Africa is a sick continent, full of sick and more recently starving people. They are passive sufferers beneath the titanic and impersonal oppression of Africa’s poor soils, hard and fickle climate, its burden of tropical diseases and the technical backwardness of African cultures. This is the popular European image of sub-Saharan Africa. It has remained constant from the time of the West African slave trade, through the colonial era of Albert Schweitzer in his jungle hospital at Lambarene to that of the films of the current famines projected during the “Live Aid” and “Comic Relief” fund-raising events. It has been hugely stimulated recently by the refrain of AIDS horror stories in the popular press.¹

Yet this view once coexisted with another. Until the last part of the nineteenth century, Europeans in Africa, especially in West Africa, trembled ignorant and defenceless for the most part before the ghastly, invisible legions of African diseases which struck them down with even greater ferocity than they did the native population. Why should such primitives survive illnesses that so swiftly felled

*Earlier versions of this article were given as papers to the inter-faculty medical and anthropological seminar in the University of Liverpool, to the African history seminar at the School of Oriental and African Studies, London, and to the Plymouth Medical Society at the postgraduate medical school, Freedom Fields Hospital. I am most grateful to the several participants for their constructive criticism. I am further indebted to Peter Burke, John Lonsdale, Miriam Borop Prins, Andrew Roberts and Richard Rathbone from whose comments subsequent written drafts benefited greatly.

¹ Recent work on the appalling mortality which occurred when West Africans were shipped as slaves into another, peculiarly modified and especially deadly disease environment in the Caribbean raises interesting possibilities on the likeliest (and certainly commonest) channel communicating this idea about Africans (and thus, by extension, Africa) to Europe before the nineteenth century. In the Caribbean it would have been based on the extensive experience which white planters had of handling the special burden of slave disease: R. B. Sheridan, *Doctors and Slaves: A Medical and Demographic History of Slavery in the British West Indies, 1680-1834* (Cambridge, 1985). I owe this idea to Richard Rathbone. On the modern case of the presentation of AIDS, R. Sabatier, *Blaming Others: Racial and Ethnic Aspects of AIDS* (London, 1987).
civilized whites?2 “Beware and take care of the bight of Benin. For
the one that comes out there are twenty stay in!”, a crude contempo-
rary couplet warned prospective traders.3 Curtin has suggested that
this perceived contrast and that reaction to it may have contributed
powerfully to the strongly drawn racial stereotyping that marks the
African/European encounter: the African as half-devil and half-child.4
In fact the two contradictory views combine to make the image: the
older and ultimately longer-lived one providing the suffering, simple,
childlike African, the other the disease-resistant demon.

Dr. T. R. H. Thomson had proved conclusively the superiority of
quinine as a malarial prophylactic on the 1841 Niger expedition,2 but
it was not until the 1870s that the alkaloid drugs were joined by
synthetics. Kolbe synthesized salicylic acid in 1874 and other drugs
followed in precisely those years when formal European rule in Africa
became fixed. In the decade after the Congress of Berlin in 1884,
Behring inaugurated serum therapy. Active vaccinations against chol-
era and typhoid followed, and in the 1900s Paul Ehrlich, the true
founder of modern chemotherapy, developed principally aniline-dye-
based synthetic agents which could duplicate the action of sera. With
drugs like antipyrene, sulfonal and phenacetin now reinforced by the
dye derivatives - methylene blue (first used against malaria in 1891),
trypan red (against trypanosomes in 1904) and Salvarsan (an arsenical
anti-syphilitic in 1910) - European doctors in the tropics could take
with them a cartridge-belt of what Ehrlich himself was the first to
describe as “magic bullets”;6 and with the bullets came the gunman’s
self-confidence: victory over fever prefigured the triumph of empiri-
cism in other matters also.7

2 The answer is partly and unsurprisingly genetic. The most celebrated example of
this is the haemoglobin defence against the deadliest strain of malaria, P. falciparum,
which is afforded by the presence of sickle cells in the blood of West Africans:
A. C. Allison, “Protection Afforded by Sickle-Cell Trait against Subtertian Malarial
Infection”, Brit. Medical Jl., i (1954), pp. 290-4. I am indebted to the late Hermann
Lehmann for patiently explaining elementary haematology to me. A convenient
summary of this and other bio-genetic aspects of human adaptation to the West African
environment is K. F. Kiple and V. H. King, Another Dimension of the Black Diaspora:
Disease, Diet and Racism (Cambridge, 1981), pp. 4-23.
3 Kiple and King, Another Dimension of the Black Diaspora, p. 12.
4 P. Curtin, The Image of Africa: British Ideas and Action, 1780-1850 (Madison,
Lancet, 28 Feb. 1846, pp. 244-5; Curtin, Image of Africa, ii, p. 356.
687-9.
7 This argument is expanded in E. Hobsbawm, The Age of Empire (London, 1987),
pp. 250-8.
A variation on the theme of sick Africa now became possible and has, for a century, been heard increasingly loudly (until the AIDS epidemic struck in the 1980s): Africa's endemic sickness can be cured. The gift of allopathic medicine in the hands of European doctors can not only protect Europeans in Africa but may, with enough time and charity, save Africans from their dreadful continent and from their simple selves. This is an endeavour without politics, one therefore naturally centred upon doctors and their work, a necessarily Eurocentric history in which patients figure only as their Latin root would suggest, as passive sufferers, playing no part in their own cure. In this, the African colonial variant is not conceptually different from the conventional wisdom about the general advance of allopathic medicine. However, in this article I shall argue that neither image will do. We are in the midst of a great transformation in the study of health and healing in Africa.

I shall dwell upon three themes which have emerged as central to this transformation. First, I shall review the consequences of putting illness and therapy back into their historical, colonial context. Then I shall sketch out the emerging and exciting new history of the interaction of pathogens, politics and the African disease and natural environments. Finally, I shall suggest what happens to our images of both Africans and of disease in Africa when we move from a doctor-centred to a patient-centred account.

I intend the effect to be to encourage doubt in the confident causal assertions which linked the European medical enterprise so centrally to the solution of Africa's medical problems. Simultaneously, the article questions the popular view that Africa has always been unnaturally unhealthy and that the causes of that were impersonal and almost entirely environmental: that these were diseases of God and not of Man. But I shall not argue the reverse. Rather, I will suggest that we can begin to see ways in which the active and often unintended interaction of man and nature has produced surprising and specific outbreaks of illness. All this means that we can no longer be so sure that we have correctly named the continent's disease. This therefore parallels the professional and public debate about the political economy of African famine. The Fourth Horseman of the Apocalypse

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8 So it is hardly surprising to see parallel efforts to rescue the wider dimensions of medical history taking place there. R. Porter, "The Patient's View: Doing Medical History from Below", Theory and Society, xiv (1985), pp. 175-98.
rides out to kill by all his appointed means: by sword, by famine and by pestilence. The rapidly transforming story of health and medicine may have lessons for the rapidly transforming story of food in Africa.

II

The old division of labour was simple and clear. Doctors ministered to the sick; anthropologists recorded the curious medical beliefs and practices of Africans; and historians chronicled the overwhelming of the feeble and inefficient world of "traditional" medicine by the drugs and concepts of allopathic medicine. There was a single-minded purposiveness about, for example, the conquest of malaria when viewed in the 1950s, and no question about eventual success.¹⁰ (The agent which it was then considered would bring conclusive victory was D.D.T.; and the subsequent chequered career of that agent speaks for itself.) Military idiom pervades a triumphalist and Whiggish literature.¹¹ In no other area were the differences between European and African civilization so pervasively and vividly seen; in no other area did the European presence appear so transparently benign.

But the medical St. George carried other things in his saddle-bags as he assailed the microbes. Most important was the inference that other aspects of European colonialism were as well intentioned, as worth having (and therefore as legitimate) as its medicine. This message was used explicitly by medical missionaries to promote their evangelism in anglophone Africa and explicitly by the Portuguese throughout their African episode to promote their empire.¹² But the prestige of professional status meant that medicine, like the law,

could also give power to early anti-colonialists. So it worked both ways.\textsuperscript{13}

Three features of allopathic medicine, in addition to the bandolier of magic bullets, made its power so uncontroversially precise. First, along with polypharmacy, multiple-cause (as distinct from multifactor) diagnosis had been overthrown. Monocausal, reductive, physical diagnosis helped the doctor to choose and then to fire the correct bullet. Secondly, and contingently, this therapy was value-free. The patient’s social standing, spiritual state, feelings or views of any sort beyond the most trivial were irrelevant to the cure. A patient was the sum of many, complex parts. Thirdly, this therapy was somatic and, by definition, reactive to a pre-existing and detected illness.

As René Dubos expressed it in his seminal book, \textit{Mirage of Health}, the god Asclepius who, in the ancient Greek pantheon cured the sick individual, took precedence over the goddess Hygaea whose realm was the maintenance of public health and thus, by general, communal action, the prevention rather than the cure of somatic illness. The sharply etched qualities were the god’s, not the goddess’s.\textsuperscript{14} Dubos was one of the first to argue that this order of precedence was incorrect. As epidemiological history was more searchingly probed and, notably through the work of Tom McKeown, became better known, the earlier, confident ascription of primacy to chemotherapy in the reduction of infectious disease in European history was eroded: the dates did not fit. In disease after disease decline had begun before the drug era.\textsuperscript{15}

So in much recent medical theory, if not yet in so much medical practice in industrial society, Hygaea’s stock has risen. It was, in any case, a logical response to the observed shift from microbe-borne and infectious to environment-triggered and degenerative diseases. With the sting drawn from the old epidemics, their magic also faded. For much of the mid-twentieth century, cancer was the disease which carried the awe, symbolism and threat that tuberculosis possessed a hundred years before. However, the coming of AIDS contests cancer’s crown.\textsuperscript{16}


\textsuperscript{15} T. McKeown, \textit{The Role of Medicine: Dream, Mirage or Nemesis?} (Oxford, 1979), chs. 3-8.

\textsuperscript{16} S. Sontag, \textit{Illness as Metaphor} (London, 1979); R. C. Salzberger, “Cancer: Assumptions and Reality Concerning Delay, Ignorance and Fear”, in J. B. Loudon (cont. on p. 164)
But in the old-fashioned disease environment of colonial Africa, Hygaea could be rather differently perceived. There she was for many Africans seen as the colonialist’s whore. The district commissioner’s orders, on perfectly sensible grounds of public health, that pit latrines be dug here, that cattle be penned there, standing water drained yonder to stop mosquitoes breeding, that to deny insects a resting-place crops be not grown near houses, that houses be compulsorily sprayed with D.D.T., etc., were among the most intrusive in rural Africa. Indeed I have heard in Zambia evidence to suggest that the Northern Rhodesian government’s public health measures of this type played the role in mobilizing peasant consciousness that was played by soil conservation and cattle-culling measures in the better-documented Kenyan case. In the industrial and commercial sphere, the screenings, inoculations and regimentation of the mine compounds or the medical investigation of precisely how little food (but with which trace-element additives) was required to sustain hard labour without heart failure but with maximum profit in a Natal sugar plantation were the essential underpinnings of the southern African contract-labour system.

So despite first appearances to the contrary, the intensely political nature of public health provision in both rural and urban Africa serves to erode further the detached primacy once assumed for Asclepius. It also points to one of the most fertile of the new ideas

(\textit{n 16 cont})


that are part of the great transformation now in progress: that once the political nature of medical decision-making in Africa is recognized, the conceptual walls that previously separated medicine from the rest of life can be dismantled. Then the social costs of productive activities may be calculated as openly as the material ones. Thus part of the cost of a switch to cash crops in eastern Tanzania is paid in increased perinatal mortality, itself a result of increased demands on women’s time, with resultant stress;\(^\text{19}\) colonial “development” projects in northern Ghana and increased pressure to use river-valley land carried a price of increased onchocerciasis (river-blindness);\(^\text{20}\) part of the cost of power and irrigation dams is paid in increases in schistosomiasis; a heavy part of the cost of gold-mining in South Africa was the wholesale introduction of tuberculosis into African recruiting-grounds;\(^\text{21}\) part of the cost of urban growth in Zambia is paid, in the encircling shanty towns, in infant malnutrition, resulting not from absolute food shortage but from a culturally induced decline in breast-feeding and degradation of diet to one of fizzy drinks and shop bread. Especially when associated with earlier foetal deprivation and imperfect myelination in the developing brain, the cost may extend to mental retardation, perhaps on a large scale.\(^\text{22}\) For these

\(^\text{22}\) D. B. and E. F. P. Jeliffe, “Breast Feeding: A Key Measure in Large Scale Disaster Relief”, Disasters, i (1977), pp. 199-203; author's information from staff participating in an unpublished nutrition survey in the Lusaka compounds, 1980. But note that some caution is in order. The physiological basis of the links continues to be investigated: W. J. Shoemaker and F. E. Bloom, “Effects of Under Nutrition on Brain Morphology”, in R. J. and J. J. Wurtman (eds.), Nutrition and the Brain, ii (New York, 1977), pp. 185-6. A search for evidence of mental retardation in the richest data on a famine — a man-made modern European famine — failed to find any of significance: Z. Svein, M. Susser, B. Saemger and F. Marolla, The Natural Experiment: Famine and Human Development: The Dutch Hunger Winter, 1944-45 (New York, 1975). However, when, as is common in the poor world and was not the case in Holland, the base nutritional status of the mother, especially when she was a child, was low, there is certainly a "shadow effect" into the next generation that is revealed in disorders of the central nervous system and there is evidence to support the Lusaka hypothesis from elsewhere in the poor world: for example, A. B. Wilson's Guatamalan case, “Longitudinal Analysis of Diet, Physical Growth, Verbal Develop-
unintended results of "development" the ungainly neologisms "coloniogenic" and "developogenic" have entered the vocabulary.\textsuperscript{23} Steven Feierman's sharpening of the analysis of such social costs gives us a range of evidence which we did not have before and will in consequence raise the issue to equal prominence with the examination of the behaviour of therapists and patients in the study of health in Africa. It will complete the destruction of the image of allopathic medicine's political detachment and tighten the linkage of occupational epidemiology to the study of the political economy of colonialism.\textsuperscript{24}

In mentioning this critique, it is important to stress that its impact upon allopathic medicine is not indiscriminate. To calculate in terms of ill health the costs of production is not to discount the value or significance of individual treatment. From all over sub-Saharan Africa there is evidence of the enthusiastic way in which, given the opportunity (usually through mission hospitals), rural Africans took up parts of allopathic medicine from the time of its earliest introduction. These were "Asclepian" — curative — products and procedures, notably analgesics and the facilities for acute surgery, especially obstetrics. However, what puzzled many medical missionaries was that such visible, often dramatic relief of affliction did not establish the total sway of the ideas from which it sprang. I shall turn to this problem in the final section of the article.

III

I have earlier noted that it was from the efficacy of such treatment that allopathic medicine derived much of its self-confidence. But before the articulation of Feierman's hypothesis, the self-confident image of "Asclepian medicine" had already been dented in another way. In contrast to individual treatment, there is mounting evidence


\textsuperscript{24} Feierman, "Struggles for Control". It must be added that the record of colonial public health measures is not absolutely without success, even if, on present evidence, it seems to be mostly so. A good example is of the substantial improvement in the health of town-dwellers in Accra, compared to health indicators for the rural hinterland, produced by the introduction of a piped water-supply: K. D. Patterson, "Health in Urban Ghana: The Case of Accra", \textit{Social Science and Medicine}, xiii (1979), pp. 251-68.
of the conceptual failure of its campaign approach to the control of epidemics. Throughout the century colonial and post-colonial government medical services have sought to break the grip of malaria, trypanosomiasis (sleeping sickness), onchocerciasis, smallpox and, on a lesser scale, of tuberculosis and syphilis, by grand campaigns.

They were directed intensively either at the vector (especially in anglophone Africa in the case of the first three, fly-borne diseases) or — when in the last couple of decades of colonial rule, quinine’s century as the sole major agent effective against micro-organisms ended, particularly with the arrival of antibiotics — through prophylaxis administered to the population at risk with huge, compulsory vaccination or inoculation campaigns. The most ambitious of these was the Belgian attempt from 1926 until the collapse of their power in 1960 to inoculate against sleeping sickness the entire population of the Congo. But it proved to be tragically difficult to sustain in the face of disruption. In 1959 the Belgians successfully examined and injected with pentaminide 70 per cent of the human population. They experienced a rate of 0.006 per cent new cases. In 1960, during the civil war, only 2 per cent of the population were reached. A sleeping-sickness epidemic ensued.25

The British norm, as already noted, was to enforce changes in people’s day-to-day behaviour (notably in the war on the mosquito).26 All these campaigns were conceived and perceived as the best technical solutions available at the time (within the constraints, often quite tight, of cost) to epidemic threats whose presence was manifest. They did not place a high priority on understanding the reasons why the problem presented itself in the way that it did, nor on asking whether indigenous epidemic control had any lessons to teach. When historical epidemiology began to do this, some of the reasons for the failures became apparent; and they were not purely technical. They were social and political reasons.

In fact it was to be not a professional academic but a retired entomologist, who had spent a long and distinguished career in the


British colonial tsetse-control service, who wrote the book which is not only the definitive account of the colonial assault on trypanosomiasis but is also one of the great works of African studies in the last twenty years. "Unfortunately", wrote John Ford in *The Role of the Trypanosomiases in African Ecology*, "with very few exceptions, it was psychologically impossible for men and women concerned in imperial expansion in Africa to believe that their own actions were more often than not responsible for the manifold disasters in which they found themselves caught up".27 Discovering how that came about, sometimes consciously, more often not (for the reason which Ford mentions), has become a major concern of historians as a result of that transformation of perspective which John Ford more than anyone helped to initiate. But another major impetus came from a different source. The history of the "Columbian exchange" between Europe and Latin America showed how after 1530 alien pathogens wrought a destruction upon the Amerindians which the conquistadores unsupported could never have done. Estimates for the scale and speed of population decline in central Mexico are catastrophic (90 per cent in fifty years from Cortes' arrival) and can only be matched by predictions for the medium-term aftermath of nuclear war.28 The example is compelling in its awfulness. Developing it, W. H. McNeill promoted the view that in the European expansion, disease germs were the usual concomitant of the "macroparasitism" of human predation upon other human societies by the armed force of disease-experienced aggressors. His two books on the global history of disease and of warfare are therefore presented as one story.29 Marxist and nationalist writers in particular used such ideas to suggest that Africa's burden of disease had been increased as a direct result of invasion. The most powerful example was that of the great rinderpest epidemic of 1896 which swept Africa from Eritrea to the Cape and which, through destroying their stock, helped to weaken some African societies on the eve of European conquest (although, in at least one case, it did

precisely the opposite). But this linear argument is not as penetrating as Ford’s and, while useful to a point, is ultimately superseded by his. This is well demonstrated in his subtle argument that the rinderpest was as significant in its hitherto unseen, synergistic relationship to other epizootics, for which it prepared the way.

Ford had dissented from the conventional wisdom of the colonial scientific service in which he served, which was that the tsetse was just another of Africa’s God-given tribulations whose spread was aided by the stubborn incompetence of peasant agriculture. He had argued instead that colonial tsetse control had done unwitting damage, but that that damage was secondary to the effects of political disruption, for he argued that the destruction of pre-colonial African states during the Scramble had been a major cause of the expansion of fly-infested land shortly thereafter: “If it is possible to point to any single factor that ensured the destruction of that ancient ecological equilibrium it was the imposition of international boundaries to replace frontier zones. The mechanisms of adjustment provided by the *grenzfrewldnis* [frontier wilderness] were eliminated by the surveyor’s theodolite and the lawyer’s pen”. Now the fact is that we know at present almost nothing about the interaction of demography, climate, ecology and disease in pre-nineteenth-century Africa. We do not know the times of feast and famine in the way that we now do in Europe. But the fractured picture which may be assembled from shards of archaeological evidence, notably pollen analysis, is enough


31 The point is that it should have been the reverse, since rinderpest killed with ferocious thoroughness the animal vectors of trypanosomiasis: Ford, *Role of the Trypanosomiases*, pp. 122-40, 191-3, 296-300. An acute dissection of the debate between the “increasing unhealthiness” school and others is Richards, “Ecological Change and the Politics of African Land Use”, pp. 14-21.


to show us a long history of climatic variation, especially in Africa south of the Equator, which must have given long-run sequences of drought and untimely rains in the distant past, just as we have seen during the twentieth century.\textsuperscript{35} In West Africa we observe population levels which seem to have been consistently low in relation to resources, requiring more than merely Malthus to explain them.\textsuperscript{36} On the Atlantic coast of Central Africa sophisticated manipulation of literary sources gives a similar conclusion, suggesting that the population was not decimated by the slave trade, was in fact resilient to that attack, but was throughout at considerably lower levels than hitherto thought.\textsuperscript{37}

It is not much, relative to the size of the unknown, but it is enough to suggest that it would be unwise to believe that pre-colonial Africa was free of catastrophe, of perinatal mortality or epidemic disease; that somehow, before the Europeans came, there was "Merrie Africa".\textsuperscript{38} It is important to remember that our ignorance probably conceals suffering as well as success and to imply otherwise (as, for understandable reasons, John Ford's book does), especially so when the better-documented story of the havoc wrought by the colonial impact is laid out in its terrible splendour. The arrival of Europeans was only one episode in African history. Its qualities imply nothing about the totality of what went before, although sometimes, as with Ford's help, it enables us to see something. With an educated eye, John Ford revealed the ingenuity and success of defence against the micro-organic attack of one crucial disease by improving our understanding of the African control of Africa's sleeping sickness. Developing the findings in the 1920s of his predecessor, C. F. M. Swynnerton, in case after case it became clear that the means of control depended upon the maintenance of a dynamic tension between cultivated land and wilderness.\textsuperscript{39}

Shoshangane of the Gaza ordered his people to congregate around

\begin{footnotesize}
\begin{enumerate}
\item The phrase was coined in contrast to the more pervasive stereotype of "Primitive Africa" and with the intention of discrediting both: Hopkins, \textit{Economic History of West Africa}, p. 10.
\item C. F. M. Swynnerton, "An Examination of the Tsetse Problem in North Mossurisse, Portuguese East Africa [Mozambique]", \textit{Bull. Entomological Research}, xi (1921), pp. 315-85, and esp. Sections VII, X.
\end{enumerate}
\end{footnotesize}
him in the tsetse bush of the Mzilizwe valley. The bush was cleared, the new land cultivated (and thus kept clear), but several large areas were deliberately left uncleared. Wild game was confined to them and outside them the game was hunted. Game guards controlled their movement. The tsetse vanished. Shoshangane's son Gungunyana succeeded his father in 1885, but was driven south by the Portuguese and forced to evacuate Gazaland in 1889. Control ended, the game burst out and the area became reinfested.40 "Throughout tropical Africa the epidemics, epizootics and famines that characterised the early years of this century and in turn set off the epidemics and epizootics of trypanosomiasis during the 1920s and 30s were a consequence of the ecological, political and parasitological [my emphasis] disharmony caused by the unforeseen events that accompanied the colonial impact . . . it was not pax but bellum, an outbreak of biological warfare on a vast scale none the less terrible to its sufferers because they only vaguely perceived its cause".41

Ecological, political and parasitological are a set without immediately obvious logical connection to the scientific eye. In fact Ford's description is widely and precisely paralleled in Africa by reports of an African cultural perception of the resonant symbolic importance of the physical division between the bush and the fields — between the wild and the cultivated; and such a view is similar to that reported for pre-industrial England.42 In the African examples, the dynamic tension in turn depended not upon abstract, universal theories of scientific control measures, but upon precise and particular knowledge of the dynamics of the local ecology and, as important, the ability to act upon it by moving animals and people.

The warning signs were frequently expressed in what, for outsiders, seem to be chaotically mixed religious, political or kin terms of the health of the land; and preventative measures depended for their success upon actions legitimated and co-ordinated in embracing terms also.43 But it should not be surprising if ecological well-being should

40 Ford, Role of the Trypanosomiases, pp. 333-6, reporting Swynnerton, "Examination of the Tsetse Problem". A parallel story is reported for Shinyanga, the southernmost chieftdom of the Sukuma in Tanzania (pp. 189-90). The breakdown of control over contagious bovine pleuro-pneumonia in western Zambia in 1915 provides a comparable example with another epizootic, being linked there not to the political overthrow of a state but to trade-exacerbated distortion of a previously tight royal grip on cattle movement through control of royal herds.

41 Ford, Role of the Trypanosomiases, p. 489.


43 M. Schoffeleeers (ed.), Guardians of the Land: Essays on Central African Territorial Cults (Gwelo, 1979), pp. 2-4; M. Schoffeleeers, "A Martyr Cult as a Reflection on
turn out to be a core value in a culture, linked to others. King Lear
in the storm on the heath would have no difficulty in understanding
that; nor would an Elizabethan audience watching him.  

Let me recapitulate the argument so far. I began by offering widely
held images of Africa and of medicine in Africa which, I suggested,
were severely deficient. To the image of value-free medicine was
counterpoised new work on the social costs of production. To the
image of a naturally unhealthy continent, swept by epidemic, was
counterpoised the interactive history of pathogens, colonial conquest
and ecology, the argument being focused through John Ford’s great
book on trypanosomiasis (although always the shadow of the coming
AIDS pandemic hangs over this history). In the last part of the article,
we must now turn to the small scale, the scale of the individual
sufferer in this landscape, and so we engage, with him or her, on the
quest for therapy.

IV

Late one night a man came to my door in Zambia to ask me to take
an elderly gentleman up to the mission dispensary in my Land Rover
to visit a sick patient. The next morning I was roundly scolded by
the Zambian dispensary sister for having colluded in the introduction
of a witch-doctor into her wards. It was a rule of the dispensary that
any in-patient who had dealings with “traditional” medicine would
be summarily ejected. So, since in her view it was my fault, the sister
also told me to transport the patient back to his home, along with the
witch-doctor! It was a memorable introduction to the strong and
ubiquitous grip of the view that “modern” and “primitive” medicine
are absolutely incompatible. While this view is found as an uncontro-
versial and therefore undiscussed assumption in the older doctor-
centred history of medicine in Africa, the patient’s side of my little
adventure, hitherto dismissed, forms an equally valid part of the
experience. But if that is conceded, it at once poses puzzling chal-
 lenges. One is to do with evidence: we know that the African medical
environment is pluralist, containing many varieties of therapy, and
that episodes like the one into which I was unwittingly drawn are
common. But how do we observe and record such a process? The

(\textit{n. 43 cont.})

Changes in Production: The Case of the Lower Shire Valley, 1590-1622”, in R.

44 E. M. W. Tillyard, \textit{The Elizabethan World Picture} (London, 1943); J. F. Danby,
second is analytic: what is in people's minds when they do such things?

The solution to the first problem opens the gateway to a reconsideration of the second by providing a sufficient body of good data. It was found by John Janzen in Lower Zaire during fieldwork in the 1960s and proposed in 1978 in the single most influential book in the recent transformation of the study of health and healing in Africa. The Quest for Therapy in Lower Zaire first wove a historical tapestry of all the different therapeutic options, the threads which made the fabric of medical pluralism in Lower Zaire over the twentieth century. Then, assisted by a medical colleague who was able to give a pathological assessment of the condition of each patient at each moment, thus providing that external bench-mark, Janzen followed and observed minutely many episodes of illness. Six representative cases are given in the book. As each sufferer sought relief, Janzen was able to plot precisely when and under what conditions the patient switched from one to another of the four contemporary therapeutic traditions: these therapy systems he called "the art of the nganga" (African therapy specialist), kinship therapy, purification and initiation, and western medicine.

It was immediately apparent that the afflicted individual did not make these decisions alone. He or she was supported by a group of kin, of peers and of specialists who at different moments during the illness, took over responsibility for a switch in the quest for therapy. Together they composed what Janzen called the "therapy managers". These are the signs of an environment of weak professionalization, typical of the colonial situation, where witchcraft ordinances as well as sneering forced African practitioners underground. But that has, for twenty years, been changing. The professionalization of African medicine — the creation of traditional healers' associations, their engagement within national health services, etc. — is part of the politics of independence, as new meritocracies seek to solidify bases from which to vie for power. Therefore it may be that if this process continues, the power of lay therapy managers will recede. However, this presumes that consumers will be either satisfied to surrender

45 J. Janzen (with the collaboration of W. Arkinstall, M.D.), The Quest for Therapy in Lower Zaire (Berkeley, 1978).
46 The six cases are divided into distinct episodes and the identity of the decision-maker in each episode is laid out diagrammatically: ibid., pp. 132-3.
47 S. Feierman, "Popular Control over the Institutions of Health: A Historical Study", in Last and Chavunduka (eds.), Professionalisation of African Medicine, p. 206.
48 This is Murray Last's hypothesis, ibid., pp. 9-12.
control or can be forced to do so, both of which look unlikely. Furthermore, even if all the therapeutic options are equally bureau-
cratized, the fundamental pluralism will remain, and must be man-
aged.

For beyond the organizational level, what the Zairian cases seemed
to show was that the power of allopathic medicine, especially of
surgery, was fully appreciated, but that the full intellectual challenge
of the scientific alternative was blocked. Yet this did not involve a
rejection of some of its most powerful conceptual instruments, for
there was extensive evidence of empirical experimentation with herbal
remedies among African healers. Janzen and Arkinstall were able to
live for a time with Nzoamambu, a master healer, to observe his
practice and to assemble a detailed herbarium of his *materia medica*
which showed this beyond question.\(^49\) How could these conflicting
ideas coexist? Janzen suggested that it was because of the clear
hierarchy wherein an *nganga*’s empirical herbal science remains sub-
ordinate to his mystical powers.

Nzoamambu drew a picture to help him understand. It showed
the relationship between head, heart and belly. The healer explained
that in diagnosis, he began with a hypothesis of natural cause and
ascended a hierarchy of the body’s organs, culminating with the
heart. If he found the heart — “lord of the person” — to be afflicted,
he knew that he might have to look beyond the patient’s physical
body into the social and supernatural spheres to find the root of the
illness.\(^50\) Both the sketch and the explanation recall non-scientific
popular European medical etiologies.\(^51\)

This, argues the philosopher and anthropologist Ernest Gellner, is
the Great Divide. All scholars (and practitioners) must decide where
they stand on the issue which it poses: in that foremost determinant
of the constitution of culture is there a distinction between scientific
and other modes of thought or not? (This, notice, is not the same
question as whether there is a difference between “traditional” and
“modern” societies, to be explained by Popperian “open” and “closed”

\(^50\) Ibid., pp. 158-9. I received a similar explanation from Lingomba Mululu in 1977
in western Zambia. Harriet Ngubane stresses the centrality of balance in the Zulu
norm of well-being in *Body and Mind in Zulu Medicine* (New York, 1977). Other
scholars have reported broadly similar etiologies, for example in cases in Janzen and
Prins (eds.), *Causation and Classification*. It does begin to appear to be a widely shared
common denominator.

\(^51\) C. Webster (ed.), *Health, Medicine and Mortality in the Sixteenth Century* (Cam-
bidge, 1979); M. MacDonald, *Mystical Bedlam* (Cambridge, 1981); K. V. Thomas,
delineators or by culture-specific cognitive relativism.) Scientific culture, he proposed, is distinguished from all others by the enthronement of truth as the final judge of data. It is the sword which slays comprehensive relativism, which divides the spheres of existence and which permits the accumulation of huge quantities of effective knowledge by facilitating replicating experiments.

This triumph of cognition is prerequisite for the creation of industrial society. Its corollary is one of the three characteristics which mark the divide: (1) that in non-scientific culture, cognition has no "diplomatic immunity", in Gellner's phrase. This was illustrated above by showing how for Nzoamambu the physical, social and transcendent spheres of the cosmos interact. Associated with this are the other characteristics: (2) that non-scientific culture will possess a wider and more insistent definition of "normality" which is defined simultaneously in moral and cognitive terms specific to the particular society in question; (3) that the "core values" (called "entrenched clauses" by Gellner) encapsulating that notion will be diffused and pervasive in the society and that this will be so when the spheres of physical, social and spiritual life are weakly demarcated because ideas will be applied broadly across them: Gellner's description is of a "low cognitive division of labour".52

It will be plain that I have found each of these characteristics empirically demonstrated and therefore commend Gellner's description of them.53 Does that mean, therefore, that this account holds across all scales of such societies? If the affliction of the individual has sometimes to be treated through his kin, does the notion of health as an aspect of that special definition of normality extend to the whole society? Can a society be sick? Can a place fall ill? And if they can, with what diseases?

From the seventeenth to the early twentieth century the economy of a swathe of Central Africa, from the Atlantic coast inland up the Zaire (Congo) river to Malebo (Stanley) Pool and northwards to the Kwilu-Niari river-basin, was dominated by a vast and complex trade in slaves, ivory and copper moving from the interior to the coast, and

53 Gellner has written twice on this matter, with slight changes between the essays: E. Gellner, "The Savage and the Modern Mind", in R. Horton and R. Finnegan (eds.), Modes of Thought: Essays on Thinking in Western and Non-Western Societies (London, 1973). The four distinguishing characteristics are given on p. 169. In Legitimation of Belief they appear on p. 158. He has now situated this argument within a wider theory of historical change in Plough, Sword and Book: The Structure of Human History (London, 1988). The argument is shown there schematically at pp. 21-3.
a return traffic of European imports. Rising and decaying over the same time-span in the same area was one of the greatest of the African healing cults of which we have evidence. It was a "drum of affliction" called Lemba.\textsuperscript{54} Lemba showed itself in the individual by physical symptoms such as abdominal pain and difficulty of breathing; but these did not distinguish it noticeably from other affliction complexes. What did was the identity of the sufferers. Lemba struck the élite: chiefs, judges and especially those who serviced the long-distance trade routes that crossed the region or who participated in the trade. To throw out the disease, Lemba healers used ritual artefacts, especially the Lemba drum, containing magic medicines, and bracelets which also contained the power of Lemba. These objects were often richly decorated, and common motifs of cowrie shells and four-petalled flowers were to be seen. Small statuettes of a male and female figure, each wearing Lemba regalia and with arms entwined in a particular way, were an especially striking material relic of the cult.\textsuperscript{55} In addition, at the beginning of the century, a remarkable Swedish missionary/ethnographer called Karl Laman, had directed the collection by African catechists of what became an archive of over 20,000 pages of kiKongo cultural data, including Lemba healing texts.

For over ten years John Janzen scoured the museums of the world in search of Lemba artefacts, translated the Laman and other sources and constructed a historical taxonomy of the Lemba cult. He was able to situate its regional variants among the acephalus, segmentary societies of the Congo basin (and its daughter variants carried across the Atlantic by slaves) and to see that its ideology emphasized the removal of conflict, especially between the sexes: the name indeed derived from lembikisa, a verb meaning "to calm". Lemba texts had much to say and the statuettes much to show on marriage relations. But he could not see what the illness was that Lemba was supposed to cure until, casually, he superimposed a map of the provenance of Lemba texts and artefacts on to one of the long-distance trade routes. They matched. Things began to fall into place. Lemba priests practised in the gateways of market-places, the economic nodes of the region. Their role included elaborate market ritual. Symbolic exchange of locally produced and imported goods figured in Lemba seances. Lemba priests kept peace in the markets of lower Zaire. Their status was dependent upon personal qualities of integrity and

\textsuperscript{55} \textit{Ibid.}, Plates 18, 19, 20, pp. 253-7.
purity, not on heredity. Symbols of purity expressing the Lemba concept of the virtuous society were prominent in Lemba marriages, which in turn were a vital part of the political management of rivalry between powerful families. Such marriage links across the region provided a form of control of the trade routes. It provided a de facto system of large-scale government in a community of egalitarian, small-scale societies. But the wealth and influence which these trader families acquired brought envy and malice with them; and these evils could make the traders ill. So the Lemba cult provided a way of calming conflicts of interest between the naturally competitive and divisive activity of trade and the social order of lower Zaire: of ensuring that the presence of a massive international trade system among them did not destroy local communities. Lemba protected their health from the disease of capitalism.  

V

All this is, I realize, at first sight an uncomfortable view to propose; for behind it appears to lurk the prospect of a worse dethronement than that of the doctor triumphant in diseased Africa. It is that of universal by particular knowledge. Should that be conceded, what then is safe? In fact, as I indicated earlier, I believe that this dramatic conclusion is unwarranted. But while not dogmatically generalized in its impact, it is correct that the analysis should feel uncomfortable, for it shows that narrow, intensive scientific knowledge about pathogens is simply less efficient than knowledge rooted in the social, ecological and medical historical and present circumstances of Africa. In a similar way, the same has been shown to be true for agricultural knowledge. But even if that is so, what matters is that the sort of case which I have made in the last part of this article is widely if vaguely perceived as a generalized threat to that intellectual prowess of which Europeans are rather proud. I guess that for that reason it has found it hard to make headway: better slam the iron grid of some, any, general theory of society down on to Africans than appear to concede equal status to any non-scientific mode of thought.

This is a futile confrontation. It is also unnecessary. Why on earth should an explanation that works at the large scale be expected

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56 An elegant modern African history which shows the centrality of a perceived ritual pollution of place in stimulating a comprehensive reconstruction of a society into another form is R. Harms, Games against Naatre: An Eco-cultural History of the Nunu of Equatorial Africa (Cambridge, 1987).

automatically to explain the small also? Why should those explanations which are found to be widely applicable be assumed to be universally pre-eminent? The challenge is one of choice. I have sought to show that the present transformation of the study of health and healing in Africa contains three essential initiatives. Each tells its own medical story, but each adds something else which helps in that general task.

The examination of the social costs of production adds grim new items to the balance sheet of economic exploitation in colonial Africa. The historical analysis of the quest for therapy in a pluralist medical environment opens a more defensible route towards the core areas of colonized societies than probably any other and provides a remarkable window through which to watch how communities defend themselves against disruptive but unavoidable influences. Tracking the dynamic, unintended and calamitous interaction of pathogens, politics and African ecology reveals nature in Africa not just riding shotgun on the imperial stage-coach but, in its wonderful complexity, simply responding to treatment. The beneficial responses illuminate both the range of pre-colonial African ecological knowledge and its articulation through therapeutics with other spheres of indigenous knowledge. The malign responses illuminate the limited empirical range of scientific knowledge of African ecology, its conceptually narrow field of search and its contrastingly widespread field of application.

This article has illustrated a cautionary lesson: that there must be intellectual humility, theoretical economy and disciplinary flexibility or there will be no worthwhile progress in our understanding of Africa. There are some signs that it is being more widely heeded. In this, the study of health and healing points the way. The last decade has been one of chastening reflection in African studies, when we have learned that we know less, less reliably about modern Africa than was thought during the “Independence Decade”. It is important that this is widely and swiftly understood, as we brace ourselves for what may, indeed, be in store.

During the last part of this millennium, of all the Gaunt Riders we may most reliably predict the visitation of the Fourth Horseman to Africa, with pestilence. No one yet knows where the AIDS viruses came from. But they are there now, with a vengeance. In the last year it has become possible to ascribe rough proportions of responsibility to the transmission mechanisms of HIV infection in

Africa. It has also begun to become disturbingly clear that the existing level of HIV infection in Africa, even presuming against all expectation that further infection could be stopped in its tracks, will produce major disruption as the generation of those presently young and infected develop AIDS and begin to die in substantial number. No one has yet really thought through what the politics of despair will look like. Among our best guides are studies of the European response to the Black Death. The danger is that, as the AIDS pandemic slowly reveals itself (for it will kill over a much longer time-span than did bubonic plague), Africa past and present will again disappear behind the image of the sick and helpless continent.

Thus Africanists studying medicine and health carry an acute, double responsibility. Their work, by its methodological force, may help rescue the wider spectrum of the African past; but by exposing its medical disasters, explaining their causes and giving prominence to past patterns of indigenous defence of the individual and the society against affliction, it may also help change that powerful and persistent image of sick Africa with which I began. It is vitally important to do this while there is still time, in order to strengthen Africans in the present as they seek to find ways to tackle the awesome task of controlling the spread of HIV infection.

The work of historians may, eventually, help to change the intellectual climate. To do this is at one remove to help ordinary Africans at risk in the present to help themselves.

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20 per cent by transfusion and unsterile needles used in formal and lay therapy; 80 per cent by unprotected heterosexual sexual intercourse, the likelihood of infection being substantially increased (although within a broad range of probability, for which the reasons are not yet known) by the presence of genital ulceration associated with other sexually transmitted diseases — the so-called “S.T.D. co-factor enhancement”.