign against trachoma on camera. The idea of producing a film to document the anti-trachoma activities in Morocco originated directly from the WHO Director-General.[17] Morocco's struggle against infectious eye diseases was meant to be framed as an ongoing 'success story,' which legitimised WHO programmes, appealed to donors and policymakers, and reinforced the role of international medicine in Global South countries. While the WHO sought to present the Moroccan case as evidence of the effectiveness of international health interventions, Moroccan authorities could also benefit from the international circulation of this success narrative. In this sense, the initiative generated a form of reciprocal legitimation. Although the United Nations, involved in the project, withheld support for budgetary reasons, thereby reducing the project's scope and at one stage nearly

jeopardising it,[18] the documentary *Open Your Eyes* was eventually released a few years later.

A silent colour documentary, it embedded the narrative of modern medical intervention within neo-Orientalist imagery of bustling markets and live music in public squares. While it is true that the population generally responded positively to the campaign (Badredine 1976, 34), the filmmaker's effort was to present a completely linear and unproblematic account of public health progress. The film depicted open-air group treatments in which women and children appeared as compliant subjects, patiently lining up to receive eye medication, while mothers with newborns were entrusted to the care of nurses. Moreover, *Open Your Eyes* highlighted the training of new medical cadres and paramedical personnel in ophthalmology. At the same time, the treatment of patients with more severe cases of trachoma was portrayed as taking place within well-equipped hospital settings.[19] However, the documentary inadvertently revealed a certain degree of carelessness and inadequate hygiene in both the conduct of the open-air mass campaigns and the hospital infrastructures, where the presence of flies – among the primary vectors of trachoma – was visible even in scenes depicting ocular treatment (see Figure 2).[20]

While highly sanitised and celebratory in tone, the documentary represented only a part of the WHO's outreach efforts to highlight Morocco's



Figure 2. Frame reproduced with the permission of the WHO from the documentary film *Open Your Eyes* (1965).

progress in combating trachoma and other infectious eye diseases. This approach, which also involved Tunisia, prompted EMRO to publicly recognise and further promote the two countries' initiatives against infectious diseases. It was in this context that the Vaccination Conference and the Trachoma Conference were organised in the late fifties, in Morocco and Tunisia respectively, becoming the first official WHO conferences to be held in the Maghreb.

Tunis as an international health hub: the 1959 Trachoma Conference

Marking the first event of this kind in both WHO regions, the Trachoma Conference, held in Tunis from October 15–24, 1959, was jointly convened by EMRO and the WHO Regional Office for Europe, in collaboration with the Tunisian government.[21] By bringing together two WHO regional offices, the Conference positioned newly independent Tunisia as a meeting point for different public health and medical approaches, as well as a model for infectious eye disease control campaigns across the Eastern Mediterranean and European Regions. Overall, the Conference brought together participants from twelve countries, alongside Tunisian professional and charitable organisations involved in combating blindness (WHO Regional Offices for the Eastern Mediterranean and for Europe 1959, 2–33).

In his opening remarks, Abdul Hussein Taba, Director of EMRO, commended the choice of Tunisia as host country, citing its 'remarkable efforts to control trachoma and allied conjunctivitis through collective treatment aimed at reaching both schoolchildren and the general population' (WHO Regional Offices for the Eastern Mediterranean and for Europe 1959, 38–39). For his part, Ahmed Ben Salah, the new Secretary of State for Public Health and Social Affairs, took the opportunity to present the latest figures on the fight against trachoma and other eye diseases in Tunisia.[22] These figures showed a significant expansion in the scale of the campaign: in 1959, it reached 380.000 school-age children, while approximately one million people received treatment for seasonal conjunctivitis ('Al-Ustādh Aḥmad Bin Salaḥ Katib al-Dawla li-l-Ṣiḥḥa al-ʿUmūmiyya Yaftatiḥu Nadwa Amrāḍ al-ʿUyūn li-Duwal Sharq al-Baḥr al-Abyaḍ al-Mutawassiṭ' 1959).

The Trachoma Conference facilitated the exchange of medical knowledge, helped develop viable trachoma control strategies, and laid the groundwork for future research on the disease. The practical sessions held at the *Centre d'ophtalmologie et de trachomatologie* further positioned Tunisian health institutions as sites of international training and demonstration ('Muʾtamar Amrāḍ al-ʿUyūn Yuwāṣil Ashghālahu wa-Yaʿqidu Jalasāt li-Dirāsa Wasāʿil Muqāwama al-Amrāḍ al-Sāriya' 1959; 'Les ophtalmologistes réunis à Tunis ont visité hier le Centre ophtalmologique' 1959).

The Trachoma Conference produced recommendations on the research, planning, and regulation of anti-trachoma campaigns, including standardised diagnostic criteria, isolation procedures, and terminology, while promoting the international exchange of biological materials and strains ('Muʾtamar Amrāḍ al-ʿUyūn Yuwāṣil Ashghālahu bi-Būrṣat al-Shughl' 1959; WHO Regional Offices for the Eastern Mediterranean and for Europe 1959, 8–10). Importantly, the Conference emphasised the need to evaluate sanitary programmes through surveys assessing public attitudes toward anti-trachoma measures, while also recognising adequate water supply, clean housing, personal hygiene, and health education as essential to controlling the spread of the disease. However, the Conference failed to recommend social measures addressing trachoma-related blindness, as the disease's social consequences were considered outside the WHO's mandate and left to the welfare capacities of the states (WHO Regional Offices for the Eastern Mediterranean and for Europe 1959, 15–18).

Nonetheless, in addition to showcasing anti-trachoma treatment activities at the Djebel Lahmar pilot project, the host country decided to address social issues related to blindness, presenting Conference participants with housing and schooling initiatives using Braille, as well as vocational training offered at *La cité lumière Bir Kassa*, where the *Union nationale des aveugles de Tunisie* provided assistance to approximately 150 children in the Tunis area ('Muʾtamar Amrāḍ al-ʿUyūn Yadrusu Mawdūʿ Taṭhīr al-Bīʾa' 1959; 'Al-Ustādh Aḥmad Bin Salaḥ Katib al-Dawla li-l-Ṣiḥḥa al-ʿUmūmiyya Yaftatiḥu Nadwa Amrāḍ al-ʿUyūn li-Duwal Sharq al-Baḥr al-Abyaḍ al-Mutawassiṭ' 1959).

Tunisian zeal against trachoma was somewhat tempered during the Conference, which revealed differing views regarding the sharing of national data on health emergencies and disease outbreaks, as well as on the training of medical personnel in trachomatology. At the closing session of the Conference, Tunisian delegate Hedi Rais, Chef de Service at the *Centre d'ophtalmologie et de trachomatologie*,[23] presented two quite assertive proposals: the compulsory reporting to the WHO of cases of gonococcal conjunctivitis, given its particularly severe and fulminant course, and the mandatory inclusion of ophthalmology in medical school curricula. These proposals sparked discussions among participants. Although the importance of systematic disease notification was acknowledged, the idea of making it mandatory was softened, with the final recommendation supporting voluntary reporting. Similarly, the proposal to make ophthalmology training mandatory in medical schools was revised, with greater emphasis placed on expanding ophthalmological training among paramedical personnel (WHO Regional Offices for the Eastern Mediterranean and for Europe 1959, 24–25).

The reformulation of Rais's proposals illustrates both the nature and the limits of Tunisia's leverage within the WHO: Tunisian representatives could shape the terms of the discussion while the final outcomes remained

subject to multilateral negotiation. These limitations reinforce the idea that Tunisia's capacity within the WHO should not be equated with that of the superpowers, which were able to directly shape international health policy or promote national practices as international standards. Rather, Tunisia's leverage consisted in an enhanced ability to place nationally defined concerns on the international agenda, turn domestic campaigns into objects of transregional discussion, and negotiate their incorporation into WHO recommendations.

Overall, the 1959 Trachoma Conference reinvigorated public health efforts in both Tunisia and Morocco, leading to even more significant progress in the fight against trachoma. Significantly, in the years immediately following, the objective of providing treatment for all schoolchildren affected by trachoma in every school across Morocco was achieved (WHO Regional Committee for Europe 1960, 36), while it was estimated that self-treatment with anti-trachoma drugs – whether through distribution, immediate intervention, or the purchase of antibiotics – reached more than 3 million Moroccans, especially children ('Campagnes de masse contre les maladies oculaires' 1962–1963). For its part, in 1960 Tunisia introduced a policy of compulsory trachoma treatment in schools to ensure that all school-age children in the country were reached and cured.[24] More than an extension of the existing campaign, this measure anticipated the transition from mass intervention to the integration of trachoma control into the routine functions of the post-colonial state. In the ensuing years, phases of self-administered intermittent treatment were intended to replace the initial stages of mass screening. To facilitate this process, the Tunisian government established regulated, low fixed prices for antibiotic eye ointments.[25] Subsequently, the objective was to gradually extend treatment to the rest of the population, relying increasingly on national resources (WHO 1960, 88).

At the same time, Tunis consolidated its position as an international centre for expertise on infectious eye diseases. Interestingly, further ophthalmological meetings placed Tunisia within professional networks that extended beyond its relationship with the WHO and connected it to emerging Afro-Asian circuits of medical exchange. In this context, Tunis hosted the Second Afro-Asian Congress of Ophthalmology in April 1960, organised by the Afro-Asian Council of Ophthalmology, which had been established in Egypt two years earlier.[26] Meanwhile, medical research advanced at the virology laboratory of the *Centre d'ophtalmologie et de trachomatologie*, at that time focusing on identifying local strains of the trachoma agent and testing treatments under laboratory conditions (WHO Executive Board 1961, 18). These developments further reinforced Tunisia's role not simply as a recipient of international expertise, but increasingly as a site where knowledge about trachoma was produced, tested, and circulated across different international arenas.

The 1959 Vaccination Conference in Rabat: challenges in mass immunisation and environmental sanitation

As in Tunisia, the positive results of mass campaigns against infectious eye diseases in Morocco encouraged the WHO to promote a major international medical meeting in 1959. The Vaccination Conference in Rabat, like the Trachoma Conference in Tunis, marked a shift in public health and sanitary diplomacy in the region. At the crossroads of Europe and the Western Mediterranean, the Maghreb's first WHO conferences emerged as transregional platforms fostering sanitary cooperation and affirming Morocco and Tunisia's growing diplomatic visibility. By emerging as hubs for international medical exchange, for the production and circulation of epidemiological strategies and public health policies, Tunis and Rabat established themselves as active conveners in the global health dialogue. Moreover, by prompting the WHO to recognise their national experiences as internationally relevant and transferable, Morocco and Tunisia could help shape what the organisation chose to showcase and where it chose to convene expertise.

Held in Rabat from October 23–31, 1959, the First Technical Conference on the Control of Infectious Diseases through Vaccination Programs was convened by Paul Van de Calseyde, Director of the WHO Regional Office for Europe, who publicly presented Morocco's mass vaccination campaigns as an important experience in communicable disease control. Moroccan authorities, for their part, used the occasion to reaffirm public health as a national priority, reiterating that protecting the population from infectious diseases was a primary concern of the Moroccan government ('L'allocution du Dr Youssef Ben Abbès et celle de M. Paul Van de Calseyde' 1959; 'S.A.R. le prince héritier a inauguré la première séance de travail du Bureau régional de l'O.M.S.' 1959).

Capitalising on his position as head of state of the host country, King Mohammed V advanced a proposal for the establishment of a WHO European sub-office in Tangier, envisioned as a hub for coordinating public health initiatives across the southern Mediterranean ('S.M. le roi a reçu hier les membres de l'O.M.S. réunis en congrès à Rabat' 1959). Notably, this occurred after Morocco had secured the opening of a WHO office in Rabat just a few years earlier. The proposal for a Tangier office thus continued Morocco's earlier efforts to reshape the geography of the WHO Regional Office for Europe by shifting part of its institutional presence toward the southern Mediterranean. In this sense, Mohammed V's proposal reveals how Morocco leveraged a WHO-sponsored conference as a diplomatic platform to pursue its own public health agenda.

The Conference, which brought together representatives from twenty-three nations, focused on strategies for the implementation of mass vaccination campaigns and services, as well as on methods and techniques for

immunisation against a broad range of infectious diseases ('Séance de clôture des travaux de l'O.M.S. aujourd'hui à Rabat' 1959). Delegates identified standardised immunisation procedures and assessed the organisational frameworks necessary for the effective administration of vaccines ('S.A.R. le prince héritier présidera la séance inaugurale de la conférence du Bureau européen de l'O.M.S,' 1959). One of the Conference's key outcomes was the adoption of a comprehensive vaccination schedule for children aged two months to 15 years.[27] Notably, Moroccan health officials also participated as technical experts rather than merely as hosts, with Abdelmalik Faraj leading a session on poliomyelitis vaccination, thereby further blurring the conventional distinction between providers and recipients of international health expertise. Moreover, practical sessions conducted during vaccination and trachoma-treatment activities in the Tadla region gave this process a further dimension. Domestic campaigns served as demonstration sites from which foreign delegates were expected to draw lessons that could be transferred to their own contexts ('Les travaux du Bureau européen de la conférence de l'O.M.S.' 1959).

At the same time, social concerns were also raised during the Conference, as participants underscored that successful immunisation of the population could not be achieved 'merely by imposing compulsory vaccination' (WHO 1959b, 6–8). Accordingly, the Conference's recommendations highlighted the importance of public receptivity, especially among parents of young children, in ensuring the continuity of repeated inoculations, while recognising health education as essential to bridging the gap between international medical practices and local acceptance. Medical personnel and auxiliary health workers were recognised as key actors in raising public awareness of vaccinations and ensuring that public health initiatives were aligned with local contexts and received sustained support, a responsibility that was also expected to involve community leaders and public institutions.

In this regard, Marrakesh's *Quinzaine de l'hygiène* was presented as a model example of community engagement. A broad-based, community-oriented initiative, the event was overseen by neighbourhood committees promoting sanitary education, which included the participation of local political figures, youth and sports organisations, as well as the Moroccan Red Cross Committee ('Le congrès européen de l'O.M.S. à Rabat' 1959). This emphasis was significant because it contributed to tempering the top-down logic of mass vaccination campaigns. It reflected a growing recognition that the effectiveness of internationally promoted biomedical interventions depended on their translation into specific local social contexts. At the same time, community engagement was valued primarily as a means of improving vaccination coverage and increasing uptake, rather than as a basis for redefining public health priorities from below.

In this sense, the Conference exposed a tension within the WHO's technocratic approach. Participants acknowledged the importance of social conditions and community responses insofar as they helped improve the delivery and acceptance of vaccination. Conversely, with regard to the broader conditions that shaped health outcomes, no measures were proposed to support patients in situations of social vulnerability. In other words, the social dimensions of immunisation were framed primarily in terms of their implications for public health action and for improving future campaigns.

At the same time, both the Vaccination and Trachoma Conferences revealed notable limitations in addressing issues of environmental sanitation, particularly with regard to chemical vector control. This was especially evident in their treatment of dichlorodiphenyltrichloroethane (DDT), a pesticide widely employed to control insect vectors such as mosquitoes and flies, whose harmful effects on wildlife and human health would become increasingly apparent in subsequent years (Carson [1962] 2002).[28] The Conferences never explicitly mentioned DDT, despite its widespread use in environmental sanitation during anti-malaria as well as anti-trachoma campaigns.

Indeed, discussion of the environmental implications, as well as the potential risks associated with immunisation procedures, remained very limited. References to particularly toxic chemical agents were largely confined to biomedical and technical considerations. For instance, the Trachoma Conference recommended further studies to determine the level of fly population reduction necessary for effective disease control, while some attention was also given to incorporating non-irritant fly repellents into antibiotic eye ointments as a means of reducing transmission by limiting contact with flies (WHO Regional Offices for the Eastern Mediterranean and for Europe 1959, 16). This suggests that environmental intervention was conceptualised primarily through the immediate epidemiological objective of controlling vectors, while its possible ecological and longer-term health consequences remained outside the analytical framework of the Conferences. This omission would become increasingly significant as the environmental and health effects of extensive pesticide use moved to the forefront of international debate in the following decades, prompting a reassessment of subsequent sanitation campaigns.

Toward the elimination of trachoma in the Maghreb

By the early sixties, anti-trachoma treatments had reached the school-age population across Morocco and Tunisia, marking an important expansion of public health provision. Throughout the years, the overriding objective remained to reach the highest possible number of people affected by infectious eye diseases. According to Moroccan official data, the number of

individuals treated for eye diseases more than tripled between 1956 and 1964, increasing from 800.000 to 2.7 million and reaching 8.5 million within the following decade (Ministère de la Santé du Royaume du Maroc 1976, 96). These data, however, need to be interpreted with caution, as expanded coverage did not lead to the elimination of the disease. Although mass campaigns and extensive self-treatment activities reduced disease severity, trachoma continued to persist. This was already evident in a survey conducted in southern Morocco in the early sixties, which showed that, although the severity of trachoma had declined, its prevalence remained at levels comparable to those in the past (Kupka, Nizetic, and Reinhards 1968).

Such findings, however,were overshadowed by the perception that the two Maghreb countries had already achieved unexpectedly good results, and were therefore not sufficient to persuade the WHO to sustain its commitment to trachoma control in the long term. More generally, this approach reflected a rapid, budget-driven shift by the WHO during the sixties, with the strategy for many infectious diseases shifting from eradication to control, without first achieving elimination in the countries where progress was most promising. While archival sources indicate that the WHO continued to support Morocco and Tunisia in the fight against trachoma throughout the sixties, albeit with increasingly limited resources, UNICEF definitively withdrew its financial support as early as 1963 (Iskander 1989, 18).

The subsequent phase of the struggle against trachoma and conjunctivitis was marked by a challenging transition from the temporary, mobile, and widespread mass campaigns conducted in collaboration with international organisations to public health initiatives integrated into centralised national health systems and entirely based on domestic resources. The transition proved difficult in both countries. In Morocco, a national campaign launched in 1964 encountered significant setbacks and had to be relaunched in 1973, maintaining a distinction between school-based interventions and measures targeting the broader population (Badredine 1976, 34). Likewise, in Tunisia, trachoma remained prevalent in southern regions into the seventies, despite nearly two decades of intervention (Dawson et al. 1976; Gaumer 2006, 97). The persistence of the disease suggests that the impressive territorial expansion achieved during the first post-independence campaigns had been more effective in extending treatment than in transforming the structural conditions that sustained transmission.

From the mid-seventies, the WHO began to recognise that trachoma could not be controlled solely through medical treatment combined with indiscriminate environmental sanitation, and that factors associated with disease transmission, which had previously been overlooked, had to be addressed in order to achieve elimination goals. Experts eventually concluded that in order to break the chain of transmission, it was essential to address the social factors that facilitated contagion, namely poverty, overcrowding, and

poor environmental conditions. On the one hand, this shift led to more integrated and sustainable approaches in addressing trachoma, combining treatment and health education with improvements in living conditions. On the other hand, as greater emphasis was placed on the social consequences of the disease, blindness acquired renewed prominence as a public health concern, prompting the launch of the WHO Blindness Prevention Program in 1978.

Within this new framework, Tunisia, which had long devoted particular attention to the issue of blindness, adopted a national blindness control programme that reshaped public health priorities by identifying trachoma as a leading, though not the sole, cause of blindness (Daghfous 1989, 37–67). Likewise, in 1990, the Moroccan Directorate of Epidemiological and Health Programs launched a national blindness control programme which, nonetheless, maintained the goal of eliminating trachoma (Chami Khazraji 2002, 8–9). In this context, surveys showed that, as a result of both population aging and the anti-trachoma measures implemented in previous decades, age-related cataract had emerged as the leading cause of blindness in Morocco (Négrel, Chami Khazraji, and Azelmat 1997, 108–113). At the same time, the prevalence of trachoma continued to be monitored in areas where the disease remained endemic. For instance, a study on the prevalence and severity of trachoma in the province of Ouarzazate showed that trachoma still affected about 40% of the population, with active trachoma reaching 18%, and with particularly high endemicity in the Oued Drâa Valley (Négrel, Chami Khazraji, and Akalay 1992, 451).

Over the years, the WHO further developed its integrated model for trachoma control and, from the second half of the nineties, in collaboration with its newly established Alliance for the Global Elimination of Trachoma, relaunched efforts against the disease through a new approach: the Surgery, Antibiotics, Facial cleanliness, and Environmental improvement strategy (SAFE), which combined medical and surgical interventions with the promotion of hygiene and improvements in living conditions. While Tunisia incorporated the SAFE strategy into its national blindness control plan (Direction des soins de santé de base 1996), Morocco implemented it directly through a new mass campaign carried out between 1997 and 1999.

The campaign saw medical teams travel throughout the areas most affected by trachoma, including Errachidia, Figuig, Ouarzazate, Tata, and Zagora, performing basic surgical procedures in smaller towns and distributing approximately 4.3 million doses of antibiotics. At the same time, health education initiatives promoted regular face-washing and better personal hygiene, while infrastructure measures, such as constructing latrines and expanding access to safe drinking water, were also implemented (Levine 2007). In 1998, Ouarzazate hosted the Third Meeting of the WHO Alliance for the Global Elimination of Trachoma, highlighting Morocco's monitoring

of trachoma-related blindness and the implementation of trichiasis surgery to correct eyelashes misdirected into the eye due to trachoma (WHO 1999).

The different trajectories of trachoma control reinforce the idea that Moroccan and Tunisian adherence to international health programmes did not result in the straightforward adoption of a uniform WHO model. As international approaches evolved, both states selectively incorporated those elements that most closely corresponded to national priorities. While Tunisia continued to maintain a blindness-focused approach, Morocco's sustained efforts against trachoma led to its elimination nationwide, a milestone officially recognised by the WHO in 2016 (Chami Khazraji, Jaouad, and Jaouad 2004; Hammou et al. 2020). More in-depth studies of the subsequent decades examined in this article may help clarify why, in the Maghreb region, trachoma has been eliminated in Morocco and, more recently, in Libya and Mauritania, but remains present in Tunisia and Algeria, albeit at very low levels.[29] In the case of Tunisia, the progress made in narrowing the north–south divide during the early post-independence period appears to have gradually eroded over time as resources became increasingly limited, resulting in greater emphasis being placed on the social consequences of the disease.

Conclusions

This article has argued that sanitary diplomacy offered newly independent Morocco and Tunisia a new form of agency within the WHO. Their influence did not lie in determining the organisation's overarching medical doctrine, but in their capacity to place national priorities on international agendas, negotiate access to resources and expertise, challenge inherited structures of representation, and transform domestic public health campaigns into internationally visible models. Seen from Morocco and Tunisia, the history of the WHO therefore looks different from accounts centred primarily on superpower rivalry or international organisations as vectors of non-negotiable technical intervention. Moreover, decolonisation reshaped international health and altered, albeit unevenly, the range of actors able to bring their own priorities to the table, promote new institutional geographies, and establish previously overlooked sites as centres of medical knowledge production and circulation.

At the same time, the anti-trachoma campaigns revealed both the possibilities and the limits of this agency. WHO and UNICEF assistance enabled the rapid expansion of treatment, while Moroccan and Tunisian authorities adapted international programmes to territorial and political priorities of postcolonial state-building. Yet persistent inequalities in infrastructure, gendered access to health care, the lack of attention to the environmental and social factors related to the disease, as well as the WHO's predominantly

technocratic approach constrained these achievements. In this sense, sanitary diplomacy could contribute to the redistribution of resources and recognition without completely eliminating the structural asymmetries within which international health operated.

These limits are particularly revealing when viewed against the 1959 Conferences. In Tunis and Rabat, while the environmental impact of sanitation campaigns was completely overlooked, social conditions received attention as factors affecting the success of disease-control campaigns, largely at the initiative of the host countries. Nevertheless, the interventions and measures proposed remained predominantly biomedical and technocratic. At the same time, the withdrawal of international support for trachoma-control efforts in Morocco and Tunisia revealed that, while international cooperation could accelerate campaigns by providing resources, expertise, and funding, the sustainability of interventions over the medium to long term ultimately depended on the capacity of national health systems to bear their costs, particularly in terms of personnel and infrastructure.

The WHO's later emphasis on poverty, housing, hygiene, and environmental conditions therefore implicitly recognised the importance of social factors that had already surfaced at the 1959 Trachoma and Vaccination Conferences, when Tunisian and Moroccan authorities called for greater attention to education, prevention, and the local responses to immunizations. Taken together, the cases of Morocco and Tunisia demonstrate that both countries tended to emphasise those WHO directives that, over time, most closely aligned with their respective national public health priorities. Thus, while Tunisia focused more on the social consequences of the disease and on measures to prevent ocular conditions from progressing to blindness once contracted, Morocco maintained a disease-oriented approach to trachoma control, emphasising prevention, early treatment, and surgical interventions.

Overall, the Maghreb experience in the struggle against trachoma suggests that, although the WHO's 'era of eradication' as a mass-based global public health project had long ended, new synergies between the organisation and national initiatives enabled further progress, gradually turning the elimination of trachoma into an achievable goal across the region.

Notes

1. For an epidemiological history of trachoma in the Middle East and North Africa, see Moulin (2005) and Zarei-Ghanavati et al. (2014).
2. These were the International Sanitary Bureau, founded in Washington in 1902, which was the precursor of the Pan American Health Organization (PAHO), and the International Office of Public Hygiene, founded in Paris in 1907.
3. PAHO was then designated as one of the six WHO Regional Offices, alongside those for Africa, the Eastern Mediterranean, Europe, South-East Asia, and the Western Pacific.

4. Control of an infectious disease refers to the reduction of disease incidence, prevalence, morbidity, or mortality to a locally acceptable level as a result of deliberate public health efforts. Elimination indicates the reduction to zero of the incidence of a specified disease or infection within a defined geographical area, while eradication denotes the permanent reduction to zero of the worldwide incidence of an infection. In this context, incidence refers to the number of new cases occurring within a specific period, prevalence to the total number of existing cases at a given time, morbidity to the overall presence of disease in a population, and mortality to the frequency of deaths due to a specific disease (Beigbeder 2018, 73).
5. While on September 1, 1956, Tunisia was officially included in the Eastern Mediterranean Regional Office (EMRO) (WHO Regional Committee for Europe 1956a, 26), Morocco's case was more complex. As an associate member, the country was divided into two WHO regions: French Morocco was linked to the European Region, like Tunisia, while Spanish Morocco fell under the African Region. Upon independence, Morocco requested to remain provisionally within the WHO Regional Office for Europe. This decision, largely driven by logistical ties with France, was framed as a temporary arrangement pending a transition to EMRO, which was considered better suited to addressing the health challenges Morocco shared with other North African and Middle Eastern countries (WHO 1956, 33). This transition, however, did not occur in the short to medium term, and Morocco effectively engaged from within the WHO Regional Committee for Europe.
6. In October 1958 alone, a record 51,842 new cases of purulent conjunctivitis and neonatal ophthalmia were reported, along with 27,067 new cases of trachoma (Ministère de la Santé du Royaume du Maroc 1958, 3).
7. *Conférence nationale de la santé 1959*, n.t., n.p., Centre national de documentation du Maroc in Rabat.
8. Syndicat national des médecins tunisiens. 1956. *Premières journées médico-sociales tunisiennes, 2–3 juin 1956*, Tunis: Neby, Centre national de documentation in Tunis.
9. Troisième avenant au plan d'opérations de lutte contre le trachome et les conjonctivites aiguës en Tunisie pour la période allant du 1er janvier au 31 décembre 1957, 22/EMRO/TUN/43, DHS.4/5 Tunisie 3, World Health Organization Archives (WHOA) in Geneva.
10. Quatrième avenant au plan d'opérations de lutte contre le trachome et les conjonctivites aiguës en Tunisie pour la période allant du 1er janvier au 31 décembre 1958, 22/EMRO/TUN/43, DHS.1/39 Tunisie 3, WHOA.
11. Assistance to the Centre d'ophtalmologie, Tunis, Mémorandum, 6 June 1958, 22/EMRO/TUN/43, DHS.6/7, WHOA.
12. Report on the actual status and evaluation of the communicable eye disease control project in Morocco, January 1958, 2, 22/EMRO/MOR/067 – EUR-MAROC 1, WHOA.
13. Quatrième avenant du plan d'opérations du projet de lutte contre le trachome et les infections associées au Maroc couvrant la période allant du 1er octobre 1956 au 31 décembre 1958, 14, 22/EMRO/MOR/067 – EUR-MAROC 1, WHOA.
14. Report on the actual status and evaluation of the communicable eye disease control project in Morocco, January 1958, 4, 22/EMRO/MOR/067 – EUR-MAROC 1, WHOA.
15. Report on the actual status and evaluation of the communicable eye disease control project in Morocco, January 1958, 9–11, 22/EMRO/MOR/067 – EUR-MAROC 1, WHOA.

16. Rapport de mission. Maladies oculaires transmissibles en Tunisie, 2 au 25 mai 1959, 7, EM/TRACH/15 Tunisie 3, WHOA.
17. M. G. Candau, Secrétaire Général de l'O.M.S. à monsieur le ministre de la Santé publique au Maroc, 1 October 1957, V6/158/11, WHOA.
18. Trachoma Visual Aids Project, 1961, V6/372/2, WHOA.
19. Footage of the documentary *Open Your Eyes* (1965) can be retrieved at this link: https://www.youtube.com/watch?v=uheVV1Rjf4k (accessed January 15, 2026).
20. For a history of the fly as a disease vector in Egypt, see Mitchell (2002).
21. The Tunis Trachoma Conference was only the second of its kind worldwide. The first had been held in New Delhi in September 1956, organised by the WHO Regional Office for South-East Asia. Similarly, the trachoma control campaigns launched in Morocco and Tunisia with WHO support were the first of their kind after the pioneering campaign conducted in Taiwan from the early fifties.
22. On Ahmed Ben Salah's political trajectory, see Borsali (2008).
23. In honour of Hedi Rais, in the early nineties, the *Centre d'ophtalmologie et de trachomatologie*, which had long been known as the Institute of Ophthalmology, was renamed the Hedi Rais Institute of Ophthalmology.
24. *Journal officiel de la République Tunisienne*, 'Décret n° 60-261 du 21 juillet 1960, rendant obligatoire le traitement du trachome dans les établissements scolaires,' Secrétariat d'tat à la santé publique et aux affaires sociales, 21 July 1960.
25. Rapport de mission. Les maladies oculaires transmissibles en Tunisie, January 1961, 1–11, 22/EMRO/TUN/43, EM/TRACH/20, WHOA.
26. The Afro-Asian Council of Ophthalmology is still active today: http://aaco-ao.com/about/index.aspx (accessed December 28, 2025).
27. The vaccination schedule included smallpox vaccination and the first dose of the combined diphtheria-tetanus-pertussis (DTP) vaccine within the first six months of life, a booster dose of the DTP vaccine administered 1–3 months after the initial dose, and a follow-up DTP and smallpox vaccination at the age of 5–6 years (WHO 1959b, 21).
28. Rachel Carson's book *Silent Spring*, released in 1962, provided the first systematic account of the harmful effects of uncontrolled DDT use on human health and the environment. During the seventies and eighties, in response to growing evidence of environmental and health impacts, the WHO began promoting alternatives and recommending more targeted use of DDT. Although the WHO has restricted its use, it has never issued a complete ban. The pesticide is still permitted in controlled indoor applications for malaria control, while its agricultural and environmental uses are prohibited.
29. Libya was validated by the WHO as having eliminated trachoma in February 2026, and Mauritania in May 2025: https://www.who.int/news/item/18-02-2026-who-validates-elimination-of-trachoma-as-a-public-health-problem-in-libya (accessed February 24, 2026); https://www.who.int/news/item/19-05-2025-who-validates-mauritania-for-eliminating-trachoma-as-a-public-health-problem (accessed January 17, 2026).

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