

**Making and Unmaking  
Public Health in Africa**  
*Ethnographic and Historical Perspectives*

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Edited by Ruth J. Prince and Rebecca Marsland

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## INTRODUCTION

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# Situating Health and the Public in Africa

### *Historical and Anthropological Perspectives*

RUTH J. PRINCE

SINCE THE 1980S, MANY AFRICAN COUNTRIES HAVE WITNESSED THE decay of government-controlled health services and a corresponding proliferation of nongovernmental, transnational, private, and humanitarian organizations that target specific health-care needs, treat diseases, support service provision, or combine research with provision of health care—often through geographically and temporally limited projects. Since the turn of the twenty-first century, the language of health “emergencies” in Africa has gained increasing purchase in international concerns about security, conflict, and the spread of disease and is being linked to moral agendas and discourses of human rights. Africa has emerged as a prime arena of “global health” interventions focusing on the control of particular diseases. These high-profile interventions are reshaping social and political landscapes as well as infrastructures of health. Yet they exist alongside more mundane and persistent conditions and concerns. While global attention is focused on HIV activism and the terrain of antiretroviral provision, most African doctors, nurses, and health-care workers struggle with the day-to-day challenge of providing a reasonable standard of care in underresourced public health facilities.

This volume rethinks public health and what it means in Africa. The term public health implies the duty of government to provide for the health of its citizens, yet this situation has never been fully implemented on the continent. Attending to the legacies of earlier ameliorative drives

to provide health care to national publics, to neoliberal structural adjustment, and to novel transnational interventions and biopolitical configurations, the volume assesses the uneven terrain of public health in Africa. It offers a critical analysis of widening global and national inequalities and the emptying out of the public as an inclusive terrain, as health-care provision is shifted towards the arena of the market and of nongovernmental and transnational organizations. At the same time, less visible engagements with the health of the public and with a public good open up new perspectives on the present and future. The book thus casts a critical eye on both the radical shifts in health-care provision and the less visible concerns and practices that connect the realm of “health” with that of the “public” (or publics) in Africa today. It presents ethnographic and historical perspectives on landscapes of what can be broadly termed “public health” in Africa, as well as on the regimes, relations, and tensions that animate them.

Contributors to the volume analyze the place of public health within emerging global “biopolitical” formations of political institutions, markets, human populations, and health, and explore how African professionals and citizens approach questions of responsibility for public health as they navigate contemporary landscapes of NGOs and transnational projects, faltering state services, and expanding privatization. The authors also attend to the broad range of moral and political practices that Africans have drawn upon to intervene on the health of a collective, practices that have a long history going back to the precolonial period. Individual chapters explore confrontations of official versions of public health with indigenous concerns about collective well-being in Tanzania; tensions between private and public spheres of responsibility for health and welfare in northern Nigeria; and attempts by pharmacists in Senegal to mediate public and private health sectors, state responsibilities, and citizenship. Other chapters follow how medical professionals, patients, “community-based organizations,” and “volunteer” health workers navigate new regimes of HIV treatment in East Africa; negotiations of care for cancer patients in an underresourced public hospital ward; the struggles of people with diabetes within a disparate and uncoordinated landscape of health promotion, advice, and therapy in Uganda; and the interweaving of transnational medical research trials with health-care provision. Together, the chapters offer insights into widening global and national inequalities as well as present and future trajectories of public health in Africa.

The term *public health* conventionally refers to the duties of the modern state concerning the protection and care of the health of its citizens, through the application of modern, scientific medicine and rational administration—providing health-care services, preventive medicine, and environmental sanitation, as well as protective legislation concerning exposure to industrial, agricultural, or environmental hazards.<sup>1</sup> A vision of amelioration guides this drive toward public health, which applies biomedicine and bureaucratic procedures to state intervention and control, financed by national systems of taxation and health insurance. This vision, and the unity between “state” and “society” that it both assumes and strives for, was embodied most fully in the socialist and welfare regimes that were established in western European states during the mid-twentieth century.<sup>2</sup> It was exported to Africa in the halfhearted attempts of some colonial administrations in the 1940s to extend health and welfare services to broader segments of the population and was more enthusiastically pursued by some independent African governments in the “developmentalist” era of the 1960s and 1970s.<sup>3</sup> This vision of public health appears anachronistic when we consider contemporary landscapes of health-care provision, whether in Africa or in Europe. Yet it is one that should be taken seriously. The appeal of biomedicine to inclusive and expansive visions of progress and development and associated ideas about government responsibility, public service, and the public good are concepts that are now rarely associated with African states, yet they did play a part in the hopes and expectations many Africans had for development and for a national future.<sup>4</sup> In many countries after independence, especially those that appear in this book—Senegal and Nigeria in West Africa, and Uganda, Kenya, and Tanzania in East Africa—the extension of public health to an expectant citizenry became a nationalist project. It was pursued by governments and backed up by foreign aid and by the World Health Organization (WHO), and it had some success: hospitals and clinics were built in rural and urban centers; medical schools were set up; and primary health-care programs, vaccination and immunization campaigns, and maternal health services were extended. These visions were not, of course, shared across African countries (some of which were still fighting white supremacist regimes while others faced civil war, backed up by foreign political interference). They were also often tied to authoritarian and paternalistic regimes; they had to contend with, and were often deflected by, the very different concerns of what Rebecca Marsland in her chapter refers to as “indigenous”

public health; and they were undermined by scarce resources. Still, their legacy is apparent today in the material and human infrastructure of government health services, even if much of this is currently in a state of disrepair and even ruin.<sup>5</sup>

The first objective of the book is to take these histories and legacies of biomedical modernization and associated public health initiatives seriously in our attention to how African publics—including medical professionals, scientists, government officials, staff of nongovernmental organizations (NGOs), community health workers, “volunteers,” patients and their families, and clinical trial subjects—seek to provide or receive medical care. In doing so, we try to understand both why these initiatives often failed and how these actors navigate within contemporary landscapes of NGOs and transnational projects, faltering state services, and expanding privatization. The hospitals and clinics proudly built in the 1960s and 1970s today display peeling walls and leaking roofs, electricity and medical supplies are intermittent, and staff are overworked and often absent. The treatment of disease is always an uncertain task, but in the context of scarce resources, lack of diagnostic equipment, and poor working conditions, biomedical practice is often poor and may even be counterproductive. Lack of laboratory equipment to diagnose disease and the poor quality of existing equipment mean that medical professionals have to treat most diseases on a “best guess” basis.<sup>6</sup> In the face of this destruction and dysfunction, many of the doctors and nurses trained in African medical schools have migrated to work in countries of the Global North.<sup>7</sup> Others leave public medicine for private practice. Yet many continue with the struggle to diagnose disease and offer good care to the public under extremely difficult conditions, and many believe the state should take an active role in health-care provision.<sup>8</sup> Several of the chapters in this book observe the hopes and expectations that medical staff and patients initially bring to biomedical care and the afterlives of these hopes in the face of long-term illness and inequalities in access to treatment. Benson Mulemi, for example, shows how Kenyan doctors and nurses in a public hospital’s cancer ward struggle to provide care to often very poor patients who arrive in a late stage of their illness, having been consistently misdiagnosed. Prince’s chapter follows medical staff, volunteers, and patients attached to well-resourced, transnationally funded HIV clinics in the same country, while Susan Whyte explores the uncertain and diffuse landscape of diabetes treatment in Uganda.

A second objective of the book is to take a bearing on contemporary and past landscapes that connect health to—or disconnect health from—African publics. Despite the hopes placed in the developmentalist state, a national context in which public health is promoted by the government and extended to citizens on an equal basis has never really existed in Africa, either in the past or in the present. Moreover, conceptions of the public sphere, the public good, and the public itself are plural and cannot be taken for granted. There are three reasons for this.

First, health services have never been provided exclusively by the state. Colonial administrations began to attend to the health of African populations belatedly, and then only in limited ways.<sup>9</sup> Up to the Second World War, missionaries and private companies were more active providers of medical services, although rarely involved in extending them beyond a particular locality.<sup>10</sup> The attempts to extend public health provision by African governments after independence were undermined by global economic policies and political interests, lack of resources and political will, and large differences between urban and rural services, as well as by the burden of disease, and public health services remained patchy and inadequate. During the 1970s, as world economic recession impacted fragile national economies, modernization faltered and the vision of public health pursued by the developmentalist state was downscaled.<sup>11</sup> The 1980s saw a decisive shift away from developmentalist African states as aggressive neoliberal policies pushed by Western donors promoted privatization of health services and a dominant model of voluntary provision by humanitarian NGOs.<sup>12</sup>

Furthermore, the ideal vision of public health relies on a social contract between citizens and state and the existence of a state bureaucracy and civil service that serves the public interest, defined in this case in terms of biomedical health. As Murray Last argues in his chapter, both colonial and postcolonial government bureaucracies and political power may have only partially, if ever, functioned in this way, while Rebecca Marsland shows that district health officials' conceptions of public health and the public interest are not straightforwardly biomedical. Other "moral economies" relating to power, authority, the health of publics, and the relations between public and private interests operate as well.<sup>13</sup> Medical professionals, government officials, and patients must take into account these often-conflicting values and mores, and their own positions within them—shaped by past and present socioeconomic, class, education, religious, and ethnic differences—may be vastly different.<sup>14</sup>

Second, the association of biomedicine with colonial regimes of power and with national and global inequalities in the postcolonial era has undermined its promise as a means of amelioration. Biomedicine in colonial Africa was intimately tied to a repressive, coercive, and violent system of power and knowledge, which reached deep into African lives and identities.<sup>15</sup> Biomedicine's association with an externally imposed system of knowledge has continued to color encounters with health interventions in the postcolonial era. Suspicions and rumors about the nefarious intentions behind health interventions and medical professionals continue to circulate among African publics and have occasionally spilled out into resistance to public health campaigns.<sup>16</sup> This has not been confined to ordinary citizens or religious leaders. For example, in South Africa, former president Thabo Mbeki, together with other politicians and government officials, ignited fierce national and international disputes when he challenged the scientific consensus regarding antiretroviral treatment for HIV-positive people, evoking "dissident science" and the superiority of herbal and "indigenous" medicine.<sup>17</sup> Such suspicions of biomedical progress do not only speak truth to experiences of colonial and postcolonial domination. They also rest on experiences of scientific failure, as biomedicine often operates without adequate resources and in situations of deep uncertainty, in which mistakes are easily made. In her analysis of parents' resistance to polio vaccination in northern Nigeria, for example, Elisha Renne argues that mass immunization disrupted established patterns of immunity and led to the increased exposure of children to wild poliovirus, which fuelled fears of vaccination.<sup>18</sup>

Third, Africans have long been used to taking matters of health into their own hands. As the chapters in this book show, ordinary people are not passive recipients of health interventions. They have their own views on public health and their own concerns. These may include expectations of government action in relation to modern, formal public health, but responsibility for health and well-being has never rested in the hands of government or other biomedical authorities, and a thriving medical pluralism attests to the resonance of ideas about health and healing other than the biomedical. Biomedicine has had to coexist with these other epistemologies and practices, which locate health and therapy in arenas beyond the biological body, outside the clinic and the hospital and among nonbiomedical authorities. Given that biomedical practice has often been uncertain, inadequate, and sometimes counterproductive, its superiority over these other medical practices and forms

of healing is fragile. Colonial governments recognized and feared the authority and power underlying indigenous forms of public health and therapeutic practices; the latter were labeled as antimodern and were repressed, sometimes violently. Yet they persisted and continue to shape conceptions of health, well-being, healing, and harm. In her chapter, Rebecca Marsland attends to the divergence in rural Tanzania between “indigenous” public health and district officials’ visions of public health; she shows that although people cannot ignore government interventions, they can bend such interventions to fit their concerns.

Recent scholarship argues that a new form of “biopolitics” has emerged during the past two decades and is taking shape globally amid the shifting relations between political institutions, global markets, human populations, and health.<sup>19</sup> While Michel Foucault located biopolitics in the relations between the state and its populations, contemporary interventions into “life itself”—as the narrowly defined sphere of the vital processes of biological life—are driven by the market, specifically, the pharmaceutical industry and its pursuit of “biocapital.”<sup>20</sup> As a result, health care is increasingly bifurcated: those who can afford it are offered the chance to “optimize” their health through advanced biomedical technology, produced through market investment, while the rest are left with a minimal form of care directed at their “bare life” and organized through voluntary and humanitarian interventions.<sup>21</sup> This zoning of health care reflects wider political and economic shifts in the relations between states, markets, and citizens as transnationalism and globalization create novel spatial and temporal forms of government: zones of “exception,” a reconfiguration of sovereignty and belonging, and the fragmentation of national publics into smaller collectives gathered around specific needs.<sup>22</sup> While the example of AIDS activism and the new collectives forming around “rights to health” suggest that this situation does not necessarily prevent collective action and the pursuit of public goods, it is also true that the notion of “public” is heavily curtailed. As Nikolas Rose argues, “the idea of ‘society’ as a single, if heterogeneous, domain with the national culture, a national population, [and] a national destiny, coextensive with a national territory and the powers of a national political government, has entered a crisis.”<sup>23</sup>

Between the vision—if not the reality—of the “developmental” past and this picture of a deeply fragmented present and uncertain but dystopian future, where does African public health lie? In the past two decades, attempts to build national health-care systems, patchy and

fragmented as they were, have been replaced by humanitarian interventions and vertical disease programs with narrowly technical, targeted services—by projects that pursue “bare survival” rather than a vision of comprehensive care. The past decade has witnessed a narrowing of public health to target biologically defined (for example, HIV-positive) populations rather than a national public and citizenry. As such interventions focus more on the containment of diseases defined as “health emergencies” than on public health as a developmental goal, visions of public health have retreated further from the “health for all” goals of the 1960s and 1970s pursued by many African governments together with the World Health Organization. This increasingly transnational sphere of health provision has also created further shifts in the role of the state in relation to NGOs, in relations between public and private health services, and in imaginations of public health. While the displacement of the state and reduction of national sovereignty have not been confined to Africa, it has become a site par excellence of the “intermediary power formations”—the unstable and seemingly diffuse hybrids of public and private, state and nonstate, and national and transnational—that embody contemporary government.<sup>24</sup> Many African states, never strong in terms of trade relations with former colonial powers, foreign capital, or accountability to their citizens, have been particularly weakened in this move away from the modernist and nationalist project. Transnational and nongovernmental organizations often bypass national ministries of health and state institutions, leaving the state a weak role as “coordinator.” Africa’s marginality in what James Ferguson calls the “shadows” of the global political and economic system has left it open to a high degree of foreign intervention—to what Thandika Mkandawire calls a “reckless experimentation with African institutions.”<sup>25</sup> Some scholars argue that this marginality and “crisis” have enabled African terrains to become sites of “experimentation” by external agents.<sup>26</sup>

This situation—and the claims made about it—calls for closer investigation. African states never formed taken-for-granted rational bureaucratic institutions but were always partial, in a process of being made (and unmade); moreover, they have always operated in an international field and have made use of external connections and relationships to pursue their own interests.<sup>27</sup> Health and the pursuit of treatment have also often escaped biopolitical framings in Africa, and citizenship has not been reduced to the “biological” or “therapeutic” domain, as has been claimed,<sup>28</sup> but remains, as Noémi Tousignant shows in her chapter,

a complex field of negotiation and action. While people may make use of current opportunities to pursue livelihoods and careers, visions of a public good are not absent; they suffuse popular culture, public discussion, and national debates.

These tensions and the ambiguities that animate the relations between health and African publics suggest that the question of what public health actually *is* in Africa, whether today or in the past, cannot be taken for granted. An ethnographic and historical focus on the meanings and configurations of “public health” in Africa is therefore both timely and important. To locate and understand present and past forms of public health, we need to grasp the *particular* historical relations between political authorities, individuals, and collectives, as well as the often *plural* concepts of a “public” and practices of “public” health that exist. What has “public health” meant in particular African countries, at particular times? Did it ever exist, and if so, in which forms? Was there ever a narrative of “public” health, conceived of as the responsibility of the state to its citizens, and if so, what has become of it in a situation in which health interventions are funded and organized to a large extent by nonstate and extranational institutions? Which forms of responsibility, civic commitments, and collectives animate these new configurations of health care and intervention? What role do African states play in this? And what are the implications for African health—for the experiences of patients and the provision of services, as well as for notions of the public good and the responsibility of government? These questions provide a framework for this book. We use them to investigate the multiple relations between “health” and “the public” rather than assuming that there is a “system” of “public health.”

The book explores, then, the regimes and relations, the interests and concerns, and the contradictions and negotiations that motivate, animate, or undermine the nebulous realm of public health in Africa. It asks who is taking care of whom, on what terms, and with which social, political, economic, and personal consequences.<sup>29</sup> It shows how those acting in relation to public health must contend with different historical legacies, conflicting interests, and uncertain futures. Offering insights from research in Nigeria, Senegal, Kenya, Uganda, and Tanzania, the contributing chapters examine the concerns and tensions that animate health-care provision and public health projects. The chapters explore various landscapes in which health is connected to—or disconnected from—various publics and follow the trajectories,

motivations, expectations, and hopes of the actors that move within them. Thus, they explore how pharmacists, scientists and science workers, government officials, doctors, NGO staff, community health workers, and volunteers, as well as patients and laypeople, seek treatment or provide care, negotiate careers and seek livelihoods, and pursue their visions of development. Our analyses move between different levels of scale (the global, national, local, and individual), between public and private spaces, and between lives and technologies, medicines and bodies, organizations and individuals, and policies and practices, as well as between past and present. Some chapters attend to the hopes that Africans invest into biomedicine and health services and their visions of the public good in relation to health. Others point to the evacuation of the public as a national collective and the fragile status of the public good in the sphere of health, and trace the contours of new landscapes of health—"archipelagos," to adopt Geissler's term—that zoom in on particular groups and circumscribed publics or appeal to growing socioeconomic distinctions in an expanding market of privatized care. Several chapters point to a new "projectification" of health care and explore its implications. Others attend to older historical relations between health and the public or to "indigenous" forms of public health, which interact with formal health-care interventions in surprising ways. Together, they point to tensions between different versions of "public health" and open up debates about the very relevance of the term. In their exploration of the polyvalence of this landscape, the chapters offer an anthropology of public health in Africa.<sup>30</sup>

Within history and anthropology there is a rich literature on the coercive nature of the colonial campaigns against epidemic disease, the imperialist and racist visions that infused medical interventions, and the unequal power relations that continue to define biomedical intervention in Africa.<sup>31</sup> These analyses of repression and resistance are important, but they do not necessarily define the experience of Africans with public health and biomedicine.<sup>32</sup> Many Africans also appreciated scientific medicine and the opportunities it offered for curing disease. Scholars have paid much less attention to the hopes for health and the visions of national development and societal progress that many Africans associated with biomedicine and the pursuit of public health, especially in the years around independence but also since then. Even during the colonial period, biomedical interventions were not experienced solely as repressive; mission clinics and urban health centers were flooded with patients

hoping to be cured, and Africans were eager to practice such medicine themselves.<sup>33</sup> In the years leading up to independence, biomedical services and public health campaigns offered people a vision of progress, and newly independent governments pushed the extension of public health services as a tool of “development.” This drive for development by the state was fragmented, internally divisive, and contradictory and was quickly undermined by African governments themselves as well as by international interference. Yet it did provide a narrative of progress in independent Africa.<sup>34</sup> In the face of the destruction and fragmentation of public health systems by neoliberal policies and the massive privatization that has opened up health to market forces, including transnational business, on a new scale, these visions of the public good associated with public health appear as important objects of anthropological attention.

This book, then, offers various angles onto the differentiated forms of public health—or forms that relate to public health—that have emerged in recent years on the African continent. We pay attention not only to the new and old forms of power, and the violence, exclusions, and inequalities that are present within these formations, but also to the ways actors circumnavigate them, act upon them, and bend them to local interests and concerns. We use the frame of public health to interrogate visions of the public, the public good, and the public sphere that undergird particular interventions and to scrutinize the uneven and unstable relations between public and private health care and between public and private, government and nongovernmental organizations. We also examine the ways in which public health activities produce and interact with particular spheres of intervention—such as the domestic, the community, the market, lifestyle, behavior, the individual subject, and individual responsibility for health. Throughout, we point to historical legacies and present trajectories.

### From Ritual and Healing to Biomedicine and Globalization

A rich historical and anthropological literature shows us that health and healing are at the heart of the socio-moral, political, and cosmological order in African societies past and present. Edward Evans-Pritchard’s classic study of Azande witchcraft showed that Zande witchcraft beliefs and practices were at the center of societal order and notions of personhood. He argued that they formed a logical system of thought and practice, but he retained his faith in the ultimate truth of his scientific worldview and its superiority over what were, according to this

perspective, cultural beliefs. His work is a reflection of his position as a colonial anthropologist, tasked with explaining African society to a bewildered colonial administration that was faced with the “otherness” of vastly different epistemological and ontological practices. Yet this cultural and political position on “science” versus “culture” has continued to shape anthropological analysis and to inform postcolonial governance and interventions into health and healing. Even though many anthropologists suspended their disbelief in the realities of African cosmologies and entered into different life worlds, the realm of scientific medicine was not treated with the same degree of symmetry.

From the 1950s to the 1970s, anthropologists’ analyses of ritual and healing in African societies produced powerful insights into the rich cosmological worlds of African peoples and into the experience of illness, health, and therapy. Working in 1950s and 1960s Zambia, for example, Victor Turner explored the relations between symbols and experience and the transformative effect of ritual, laying the grounds for later anthropological treatments that related ritual practice to power, historical agency, and resistance to colonial hegemony.<sup>35</sup> In 1960s and 1970s Zaire, John Janzen explored the social organization of healing and the importance of “therapy management groups,” that is, associations of family, neighbors, and friends that decide treatment pathways and manage the body of the patient.<sup>36</sup> By following case studies of illness and misfortune, he showed that people sought therapy within a landscape of medical pluralism, trying out both biomedical services and other forms of healing and approaching both therapeutic systems with caution, as medicine was understood to have the capacity to harm as well as heal. Janzen argued that the colonial suppression of healers and healing and accompanying shifts in the political and social landscapes of therapy had deeply influenced the therapeutic practices he observed. A growing body of historical research on how indigenous forms of healing were increasingly circumscribed by colonial power, administration, law, and medicine supported Janzen’s views.<sup>37</sup>

These evocative studies of ritual and healing in Africa influenced subsequent work on cultural histories and colonialism, and they shaped a new subdiscipline, medical anthropology, which took seriously experiences of illness and therapeutic practices outside of scientific medicine.<sup>38</sup> Despite the recognition of medical pluralism, however, these and subsequent studies in Africa gave more attention to vernacular forms of healing than to the practice of biomedicine itself. This is strange, given

that by the mid-twentieth century, particularly the anthropologists associated with the Rhodes-Livingstone Institute had already taken a keen interest in processes of colonialism, race relations, labor migration, and industrialization. Perhaps this blind spot was due to the fact that biomedical services were patchy and African encounters with them were more limited than with other colonial interventions, or perhaps it was because at the time anthropologists could not treat modern biomedicine with the same degree of cultural relativism. It was science, thus universal and outside the interests of the anthropology of the time.

In the 1980s and 1990s, however, anthropologists began to take a fresh look at the colonial encounter.<sup>39</sup> Influenced by Marshall Sahlins's work on Fijian histories, Jean and John Comaroff argued that dominant colonial, capitalist, and Christian practices and ideologies entered into extended interaction with African practices, producing "something altogether new."<sup>40</sup> This historical anthropology of colonialism opened up the study of colonial medicine as a system of power and knowledge and of contradictory practices.<sup>41</sup> Historians and anthropologists began to approach biomedicine as a "cultural system."<sup>42</sup> Influenced by Michel Foucault and Frantz Fanon, Megan Vaughan and Jean Comaroff scrutinized biomedicine as a system of knowledge and power that was imbued with racial and colonial stereotypes, objectifying Africans and Africa.<sup>43</sup> In her work on "blood stealing" rumors, Luise White points to the fears and suspicions, the ambivalence and the violence that suffused African experiences of colonial medicine, while Nancy Rose Hunt's account of the encounters between medical missionaries and Congolese in Belgian Congo offers a nuanced reading of the translations and misunderstandings as well as the violence of the exchanges that took place around biomedical practice.<sup>44</sup> Such studies underline that biomedicine cannot be considered predictable, coherent, or monolithic.

Medical anthropologists also began to turn their attention to biomedicine, offering acute analyses of the disconnects between biomedical disease and the patient's experience of illness, the political economy of health under capitalism, and the effects of globalization and neoliberal policies on the health of the poor.<sup>45</sup> Within Africa, however, ethnographic study until recently focused mainly on the informal sectors in which people accessed biomedical practice rather than on medical encounters within clinics and hospitals.<sup>46</sup> For example, Susan Whyte, Sjaak van der Geest, and Anita Hardon explored lay use of pharmaceuticals and the social histories of medicines as they circulated in the "informal"

sector.<sup>47</sup> In revealing the mobilities of medicine, both within and beyond Africa, this work laid the grounds for more recent ethnographies of biomedicine and globalization. A new anthropology of biomedicine has taken shape,<sup>48</sup> which brings into focus new ethnographic sites. These include policy making, government bureaucracies, transnational NGOs such as World Vision and Médecins sans frontières (MSF), clinical research trials, drug donation projects, vaccination campaigns, and anti-retroviral treatment programs—and the “assemblages” of transnational politics, ethics, science, technology, and expertise that support them.<sup>49</sup> Anthropologists have also turned to more mundane arenas of medical practices, such as hospitals, clinics, and medical colleges, the privatization of care, and its globalization.<sup>50</sup> Rather than engendering the inevitable transformation of “local” social and cultural forms by “universal” ones, globalization is recognized here as an unpredictable process that brings different trajectories, histories, and interests into friction as “universals” are engaged and made to work.<sup>51</sup> At the same time, neoliberal globalization has accentuated political and economic inequalities, particularly in Africa, where resources and technologies have leaped into bounded enclaves, benefiting an exclusive set of interests, often extractive and exploitative ones.<sup>52</sup> The anthropology of biomedicine has been inspired by recent ethnographies of development, which shift critique away from the hegemonic interests underlying development discourse to consider the practice of policy itself, the unexpected directions that development projects take, and ways different actors position themselves in relation to it.<sup>53</sup> These perspectives challenge the built-in bias of health interventions and development projects toward representing success rather than failures, and remind us of histories of dystopias.<sup>54</sup> Yet they also recognize that there may be, to use Julie Livingston’s term, “productive misunderstandings,” which enable public health interventions to encompass the multiple interests of actors involved.<sup>55</sup>

Social scientists argue that the present “neoliberal” order, with its particular imaginaries of society and the state, has narrowed the responsibility of health down to the individual while relating this individual—through his or her particular disease—to an increasingly transnational sphere of governance and privatized health. National sovereignty is pared away in this process, as state institutions are to a large extent bypassed or given a weak role. Such characterizations contain much truth yet also simplify a more complex reality. They lay bare political and economic exclusion, domination, and inequality, yet in privileging a

narrative of biopolitical domination, they obscure other possibilities that may lie within the present.<sup>56</sup> The high-profile “global” regimes shaping health-care provision such as transnational HIV treatment programs are important objects of anthropological analysis. Yet they highlight only one arena shaping what has become of public health on the continent and overshadow the more mundane practices, policies, and struggles that form its less visible side. We must be careful not to privilege the agency of the global and overlook how local interests, actors, sensibilities, and social forms are often what anchor externally planned interventions in a meaningful way. Furthermore, Africa is not merely a recipient of humanitarian and development interventions; it is also a site of a thriving private therapeutic sector that builds on longer histories of mobility and encounters between different therapeutic traditions and health experts.<sup>57</sup> Public health care and interventions in Africa share the medical space not only with a vast variety of nonbiomedical therapies and traditions but also with increasing numbers of private hospitals and medical insurances, which offer biomedical treatment to the better-off middle classes, some of whom also go abroad for private medical care or fertility treatment.<sup>58</sup>

Such perspectives underline that the relations between health and the public in Africa encompass multiple interests, socioeconomic forms, and trajectories and that we cannot approach them through a singular object of study. These approaches inform the ethnographies of public health that we offer in this book. We show that public health cannot be taken for granted; it does not form a predictable space of intervention but is currently an open and even experimental arena, the future trajectories of which remain unclear.

### Locating Health, Healing, and the Public in Africa

Steven Feierman’s work on the “invisible histories” that surround biomedicine and colonialism reveals that present formations of health and the public have been shaped by longer histories, ideologies, and practices.<sup>59</sup> The encounter of these arenas in the colonial era with biomedicine involved violence and repression. These histories allow us to better understand contemporary encounters between health interventions and African publics.

In precolonial Africa (and up to the present day), health was understood to extend beyond the boundaries of the body and to be intimately tied to matters of production and reproduction, prosperity, and power.<sup>60</sup>

Interventions into health and well-being were directed not exclusively at bodies but also at the fertility of the land and livestock and relations with others, living and dead, while bodily health itself was conceived as part of wider relations. Given that such relations were always fraught and fragile, therapeutic power was considered highly ambivalent, as it could be directed to harm as well as to heal. Historians of Africa describe these forms of power, knowledge, and intervention that were concerned with the vitality and health of the collective as a kind of “public health.”<sup>61</sup> Control over healing was at the heart of political power, albeit in different and often highly contested ways.<sup>62</sup> Chiefs were invested with power over the land, its fertility, and its vitality through their persons, their use of medicines, and their control over ritual and through their authority over healers and spirit mediums, rainmaking, and witchcraft. They could use this power to cleanse the land and persons of pollution but also to hold back growth and fertility. Yet healing was multifaceted. There was no one source of authority; chiefly power was not absolute, and chiefs were dependent on their people. If they were unable or unwilling to respond to misfortune, they would be deposed. Healers were not always intimate with those in political power; they could undermine such power or destabilize it.<sup>63</sup>

Through the introduction of Christianity, the suppression of uprisings, the killing and exile of chiefs and kings as well as healers and prophets, the reorganization of political economy, and the imposition of alien systems of authority and law, colonialism repressed and ruptured these forms of power and knowledge.<sup>64</sup> In the process, healing became severed from the political order. By the time anthropologists began observing rituals of healing and describing them in the 1930s and 1940s, many forms of public healing had gone underground or were forced to operate within a more circumscribed, private sphere.<sup>65</sup> Chiefs often became co-opted by colonial authorities as headmen; they lost their ritual authority but gained a position in the colonial order.<sup>66</sup> Meanwhile, colonial authorities began to intervene in matters of public health, such as disease epidemics and famines. At the same time, they tried to confine the realm of “African healing” to that of timeless, archaic tradition and sought to render healers’ practices illegal.<sup>67</sup> The introduction of antiwitchcraft laws and the grouping of all practices regarded by the colonial authorities as “irrational” or “occult” into the category of witchcraft added to the confusion.<sup>68</sup> Christian missions reinforced these attitudes toward the realm of healing more

intimately and intensely, as they demonized the African past, introducing polarities between “traditional” and “modern” and placing practices concerned with healing in the realm of the (archaic) past.<sup>69</sup> In their push for “development” and modernization, postcolonial governments largely took on colonial attitudes toward indigenous healing—at least officially—and labeled the realm of nonscientific medicine and healing practices as irrational and antimodern.<sup>70</sup> In the name of development or “scientific socialism,” they continued to push popular concerns with the health of the public, and its location in practices pertaining to the growth and vitality of land and people, into the realm of custom, tradition, witchcraft, and the occult.

Even while public healing and public ritual were suppressed, however, “indigenous” understandings of health and healing did not disappear. The social, political, and economic tensions of the colonial era led to a rise in witchcraft accusations and the proliferation of witchcraft eradication movements and new forms of healing. The emergence of Christian healing and the persistence of ritual specialists and healers point to concerns about a broad realm of growth and vitality anchored not only within the body but also in the social, moral, and spiritual order. These concerns are still resonant today, even while they are deeply contested.<sup>71</sup> By contrast, biomedical practice attends to a circumscribed arena, that of the biological body. These issues are explored in the first section of this book. The chapters by Murray Last on northern Nigeria and Rebecca Marsland on contemporary Tanzania argue that colonial biomedicine and postcolonial attempts to intervene in public health share a tense space with other ideas and practices around health and healing, which engage with public morality.

### Health, Development, and the Colonial State in Africa

While the particular interventions into health taken by different colonial governments in Africa—French, Portuguese, Belgian, and British—are diverse, until the 1920s colonial authorities confined their activities to providing health services to settler populations and combating epidemics of infectious and tropical disease that threatened pools of native labor and thus economic productivity.<sup>72</sup> Early disease campaigns focusing on sleeping sickness, plague, and smallpox were often coercive and violent and left a deep mark on African consciousness.<sup>73</sup> Curative services were mostly left to missionaries—although some medical care was provided to urban employees.<sup>74</sup> Colonial administrations gave African health

more attention after the First World War but were mostly concerned with the reproduction of a healthy labor force, as the greater exposure to disease and poor nutrition of populations under colonial rule became apparent in high mortality and low birth rates. In the late 1920s and in the 1930s, some progressive voices called for improvement in socioeconomic conditions and for a focus on “African welfare,” but the lack of political will meant that few of these initiatives were sustained.<sup>75</sup>

In the 1940s, the development of vaccinations and antibiotics and the increasing agitation of colonized peoples for better living standards and for political participation led to efforts, in the British and French colonies at least, to extend some health-care services and medical technologies to broader populations.<sup>76</sup> In the British colonies, postwar “development” and “welfare” acts were introduced, driven in part by self-interest but also by more progressive, if paternalistic, ideas about colonial trusteeship, in which government planning and investment would promote economic and social progress.<sup>77</sup> Interventions to improve living conditions and promote development remained half-hearted, patchy, and unfinished, however, and mostly focused on the most politically vocal groups, such as urban wage laborers, in the hope of diverting them from political protest.<sup>78</sup> This proved counterproductive to colonial rule, as “development” became a concept around which colonized peoples could formulate political and economic demands, while continued repression increased resistance to imperial power.<sup>79</sup>

### The Developmentalist State in Africa

Frederick Cooper argues that “no word captures the hopes and ambitions of Africa’s leaders, its educated populations, and many of its farmers and workers in the post-war decades better than ‘development.’”<sup>80</sup> However, development in general, and public health in particular, was crisscrossed by contradictory impulses and experiences, as repression and violence coexisted with attempts at melioration across the colonial and postcolonial eras.<sup>81</sup>

From the 1950s to the 1970s, in the years up to and after independence, the vision of government planning and government investment as the key to economic and social progress had immense appeal both within and beyond Africa.<sup>82</sup> Despite different political approaches to economic development (for example, capitalism in Kenya and Senegal, socialism in Tanzania and Zambia), there was broad consensus that economic growth was to be complemented and driven by improving

the education and health of citizens—and in the first two decades after independence, health, education, and social protectionism became a central part of the nation-building project and a central demand by the public of their government.<sup>83</sup> At the same time, development was located firmly in the international sphere and often undermined by cold war interests. Former colonial powers jostled with the United States and the Soviet Union to maintain trade and aid relationships with African states, setting up national “development agencies,” which, together with the international organizations created in the 1940s under the Bretton-Woods Agreement, provided technical expertise as well as financial resources. This did not happen across Africa: South Africa, Mozambique, Namibia, and Rhodesia were still under colonial rule, while many newly independent states experienced further violence, even civil war. Still, development was a promise that captured the imagination of the African public.<sup>84</sup>

From the 1950s to the early 1970s, development through state planning had some success, even though its results were uneven. Growth rates in the 1960s and 1970s were mixed but largely positive. Urban economies expanded, as did agricultural exports and some industrial production.<sup>85</sup> The fruits of economic growth were unevenly distributed, disproportionately benefiting the elites, but between the 1950s and 1970s, life expectancy grew and mortality rates fell in many countries—the result of improved maternal and infant care services, the control of epidemics, the elimination of smallpox in 1950s, and the extension of immunization—while literacy rates also improved.<sup>86</sup> Some of the newly independent African states tried to address the imbalance of health services concentrated in urban areas, and there are indicators of widening access to health services and to education.<sup>87</sup>

Many Africans now look back on this era as one of optimism in the ability of the nation-state to deliver development.<sup>88</sup> Yet many states continued to be politically and economically subordinate to former colonial powers and to the international development regime, with its privileging of Western knowledge and technical expertise and belief in the “trickle-down” benefits of modernization projects.<sup>89</sup> At the same time, many postcolonial states continued to practice divisive and unequal forms of governance, inherited partly from their colonial predecessors.<sup>90</sup> Emerging elites rode roughshod over local knowledge and expertise, which contributed to the failure of many development projects. The period also saw the entrenchment of clientalism and political authoritarianism

and the suppression of dissent by regimes that were often supported by the West.<sup>91</sup> As the rhetoric of participation in national development was replaced by policies of coercion and control, confidence in the nationalist project was “deeply undermined.”<sup>92</sup> Recent scholarship on the rhetoric and realities of “development,” “citizenship,” “participation,” and other postindependence nationalist projects further breaks up the vision of coherent wholes.<sup>93</sup> Still, critiques of the developmental state should not assume that developmentalism has disappeared without a trace; it was never a monolithic category, and for many Africans the project of national development is still one worth striving for.<sup>94</sup> Noémi Tousignant takes up these debates in her chapter on how Senegalese pharmacists have positioned themselves in relation to the state and its responsibility for public health.

The period of the developmentalist state was short-lived.<sup>95</sup> The dependence of many African economies on agricultural or mineral exports meant that the oil shocks and world economic recession of the early 1970s had immediate effects on economic growth. “Whereas in the decade before 1976, GNP per capital from Sub-Saharan Africa as a whole grew nearly 20 percent, in the next decade it fell 20 percent, and as of 1996 was only a little ahead of 1966.”<sup>96</sup> If the 1960s was a period of “developmental authoritarianism,” by the late 1970s “only the authoritarianism was left, for rarely was the state actually delivering on its developmental promises.”<sup>97</sup> State leaders could no longer pass out resources to clients, leading to a highly unstable situation and giving rise to numerous coups and regional conflicts (exacerbated by cold war tensions) and to disillusionment and an increasing lack of faith in the state itself.<sup>98</sup> Governments were forced to borrow from Western institutions at high rates of interest. Growing debt and stalling economic growth began to reverse social and economic improvements; education systems declined, and there was a growing lack of medical facilities and supplies.<sup>99</sup>

The postcolonial period also saw the development of the field of “international health,” led by the World Health Organization (which provided technical expertise to African governments) and funded by Northern governments through their development agencies. Health measures and advances were varied. Population control became a focus of intervention beginning in the 1960s, pushed by donors such as the U.S. Agency for International Development (USAID) and pursued by African governments, often through coercive measures. The World

Health Organization's successful eradication of smallpox in 1979 was a breakthrough for its role in overseeing and coordinating primary health campaigns. Overall, disease-eradication programs were favored until the 1970s, when growing disillusionment with "top-down" approaches led to calls for international and national efforts to focus on primary health care and the "grassroots"—captured in the World Health Organization's 1978 call for "Health for all by the year 2000" at its Alma Ata conference.<sup>100</sup> This was part of a broader critique of top-down, "one-size-fits-all" development in the face of the failure of large-scale modernization projects, and a turn toward small-scale projects, popular participation, and sustainable technology—in countries such as Kenya and Tanzania, it resonated with earlier calls for *harambee* ("pulling together") and *kujitegemea* ("self-reliance") in the name of national development.<sup>101</sup> The Alma Ata declaration called for strengthening health-care infrastructures, health worker training, redistribution of health resources to rural areas, and building on existing "community" strengths such as traditional midwives.<sup>102</sup> It emphasized preventive health care through a focus on immunization, reproductive health, contraception, sanitation, and the promotion of "safe motherhood." Based on successful models of health development in the socialist and communist world, it encouraged "community participation" as the means through which public health efforts would be responsive to local needs—"it was cheap, effective socialized health care."<sup>103</sup>

However, the Alma Ata vision of primary health care was also short-lived. Criticized for being overly ambitious and even expensive, it was disrupted by continuing economic recession in the 1980s, in addition to the rise of neoliberalism, market ideologies, and structural adjustment policies—and by new epidemiological challenges, foremost among them the appearance of HIV/AIDS. It was replaced, in the 1980s, by "selective primary health care," which focused on a few cheap and effective interventions requiring little investment in infrastructure—such as oral rehydration therapy for diarrheal disease in children and growth-monitoring, breast-feeding, and immunization programs.<sup>104</sup> During the 1980s, many national health-care systems were dismantled, and "the terms of Alma Ata, never fully implemented, were simply overtaken and made irrelevant by . . . global processes."<sup>105</sup> As neoliberal policies became dominant, health interventions became narrowly focused on promoting individual responsibility for health, rather than attempting to tackle the broader socioeconomic and political conditions underlying ill health.<sup>106</sup>

## The 1980s: Neoliberalism, Structural Adjustment, and NGOs

The 1980s was a period of economic decline in Africa, engendered by increased oil prices and world economic recession, fluctuations in export prices, and governments' growing debt. At the same time, authoritarian governments became increasingly repressive (many of them, such as those in the Congo and Cameroon, were put in place and supported by Western powers). Faced with downward-spiraling revenues, African governments applied for financial loans to the International Monetary Fund (IMF) and World Bank, which imposed stringent conditions, known as "structural adjustment," forcing them to cut down expenditures and scale back development objectives. IMF economists considered Africa's economic crisis to be caused by misjudged economic policies but also, above all, by what they saw as "bloated" state institutions and corruption ("rent-seeking" behavior). While this diagnosis contained some truth, the solution imposed—drastically cutting state resources for health and education and cutting back finances for the civil service, including teachers and health workers—is now widely accepted to have done little to reduce corruption, while having devastating effects on health and education provision, on the morale of civil servants, and on living standards, as formal sector wages fell, while more and more people were forced to find a living in the informal economy.<sup>107</sup> The collapse of primary health care services and the decimation of public health systems pushed people to seek treatment outside the formal sector, in informal pharmaceutical markets and within the diverse arena of "traditional" medicine.<sup>108</sup> National pharmaceutical industries collapsed, too: "By 1990," argues Kristin Petersen, "the domestic production of pharmaceuticals ceased almost entirely not only in Nigeria but throughout Africa; most pharmaceutical and medical supply industries were pushed into bankruptcy."<sup>109</sup> This further opened up African markets to the global pharmaceutical industry. It reflected a widespread "dispossession" of local manufacturing and small-scale enterprise by neoliberal policies across the globe.<sup>110</sup>

The story of 1980s neoliberalism in Africa and beyond (and its consequences for power relations between national, transnational, and global scales) is by now well-known.<sup>111</sup> The 1970s economic crises led to the dismantling of the Bretton-Woods system of fixed exchange rates and controls on capital and to the encouragement of speculative financial movements. The New Right, led by the United States and the United Kingdom, endorsed neoclassical economic theories advocating growth through opening up markets and reducing the role of the state.<sup>112</sup> Liberal

theories in which the state and citizens are conceived as separate and antagonistic entities replaced social democratic ideas of the duties and relationships between them. Neoclassical economics came to dominate powerful international institutions such as the World Bank and International Monetary Fund (IMF), which “shifted their focus from economic specialization within a national framework to specialization in a world economy; thus, for the Bank, development became ‘participation in the world market.’”<sup>113</sup> Health markets were opened up to transnational corporate entities, leaving national governments with little control over prices and supplies of medicines and equipment.<sup>114</sup> At the same time, responsibility for health development in African countries increasingly shifted out of the hands of ministries of health and into a globalized policy environment, dominated by the World Bank and IMF.<sup>115</sup>

The World Bank’s 1981 *Berg Report* made the case for structural adjustment and the minimalist role of the state, while the 1991 World Bank Development Report, titled *The Challenge of Development*, signaled the final break from state-led development approaches: the role of the government was to be confined to providing a legal and regulatory framework within which markets could operate, that is, to being a “night-watchman.”<sup>116</sup> The 1993 World Bank Development Report (titled *Investing in Health*) observed that direct government provision of health care is inefficient. Governments should provide a “minimum package” of health services, which World Bank experts believed would ensure equal access to basic health services, leaving all other services to be covered by medical insurance or shifted to the private sector.<sup>117</sup>

The degree to which governments and citizens accepted the neoliberal ideology of reduced state expenditure and bureaucracy varied—Kenya adopted it with less resistance than did Tanzania or Zambia.<sup>118</sup> However, African governments applied structural adjustment policies through the 1980s while development policies became driven by the neoliberal agenda—termed the “New Policy Agenda.”<sup>119</sup> This focused on a “roll-back” of the state, the encouragement of private-sector health services, and an increased flow of external aid to nongovernmental organizations rather than to governments.<sup>120</sup> It involved not only the cutting back of state expenditure but also experimentation with new social forms in health service delivery. Characteristic public health interventions of the time were the Bamako Initiative—a form of “cost sharing” that involved the introduction of “community pharmacies,” for which the community had to pay, and “social marketing” initiatives, for example, marketing

condoms as a response to the HIV/AIDS epidemic.<sup>121</sup> Cost sharing was supposed to make individuals more responsible for their consumption of health services, and in the 1980s and 1990s the ideology of the patient as a “consumer” who should exercise “choice” (reflected in the use of the term *client*) became dominant.<sup>122</sup>

There is ample evidence that privatization of previously public services gathered pace and that this occurred within a fundamental shift in the ideology of public health. However, this overlays a complex intertwining of public and private health care from the colonial period on, particularly in African nations that followed a capitalist model of development.<sup>123</sup> The shift away from state health provision is indisputable, yet an association of the pre-1980s with public health and the post-1980s with private health is too simple. As Noémi Tousignant’s chapter in this volume underlines, since independence in Senegal, pharmacists have mediated and moved between public and private sectors, appealing to state responsibility for public health care while taking advantage of the state’s support for private enterprise. This story could be told elsewhere, particularly in countries, such as Kenya, that followed a capitalist model of development. John Iliffe documents how the Kenyan government encouraged the commercial sale of medicines and of medical expertise; only a minority of Kenya’s doctors, even before the 1980s, were in public medicine, and those who were supplemented their state incomes with private practice.<sup>124</sup> The prominence of NGOs or “private voluntary groups” in the provision of health care in African countries also has a long history, as already noted.<sup>125</sup> Their increased role does not necessarily cancel out the state; many health workers are still employed by the state, and clinics and hospitals are run by it, but public health institutions are crisscrossed with “public-private partnerships” and non-governmental projects. “Demarcation between the public and private sectors is blurred and there are transfers of control, funds and personnel not only from the state to the voluntary sector but also in the reverse direction. Links between the voluntary sector and the state are becoming more—not less—important for service provision: ‘straddling’ between the public and voluntary sectors is a key feature of privatization.”<sup>126</sup>

### Nongovernmental Governance?

NGOs became popular vehicles for the implementation of official donor aid objectives at a time of dissatisfaction with state-led development and a search for alternatives. They were endorsed by both sides of the

political spectrum, as the Left was frustrated with corruption and political repression in some African states and with “top-down” development. Supporting nongovernmental organizations thus became a strategy to build up “civil society,” framed again by the liberal idea, dominant in the United States, of state versus citizens.<sup>127</sup> NGOs were also regarded as more transparent, less weighed down by bureaucracy and corruption, more efficient, and closer to “the grassroots”—hence, better able to deliver the promises of “bottom-up” development.<sup>128</sup> Because of their humanitarian or mission roots, NGOs were also regarded by those on the Left as better advocates for the world’s poor than were aid bureaucracies of donor countries or international institutions such as the United Nations. Meanwhile, the political Right regarded the voluntary sector as a cheaper and more efficient alternative; the small size of NGOs gave them a supposed “comparative advantage.”<sup>129</sup>

The 1980s and 1990s experienced an “NGO revolution” in many African nations<sup>130</sup>—such that by the mid-1990s, collaboration with NGOs was an established feature of international development. International NGOs have become household names in many African countries.<sup>131</sup> Major bilateral and multilateral actors in international health, including USAID and the World Bank, increasingly channeled aid to the health sector in poor countries through NGOs, producing an “unruly *mélange*” of international donors and NGOs.<sup>132</sup> Meanwhile, the number of development NGOs in the global North rose from 1,600 in 1980 to between 3,000 and 5,000 in 1993, many of them funded partly by Northern governments.<sup>133</sup> The largest NGOs have budgets larger than the gross domestic product of some African nations.<sup>134</sup> A significant proportion of the NGOs operating in East Africa are American evangelical Christian groups, which registered as NGOs to receive USAID funding,<sup>135</sup> underlining the growing prominence of faith-based organizations in development projects and in providing health services, particularly those directed at HIV/AIDS.<sup>136</sup>

While the focus on civil society and NGOs has contributed to political democratization, in the field of health provision it is generally accepted to have led to poorly regulated, often parallel and competing “projectification” of health care—a focus on isolated islands of intervention rather than national development.<sup>137</sup> There is a large literature on the NGO phenomenon and the largely negative consequences of this model of development, including lack of aid coordination, fragmentation and decline in quality of health services, and increasing inequality.<sup>138</sup>

For example, in East Africa, AIDS interventions aim at getting people to “own” development projects, drawing on a language of “stakeholders” and community “participation.” Yet NGOs and “community-based organizations” end up responding more to pressures from above—from donor funding cycles and bureaucracies—than to interests from below, creating an externally orientated and highly dependent health sector.<sup>139</sup> In Mozambique during the late 1990s, the multiplicity of organizations working on health projects and providing health services were found to “duplicate programme support, create parallel projects, pull health services workers away from routine duties and disrupt planning procedures” and to reinforce “a two-tiered provision of services that siphons off resources and personnel from a poorly funded public system, further undermining morale, commitment and organizational capacity.”<sup>140</sup> NGO projects pay higher salaries, drawing professionals out of the state system both permanently and on a daily or weekly basis (as they attend training “workshops” run by NGOs and supplemented by generous allowances). State actors are reduced to “coordinators,” but they have little incentive in trying to control NGO projects, as these bring in much-needed income and resources.

Across East and southern Africa, then, the turn toward NGOs has increased donor power to direct agendas, weakened state authority, and created a poorly regulated “NGO-isation of society.”<sup>141</sup> Moreover, the very qualities that give NGOs a supposed “comparative advantage” limit their effectiveness at promoting societal development. Developmental problems are vast and cannot be tackled by islands of intervention targeting specific populations. Operating short-term and discrete projects, NGOs do not have the reach of state institutions.<sup>142</sup> As NGOs are given an increasingly prominent role, the unit of development is no longer society but the “community”: “Some fortunate individuals and communities may experience an improvement in their living standards and quality of life as the result of NGO interventions but the rest of society around them remains stagnant and impoverished.”<sup>143</sup> The process of development is, by definition, fragmented, with no provision of universal services and no attempt at equity. As NGO projects, directed at meeting survival needs, replace a vision of development (however fragmented it actually was) as broad-based, equitable economic growth and improvement in living standards, two models of development are produced: “survival of sorts in Africa, and progress for the rest of the world.”<sup>144</sup> Despite their avowedly nonpolitical and humanitarian stance, NGOs

are political actors whose presence and activities have reconfigured the politics of health provision, development, and ultimately statehood and citizenship.<sup>145</sup> Although old hierarchies have not disappeared—the state is by no means absent, or simply “failing,” despite Afro-pessimistic diagnoses—there has been a fundamental rescaling of power.<sup>146</sup>

There is ample evidence that the turn toward NGOs and “civil society” organizations has had detrimental effects. But what of the argument that state institutions were inefficient, corrupt, and unable to deliver development? Alan Fowler argues that the “comparative advantage” of NGOs was deliberately constructed, lying in their ability to mobilize resources.<sup>147</sup> Thandika Mkandawire argues that the neoliberal view of state inefficiency became a “self-perpetuating reality” and, moreover, that it rested on a misinterpretation of the policies behind the East Asian “tiger” economies’ successes.<sup>148</sup> From the early 1990s on, as African countries’ economic performance continued to decline while social and health indicators worsened, structural adjustment was reappraised. Recognizing that the tiger economies were in fact dependent on strong states governing markets and ensuring national self-interest, the World Bank has moved toward a more positive view of the role that the state can play in development. It now urges combining financial rigor with a return to basic priorities—health, education, and quality of government.<sup>149</sup> But this return of the state, argues Mkandawire, has focused on issues such as technical competence and “capacity” rather than dealing with the low morale and poor pay of government employees.<sup>150</sup> Governance, which began as a concern for accountability, has become “entirely about accounting,” a “depoliticized quest for technocratic governance” underlying what he sees as an “ideological vacuum” in which African elites pursue their self-interest, with no sense of the public good.<sup>151</sup> Mkandawire’s analysis, however, does not analyze terms such as *accountability* and *good governance*, nor does it raise the important questions of what a “public good” is, who defines it, and how it is acted upon.<sup>152</sup> Several chapters in the book take up these questions surrounding the role of the state and provocatively address issues of the “public” and the public good in relation to public health.

### From Public Health to Global Health?

The twenty-first century has seen major shifts concerning how health problems in Africa are conceptualized and in the international responses to them—a shift, some argue, from public health to “global health.”<sup>153</sup>

Political scientists define global health normatively as the field of policy and intervention addressing problems of health that “circumvent, undermine, or are oblivious to the territorial boundaries of states, and thus lie beyond the capacity of states to address effectively through state institutions alone.”<sup>154</sup> The turn toward global health has taken shape in an ideological framework dominated on the one hand by “emergency,” “crisis,” and concerns about “global security” and on the other by humanitarianism, both of which have proven powerful forces for mobilizing resources and action.<sup>155</sup> It occurs within a globalized landscape of science and pharmaceutical research, in which there is a dense interpenetration of public and private interests. In the past fifteen years, an increasing number of transnational and nongovernmental organizations compete to provide health services and target disease—from development agencies to private philanthropic groups, transnational NGOs, well-endowed Northern universities (which conduct research and provide health care), and pharmaceutical companies—whose scientists, researchers, policy makers, and academics belong to a powerful “global health elite.” Below, I sketch out this new landscape of global health and consider whether the global health orthodoxy oversees a further seeping of power away from African states and their citizens into the nonnational and transnational arena.

The African AIDS epidemic appeared in the 1980s and quickly gathered force. It reached epidemic proportions first in Uganda, moving across East Africa and then to southern Africa.<sup>156</sup> Its effects—during a time of economic crisis and of huge cuts in health budgets—were catastrophic. Most governments did not face up to the problem, with the exception of Uganda, which mobilized a “multisectorial” approach, setting up a National AIDS Control Council and encouraging donor agencies, NGOs, and church-based and grassroots efforts (often by women who were faced with the burden of care).<sup>157</sup> A few other countries, notably, Botswana and Senegal, made early attempts to address AIDS through public education and blood surveillance. Senegal, like much of West Africa, was spared a devastating epidemic, partly for biological reasons, while Botswana’s following of expert advice, which at that time linked HIV/AIDS to “risky” behavior, proved irrelevant for much of the population, and HIV prevalence soared.<sup>158</sup>

The AIDS epidemic focused international attention. Beginning in the mid-1980s, the World Health Organization worked with governments to set up national AIDS control councils, introduce national surveillance

and blood screening, and oversee preventative efforts.<sup>159</sup> Yet prevention was for many years modeled on ideas of individual responsibility and focused on “risk groups” rather than the socioeconomic conditions that render people vulnerable to HIV infection.<sup>160</sup> Meanwhile, despite the known extent of the epidemic, external funding for health interventions in Africa declined during the 1990s, and African governments had to deal with the surge in morbidity by themselves. Grappling with structural adjustment, they had few resources to mobilize: clinics and hospitals were overwhelmed and doctors and nurses faced appalling conditions, while patients and their families had to sell off assets to pay for medicines and hospital care.<sup>161</sup> Only a tiny proportion of patients could access the new antiretroviral therapies—those who were wealthy or managed to enroll themselves in research programs (or, more rarely, HIV activist networks).<sup>162</sup> The majority sought treatment for opportunistic infections, from which they eventually died.

Beginning in the year 2000, this situation began to change. After effective antiretroviral medicines became available (in 1994), HIV activists pushed the lack of access to treatment in the Global South into a moral issue, forcing the suffering of AIDS patients—and the associated role of global markets, pharmaceutical companies, and governments, together with questions of ethics and responsibility—onto the global health agenda.<sup>163</sup> In 2001 in South Africa, a coalition of HIV activists, international and local NGOs, and the South African government successfully used “right of access” arguments to pressure pharmaceutical companies to lower prices.<sup>164</sup> Earlier, the South African “Treatment Action Campaign” group had, together with MSF, successfully taken the government to court for its refusal to authorize the purchase of generic nirsevimir for the prevention of mother-to-child transmission of HIV. These cases drew attention to the vastly unequal resources and inadequate care available to African citizens and to the positive role that NGOs and activist groups could play in publicizing such inequalities. Funding for interventions into HIV/AIDS and, to a much lesser extent, tuberculosis and malaria in Africa increased hugely in the 2000s, with the introduction of the Global Fund to Fight AIDS, Tuberculosis and Malaria in 2001 and the President’s Emergency Plan for AIDS Relief (PEPFAR, set up by George W. Bush) in 2003. Together with Northern donors, the World Bank and private philanthropic groups, they channel funds to a *mélange* of governmental and nongovernmental organizations that are involved in antiretroviral treatment (ART)

programs.<sup>165</sup> The deployment of power through the new global funds and interventions is enormous; according to Vinh-Kim Nguyen, in some African countries, PEPFAR and the Global Fund together have at their disposal funds exceeding the entire national health budget.<sup>166</sup> Like NGO-led development, these interventions focus on geographical enclaves, particular populations, and “hot spots” of disease. Although they operate within a language of “partnership” between Northern and Southern institutions, they have been criticized for draining resources and professional expertise away from government health systems, undermining their sustainability.<sup>167</sup>

A body of anthropological scholarship has emerged in response to the AIDS epidemic. This can be divided into pre-ART and post-ART ethnography.<sup>168</sup> Initially, anthropologists examined the disjuncture between public health and prevention messages and local concerns around AIDS, including religious engagements with the epidemic and the attempts of African citizens to make sense of it and to cope with illness and death.<sup>169</sup> Once ART was introduced, attention shifted to the “global assemblages” connected to HIV treatment: the movements of medicines, resources, and expertise, as well as global HIV scripts such as the “confessional technologies” that developed around positive living, new forms of “biosociality,” and activism.<sup>170</sup> Steve Robbins, writing from South Africa, argues that these new languages and alliances form a novel political force with effects outside of AIDS activism, producing “empowered citizens” aware of their rights and entitlements.<sup>171</sup> Aside from these pockets of activism in South Africa, however, the apparatus of ART programs in Africa has been accompanied by little political agitation, let alone transformative politics. Instead, ART programs tend to reduce health outcomes among people struggling to survive amid the ravages of structural adjustment to individual responsibility for “adherence” to medical regimens.<sup>172</sup> Ethnographic work from both West and East Africa shows that grassroots activity around HIV/AIDS is marked more often by patronage networks than by political activism; most PLWHAs (people living with HIV/AIDS), as they are now referred to, are struggling to survive in the informal economy, and they are more concerned with accessing resources made available by NGOs than with agitating for their rights in relation to the state.<sup>173</sup> At the same time, ART programs represent a shift away from national sovereignty to the global scale, leaving populations dependent on external aid and depleting resources and expertise from other health-care services.<sup>174</sup>

Some argue that the current structuring of AIDS treatments and the humanitarian economy allow African states to continue to pursue their own modes of accumulation—which means channeling resources to political and economic elites, while leaving the rest to survive in the informal economy or to struggle for charitable handouts.<sup>175</sup>

In summary, although the provision of free ART is a vast improvement over the neglect of the past, the structures in which it is organized produce an impoverished sphere of public health in which specific populations receive specific treatments, while other pressing health issues, the socioeconomic inequalities producing ill health, and the challenges facing national health-care systems are inadequately addressed. Rather than being tied to a developmentalist vision of a national public health system, visions of health are further reduced to survival needs, and public health-care provision is reduced to a technology-driven humanitarian intervention.

Still, HIV/AIDS interventions have introduced new languages of rights and entitlements into national and global arenas, and they have been incredibly productive—of new networks, new identities, and new associations and forms of belonging. They have also intersected with government health services and sites, rather than bypassing them completely. In this book, the chapters by Lotte Meinert, Hannah Brown, and Ruth Prince offer perspectives on AIDS interventions that move away from metanarratives of “biopower” to explore how new therapeutic regimes and governmental practices overlay and interact with existing relations, associations, and connections. Rather than being victims of therapeutic domination, those on the receiving end of such interventions use them to explore new opportunities and pursue their own interests.

The prominence of ART programs as a paradigm of public health in many African countries points toward a new political economy of pharmaceuticals shaping the contours and imaginations of public health—a “pharmaceuticalization of public health,” as João Biehl puts it. The focus of public health interventions on problems that can be solved through biomedical and technological intervention was a feature of international health efforts throughout the twentieth century, driven by scientific progress and the desire to solve problems quickly and “efficiently.”<sup>176</sup> Progressive moves toward the promotion of health through socioeconomic reform that were discussed and occasionally implemented during the 1920s–40s were quickly supplanted by disease control through the magic bullet of medicine.<sup>177</sup> This technical orientation has only become

stronger in recent years. It is supported by the dominance, across wide domains of policy and intervention, of an “audit culture,” which evaluates the success of vertical disease programs in terms of numbers of drugs dispensed or numbers of people receiving pharmaceutical treatment, rather than in relation to longer-term health outcomes. Commenting on charitable drug donation programs by pharmaceutical companies to African “communities,” Ari Samsky argues, “We no longer talk about health, really, we talk about disease, but when we talk about disease we’re really talking about treatment, and even when we elaborate treatment philosophies and techniques we’re really talking about a drug.”<sup>178</sup>

The pharmaceutical paradigm of health is also driven by an ever more powerful global pharmaceutical industry, its pursuit of “biocapital,” and associated intellectual property regimes.<sup>179</sup> Even public health initiatives such as PEPFAR are intimately tied to the North American and global pharmaceutical industry: for the first five years of the program (2003–8), PEPFAR was licensed to purchase only U.S.-patented drugs; it shifted to cheaper generics manufactured in India and Brazil only after vociferous criticism.<sup>180</sup> The subservience of public health to global capital and the drive for profit on a transnational scale is not confined to Africa, of course. We see this in the current privatization of national health systems in Europe such as the National Health Service in the United Kingdom. Meanwhile, in Brazil and Mexico, the state encourages profit-motivated pharmaceutical companies to cater to a citizenship that is regarded as a “therapeutic market,” leading to an increasing interpenetration of public with private sectors.<sup>181</sup>

In many African countries, competing kinds of drug markets characterize the production and distribution of pharmaceuticals. Although some countries, such as Nigeria, developed a strong generic drug manufacturing industry, this was decimated by structural adjustment policies in the 1980s, which made the costs of production too high.<sup>182</sup> Meanwhile, African governments are under intense pressure to conform to the World Trade Organization’s TRIP (Trade Related Intellectual Property) Agreement, which gives proprietary (U.S. and European) pharmaceutical companies exclusive twenty-year rights on their drug patents. This is undercut, however, by a thriving informal market in pharmaceuticals—in which the production and sale of counterfeit drugs overshadows the formal sector of licensed pharmacies. In Nigeria, not only private doctors but also public hospitals and clinics prefer to buy their drugs from these informal markets; these “out-compete” both U.S. proprietary drugs and

Nigerian generics but at a great cost to the safety of the populations consuming these poor-quality medicines.<sup>183</sup> National and international attempts to ensure better regulation of quality in the name of public health are a drop in the ocean in the face of these illegal pharmaceutical markets.<sup>184</sup> Meanwhile, it is difficult for qualified pharmacists to make a living in a country flooded by cheap counterfeit drugs. In her chapter, Noémi Tousignant shows how, in appealing to the state to take more control over the quality of the medicines available, Senegalese pharmacists struggle to make a space for their professional commercial practice (and livelihood) in the face of the flourishing informal market and to ensure the protection of the public from poor-quality and unsafe medication.

The interpenetration of private and public interests in the name of public health and global philanthropy is reflected in the new orthodoxy of “public-private partnerships” (or PPPs) as a paradigm of global health intervention, and indeed of governance.<sup>185</sup> The term *PPPs* refers to the transnational partnerships between private philanthropic groups, NGOs, charities, and governments, which together pursue health or humanitarian interventions, such as organizing malaria control or conducting publicly funded research into HIV treatment. Public-private partnerships also frame the charitable donations of drugs by pharmaceutical companies, which work with African governments to target communities exposed to “neglected tropical diseases” in the name of “corporate social responsibility.”<sup>186</sup> The use of the term *partnership* in both global health and development interventions is a self-conscious move away from paternalist regimes of international development, yet it conceals the continuing, even deepening, inequality between Northern and Southern institutions and, in doing so, may reinforce the discourse of Western “donor(s)” and African “recipients.”<sup>187</sup> These unequal power relations have become more embarrassing than they were in the colonial era, but rather than confronting them, the response is to look away, to clothe inequality in a language of equality and deflect it through the language of technical intervention.<sup>188</sup> P. Wenzel Geissler argues that the power inequalities of both past and present are not simply overlooked by the rhetoric of “partnership” (or, in the humanitarian domain, by that of “saving lives” and “numbers on treatment”); rather, this entails an active state of “not-knowing.”<sup>189</sup>

Global health interventions targeting HIV/AIDS and other vertical disease programs also pay lip service to another orthodoxy of development practice: “community participation,” or getting a community to

“own” intervention projects—whether HIV/AIDS prevention, malaria control, or drug donation programs. Yet rarely are people in “the community” the ones who decide what kind of health intervention they receive, and if they are asked, they often have different opinions of what they find most useful: “We are very thankful for this unique chance, because we are selected from the district,” a hamlet chairperson told Samsky in reply to his questions about drug donations for river blindness, but she went on to suggest that a primary health-care clinic would be even more useful.<sup>190</sup> Elisha Renne argues that in refusing to let their children get the polio vaccine, parents in northern Nigeria were showing “their disapproval of their own government’s support for international health programs while failing to provide local primary health care” or to address child health problems that they considered to be more serious.<sup>191</sup>

As in other regions of the world where populations are poorly protected by their governments, African countries have also become sites for clinical trials by pharmaceutical companies. Some notorious clinical trials conducted by pharmaceutical companies—for example, Pfizer’s trial of Trovan in Nigeria in 1996, which resulted in the deaths of children and a court case—draw attention to the “ethical variability” characterizing such profit-motivated research.<sup>192</sup> Although the majority of medical research in Africa is public health research, conducted through collaborations between public institutions from the Global North, such as universities and government research groups (for example, the UK’s Medical Research Council and the U.S. Centers for Disease Control and Prevention), and African state institutions, often parastatals—and it is motivated not by profit but by the desire to improve health outcomes in Africa<sup>193</sup>—such research sites are still structured by inequality. Geissler’s chapter in this volume is based on a long-term ethnography of a “trial community”—the scientists, researchers, fieldworkers, and trial participants who gather around publicly funded clinical trials in Kenya. It explores the implications of the architecture of research “zones” for landscapes of public health in East Africa.

### Futures?

Can we find ways of thinking creatively about the progressive policies (and not only the reactionary dangers) of this new terrain of transnational organization of funds, energies and affects? Can we imagine new “arts of government”?<sup>194</sup>

This discussion of historical trajectories and recent developments underlines that, far from the scenario imagined by modernization theories of the 1950s, the space of public health as a relation between the state, biomedicine, government, and citizenship has, in most African countries, never developed in a predictable fashion—just as the global movement of science, modern government, and economic progress has not transpired as earlier historians of science imagined. The present situation is even less clear. Unlike an earlier era in which health interventions were framed by grand narratives of modernization and by a broad consensus in state-led development, the only strong political ideology of the day pushes, from the Right, for minimal state intervention, for private enterprise and individual responsibility for health. Meanwhile, the Left calls weakly for grassroots and community development. Public health measures are concerned with the containment of disease—pushed by a language of emergency and crisis—rather than tied to a language of social transformation and society-wide progress.<sup>195</sup> The transnational space in which public health concerns are formulated promotes disparate, not very well coordinated, interventions. Meanwhile, the privatization and marketization of health care has reached new dimensions, in Africa and across the world. The present situation thus involves emerging, unstable, and contingent assemblages and a multiplicity of actors and collectives, which narrow the space of public health to disease control and targeted interventions, leaving the rest of health care to the private sector. The 1990s and 2000s also saw the emergence of new forms of health activism, the global circulation of human rights and humanitarian discourses, new networks, and new forms of politics, which, while allowing states to divest themselves of responsibilities at one level, create new obligations at another level. Thus, there are openings as well as closures. This situation calls for ethnographic scrutiny—for us to bring ethnographic tools and anthropological methods to bear on the question of what public health is, who makes it, and with what consequences.

The volume offered here, through its attention to policies and practices and their effects on the ground, will help take our thinking about the present and future relations between public health, biomedicine, and social progress further and in new directions. While this book does not offer solutions, it offers close readings of actual practices and formations—which speak of power, inequality and dispossession, pain, frustration, and disillusionment but also of solidarities and common

concerns. It underlines the fact that public health in Africa is pluralistic and polyvalent. This situation can be considered as an opportunity to look at the present as a starting point for possible futures, to move away from deterministic visions of neoliberalism and transnationalism in order to appreciate present opportunities and to develop a vision of possible ways forward toward the progressive goal of public health—a citizenry with equitable access to public health care, protected by a more accountable state. The authors of this volume reject singular descriptions of the present to offer analyses of the heterogeneous regimes and relations, the policies and interests, tensions and contradictions that produce, negotiate, or undermine the health of the public in Africa.

### Overview of the Chapters

The chapters are grouped into three sections. The first section, “Whose Public Health?” unpacks the concept of public health, holding up to scrutiny the question of what public health is, whose interests define it, the relations between the public and private sphere of health, and conceptions of the public sphere, the public good, and the public itself as an imagined collective.

Drawing on historical and ethnographic research and his long engagement with Nigeria, the first chapter, by Murray Last, embeds what he argues is an absence of “public” health in northern Nigeria within a discussion of imaginations of and relations between “public” and “private” in the wider region—which have been shaped by class and ethnic relations, by Islam, and by British colonialism, as well as by the policies of the postcolonial Nigerian state. His chapter lends historical texture to received visions of “failing” or “absent” states by pointing to the historical, cultural, and political trajectories that shape relations between the Nigerian state and its public.

Rebecca Marsland likewise explores the tensions between different versions of public health, this time in present-day Tanzania. Here, district health officials have attempted to legislate against “misleading traditions,” mostly concerned with funeral practices, which they present as threats to the public health order. However, these funeral practices speak to an indigenous realm of public health that is concerned with maintaining the social-moral order. She argues that public health in Tanzania has never constituted a straightforward concern with “citizens.” Government officials’ attempts to control public health draw upon other imaginations of publics—as crowds and populations—that

are interwoven with class, regional, and ethnic prejudices, as well as with techniques of government. Some populations were considered less as citizens and more as crowds to be controlled.

Both Last and Marsland embed their discussion of governmental imaginations of public health in broader histories; they show how district health statecraft coexists with an “indigenous public health” concerned with the well-being of the social collective and explore how it overlays older ways of conceiving political power and responsibility. Colonial and postcolonial forms of public health coexist with, and must often contend with, other practices concerned with well-being—although the relation of these older practices to governmental forms of public health may seem obscure, irrelevant, or even, as Marsland shows, antagonistic.

Moving to Senegal, Noémi Tousignant’s chapter suggests that state-directed attempts to improve public health and access to services have, since independence, encompassed efforts to develop the private sector, through the privatization of pharmacies. Pharmacists’ private practice, together with the development of the public’s pharmaceutical consumption, was promoted in this context as an engine of national development and economic growth. In the wake of structural adjustment policies, pharmacists have become concerned with the lack of regulation over pharmaceuticals and have begun to call for the state to take a stronger role in monitoring, controlling, and assessing the quality of medicines. In doing so, they see themselves as both protecting their profession and providing a better service to the public.

The chapters by Tousignant and Last encourage a rethinking of divisions between “public” and “private” in the incorporation of people into wider collectives and in related visions of social responsibility and the public “good.” While Tousignant’s chapter underlines how African professionals draw upon both older developmentalist narratives and neoliberal concerns in their quests to “develop” their country and attend to the public “good” as well as to their professional careers, Last suggests that in northern Nigeria, the public good, outside of personal relationships, has never carried much weight.

The second section, “Regimes and Relations of Care,” asks who is taking care of whom, on what terms, and with what social and personal consequences. The chapters by Lotte Meinert and Hannah Brown look into the intimate spaces of public health care and the personal lives and motivations of patients and caregivers within the “public” system. Through case studies of HIV/AIDS interventions in Uganda and Kenya,

respectively, they examine conceptualizations of “community” and the “domestic,” as well as “care” and “patient-responsibilization.” They offer insights into contemporary arts of government that characterize public health formations beyond AIDS care but also show how the targets of interventions use them to create unexpected connections and opportunities.

Lotte Meinert moves away from metanarratives of biopower to offer a subtle reading of the interaction of ART programs in Uganda with individual lives and the environments in which they live. Meinert follows the case of “Anna” as she falls sick, seeks care, is incorporated into an HIV treatment program, and then finds that the regimes of care it imposes upon her chafe against her desires and hopes for the future, as she moves beyond simply keeping alive. Here, Meinert builds on her ongoing work with Susan Whyte and colleagues in Uganda, which follows the first generation of people on ART in Uganda.<sup>196</sup>

Hannah Brown shows that recent home-based care interventions in Kenya are layered upon older histories of governmental interventions, which targeted particular public and private spheres—such as the “domestic” and the “community”—for “development.” Focusing on a women’s grassroots group that provides home-based care, she shows how rural women appropriate these interventions for their own ends as they strive to bring development into their locality and to benefit from it.

The third chapter in this section, by Benson Mulemi, describes the struggle to treat cancer in Kenya’s largest public oncology ward. He highlights the concerns of doctors, nurses, and patients and their families as they seek to provide or access care in the absence of adequate medicines as well as diagnostic technologies—and the limited resources they have to draw upon. He shows the tensions that develop around diagnosis and prognosis, between hospital staff and patients and their families, as cancer upsets and challenges expectations of biomedical technology and hospital provision of care. He also follows how patients, sometimes with the help of nurses, experiment with the wide range of alternative therapies and discourses about health promotion and prevention that are currently crowding into the medical marketplace.

The final section, “Emerging Landscapes of Public Health,” explores new geographies of disease, health-care provision, and medical research, which overlap and are layered upon one another, appearing as transient and unstable. The chapters in this section show how these landscapes animate particular collectives, lifestyles, and aspirations for the future but at the same time heighten socioeconomic and political inequalities.

Like Mulemi, Susan Reynolds Whyte draws attention to a disease that has been much less visible to funders and governments but is increasingly intruding upon people's lives—in this case, diabetes. Like cancer, diabetes has been ignored in recent concerns with global health, and the landscape of diabetes in Uganda provides a stark contrast to that of global health interventions focused on HIV/AIDS. Knowledge of the condition and the search for ways of managing it and for therapeutic intervention are left to individual initiative, piecemeal NGO projects, and the marketization of health promotion and care. The chapter draws attention to the gaping holes in public health provision and the flourishing market in private health care in places such as Uganda and explores how these intersect with the socioeconomic relations and conditions that underlie diabetes in Uganda. Whyte points out that the focus on individual “lifestyles” in diabetes management—on diet and exercise and the proliferation of private and expensive dietary and medical supplements—overlooks the more challenging burden of “life conditions,” as well as the relation of diabetes to pathologies of stress that seem to be increasingly affecting both the poor and the middle classes.

The chapters by Ruth Prince and P. Wenzel Geissler explore the landscapes that global health interventions and medical research activities produce as they pour resources, expertise, and globally circulating regimes of knowledge into an East African city, superimposing a layer of global connectivity on a crumbling public health infrastructure.

Focusing on the city of Kisumu in Kenya, Prince follows the frictions that arise as globalized health resources, discourses, technologies, and expertise—embodied in the new HIV clinics and time-limited projects—intersect with local economies and livelihoods and with aspirations and imaginations for “development,” in a city marked by poverty and inequality. Following how various actors—health professionals, patients of HIV clinics, and “volunteer” health workers—navigate these spaces, the chapter explores the gaps left behind and opened up by global health interventions, as they touch only particular nodes and operate within circumscribed locations. While these gaps are supposed to be filled by “self-help” and “community-based” initiatives, this move merely deflects responsibility for a more robust public health onto the poor and onto unsustainable structures. The chapter draws attention to the insecurity and vulnerability of those who seek health, livelihoods, and futures in this unstable landscape of global health.

In the final chapter, Geissler explores a trend that is becoming increasingly evident in African public health—the interpenetration of scientific medical research work with health-care provision. He examines how scientific research work operates spaces of inclusion and exclusion, reflecting and extending the targeted interventions and archipelago pattern that have become typical of public health projects. He looks at the “in-between” lives and movements of “science workers,” those involved in medical research projects, and calls for an ethnography of the spatial forms, the geographies of connection and disconnection, and the movements and circulations that contemporary public health research produces and extends in Africa.

## Notes

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