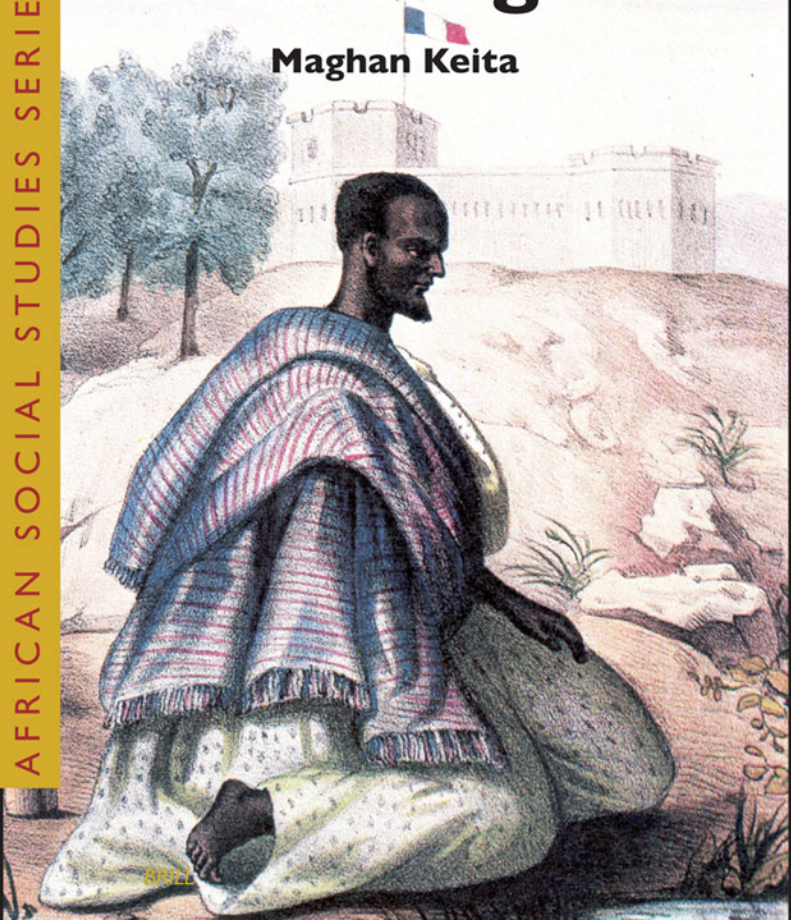
A Political Economy of Health Care in Senegal

Maghan Keita



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A Political Economy of Health Care in Senegal

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by

Maghan Keita

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On the cover: Marabout mandingue (Plate # 10) in Esquisses sénégalaises (published 1853) by Abbé David Boilat.

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For the people of Senegal, and the people of Niandane, in particular. For the Tambas, the Ndiayes, and the Keitas. Above all, for Aymerou Mbaye, the best of brothers and friends.

CONTENTS

ACKNOWLEDGMENTS

It is hard for me to fathom that more than a quarter of a century has passed since this project began. It has been more than a quarter of a century since a young graduate student disembarked from a plane in Dakar and was warmly greeted and accepted all around, in spite of the obligatory name changes. It may be because of time and the welter of names—particularly my own—that I have forgotten some that were key to this work. For this I truly beg forgiveness.

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The intimacies of my appreciation begin in 1979. Bob Cummings was head of my dissertation committee. He impressed upon me that this could done. It was Joe Harris who said "No." Dr. Harris convinced me that Senegal, rather than elsewhere, was the place to do this work. It was a work that could have never been started without the delicate and diplomatic, yet sometimes brusque, interventions of my mentor, the late Léon Gontran Damas. Damas was responsible for a young boy from Cleveland believing that he might work in French in a place like Senegal. Damas was responsible for that fact that a young black American might have a *patron*, and that that patron was none other than the late president of Senegal Léopold Sédar Senghor. It is almost impossible for me to express my gratitude to this quartet. They however, must share space with Bob

Edgar. It was Bob who called my New York office one day and, in not so gentle terms, reminded me that I had work to finish. The product is the pages that follow.

Dakar was punctuated by many friendships, and many of those friends and colleagues figure prominently in my efforts here. I will never forget my first meeting with Samir Amin, nor the ways in which my knees wobbled when he indicated not only that I was welcome to use the research facilities at the United Nations African Institute for Economy Planning and Development, but that I might also consider being attached to his staff. This meant "attachment" to a wonderful, lively, and unconventional set of intellectuals that included Cadman Atta-Mills, and Abdullah Bujra and Thandinka Mkandiwire of CODESRIA. Aside from this trio was Yasmine Marzouk, whose brilliance and ingenuity is seen in pioneering socio-political economic analysis. I am in her debt as well. If their influence is seen anywhere in these pages, I am quite pleased.

My time in Paris was highlighted by the kindness, the graciousness, and the generosity of Dr. Hassam Aloudat. Professor Aloudat's largesse is a constant reminder as I glance at my bookshelf and see the copy of his dissertation. He presented this to me on our first meeting and it has been of critical importance to me in all of my conceptualizations of health and health care in Islamic space. My time in Paris would not have been possible without the generosity of Villanova's late Vice President of Academic Affairs, Father Larry Gallen.

My deepest personal gratitude is reserved for two groups of people south and north of the Gambia; two groups of people who adopted me as family. In the south, in Casamance, in the village of Niandane, my name was changed to "*Ousman Tamba*" and I was invited into the confidences of old men as the power of Diola women attempted to instruct me in the nuances of their political economy.

In Dakar, the most intimate of my relations occurred in the Ndiaye household where my "oldest sister," Titi, immediately dubbed me "*Samba Ndiaye*" or "*Bach.*" In that household, over midday meals I was instructed on life in Senegal and loved by a host of other brothers and sisters: Ousman, my older "brother," head of house with Titi; Diary and Dior-ba, younger sisters. Then, my cohort of "brothers" that included Ebon, Moussa, the young Omar, and Mbaye.

It is Aymerou Mbaye who deserves the greatest of all accolades here. He literally shepherded me through the streets of Dakar; coun-

seled me and intervened on my behalf, in ways great and mundane—all too numerous to be remembered or recounted. His gentleness and generosity cannot be rewarded, and so the best I might provide is that they not be forgotten.

PART ONE

METHODOLOGY, THEORY, AND CONTEXT

CHAPTER ONE

A POLITICAL ECONOMY OF HEALTH CARE IN SENEGAL

> African Christians, because of the extensive communication they have with the others and their lack of [Church] doctrine, turn easily to certain rituals, foreign . . . to our sacred Faith . . . *there are fetishers . . . who perform divination and cure with remedies and words* learned in the school of Satan.
>
> Alonzo do Sandoval, 1627

This observation is taken from the report of a Portuguese explorer on the peoples of the Basse Casamance region of Senegal.[1] (Italics added).

A political economy of health care in Senegal. How might such a premise be explained? Do Sandoval's concerns are political economic concerns. They reflect the two most fundamental elements of political economic analysis: a) the way in which resources are controlled and distributed; and b) the human interaction which is both the catalyst and the consequence of that control and distribution. Here, do Sandoval clearly identifies health care as a resource, and he uses it to describe the nature of African/Portuguese relations in the region, and the history that is about to unfold around those relations. Do Sandoval's remarks are also a lament. They are a lament on the lack of control; a lament over the control that the Portuguese and their state church were unable to exert. They are a lament on distribution; a lament on the access of the peoples of Casamance to rituals, divination, cures and remedies which frustrated the Faith. That faith was one of the engines of state of the Europe of do Sandoval's time; it was the great justifier. In its broadest depiction, do Sandoval's lament was a lament on interaction; a lament that

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[1] Alonso do Sandoval, *De Instauranda Aethiopium Salute*, quoted in Peter Mark, *A Cultural, Economic and Religious History of the Basse Cassamance Since 1500* (Stuttgart: Franz Steiner Verlag, 1985), 33.

neither the powers of church nor the state, nor their combination, were great enough to humble the beliefs and practices they encountered in the peoples of Senegal. In essence, do Sandoval's lament reflected a church and state undermined by the practices of health care among the indigenous peoples of Senegambia.

Explaining "health care in Senegal" is not a straightforward proposition. There is no comprehensive work on the numerous health care institutions and structures that make up Senegal's historical and contemporary landscape. This is a fundamental limitation to an examination of the political economy of health care in Senegal. The intention here is not an exhaustive review of the historical and contemporary health care structures of the Senegambian region. This is a conceptual examination of the institutions of health care and the ways in which they further a given political economy. It is an examination of these structures and the ways in which they participate in the control and distribution of resources and how they aid in the ordering of human interaction. It is an examination that can only be illustrated discretely; illustrated by reference to very specific players and the inference they cast on a much broader understanding of health care in Senegambia.[2] This work is an attempt at what Bogumil Jewsiewicki terms "speculative history."[3] On that basis the institutions of health care are defined and explained as political economic entities. Within a context framed by human and institutional interaction, this is an examination of the historical development of institutions of health care in Senegal over a period of three and a half centuries, beginning with do Sandoval's accounts and focusing on Islamic incursions, and then, the French military and medical missions to the region at the beginning of the 18th century through independence.

The three and a half centuries demarcated here are a period of intense interaction and rivalry among the major political economies of the region: indigenous, Islamic, and French. Health care is an

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[2] "Senegal"/"Senegambia" are used interchangeably here. Emphasis is placed on the regional dynamics of an unfolding political economic history and the institutions of health that help us to understand it. The contextual referents become more specific as the discussion moves along.

[3] Bogumil Jewsiewicki, "*Présence Africaine* as Historiography: Historicity of Societies and Specificity of Black African Culture," in Valentine Y. Mudimbe, ed., *The Surreptitious Speech*, (Chicago and London: University of Chicago Press, 1992), 104. Jewsiewicki actually refers to this as "the speculative philosophy of history."

interesting barometer of historical interaction and development because of the ways in which it can be linked to the fortunes of the overall political economy that it represents. In the case of indigenous and Islamic institutions of health care, their relation to their respective political economies is apparent. Both exist within a matrix that is theocentric. The relation of health care to religion, of health care provider to cleric, and of religion to overall state function makes this abundantly clear. In that light, health care becomes a political economic entity. It plays a significant role in the defense, expansion and maintenance of the political economy.[4]

From the French standpoint, do Sandoval's remarks (though he was Portuguese) illustrate the great stock which early advocates of the colonial enterprise placed in the Church to bless, sanction, and guide their efforts. And it is evident that, through the nineteenth and into the twentieth century, religion played a crucial role in the subjugation of the region.[5] Yet, even while missionary efforts were substantial in the early years of the colonial experience and significant in the provision of health care, the revolutions of nineteenth century Europe placed a primacy on secular administration and control. This might explain, in part, the French disdain for Islam and indigenous faiths as well.[6] However, the shift from sacred to profane

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[4] Steven Feierman, "Struggle for Control: The Social Roots of Health and Healing in Modern Africa," *The African Studies Review*, 28, 3, (June September, 1985), 105. Peter Gran, "Medical Pluralism in Arab and Egyptian History: An Overview of Class Structure and Philosophies of the Main Phases," *Social Science and Medicine*, 13B, 4, (December, 1979), 339–341. John M. Jantzen, "Ideologies and Institutions in the Pre-colonial History of Equatorial African Therapeutic Systems," *Social Science and Medicine*, 13B, 4, (December, 1979), 317. Haissam Aloudat, "L'Islam et la Maladie" (unpublished Doctoral dissertation, 1983), ii; vii; 38–39; 117–118; 272. As Jacques Leonard states:

> medical science is never an isolated speculation, it is the medicine of a cultural context. In the same way, professional medicine is never a neutral reality, it is the medicine of a socio-political milieu.

La médecine entre les pouvoirs et les savoirs (Paris: Editions Aubier Montaigne, 1981), 8.

[5] If there is any doubt on this point, one only need review the work of Christian missionaries throughout Africa. Their work was so extensive that "the cross, the sword and the flag" became their standard; so significant that its cognizance became almost poetic: "Christianity, commerce, colonization". Religion's importance is only underlined when the role of the various Islamic *tariqas* in the subjugation of the region is examined. They too, represent the power of "organized" religion. As Yasmine Marzuk has written, Islam was also a colonizing power. "Social and Economic Study of Agriculture in Lower Casamance" (unpublished manuscript, February, 1979), 1.

[6] According to Christopher Harrison, the French regarded the marabout as a

did not diminish the potential for French institutions of health care to do the bidding of the state. The establishment of the Corps de la Santé as the medical arm of the Troupes de la Marine in the seventeenth century was indicative of the role the French knew health care would play in advancing the interests of empire. In short, the power of health care was recognized by all three political economies.

If we accept such an intimate linkage between the institutions of health care and the destiny of the state, then certain attendant features of the political economy also have significant relevance in a history that centers on health care as a driving force. Consider the context carefully: Senegambia from the early 17th century through the post-independence period. Conflicts that focused on the dominance of the region by one power or another shaped the health care systems of present-day Senegal. Those conflicts played themselves out in the delivery of health care services based on class, ethnicity and religious affiliation, and, of course, race.

These rivalries were indicative of pluralism within the sphere of Senegalese health care. They are a reflection of competition for scarce resources and clientele. Competing health care systems mean competing political economies.[7] Such competition suggests the need for analysis of relations of production and changes in those relations. Such competition also suggests serious implications concerning the issues of African agency during the colonial period and how that agency affects the re-writing of the history of colonialism. That analysis points to ways in which health care, as a feature of contention, helped to shape productive and social relations.[8]

Political Economy as Methodology

A defining feature of this work is its emphasis on health care as a key element rather than a peripheral one in the development or underdevelopment of Senegal. Political economy as it is expressed

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parasite of the same stature as the French village priest. The attitude was indicative of French anti-clericalism. *France and Islam in West Africa, 1860–1960* (Cambridge: Cambridge University Press, 1988), 42.

[7] Gran, "Medical Pluralism," 339–41.

[8] Steven Feierman, "Change," *Social Science and Medicine*, 13B, 4, (December, 1979), 282. John Janzen, "Ideologies and Institutions," *Social Science and Medicine*, 13B, 4, (December, 1979), 317.

here considers material conditions as decisive in the formation of social life and the exploration of social dynamics. This methodological approach allows me to see some of the most prominent features of the historical development of the society in question. As a reflection on the material conditions, the emphasis is on the control of the distribution of resources. This includes the expanse of the social product and the institutions constructed to regulate it. Those resources are material, intellectual, and human. It is their ordering, their control, their distribution, that most concerns me. And here, the examination of that concern is given to the historical development of institutions of health care in Senegal from the early seventeenth century through the late twentieth century.

The work of the late Claude Ake, *A Political Economy of Africa*, has been most helpful in defining this methodology. Ake's clarity and conciseness in describing political economy provides the three basic characteristics that implicitly guide my analysis:

1) the "primacy of material conditions";
2) the "dynamic character of reality"; and
3) the "relatedness of different elements of society".

1) *The Primacy of Material Conditions*
   Because economic need is fundamental and economic activity is necessary for survival, Ake argues that it is essential to understand the "material assets and constraints" of society. This understanding casts light on social and political organization and even the mode of thought of a given society.[9] A broadly articulated recognition of economic factors allows for movement beyond the conventional treatment of a given problem.
2) *The Dynamic Character of Reality*
   Political economy acknowledges a dynamic continuity and relatedness in the world; a complexity, which at times, may prove problematic. This aspect of the methodology refuses to regard the world in terms of "simple identities or discrete elements, or as being static."[10]

[9] Claude Ake, *A Political Economy of Africa*, (Nigeria: Longman, 1981), 1–2.
[10] Ibid., 3–4.

3) *The Relatedness of Different Elements of Society*
Political economy also allows for a systematic account of the interaction of different elements of social life. It assumes relations between all social structures and all aspects of social life. As Ake indicates, by using political economy and "by following the dynamics of the economic system, we see how it leads to the transformation of the existing social structures, and how it leads to the emergence of new social structures."[11] I see the advantages of this methodology as being four fold:

a) Given the conservative focus of conventional social science approaches and their emphasis on the status quo and stability, the methodology which Ake supports provides insight into the dynamics of a social world in which the status quo itself is dynamic. This methodology provides the possibility of understanding change.
b) The methodology implies that the question of underdevelopment is not reducible to discrete elements or simplistic theoretical formulations as modernization theory might suggest with its examination of aggregates such as the lack of capital, sufficient savings, technology, diversification, etc. This latter list reflects the symptoms rather than the root causes of underdevelopment. The methodology provides for effective analysis of problems and not isolated symptoms.
c) The methodology also provides a comprehensive view of society that cannot be found in the fragmentary, uni-disciplinary approach that characterizes conventional social science methodology. The fragmented approach in the final analysis tends to be problem creating and not problem solving. The complexity of social relations demands a comprehensive approach.
d) Finally, political economy leads to a concrete, rather than a simply abstract assessment of the problem. It attempts to provide a concrete basis for attitudes and abstractions through an assessment of the concrete historical circumstances out of which they arise.[12]

[11] Ibid., 4–5.
[12] Ibid., 5–8.

This methodological approach requires some investigation of related structures. In forming its historical dimensions, this examination of health care in Senegal reviews data that also illustrates (i) the usage and distribution of health care resources, both public and private; (ii) the objectives and implementation of national health plans; and (iii) the socio-political economic factors influencing the demand for health care.

This moves the work beyond ethnographic interpretations of African health care and the limitations of modernization theory. The interdisciplinary and integrative nature of political economy provides the basis for the necessary methodological framework and the tools that make this analysis feasible. My hope is that this discussion will move away from questions of the integration of traditional and modern health care and the merits of that integration to an understanding of what has been achieved through integration over a period of centuries and how those achievements have been manifested in the lives of the people of Senegal.

A Clarification of Terms

Terms such "modernity," "colonialism," "development," "underdevelopment" and their implications are referenced here. These are terms I have debated in the attempt to write this piece. I have debated their use here because in some ways I question their utility, and in other ways I question their meaning and import. I also question why they are privileged in this sort of discussion. I am, however, at a lost in any attempt to replace them. What seems in order then, is some attempt on my part to explain my use of them.

"Colonialism" and Related Terms

The "Colonial Moment" and its attendant manifestations is one of the terms that needs unpacking, if only in its interrogation, as both Andrew Roberts and A. Adu Boahen indicate.[13] If indeed, as Roberts implies, this is only a "moment" in the broad span of African history, then why is the colonial period so privileged? The conventional

[13] Andrew Roberts, ed., *The Colonial Moment in Africa* (Cambridge: Cambridge University Press, 1990). A. Adu Boahen, *African Perspectives on Colonialism* (Baltimore: The Johns Hopkins University Press, 1989).

answer is the "great change" that colonization and the processes of imperialism wrought across Africa. Yet, Boahen challenges these assumptions by asking questions about how colonization actually worked, and within those workings what were the manifestations of African agency—what worked because Africans were, in some part, willing to have them work; what was "un-useable" ("*inutile*") because Africans deemed it such as well?

Terms like "colonial" are privileged in our referencing of "pre" and "post" colonial as indications of time and space other than this defining moment. Intellectually, this categorization is problematic, yet it remains the "best" that any of us seem capable of for the time being.

Systems of Health Care

In much the same way that "colonialism" is troublesome, so is the task of characterizing the various systems of health care that are the central focus of this work. Here generality has subsumed nuance. Notions of "French" health care seem direct enough, though even here there are enough nuances to dispel this idea. Are the health care institutions of the French state referenced here, or those of non-governmental and religious orders as well? All of the above where those various health care vehicles relate to the maintenance and expansion of the French political economy.

"Islamic" health care poses the same difficulties. In this work, questions of specificity arise in the referencing of Qadiriya, Tijaniyya, and Mouridiya as distinct political economic actors in the distribution of health care in the Senegambian region.

However, the most troublesome of these ideas is that of "indigenous" health care. Here is terminology that seems outdated, yet has to be used because there is nothing else that remotely expresses the category. However, as Samir Amin has pointed out in relation to the term "traditional" as it is applied to Africa, here "indigenous" means "neither isolated nor primitive."[14] "Indigenous" health care as it is used here includes the institutions of the Wolof, the Serer, the Diola, and to a limited degree the Manding, as they existed prior to the coming of Islam, Christianity, and European imperial-

[14] Samir Amin, "Préface," in Boubacar Barry, *Le royaume du Waalo: Sénégal avant la conquête* (Paris: Karthala, 1985), 11.

ism, and as they existed in opposition to those forces. The references to them are reflective not so much of the uniqueness of health care practices as they are of the political economic interests that guide them. Steven Feierman and John Janzen offer one possible change in terminology by referring to these institutions as "popular" as opposed to "indigenous." But in this another problem revolves around separating the "popularity" of Islamic, or even western forms of health care, from their "indigenous" counterparts.[15]

> Health care for all by the year 2000
> World Health Organization
> Alma Ata (former Soviet Union)
> 1978

Terminologies take us back to a careful consideration of the context. That careful consideration reveals the historical dynamics of the subject: "A Political Economy Of Health Care In Senegal." We are dealing with the post 1492 modern world. It is a world witness to the expansion of capital and capitalism. It is a world characterized by modern imperialism and colonization. The analysis provided by a political economy of health care has serious implications in the rewriting of this historical epoch, and our assumptions concerning the ubiquity of the colonial process.

Obviously, the declaration of the World Health Organization has not been achieved. Even for the wealthiest nations, the provision of universal health care remains a problem. It is one of economics compounded by questions of political will. The immediate situation of health care in the United States helps to illustrate the basic theoretical assumptions that guide me. They are rather straightforward. If health care is regarded as a resource (an element of the "economy"), then the policies (the political devices) that are contrived to control the distribution of that resource give us an understanding how the terminology "a political economy of health care" might be interpreted here. At the risk of being repetitive, the usage refers to the control of the distribution of health care as a resource. It refers to the abilities of any given party to confer or deny access to the resources they control. Those abilities—that power—often registers itself as conflict, or contention, and through it a historical record is manifested.

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[15] Steven Feierman and John M. Janzen, eds., *The Social basis of Health and Healing in Africa* (Berkeley: University of California Press, 1992), 16–19.

Proclamations like those of do Sandoval, or even Alma Ata are indicative of a particular historical moment. They are also reflective of a historicized way of thinking. It is a way of thinking of which few of us seem conscious. We are not conscious that our regard for health care in Africa—the achievement of "health care for all" in Africa—is part of a historical process. A historical process that, along with Africa itself, holds much more complexity than a proclamation such as Alma Ata, or its attendant background, or even the most recent analysis on a scourge such as AIDS, anticipates. We have not fully grasped that when we conclude that there should be "health for all" such a conclusion is made in light of certain historical dynamics.[16]

[16] Of course, among the historical dynamics guiding our assumptions on health care are the Enlightenment biases of "science" and "rationality" that define the "modern age," and that preclude such activities among "savages," Africans included. The acknowledgement of these conditions make this discussion an intellectual history as well as a political economic one in that it engages, in the broadest senses, issues of historiography and epistemology. In relation to the latter, the body of knowledge through which healing occurs is clearly shown to be a source of contention in the political economic history of Senegambia.

CHAPTER TWO

THEORY: HEALTH CARE AS A POLITICAL ECONOMIC ENTITY

> The interposition of *Mumbo Jumbo* . . .
> is always decisive.
>
> Mungo Park, 1795–97

Political economic entities, whether we term them states or something else, have historical legacies that are shaped by both internal and external activities. In the space of the past five centuries, in a world capitalism has helped to shape, there are few peoples who have been untouched by its processes. Imperialism and colonization have provided a particular legacy whose structural manifestations helped to determine the direction of former colonized states. That direction is due, in part, to the way in which colonialism was introduced, the way in which it was maintained, and the way in which it came to an end in a given colony. It is also witnessed in the retention of many of the devices that made colonization possible.

Development, or the lack thereof, can be measured, in part, in institutions, infrastructures, and attitudes. The legacy of colonialism does provide some keys to understanding a state's political economy. The power of those institutions, infrastructures, and attitudes gives *some* indication of the degree to which any independent state will be able to break with its colonial past. We tend to measure this in terms of whether a state develops or declines in "modern" socio-political economic terms. There is, to be sure, a certain lack of clarity as to what we mean here. Yet, when we relate this idea to health care in Africa, as it now exists, we are obliged to consider the context of colonial formations. In this light, western medical services during the colonial period were an aid to the administrative control and to the expansion of the colonial power's political economic base.

In many cases, the colonial experience provided the basis for the improvement of health care in the metropolitan center. Health care systems, from the colonial period through the present, placed emphasis on class, race, and gender, as well as the economics, and the

geography of the systems. The development of urban-centered, curative, capital-intensive facilities is reflective of the needs of an unfolding colonial system, and the thought processes that guided it.

Under these circumstances, one of the best ways to examine health care as a political economic entity is within the framework of imperialism. However, here, we would be well served to regard imperial relations as reciprocal, though albeit, unequal. The point is that there are exchanges within this context that are manifestations of power by any one of the participants. In that regard, the current state of health care in Africa is not a "natural stage" in third world development as held by modernization theorists. The ideas that underdevelopment is inherent to traditional society, and that the practice of traditional medicine is of no value are false as well. In fact, like the terms "indigenous," and "traditional," the terms "development" and "underdevelopment" deserve interrogation as well. Here again, they merely suffice for lack of better terms.

An analysis of postcolonial Africa indicates that imperialism did help to define emerging institutions and did help to restrict their growth as well as their range of possible alternatives. Because of this, one approach to understanding the implications of this is an assessment of the material basis of Africa's historical development and its relation to the evolution of health care.[1]

Let me illustrate this in this way: is modern health care, as it is known in Africa, simply a product of imperialism? Clearly, colonial expansion made the introduction of "modern" western medicine essential for its success. The ill health of Europeans and the diseases they encountered were real factors in inhibiting the advance of colonization and in delaying the entrance of Africa and other colonial regions into a re-organized, modern, capitalist, world economy. With the establishment of a new medical field, "tropical medicine," new types of economic exploitation could be undertaken that were otherwise questionable. The list of medical "breakthroughs" associated with imperialism, either by way of expanding the market or by the construction of infrastructure in the periphery, is extensive. For example, the work of Reed and Goethals in Central America, Livingstone in Africa and Dooley in Asia under girded colonial expansion.[2] Over

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[1] Vicente Navarro, "Social Class, Political Power and the State and their Implications in Medicine," *International Journal of Health Services*, VII, 2, (1977), 255–292.

[2] William J. Barber, "The Movement into the World Economy," Melville Herskovitz, ed., *Economic Transformation in Africa*, 305–308.

time, the use of health care as a form of direct or indirect intervention became widespread. Earlier in the twentieth century John M. Wier, an official of the Ford Foundation, expressed it in this fashion:

> There clearly was a need . . . to provide guidelines for the architects of medical systems for the developing countries and to serve as a reference, at least, for their political leaders to use in making judgments on how to best use their limited resources.[3]

The analogy this statement makes referencing health care as a resource clearly indicates the political economic intent of its source. The statement, directed at planners and policy makers, also illustrates the class content of the decision making process. A multinational concern drew up plans for the dissemination of health care in areas defined as "underdeveloped." Those plans were to be implemented by the elite classes of the societies in question. The goal of that type of planning on the part of metropolitan concerns is given greater clarity when we reflect on the thoughts of former Rockefeller Foundation president, George Vincent:

> Dispensaries and physicians have of late been peacefully penetrating areas . . . and demonstrating the fact that for the purpose of placating primitive and suspicious people medicine has some advantages over machine guns.[4]

Of course, Anne Raffenel had drawn the same conclusions more than a century earlier. The health care apparatus is part of a system designed to protect and expand ruling class interests in the periphery as well as in the metropolitan center. Yet, even after having said this, there is still the implication that there are other class and institutional dynamics inherent in the regions in question that cannot be underestimated. There is also the idea that all institutions of health care, "indigenous" or otherwise, carry the same function: the protection and expansion of ruling class interests—the protection of the interests of the "state." The health care that accompanied colonialism was to assure that colonial officials could perform

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[3] John Bryant, *Health and the Developing World* (Ithaca: Cornell University Press, 1969), p. viii. Victor and Ruth Sidel, *A Healthy State: An International Perspective on the Crisis in United States Medical Care*, (New York: Pantheon Books, 1977), 103. E. Richard Brown, "Public Health and Imperialism: Early Rockefeller Programs at Home and Abroad," *American Journal of Public Health*, 66, (1976).

[4] Navarro, "Social Class", 259.

their services in hostile environments. Part of that function was to aid in the "placation of primitives" and to instruct those who would become administrators of the system in the proper procedures for spending their meager health care budgets. We must not lose sight of the fact that these two goals, in many ways, were meant to undermine indigenous class and institutional structures. All this was done within the realm of an expanding capitalism and the drive for greater productivity throughout the world. The extension of health care allowed for the greater exploitation of the workforce. As Ram Rati and Theodore Schultz illustrate

> [T]he gain in the state of health that a longer life span implies is an addition to the stock of human capital and should increase the productivity of workers in a variety of ways. The obvious point is that a longer life span results in more years of participation on the labor force in low income countries is of major importance. There is also a clear implication of an increase in the physical ability to engage in work from day to day and a reduction in days lost because of illness. Thus the daily amount of work per worker increases.[5]

Ironically, in most of these countries, the health care in question has never been extended to the population that is the real key to the expansion of the economy—the rural agricultural worker. In fact, the consequent policies of "modernization," industrialization and urbanization helped to create demographic variations that are characteristic of a political economy of underdevelopment.

In a context where health care is commoditized, the difficulties surrounding the *purchase* of "modern" health care are obvious. The transfer of prices from the metropolitan center through the peripheral metropole to the periphery is an illustration of this. The result is an example of unequal exchange in health care that impacts the vast majority of the population—almost all of whom are poor. Consequently, access to certain types of health care becomes a dynamic of class that has serious repercussions.

The point to be made here is that as an apparatus of the state, health care can never be thought to be neutral; no matter how the state might be defined. Health care—in particular its dissemination—serves the purposes of the state and therefore has a political economic

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[5] Ram Rati and Theodore Schultz, "Life Span, Health, Savings and Productivity," *Economic Development and Cultural Change*, XXVII, 3, (April 1979), 402.

character. The health care apparatus is a reflection of the socio-political economic structure of the state and the class that controls that state. Vicente Navarro has argued that the class composition of the state is determined by the class nature of the society. In societies dominated by capitalist interests, a health care sector has emerged that "replicates the class hierarchy that characterizes capitalist societies" in its administrative structure as well as in the distribution of its services.[6] However, Navarro's analysis also poses several other issues: how do we understand "capitalist dominated societies" and what is the nature of intra- and extra-class relations in them and between them and their hegemonic partners? What is the nature of modern imperialism; what was it to achieve? How have the arguments concerning its nature and consequences been made? What have those arguments omitted or overlooked?

It can be argued then, that the state, in many instances, may not be the best arbiter of the health care process. Especially, not in cases where the state's fundamental concern is the commoditization of the health care process, and that commoditization is related to the political economic structure of the state and the class that controls it.[7] Therefore, shortages in manpower, the technological deficiencies and the distribution of health care services in colonial and postcolonial states, themselves are symptoms and consequences of the problem and not the problem itself. At the root of the problem is the process of the integration of various systems into a world system and the resultant internationalization of the division of labor. Even if the adoption of the types of models of health care implied in World Health Organization, World Bank, Rockefeller, or Ford Foundation studies were ideal, the problems posed by the international division of labor would still exist, as would the ways in which such a division dictates access to resources on a global scale.[8] The argument

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[6] Navarro, "Social Class," 270–275. Phyllis Gabriel and Susan Steward, "The Role of Health Care in Socialist Revolutions: Mozambique and Cuba," *Ufahamu*, VIII, (1978), 36. Michael Bader, "The International Transfer of Medical Technology—An Analysis and a Proposal for Effective Monitoring," *International Journal of Health Services*, VII, 3, (1977). Samir Amin, *Unequal Development*, (New York: Monthly Review Press, 1976), 221–224.

[7] Navarro, "Social Class," 282–287.

[8] Navarro has noted:

> Moreover, this problem of economic concentration and concomitant industrialization determines the mode of production and the distribution in medicine

can be made that the citation of Alonzo do Sandoval that opens this work speaks to the initial phase of the integration and internationalization (globalization) of Senegambian space and its healthcare apparatus.

Underdevelopment theory infers that in the area of health care increased dependency takes many forms. For instance, in general economic terms it can be argued that increased productivity in the dependent state, tied to more person-hours and greater industrialization, means greater inequality between the elite and the working population. This rise in productivity on the part of the workers coupled with increases in income for managerial classes can also mean a greater inequality in the distribution of health care. Samir Amin emphasizes that "modernization" can mean an increase in the number of person-hours exerted in the productive process. Those increased person-hours are equated to increased physical exertion and greater exposure to the hazards of the occupation.[9]

Richard Vengroff has demonstrated that increased dependency can be witnessed in increased productivity. Roy Elling has expanded this to the area of health care by showing that increased dependency through increased production has meant increased health problems for the workforce. The increase in health problems for the workforce can be viewed as tangible, measurable evidence of the increase in inequalities between the elite and the working population.[10] Yet, here as everywhere else in this analysis, we need to return to a central question: how do workers cope; how do everyday people get along under these conditions?

Within postcolonial health care systems the most demonstrable examples of dependency are found in the systems of health education. In large part, these are systems designed and based on curricula that apply to conditions that existed within the former metropolitan

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that replicates the characteristics of the overall process of economic production and distribution, i.e. specialization, concentration, urbanization and the technological orientation in medicine.

Ibid., 283.

[9] Samir Amin, *Neocolonialism in West Africa*, (Great Britain: Penguin Books, 1973), 54. Roy Elling, "Industrialization and Occupational Health in Underdeveloped Countries," *International Journal of Health Services*, VII, 2, (1977), 221–224.

[10] Richard Vengroff, "Dependency and Underdevelopment in Black Africa: An Empirical Test," *Journal of Modern African Studies*, XV, (1977), 613. Navarro "Social Class," 277, Elling: "Industrialization and Occupational Health," 221–224. Bryant, *Health*, xi. Sidel and Sidel, *A Healthy State*, 98.

center. The models came complete with personnel who identified with all aspects of medical practice as it was defined in the center: its individualistic nature; its curative, highly technical aspects; the depersonalization of the relation between the practitioner and the patients; and the commoditization of the health care sector itself.

These models are at variance with the needs of "underdeveloped" states, if for no other reason than they have not fully met the needs of the states for which they were designed. Yet, this system, "imposed" on colonized space, was designed to produce a return on the investment supplied by developed states for their conceptualization and implementation of these models. In part, the return could be realized in the newly trained medical personnel's desire for the most sophisticated technical equipment, their willingness to provide their patients with the most recent pharmaceuticals no matter what the cost to the consumer, and their fierce desire to safeguard the privileges of profession and class.

One of the characteristics of this metro-centric medical education is its fascination with medical technology. The act of modernization signifies increased dependency when the technological nature of that dependency is considered. In the urban orientated, capital intensive, technology driven health care apparatus that characterizes the metropolitan centers of most "underdeveloped" states, the question of high technology is one that is more associated with prestige than with healing. Technological transfers include not only the actual hardware, but also the personnel, the expertise and the equipment to run and maintain that technology. This presents problems of overwhelming proportions for the health care system, and the state as well. Within the health care system, the transfer of technology from the center to the periphery maintains the gap between the health care for a select segment of the population as opposed to the majority. The monopoly exercised by western nations in providing and determining the specific types of technological and industrial transfers cannot be regarded as a neutral scientific exchange: "it is permeated by the consumer values of the civilization from which it stems, and the *technological advance in medicine will not insure its healthy social application*".[11] (Italics added)

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[11] Bader, "International Transfer," 443. Bruce Johnson and Anthony Meyer, "Nutrition, Health and Population Strategies for Rural Development," *Economic Development and Cultural Change*, xxvi, (October 1977), 3.

This transfer of technology has aided in the distortion of the medical sector. It has reinforced the principles of the international division of labor by providing technology that can only be serviced by technicians trained in the metropolitan center. The functional ability of the equipment, as well as the cost of running and maintaining it, is extremely expensive, draining resources from "developing" states while denying them the continued presence of their own expertise. Yet, even the value of that continued presence is questionable when the price of training such personnel is considered. Both Ivan Illich and Jorge Ahumada illustrate the point:

Modern hospital beds, incubators, laboratory equipment or respirators cost even more in Africa than in Germany or France where they are made; they break down more easily in the tropics, are difficult to service, and are more often out of use. The same is true for the investment in the training of doctors who use such highly capitalized equipment.[12]

Each dollar spent in Latin America on highly specialized hospital services costs a hundred lives. Had each dollar been spent on providing safe drinking water and in supplying food for the population one hundred lives could have been saved.[13]

Technological dependency is also a reflection of the fact that health care has become a "service industry." The level of multinational pharmaceutical and technological transfers, and the promotion of curative medicine over preventive practices underline this fact. The multinational corporations' view of health care as an expanding market and the opportunity for the maximization of profits is indicative of the monetization of the health care sector in the underdeveloped world.

Multinational corporations have been able to make serious inroads in the distribution of goods and services in Africa aided by agencies of the state. For example, the United States Agency for International Development's policy of assisting U.S. multinational firms in the distribution of their products illustrates the point. Victor and Ruth Sidel have written that in very many cases "foreign aid" is tied directly or indirectly to the purchase and use of U.S. products, consultants and models. Michael Bader supports the Sidels' argument by docu-

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[12] Bader, "International Transfers," 447.
[13] Ibid.

menting the amount of USAID money funneled through multinational corporations. He indicates that in 1971 USAID purchased from some 4,000 U.S. corporations and paid at least 1,000 firms for technical assistance. In 1971, USAID contracts accounted for 7.1% of all U.S. exports to underdeveloped countries, illustrating that there is a return on foreign aid and that the entire foreign aid process is investment oriented. However, USAID "aid" to multinational corporations is not totally scrupulous as the November, 1979 issue of *Mother Jones* magazine documented. The Agency, *Mother Jones* reported, actively participated in the dumping of worthless and harmful surpluses in underdeveloped states, taking advantage of health situations that were already precarious, and in many cases, exacerbating them. The documentation indicates that the rest of the developed world followed suit.[14]

A case in point is the growth of multinational pharmaceutical concerns in the last five decades. The profits of multinational pharmaceutical firms have been enormous. In the period between 1955 and 1974, their revenues increased tenfold. Using questionable advertising techniques and failing to provide substantial warning on product usage, pharmaceutical firms supplied underdeveloped states with products that could not be legally sold in the United States or other western nations.[15] In some cases, drugs firms experimented on entire populations with drugs that had not been approved for human consumption in their place of origin.[16] This can be coupled to the most recent examples that come from the AIDS crisis in Africa. Here, we find that the price of pharmaceuticals is prohibitive in most cases, while the issue of questionable research persists.

It has been standard practice for pharmaceutical firms to "employ" various professionals. These have included advance men and doctors and nurses themselves. The advance men have been, ironically, the ones who "prescribe" new drugs to doctors in these countries, often hailing their multiple uses while completely neglecting to relate their dangers.

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[14] Sidel, *A Healthy State*, 98. Bader, "International Transfers," 451. Mark Dowie, "The Corporate Crime of the Century," *Mother Jones*, IV, 9, (November 1979), 32–33.

[15] Sidel, *A Healthy State*, 101. Dowie, "Corporate Crime," ibid. Bader, "International Transfers," 446.

[16] Dowie, 23.

The marketing of infant formulas provides one of the strongest examples of the way in which multinational corporations have used doctors and nurses. Substantial sums of money have been spent in what Derrick B. and E.F. Practice Jelliffe termed the "unethical promotion of formulas by commercial concerns." The formula's appeal was based on the persuasive image that bottle-feeding provides the consumer with prestige and the image of upward social mobility. The mass media is very much dependent on advertisements. These advertisements, no matter how adverse, have been widely used in these pharmaceutical campaigns. Milk company promotions frequently found their way into government health care facilities in the guise of promotional material designed to 'assist in the running of the clinic'—often to the detriment of prescribed facility regulations and goals.[17]

The impact of such practices has been illustrated in an Ibadan, Nigeria study that noted that if infant formula were given to children exclusively, one quarter of the total family food budget would be exhausted. The study went on to recommend the banning of milk company representatives from hospitals so the mothers could be taught what is in their own interest.[18]

The pharmaceutical industry is clearly adept at molding professional opinion at comparatively low cost in these countries through "manipulation by assistance" and through "endorsement by action." The Jelliffes quote Dr. Cosma Cagas from an article in the *Philippine Journal of Pediatrics*:

> Drug company sponsorship of medical society activities has reached alarming proportions . . . Has it occurred to us that we are partly responsible for the burgeoning cost of drugs and infant formula? That we have become, so to speak, unwitting drug agents.[19]

In an article, "Avarice, Inefficiency and Inequality," Alan Maynard suggested that "manipulation by assistance" and "endorsement by action" were to be expected when the physician acts on the basis of self interest. Speaking specifically of West European doctors, Maynard contended that doctors are basically guided by avarice.

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[17] Derrick B. Jelliffe and E.F. Practice Jelliffe, "The Infant Food Industry and International Child Care," *International Journal of Health Services*, VII, 2, (1977), 249–250.
[18] Ibid., 250–251.
[19] Ibid.

Through the medium of professional organizations, the medical establishment has assumed monopoly power that has led to inefficient and inequitable health care. The historical evolution of the medical profession in France over the past 150 years underlines Maynard's assessment of the construction of "monopoly" power. By extension, the French example illustrates the political economic and historical arguments put forward here, and expanded later in the analysis. By Maynard's logic, the ties of the medical establishment to multinational corporations are part of the phenomenon and if the demographic, class, and income variables he cites to illustrate the case are of any consequence, his premise is applicable to third world practitioners as well.[20]

The concept of self-interest may be misleading. Class interest is a much better descriptor of the motive force. The medical establishment is one of the elite bodies within ruling class structures, globally. This is an historical phenomenon that crosses cultures. As ruling class elites, health care professionals are unified around the very pertinent issues that define their being and the basis for their survival.[21]

The medical elite's activities are dictated by the context in which it operates. As Navarro has pointed out, distribution and access to health care as well as its hierarchical class structure are simply replications of the political economic organization of the society in general. Navarro goes on to stress the need for understanding the role of the medical practitioner within the context of the political economic scheme of her/his respective state. Such an understanding, according to Navarro, clarifies the class position.[22]

It is in fact the class relationships within "underdeveloped" states as well as their manifestations on the international level that dictate distribution and access to health care. Within this context, class relations are reproduced throughout the medical establishment.

Class relations are reproduced along geographic as well as economic lines, and an urban-rural dichotomy becomes evident as a manifestation of class. Health care becomes sufficiently dualized between the "haves" and the "have-nots," urban and rural.

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[20] Alan Maynard, "Avarice, Inefficiency and Inequality: An International Health Care Tale," *International Journal of Health Services*, VII, 2, (1977), 179–182.

[21] James O'Connor, "The Meaning of Economic Imperialism," Robert Rhodes, ed., *Imperialism*, 118. Navarro, "Social Class," 261.

[22] Navarro, "Social Class," 261, 274, 283.

Questions of "to where," "to whom," and "for what price," are followed by "how?" The technical and class aspects of health care, the elevation of the curative practice to the status of commodity, and the need to protect the class interests around which profits are made, lead to the special characteristics which delineate the doctor-patient relationship within a curative, technologically oriented, capital intensive health care system. These characteristics, highlighted by the estrangement between doctor and patient, bring to mind the same forms of "mystification" that anthropologists use to describe the activities of traditional practitioners, i.e. "witch doctors." In both arenas the process is roughly the same—it is dominated by the need to protect the interests of profession and class through the mystification of medical technology and knowledge.

The patient is not the only victim of the medical hierarchy and classism. The hierarchy also creates divisions between personnel as well as between specific medical disciplines. For instance, nurses are not "as good as" doctors, paramedics are not "as good as" nurses, and so on. Within the conflict between various disciplines, psychology does not have the empirical veracity of neurology, while pharmacology is seen as the stepchild of both. While the differences between disciplines in "developing" states may not be quite so pronounced, the class differences exhibited in the medical hierarchy are replete.

Again, the French example is pertinent here. The historical dynamics of professional hegemony in the metropole had serious consequences for its replication in the colonies. These repercussions speak to hierarchical divisions that break along lines dominated by gender and race, and consequently, class.[23]

In all, the cumulative effect of such things as the commoditization of health care; its technical, curative and capital intensive nature; its mystification in order to protect class interests, begin to touch the roots of health care as a political economic entity. The historical evolution of the "underdeveloped" world and its institutions is inextricably tied to the past five hundred years of the expansion of capital and the re-constitution of a unitary world system.

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[23] Jacques Leonard, *La France Medicale au XIX^e Siecle* (Mesnil-sur-Estree: Archives Gallimard/Julliard, 1978). Jacques Leonard, *La Medecine entre les Pouvoirs et les Savoirs* (Paris: Editions Aubier Montaigne, (1981).

Within the context of this historical process the present crisis in health care can be understood. Questions concerning the role of the health care system in the postcolonial world and its impact on development are contextualized here as well. Those questions reveal the nature of medical imperialism as a crucial element of that "specific relation between a subjugated society [and its institutions] and its alien rulers" and the role that health care plays in the complicated dialectic of development/underdevelopment.[24]

Having said all this, a caution must be provided. It is a simple reiteration. The political economic nature of health care, even within the context of modern imperialism, is not simply given to the dominance of technical efficiency or "scientific" prowess. Nor is the proper understanding of the political economy of health derived from the notion of the power of "external" forces and their abilities to dictate the control of the distribution of resources. All elements of the equation are capable of exercising control in various, nuanced ways that characterize certain levels of autonomy, adaptability, resilience, and resistance. Those are the aspects of agency that remain virtually unnoticed in conventional histories and analyses of "development" in a world deemed "undeveloped."

Africa and Theory

The theoretical premise I have outlined here owes a great deal to a number of writers. Vicente Navarro's ideas on the political economy of health care have enhanced my understanding of broader applications that emerge from the "dependency/underdevelopment" school and its early concentration on the political economy of Latin America. Since the emergence of that earlier school, Africa has generated more political economic interest. A number of studies addressing the political economy of health care, either directly or tangentially, have emerged.

Among the more important works are those included in the December 1979 volume of *Social Science and Medicine*, entitled "The Social History of Disease and Medicine in Africa," edited by John M. Janzen and Steven Feierman. More than a decade later, Feierman

[24] Bernard Magubane, *The Political Economy of Race and Class in South Africa*, (New York: Monthly Review Press, 1979), 3.

and Janzen followed with another equally important volume, *The Social Basis of Health and Healing in Africa*.[25] The work of Meredeth Turshen in both her doctoral dissertation and subsequent articles has also been key to my conceptualization of the political economy of health care in Africa.[26]

In their introduction to the *Social Science and Medicine* volume, Janzen and Feierman begin by stating that the "whole of modern African history has been profoundly influenced by disease and the articles included in the volume focus on the *difficulty* (italics added) in assessing the role of changing medical intervention without addressing changing disease patterns."[27] Key to their opening argument is the allusion to the conventional development theme of linkage between western explanations for ill health in Africa (e.g. disease theories) and modernization theories. The implication of this linkage is that disease causality in Africa, and therefore its solution, are tied to Africa's inability to modernize. The sources of such modernization, in general, and in the health care sector in particular, focus on intervention. The pitfall that must be avoided here is the assumption that intervention was undertaken primarily in response to disease and its effects on Africa rather than in response to the effects of disease on carrying out the colonial mission and further integrating Africa into the modern global political economy. Within the confines of this work, it is there that the intervention occurs and where one begins to view a new type of pluralistic interaction in health care that is characteristic of colonization. This is a pluralistic interaction whose residual impact permeates the postcolonial era. It is there that the political economy of health is best illustrated. Meredeth Turshen, writing of Tanzania, summarizes the situation:

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[25] Steven Feierman and John Janzen, eds., *The Social Basis of Health and Healing in Africa* (Berkeley, Los Angeles, Oxford: University of California Press, 1992).

[26] John M. Janzen and Steven Feierman, eds., "The Social History of Disease and Medicine in Africa," *Social Science and Medicine*, 13B, 4, (December, 1979). Meredeth Turshen, "The Political Economy of Health with a case study of Tanzania," (Ph.D. dissertation, University of Sussex, 1975). Meredeth Turshen, "The Impact of Colonialism on Health and Health Services in Tanzania," *International Journal of Health Services*, vii, 2 (1979), 7–35; Meredeth Turshen, "Workers' Health in Africa," *Review of African Political Economy*, 36 (1986), 24–29.

[27] John M. Janzen and Steven Feierman, "Introduction," *Social Science and Medicine*, 13B, 4. (December 1979).

> The way in which health problems were conceptualized during the colonial era, the structure of medical services established and the effects of health care on health status . . . have been determined by the economic, social and political requirements of German and British colonial rulers rather than the health needs of the Africa population.[28]

This is the conceptualization that dominates much of the present discourse.

The idea of pluralism in African health care systems is certainly not new, and as Janzen and Feierman argue elsewhere,[29] this understanding helps to correct overly simplistic notions of "modern" versus "traditional" health care. Within the Senegalese context, the notion of medical pluralism is borne out in the existence of such ethnically based treatments as the Wolof *N'dopp* and the tradition of bone setting among the Diola; and of course, the therapies associated with Islam. However, pluralism is not necessarily benign and without competition and conflict. The nature of pluralism in health care at any given point in time is the response of the health care systems in question to specific historical problems, such as Wolof dominance, Islamicization, and colonization.[30] Pluralism can reflect the nature of the conflict that exists between health care systems competing for scarce resources and clientele. And, as Peter Gran notes, competing health care systems represent competing political economies.[31]

To argue that health care is a political economic entity is to argue the role of health care in social formation. Assessing the response of health care systems to specific historical problems as Janzen and Feierman suggest means analysis of relations of production and the changes in relations of production, and their impact on health care. Just as important however, is understanding, in as complete a sense as possible, the ways in which health care helps shape productive and social relations. In this regard, Peter Gran's work on "Medical Pluralism in Arab and Egyptian History," Marc Dawson's work on "Smallpox in Kenya," and Meredeth Turshen's doctoral work on

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[28] Turshen, "The Impact of Colonialism," 7.

[29] John M. Janzen and Steven Feierman, "Joint Committee on African Studies Project on Medicine and Society in Africa," Social Science Research Council, (New York, 1979), 2–3, 7–8.

[30] Ibid., 7–8.

[31] Peter Gran, "Medical Pluralism in Arab and Egyptian History: An Overview of Class Structures and Philosophies of the Main Phases," *Social Science and Medicine*, 13B, 4, (December, 1979), 339–341.

the political economy of health care in Tanzania, and her articles on the "Impact of Colonialism and Health" and "Workers' Health in Africa" have been quite helpful in the earlier stages of this project.[32] The fundamental notions that these works provided were reinforced by the insights of later works by scholars such as Ismail Abdalla, Gloria Waite, and John Janzen, again.[33] All of these writers agree that an assessment of colonization and its impact on social formation is crucial. While that impact carried as much force, if not more, as natural and social phenomena that existed prior to colonization, they also make a case that is as important, if not more so, that prior to the "colonial moment," there were structures and institutions in African societies which systematically and rationally addressed issues of health and health care. Marc Dawson noted that the Kenyan response to colonization saw social and economic change that was similar to the general response to famine, and which led to consequences of epidemic proportions.[34] New trade patterns, cash cropping, urban migration, more frequent population movement, and larger and denser population concentrations led to the modification, and sometimes, the breakdown of existing health care practices.[35] It is here, within the new socio-political economic patterns of Africa, that new competition for scarce resources occurs. It is here that health care becomes a factor in determining who will have the larger share.

On this point, Turshen criticizes conventional development theory as analysis that "neglects structures, mechanisms and causal relations,"[36] and as Gran concludes, "isolate[s] medical thought from the rest of culture." Both Gran and Turshen associate the crucial changes from

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[32] Marc Dawson, "Smallpox in Kenya, 1880–1920," *Social Science and Medicine*, 13B, 4, (December 1979), 245–250.

[33] Ismail Abdalla, "Diffusion of Islamic Medicine into Hausaland," in Steven Feierman and John Janzen, eds., *The Social Basis of Health and Healing in Africa* (Berkeley, Los Angeles, Oxford: University of California Press, 1992). Gloria Waite, "Public Health in Precolonial East-Central Africa," in Steven Feierman and John Janzen, eds., *The Social Basis of Health and Healing in Africa* (Berkeley, Los Angeles, Oxford: University of California Press, 1992). John Janzen, "Ideologies and Institutions in Precolonial Western Equatorial Africa," in Steven Feierman and John Janzen, eds., *The Social Basis of Health and Healing in Africa* (Berkeley, Los Angeles, Oxford: University of California Press, 1992).

[34] Dawson, "Smallpox in Kenya," 245–247.

[35] Ibid.

[36] Turshen, "Political Economy of Health," 3.

the precolonial through the postcolonial periods with the forces of capitalism. In Egypt, over a twelve-hundred-year period, Gran cites emerging class patterns of medical care. A "traditional" maraboutic class eased psychological disruption and assisted the population's adjustment to the new, capitalist, market economy. This occurred in the presence of an emergent "capitalist class" that embraced western medicine as an evidence of Egypt's early "modern" and capitalist transformation.[37] The consequences of these dynamics were a medical hierarchy based on capitalism that affected every aspect from professional status and attitudes to the distribution of health care itself. This dynamic was confronted by the institutions of Islamic medical practice and the traditional approaches to health care that underpinned them. In analyzing social formation during the colonial period, Turshen and Gran are clear: an assessment of land and labor use provide the rationale for the diminution or breakdown of "traditional" health care systems and the atomization of health services based on ethnicity and class.[38] In that regard, health care is defined as a political economic entity through its "institutionalization" (re-institutionalization) and its disbursement.

Feierman also realizes the importance of analysis with "regard to a society's productive base, and the ways in which therapeutic resources and decisions are linked to units of production."[39] He implies that changes in social production mean changes in health care, and conversely, change in health care can signal change in social production.

Again, Feierman's emphasis on examining health care within the context of social action is key to the arguments presented here. As he says:

> The emergence of capitalist relations of production in both countryside and city, the growth of population and rapid urbanization, have changed the social care of illness . . . [this has resulted in] the reduction in the scope of the therapy managing group's control over the fundamental conditions of the existence of its members . . . industrialization and the commercialization of agriculture . . . often seen as signs of increasing mastery of the environment, are seen as movements in which the managers of therapy lose some of their control over the

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[37] Ibid., 341.

[38] Turshen, "Political Economy of Health," 5–8. Gran, "Medical Pluralism," 339–341.

[39] Feierman, "Change in African Therapeutic Systems," *Social Science and Medicine*, 13B, 4, (December, 1979), 277.

> social environment of health . . . [Health and health care are then] beyond the control of workers or of the unemployed, or of small rural producers.[40]

Feireman made this observation in 1979. By 1992, there was a key modification in his thinking and in that of John Janzen that recognized the agency of workers, peasants, and the "unemployed" in seeking and creating (in many instances, re-creating) their own alternatives to the prevailing models of health care.[41]

John Janzen regards the contextual change in light of the shifting base of corporate structures. For healing organizations, such as the Equatorial African *Lemba*, such a shift had an impact on their ability to control resources.[42] Using the Lemba example, Janzen goes on to illustrate the political economic nature of this African health care institution in its ascendancy over regional economics and politics. As Janzen writes, Lemba was

> uniquely suited for the control of trade and the resolution of social problems resulting from the sudden upsurge of wealth, mobility and the unrest linked to trade, especially the slave trade.[43]

In this context, Lemba is regarded as 'government'; and the 'sacred medicine of governing'; the 'government of multiplication and reproduction.' Lemba's role is that of 'calming the villages,' 'calming the markets,' and 'perpetuating the family.'[44] Janzen goes on to emphasize that Lemba sought to control or capitalize on the major human and material resources of the regions. Lemba created a social form whereby the lineage, the major local base of economic (human and material) productivity, might be integrated into the regional and international economic system.[45] He goes on to indicate that two key ele-

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[40] Ibid., 282.

[41] Feierman and Janzen, "Introduction," in Steven Feierman and John Janzen, eds., *The Social Basis of Health and Healing in Africa* (Berkeley, Los Angeles, Oxford: University of California Press, 1992), 9–19.

[42] John M. Janzen, "Ideologies and Institutions in the Pre-colonial History of Equatorial African Therapeutic Systems," *Social Science and Medicine*, 13B, 4, (December, 1979), 317. John Janzen, "Ideologies and Institutions in Precolonial Western Equatorial African Therapeutics," in Feierman and Janzen, eds., *Social Basis of Health*, 204–211. (Henceforth referred to as "Western Equatorial African Therapeutics").

[43] Janzen, "Ideologies and Institutions," 322.

[44] Ibid., 323–324.

[45] Ibid., 321, 325.

ments of Lemba social formation were the emphasis on "lineage egalitarianism" and the equitable distribution of wealth.[46]

Janzen set the tone of his piece by speaking of the way in which African health care systems, healing societies and therapeutic movements have been treated as "ephemeral" phenomena in conventional scholarship. He concludes that such a perception is the outcome of the dominant historical bias and the particular focus it provides.

Emphasis is on the 'ephemerality' of these movements, especially during the colonial period when, of course, the colonial state was the dominant corporate body of the region "*harassing all others out of existence or into subordination* . . . what are the implications of revision of such views to include the corporate, the normative, the organized and the permanent?"[47]

Feireman captures the emphasis of this work in his observation that in the 19th century African context, the "unit of social welfare . . . is not enormously different . . . from the unit of social production."[48] The interaction, the similarity, the sameness of the two were impacted upon and shaped by other political economic phenomena. This was a result of their own political economic prowess and the realization of that prowess by other forces contending for control over a discrete set of resources.

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[46] Ibid.
[47] Ibid., 321, 325.
[48] Feierman, "Change," 282.

CHAPTER THREE

THE HISTORICAL CONTEXT OF HEALTH CARE IN AFRICA

This work is a political economic history. In order to provide the basis for a discussion of the particulars of Senegambia, some attention must be given to the broader context of health care in Africa over time and space. Our knowledge of African health care systems has conventionally come from anthropologists and ethnologists. These studies generally centered on the "primitiveness" of African "traditional" medicine and implied that traditional medicine is the first stage of an evolutionary process that culminates in modern medical practice. This attitude is consistent with modernization theory. This perspective laid the groundwork for attitudes that overlook the level of interaction between traditional (or "popular") African systems of health care and Islamic and western medical systems. It also neglected reference to, or analysis of, these systems as institutions with reciprocal dynamisms within well-defined socio-political economic constructions. Moreover, it reinforces the idea that African medical systems were debilitated because of their "traditionalism." Where questions are posed concerning their interaction and integration at various levels into a global political economic system through the process of colonization, there is little implication that African systems might possess agency, in the historical or the contemporary sense.

Clearly, one of the ways of focusing on that agency is to give specific attention to the development of the health care apparatus under colonialism. This particular focus implies a number of things about the assault on indigenous systems of health care; the most obvious of which is the existence of those indigenous systems of health care themselves. Their existence speaks to a precolonial, political economic history that has had a profound effect across the continent. The historical approach contextualizes any attention given to the role of western education in the training of African medical practitioners and the formation of their class orientation. It further contextualizes the role of the colonial health care system and its impact on labor and the process of development. The context provided by

a political economic history sheds light on the commoditization and commercialization of health care and the dynamic processes of integration of the traditional, the Islamic, and the western health care sectors. A political economic history of health care in Africa—even in the cursory fashion presented in this chapter—provides an overview that speaks to contention and competition that can be read through an examination of systems of health care and their interaction at the level of general political economy. The imposition of the powers of the state and their maintenance through the health care apparatus—colonial, or otherwise—can be witnessed in the struggle for health care itself.

Yet, such an approach implies that these systems have life and dynamism prior to colonization. That life and dynamism carry over into the contours of the colonial process. They are sometimes molded by it, and at other times they mold it. Recognition of this activity is crucial to any understanding of agency within the context of colonial hegemony.

A Historical Summary of Health Care in Africa

Let me state the obvious. Various systems of health care have evolved in Africa within their own very specific socio-political economic contexts. For instance, Oliver Osborne discussed context, evolution, and development as they relate to African health care systems when he wrote of the "organized and highly elaborated health care systems" of the Yoruba of Nigeria. He deduced a historical pattern within the traditional Yoruba health care sector that was directly related to the socio-political economic growth of the Yoruba states.[1]

Ludwig Brandl's history of African medical care illustrates the existence and understanding of various medical techniques from the prehistoric period to the present. Brandl's interdisciplinary approach relied on archaeological and historical data to synthesize a short history of health care in Africa.[2]

From the earliest times, rock paintings depicted health care practices among prehistoric humans in Africa. The archeological dis-

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[1] Oliver Osborne, "Social Structure and Health Care Systems: A Yoruba Example," *Rural Africana*, 17, (Winter, 1972), 80–81.

[2] Ludwig Brandl, *A Short History of Medicine in Africa*, (undated).

covery of surgical tools in Tanzania suggests evolving levels of health care that included sophisticated practices such as trepanning.

In Egypt, from the Fourth through the Fifth Dynasties (circa 2400 BCE) there was a marked development of medical skills and knowledge. By 2400 BCE specialization had begun. Among Egyptians, physicians, oculists, dentists and veterinarians could be found. During the Fifth Dynasty, medicine became a secret profession devoted to the maintenance of the royal court. Its specialized functions continued to grow.

The secret nature and specialized character of Fifth Dynasty medical practice witnessed the hierarchical development of the health care institution as a political economic structure that approached the ministerial level and included women within its ranks. The physician was priest and the chief physician-priest exercised control over the system of medical practice in both Upper and Lower Egypt.

It was Egyptian practice to record medical treatises, prescriptions and descriptions of the bodily functions and diseases. This practice must have aided Herodotus in recording the history of the 22nd Dynasty. Herodotus indicated that the level of Egyptian medical expertise attracted Greeks to the first known medical school in the world at Sais. The school included a maternity clinic and its medical texts were found in six of the 42 books of the Egyptian god of medicine, Thot.[3]

During the classical period (circa 800 BCE) the Phoenicians took medicine further west. The Phoenician colony at Carthage had a thriving pharmaceutical trade. Records found at Turburbo Majis in present day Tunisia, illustrate the practice of both public and military medicine.

The Arab contribution to African medical skill consisted of a fine analysis and recording of health care practices that furthered specialization. Under the Arabs, hospitals were established and the practice of social medicine was recorded as early as the Tulunid Dynasty (circa 868–905 CE) in the form of free medical treatment and provisions for the supply of daily necessities after the patient was discharged. Outpatient facilities and pharmacies also existed by this period.

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[3] Herodotus, *The Histories*, translated by Aubrey de Selincourt (New York: Penguin Books, 1983), 160–162.

Janzen and Feierman speak of the interaction between various African health care systems as well as those of Europe and the Middle East. Brandl's study supports this.[4] *The Histories* of Herodotus (circa 600 BCE) began a chronicling of ethno-medical practices below the Sahara that Arab scholars expanded. The interaction of these differing health care units not only showed the ability of African health care systems to deal effectively with a number of diseases, as they are known today, but also illustrated African capacity for innovation and growth.

The women of Kukia on the Niger River were celebrated as medical practitioners, renowned for their practice of 'Kukian magic." Again, according to Brandl, their story is told by al Idrisi (born circa 1100 CE). It illustrates the relation between, and the interchangeable nature of, "magic" and "medicine."[5] Magic connotes a certain level of secrecy. The secret nature of medical technology in Africa is historically witnessed in the craft of Egyptian practitioners. The mystification of modern medical practice can be considered a historical product of these traditional actions.

However, the oath of secrecy, and the possession and guardianship of "magic," did not prevent members of the profession from sharing their knowledge and skills across international boundaries. During the fifteenth century, Ibn Ali of Songhai had such a profound medical background "that he accompanied the French physician d'Isalquir back to his home country. King Charles VII was sick. He was also asked to give advice and was successful in curing the King by means of his healing methods."[6]

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[4] John Janzen and Steven Feierman, "Joint Committee on African Studies Project on Medicine and Society in Africa." (New York: Social Science Research Council, 1979) 8.

[5] Abu 'Abd Allah Muhammad b. Muhammad al-Sharif al-Idrisi, *Nuzhat al-mushtaq fi ikhtiraq al-afaq* in N. Levtzion and J.F.P. Hopkins, eds., *Corpus of Early Arabic Sources for West African History* (Cambridge, London, New York, New Rochelle, Melbourne, Sydney: Cambridge University Press, 1981). (Hereafter referred to as *Corpus*). Al-Idrisi's Kawkaw (Gao) is the "Kukia" of Brandl's exposition. Al-Idrisi writes that "Witch craft is attributed to the women of that town and they are said to be expert, famous and proficient in it." (112) Like so many Arabic-speaking chroniclers of Africa from the 9th through the 15th centuries, health care was an important subject of observation, and political economy. Al-Idrisi's position that the women of Gao practiced "witchcraft," or what Brandl's sources cite as "Kukian magic" is indicative of the political economic activity of the times and the historiography and epistemologies those political economies spawned.

[6] Brandl, *Medicine in Africa*, 29. Hans Debrunner relates the same story of the

In many societies, African practitioners came to occupy fixed social and political economic positions. Ivor Wilks noted that medical caste-class took hold where medicine became the preserve of one particular group and where that group established a close relationship with the ruling class. In sixteenth century Benin, for example, two tiers of medical hierarchy were in operation that acted as checks on the powers of the nobility on the one hand, and the king on the other. One tier was composed of members of noble families. The other group was known as the *Ewoise*, doctor-diviners, who maintained their own levels of status and power and who served at the request of the ruling Oba. Among the Ashanti, Wilks has documented the importance of the physician-priest and the priest's access to places of power within the Ashanti political structure.[7]

There are several implications concerning the political economic nature of health care in precolonial Africa. Traditional practitioners, as individuals and as a class, acquired a "privileged" position in their communities. The expectations of the community gave the practitioner license to address any problem, physical or metaphysical, individual or societal, which threatened the well being of the community. In fact, the ability and the mandate to address a broad complex of problems coincided with the practitioner's duty as a guardian of society. Wilks has described this as the healer's "mastery of social relations."[8]

Wilks' observations and those of others confirm that there is a socio-political economic content to medicine that cannot be denied. The role of the traditional practitioner is defined by social organization

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"noble Toulousian trader," Anselme d'Ysaguier who married the daughter of a noble family of Songhai, Salam Casais. On their return to France they brought with them "Aben Ali, . . . a skilled physician who healed in 1419 the French Crown Prince Charles." *Power and Prestige: Africans in Europe* (Basel: Basler Afrika Bibliographien, 1979), 23.

[7] Ivor Wilks, *Asante in the Nineteenth Century*, (London: Cambridge University Press, 1975).

[8] Ibid. Wilks' 1975 argument is clearly underscored by the general observations of Steven Feierman, and the very specific analysis of John Janzen on the Lemba in "Ideologies and Institutions in the Pre-colonial History of Equatorial African Therapeutic Systems," *Social Science and Medicine*, 13B, 4, (December, 1979), 317; 321–325, and in "Western Equatorial African Therapeutics," 204–211. Peter Gran provides further support in his work on the evolution and dynamics of Egyptian health care practices in "Medical Pluralism in Arab and Egyptian History: An Overview of Class Structures and Philosophies of the Main Phases," *Social Science and Medicine*, 13B, 4, (December, 1979).

and the practitioner's ability to keep that social organization intact through the maintenance of institutions. This is clearly political activity. Inasmuch as that social organization is institutional, its character and the role of the practitioner are then also economic. Illness in this context becomes not only a social event, but a political and economic event as well. The practitioner's ability to cope with illness is directly related to his or her social and political economic standing within the community.

The examination of illness as a social event and support for the concept of the practitioner's social role in the community underscore the notion that illness and its relief are social processes that involve not only the practitioner and the patient, but the community as a whole. The relief of illness in the social context demands not only the recognition of the greater society but also that society's readjustment of patterns of behavior and expectations of both the sick and the well. Once disease becomes a social fact, it disturbs all other social relations around it. Within this context, political economic relations are also affected.[9]

The traditional practitioner's charge is the reordering of society in times of illness. Any time a breakdown in social function can be determined, the practitioner must act. The practitioner's role is not simply demarcated by the sick person, but more often than not, she or he has to look beyond the individual patient to a society not totally at peace with itself. This suggests that the practitioner cannot allow the patient to remain a patient for long. Because of this, one of the most attractive aspects of traditional medicine is the integration of the patient into regular social, and hence, political and economic activities of the community. In effect, this reduces alienation and allows the healing powers of the "social fabric" to exert their influence.[10]

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[9] P.A. Twumasi, "Social Aspects of Health and Illness with Particular Reference to Ghana," *Ghana Medical Journal*, 64. Osborne, "Social Structure and Health Care," 80. Harriet Ngubane, "Some Aspects of Treatment among the Zulu," in J.B. Loudon, ed., *Social Anthropology and Medicine*, (New York: Academic Press, 1976), 319, 323. Una Mclean, "Some Aspects of Sickness Behavior among the Yoruba," in J.B. Loudon, ed., *Social Anthropology and Medicine*, (New York: Academic Press, 1976), 97.

[10] T. Asumi, "Socio-psychiatric Problems in Transitional Nigeria," *Rural Africana*, 17, (Winter, 1972), 115. Joseph Westermeyer, "Collaboration with Traditional Healers: New Colonialism and New Science," Philip Singer, ed., *Traditional Medicine: New Science or New Colonialism*, (New York: Conch Magazine Limited, 1977) 103.

It is clear that this is historical fact and it is illustrated by the cases provided here. Yet, the influence of those powers has political economic ramifications that have not been explored in most of the literature on health care in Africa. Aside from allusions to hierarchy and status, there is no explicit acknowledgement in conventional analyses of the socio-political economic power of the health care apparatus, or the internal conflicts that that power might engender aside from pejorative comments about "black magic." The idea that neutralizing the institutions of health care might have been crucial to colonial designs is a subject that has not been sufficiently entertained either. Yet, the conflict of differing and competing political economic goals should be clear. The questions that difference and competition raise concern the conceptualization of Africa's "underdevelopment" and the role which health care has played in advancing or defending against that process. Here, the discussion of health care as a political economic entity attempts to explain the outcome of these conflicting political economic goals before, during, and after the colonial period.

The Political Economic Context of Health Care in Africa

An examination of the political economy of health care in Africa is based on several premises. Among these are the role of state and the effects of class relations nationally and internationally on the health care system.

The European Colonial State and Health Care

As an "apparatus of the state," health care assumes both defensive and offensive postures. It is, and has been used to defend the state in various ways. Health care has been one of the mechanisms by which the state has aggressively controlled segments of the population.[11] Health care has also been part of a concentrated assault on the enemies of the state, within and without; through its denial and its imposition.

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[11] Ronald Frankenberg and Joyce Leeson, "Disease, Illness and Sickness: Social Aspects of the Choice of Healer in a Lusaka Suburb," in J.B. Loudon, ed., Social *Anthropology and Medicine*, (New York: Academic Press, 1976), 226, 236.

With this in mind, it seems altogether proper to view the advance of colonial medicine in Africa as an assault on the indigenous medical institutions of the time as well as against the indigenous peoples themselves. This view is supported by an assessment of colonial and postcolonial health care practices in Africa.

The militarization of the medical apparatus has been well documented. In fact, George Vincent's statement that "for purposes of placating primitive and suspicious people medicine has some advantages over machine guns" is a relatively recent assessment of the situation that has its roots in modern imperialism and colonization.[12]

With European colonial expansion came the realization that the health care apparatus needed an institutional structure that would better serve the goals of that expansion. In medical terms that expansion spoke to two issues: 1) provision of the optimal conditions for European occupation and exploitation of the colonies; and 2) providing indigenous as well as European labor with health care that would help insure their productivity. In most colonies, this meant the later establishment of a civilian medical structure that functioned in conjunction with the military medical corps. To that degree, a large number of the members of the civilian medical corps were affiliated with the military.[13]

In many ways the civil administrative process represented a shift from the blatant military act of armed suppression of the indigenous peoples. However, through it many traditional institutions were crushed or neutralized by cultural innuendo or legislative edict. Because of its political economic dynamic, traditional health care was a key target of the colonial administration.

Historically, indigenous health care practitioners played a number of roles within their societies. These roles indicate some of the problems they posed for colonial officials. In numerous instances, the traditional practitioner gave legitimacy to political order and had the power to restore the entire social fabric of a people. In many cases,

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[12] Sidel, *A Healthy State*, 103.

[13] Andre Prost, *Service de Santé en Pays Africain*, (Lyon: Masson & Co., 1970), 23. Wolfgang Bichman, "Primary Health Care and Traditional Medicine: Considering the Background of Changing Health Care Concepts in Africa," unpublished paper presented at the "Forschungborse 1978", (June 14–15, 1978), 1. F.M. Mburu, "The Social Production of Health in Kenya," in Feierman and Janzen, eds., *Social Basis of Health*, 409–411.

because of the supernatural powers attributed to his/her role, healers could lead people in revolt. The traditional practitioners' hold over entire communities made them direct intermediaries between their people and the gods. Throughout African history, there are detailed accounts of people who have risen against their oppressors because of the admonitions of priests, shamans, oracles, and religious mediums. For example, religious leaders/healers were key to the initiation of the first Chimurenga in Zimbabwe (1896–97), the rise of the Madhi in late nineteenth and early twentieth century Sudanese history, and the Maji Maji rebellion of 1905–07 in Tanzania. In West Africa, and the Senegambia in particular, two centuries of Islamic activity saw the emergence of cleric healers—the marabouts—of whom al-hajj 'Umar b. Sa'id Tall was the most prominent.[14]

The consolidation of colonial administrative control meant that the traditional practitioner and the institution that she or he represented had to be destroyed or neutralized. The colonial administration took action to undermine indigenous health care using the medical corps as its offensive arm.

As an arm of civil administration, the health care apparatus was equipped to take the offensive in several areas. The first of these was with the initial European ventures into colonial territories. Documents of the early colonial period written by medical officers describe the indigenous condition in such a way as to serve as a rationale for colonization. There was a tremendous emphasis on the cultural

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[14] B.O. Oloruntimehin, *The Segu Tukulor Empire* (New York: Humanities Press, 1972), 36–41. B. Olatunji Oloruntimehin, "The Western Sudan and the coming of the French," in J.F.A. Ajayi and Michael Crowder, eds. *History of West Africa, Vol. II* (New York: Columbia University Press, 1974). Emerging in the mid-nineteenth century, the Islamic movement led by al-hajj 'Umar came into direct conflict with French designs in Senegambia. So much so that Oloruntimehin called their interaction "the clash of rival imperialisms." ("Western Sudan," 360). 'Umar was intent on the establishment of a theocratic state. In his drive to achieve this, medicine became a key component of his activity. Again, Oloruntimehin relates that in an alliance with Muhammad Bello, "[h]e ['Umar] became important as the author of powerful charms (*grisgris*) which were considered instrumental to some of the victories which the Sokoto army scored in the continued wars to preserve the caliphate." (*Segu Tukulor Empire*, 41). 'Umar's concept of medicine and health care for his troops could hardly be lost on the French and their African troops. 'Umar's rise to power instigated the development of the *Tirailleurs Senegalais*—the "African sharpshooters"—who along with other African men at arms serving the French, most certainly demanded the protections that various forms of "medicine" might provide in an environment of heightened hostilities. (Oloruntimehin, "Western Sudan," 362).

backwardness of the indigenous people that pointed to their subjugation by a world of supernatural forces embodied in the personality of the "witch doctor." In these works the "irrational and superstitious" practices of indigenous peoples could be assaulted through the negative stereotyping of the indigenous health care institution.

This literary and cultural thrust gave way to a legislative era that outlawed various activities including some indigenous health care practices. Andre Prost noted in *Service de Santé en Pays Africain* that the public health sector in the colony derived its powers through both legislation and the activities of the police.[15] Legislative actions included a number of activities designed to deal with the sociopolitical economic dynamics of the indigenous health care system.

Debebar Banerji's insight on colonial medicine in India is applicable to the African setting:

> the interrelations of the indigenous (traditional) and western (modern) systems of medicine are a function of the interplay of social, economic and political forces within the community. In India, western medicine was used as a political weapon by the colonists to strengthen the oppressing class and weaken the oppressed. Not only were the masses denied access to western medicine, but this system contributed to the decay and degeneration of the pre-existing indigenous systems. This western privileged-class orientation to the health services has been actively perpetuated and promoted by the postcolonial leadership of India.[16]

Class Orientation and Western Education

While a number of scholars have argued that the concept of class is nonexistent in traditional Africa, the historical record clearly establishes class differentiation. In some cases, as with the Yoruba in Nigeria, class dynamics have had some historical manifestation in the urban-rural dichotomy that characterized pre-colonial Yoruba society. In other cases, an analysis of the relationship between the royal court or the chieftaincy and the social organization of the peasantry directly speaks to class differentiation. Other African examples have occurred in time frames and physical locations as far apart as

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[15] Prost, *Service*, 103–105. Mburu corroborates this position for colonial agency in Kenya, "Social Production of Health," 410–411.

[16] Debebar Banerji, "The Place of Indigenous and Western Health Services in India," *International Journal of Health Services*, IX, 3 (1979), 511.

dynastic Egypt and nineteenth century Nigeria. Ludwig Brandl deals with classism in his work. Ivor Wilks, in his political and economic histories of the Asante (Ghana) has also examined class or status group relations as they relate to the political economic process. Oliver Osborne has also discussed social structure among the Yoruba people in "Social Structure and Health Care: a Yoruba Example."[17]

Class dynamics were enhanced and exacerbated by the intervention of the colonial state. Looming large among those activities was the opening of medical education to indigenous youth. This provided several means for the colonial medical apparatus to neutralize indigenous health care. Colonial medical education for selected African youth meant that the traditional exclusiveness of indigenous medical practice could be compromised. Compromise was a challenge to the caste-based and hereditary social arrangements of the traditional sector and the political economic power associated with them. Medical training for a portion of the African community had another effect as well. It created an elite with a European cultural orientation who possessed a limited amount of training in western medical technology. This amounted to just enough training to work with Africans and to create a new dependency on the part of the practitioner as well as the patient.[18]

These medical personnel were bound by varying degrees to a European culture that alienated them from their own. This was a form of dependency illustrated by a western educational motif that revealed itself in terms of high capital and high technology hardware.

By and large, African medical personnel were trained in techniques that were most applicable in the European settings such as the urban centers of the colony. The political economic consequences of such training resulted in the replication of the basic dynamics of the international division of labor complete with all the class tendencies that characterize it at both the international and national levels. Several scholars speak of these political economic consequences

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[17] Catherine Coquery-Vidrovitch, "Research on an African Mode of Production," Peter C.W. Gutkind and Peter Waterman, eds., *African Social Studies*, (New York: Monthly Review Press, 1977), 81–83. Brandl, *Medicine in Africa*, 29. Ivor Wilks, *Asante in the Nineteenth Century and Political Bipolarity in Nineteenth Century Asante*, (Edinburgh: Center for African Studies, 1970). Oliver Osborne, "Social Structure and Health Care: A Yoruba Example." *Rural Africana*, 17, (Winter, 1972).

[18] Carman, *Medical History of Kenya*, pp. 59–60; 70. Sankale, *Médecins*, 38; 47. Una Maclean, "Medical Expertise and Africa," *African Affairs*, 78, 312, (July 1979), 331.

as the result of the structural dynamics of imperialism and colonization. The editors of *African Environment* stated that

> these health considerations are due to factors which extend further afield than the medical sphere and must be analyzed in terms of underdevelopment and domination. . . . The function of modern medicine in Africa is ambiguous and we are confronted here with another aspect of the present situation, i.e. mimicry: whether in the language, the medical practice or the medical products which are used, it often seems as if *people are trapped in a conception of health imported from abroad.*[19]

Privatization and the Urban/Rural Dichotomy

One of the clearest indicators of class in the health care sector has been the dichotomy in distribution between urban and rural areas. Imperialist extraction from the African colonies meant the construction of infrastructure that facilitated that aim. In most instances this meant the building of coastal cities that served as the centers for colonial administration and the hubs of the extractive process.

The administrative and commercial roles of the urban centers facilitated the development of the aim and the infrastructure. A part of that development was the creation of a relatively extensive, curative, and highly technical, capital-intensive health care system. This system, poorly modeled after European systems, was intended primarily for colonial officials.

The city also played an important part in the formation of an African elite. Elite formation was based on several factors, including education. In the area of medical training, the education of the African health care practitioner was the basis for elite formation. That training took place in the capital city, the regional capital or the metropolitan center. As Prost has pointed out:

> It is quite evident that such a system in an underdeveloped country, at the very most corresponded to the needs and the financial possibilities of a well-to-do, almost totally urban class. This is the framework in which all the doctors practicing in the private sector are concentrated in the capital and the large cities: look at what has already been said of Morocco and Senegal.[20]

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[19] "Health and Environment," *African Environment*, I, 4, (1975), 3. (Italics added).

[20] Prost, *Service*, 105. Sankale, *Médecins*, 38. Turshen, "Impact of Colonialism," 28–33. "Health and Environment," 3. Guy Belloncle and Georges Fournier, *Santé et Développement au Milieu Rural Africain*, (Paris: Les Editions Ouvrières, 1975), 130.

Western-trained African medical elite tended to have a European orientation despite the fact that most of them were destined to work in the rural areas of the colonies. Their distance from their roots was seen in their resistance to placement in the rural areas. Practice in the rural setting meant banishment not only from the inner circles of medicine in the capital city and the metropolitan center, but also from all modern technology, formal structure, etiquette, privilege and prestige that a doctor had been taught to expect by virtue of medical training.

In the beginning, however, the training of the "African doctor" was clearly for the purpose of staffing rural locations.[21] By law and convention, the training that these new African practitioners received only permitted them to work among Africans. However, the context of that training, its metropolitan orientation, and its emphasis on working for the state, made each African practitioner appear to be a representative of and collaborator with a repressive structure. For many, this manifested itself in their attitudes and their desire for private practice.

Looking at the period immediately after independence between 1960 and 1968, Andre Prost cited the following statistics on the ratios and distribution of health care personnel in urban and rural areas. Using the World Health Organization (WHO) standard of one doctor to every ten thousand persons (1:10,000), the general picture for Africa in 1960 with a population of 199,400,000 is indicated in Table 1.

Table 1. 1960 Ratios for Health Care Personnel in Africa.

Doctors	9,869	1:20,202
Pharmacists	2,657	1:75,300
Dentists	1,667	1:170,800
Nurses	47,399	1:4,200[22]

[21] Belloncle and Fournier, *Santé et Dévelopment*, 130–131.

[22] Prost, *Service*, 59. *Budget Général: Ministère de la Santé Publique et de l'Action Sociale Année Financière 1977–1978*, 983–1010. Lionel Robineau, *Environnement Africain: Approche Cartographique de l'Environnement Medico-Sanitaire au Sénégal*, (1978), #6.

While a number of states were able to meet or pass the WHO standard, there was still great inequality in the distribution of medical personnel and infrastructure—both to the advantage of the urban settlements.

For instance in 1960, Tunisia and Algeria, both of which provided doctors at a rate which exceeded the WHO mandate, had a concentration of 25% of their doctors serving 10% of their populations. In Tunisia, three cities with no more than 12% of the population had 46% of the doctors.[23]

In Senegal in 1968, there were 214 doctors—117 Senegalese and 97 expatriates—serving a population of 3,580,000. Of those doctors, 147 or 68% served Dakar, the capital city, or 13.4% of the population. Adding the medical services provided to the other urban centers of Senegal, the number of physicians serving those areas rose to 188 or 88% serving 22% of the entire Senegalese population. If the chief towns of the regions and the prefectures are included in these calculations, then 206 doctors, 96% of the profession, served 25% of the population.[24]

Despite their age, these figures support the fact that the distribution of medical personnel has changed very little since 1968. To cite an example, the number of doctors serving the public health sector of Senegal for fiscal year 1977–78 was 42. In fact, the ratio of doctor to population for the year 1976 was only 349 persons lower than that for 1968: 1:16,351 and 1:16,700, respectively.[25]

However, these figures and the discussion they engender must be qualified. Health care is not simply disseminated according to urban and rural peculiarities. Within the cities and towns are considerable numbers of urban poor—a majority of their populations—who are denied access to western oriented health care because of their poverty. Ironically, these urban poor are the bridge between the urban and rural discrepancies. They are the rural poor who have come to the city to alleviate their condition only to encounter circumstances similar to those they left.

The plight of the urban poor and their limited access to health care emphasize that the dichotomy that epitomizes this problem is more so one of class than of geography. The attitudes of the elite

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[23] Prost, *Service*, 50–65.
[24] Ibid.
[25] Ibid.

and their actions are as readily manifested in the city as they are in the countryside, and there is historical precedence here in both the precolonial and colonial eras. The centralization of health care in the urban areas still does not provide for the overwhelming majority of those areas.

Commoditization and Commercialization

The inclination towards private practice points to another element in the political economy of health care in Africa: its commercialization and commoditization. The limited number of health care professionals who join public practice and the requirement of most African countries that medical students work in rural areas underline the problem. Most medical students would rather practice where the money is. The 1976 statistics for Senegal illustrate this. Senegal had roughly 2,140 doctors of whom 42 or 2% were in the public health sector.[26] The preferences of a professional class are an illustration of the service it provides for the state and its particular political economy.

The role of health care has changed only slightly during the transition from the colonial to the post-colonial state. Pacification through the debilitation of existing institutional structures, helped to develop a dependency that is both political and economic. The economic aspects of the process have been realized in the fact that Africa offers modern health care a new market. That market's dependence on western medical expertise, technology, equipment and goods, has determined the degree to which it can be exploited.

The commoditization and commercialization of health care in Africa means that health care has been reduced to a convenience or advantage only available to the highest bidder. The fact that African health care is now in the international marketplace means that it can be used to further exploit greater portions of the African population.

The health care apparatus also has served a political economic function by adding to the process of accumulation and maintaining dependencies of and for other political economic entities, among

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[26] Robineau, "Environment and the Social Implication of Modern and Traditional Pharmaceutical Technology in Senegal," unpublished paper, (1978), 6. *Ministère de la Santé*, 983–1010. Alan Maynard, "Avarice," 179–190. Turshen, "Impact of Colonialism", 27–28.

them, developed states and multinational corporations. The prospect of new markets has placed emphasis on the provision of health care to other segments of the African population: the urban industrial workforce and rural agricultural labor. The current debate relating to treatment for AIDS, and access to that treatment is illustrative of the process. Access to western oriented health care for these segments of the population can be translated into political support for the state. The denial of access for any given segment of the population may also be an exercise of political will or even the consolidation of it. In some cases, it may also illustrate the weakness of the state and its political economy in relation to international capital. Here, the prime examples are multi-national pharmaceutical concerns.

Health Care, Labor and Development

Planners have realized that health care must be considered along with other development variables. Adequate health care not only sustains the development process, but it increases the potential for growth because it helps to maintain and increase productivity.[27]

Inadequate health care is a drain on the development process because it cannot effectively combat illness among the workforce. The result is a drain on productivity and a retardation of development. In a society where health care is inadequate, most people suffer from lack of services. Those who can afford them pay so much for them that in effect their resources are squandered. The high cost occurs because the services offered are overwhelmingly curative, capital intensive, technologically inappropriate, and urban centered.

Here, the implications of health care as a commodity subject to the forces of the market must be emphasized. This emphasis gives a new perspective on health care's ability to overlap and to interact with other dimensions of the political economy. The historical extension of western health care to African labor forces has been based on increasing the dependency as well as the productivity of those workforces. Turshen, Banerji, Feierman and Janzen are among those who support the argument that dependency occurs when the labor force, or any other segment of the population, must rely on health services that are provided by a class other than its own. In

[27] Ram and Schultz, "Life Span," 402–419.

some situations, Turshen, Feierman and Janzen have noted that the class in power can use the health care system as a way of placating labor and forestalling fundamental change.[28]

Colonization in many parts of Africa began with a labor system and style of work that, while not totally alien to the African environment, brought with it changes as it introduced a new mode of production. The plantation economies that began in the colonies produced a new type of labor force. Rather than typical peasants, the tillers of colonial lands were now agricultural laborers. It was therefore, in the interest of the colonists to have a healthy labor force to work the plantations.

The plantation model, with its provision of health care at the worksite, set the pattern for a curative, hospital-based health care facility designed to deal with work related illnesses only. There was little regard for preventive health care, and those workers with chronic problems were dismissed or not employed.

Health care was centered on the worksite, thus making the "provision of facilities more economical at the worksite, than in the labor supply areas."[29] This meant that the health care offered to the laborer was not available to women, children, and the elderly who were usually left in the labor supply areas. Turshen noted that "the geographical distribution of colonial medical facilities and the type of health care offered are best explained in the context of the labor process and the wage earning population."[30]

Another connection between health care, production and attitudes towards work can be made. Health care for the workforce meant "more contented labor on plantations and in the mining industry and contented labor brings the best type and adequate supply of workers."[31]

The characteristics of the plantation health care system were also found among the industrial health care systems. They, too, were constructed to stimulate productivity and development by having a healthier, more contented and, therefore, more productive workforce.

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[28] Turshen, "Impact of Colonialism", 13, 28–29. Banerji, "Indigenous and Western Health Services," 513. Feierman and Janzen, "Project on Medicine," 12–13.

[29] Turshen, "Impact of Colonialism," 28, 29.

[30] Ibid.

[31] Ibid.

Integration of Traditional and Modern Health Care

During the 1970s another correlation was made. It was determined that the underdevelopment of African states was tied to the underdevelopment of the rural sector as well as the industrial base. A great amount of attention was placed on the rural sector, not only as the supplier of raw materials, but also because of its crucial role in the reproduction of labor.[32] In today's market, both of these factors greatly influence the accumulation of foreign exchange.

The recognition of the importance of the rural sector and its relation to national economic growth has led to the rethinking of a number of propositions concerning development. Among these is the idea that both rural and industrial development must be coordinated, and that the integration of the traditional and modern health sectors could aid the development process. The year 2000 Report of the World Health Organization draws the same conclusion with its references to a "new" conceptualization of the "health care system.[33]

However, long before national and international interest in the idea of the integration of the traditional and modern health care sectors, the two sectors were being integrated. One argument is that capitalist expansion initiated the integration as part of a long process weakening and distorting the political economy of pre-capitalist Africa. Another, no less conflicting, yet complimentary thesis, is that the health care institutions of the region had always been sharing, transforming, and adapting to changing social and political economic conditions. In such a context, western health care and the institutions and technologies of the colonial systems were simply another set of variables to be absorbed into the process.

The success of modern health care in both its curative approach and its ability to aid in controlling the populace had a profound effect on the traditional institution of health care in Africa. Yet, the traditional health care practitioner has always been flexible enough to adopt techniques that seem effective.

The inclusion of hypodermic needles, aspirin, diagnosis, consultation and even referral to their counterparts in the modern sector as part of their therapies are clear indications of adaptability at both

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[32] Bichman, "Primary Health Care," 1.

[33] World Health Organization, *The World Health Report 2000: Health Systems: Improving Performance* (Geneva: World Health Organization, 2000), xi–xix.

individual and institutional levels. Yet, given the large volume of exchange between the traditional and modern sectors, acceptance of traditional practitioners by their western-oriented colleagues has not been reciprocal. And at almost every phase it has faced considerable difficulty.[34] However, there has been a greater inducement for the traditional practitioner—one that neither the practitioner nor the peasant could resist—the pull of the monied economy.

The colonial policy of extracting capital as well as material from the colonies also helped to weaken and distort systems of traditional health care. The distortion seems to have occurred in two phases. The first was the traditional practitioner's need for capital in meeting the demands of the colonial administration and those of a greater monied economy. The second was the commoditization and commercialization of health care itself. Health care became a product to be sold. The spin-offs and emulative effects of the processes had considerable impact on the institution of traditional health care. A number of these effects have been mentioned above in terms of the adoption and adaptation of various western devices and medicines. Another example was the charging of cash for services.

These two phases culminated in the present situation where modern health care now dominates, or seeks to dominate, traditional health care through control of the market. The realization that there is a market for the modern health care sector among people who have been historically excluded from its services carries the implication that by the same token a potential clientele must exist for the traditional sector that is virtually unfamiliar with the attributes and benefits that traditional health care might offer. The market for traditional health care exists in the rural sector as well as in Africa's urban centers. However, the modern medical sector is employing

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[34] Frankenburg and Leeson, "Health in an Urban African Environment," 16. Jean Benoist, "Patients, Healers and Doctors in a Polyethnic Society," *African Environment*, I, 4 (1975), 41, 60. Bryant, *Health*, 1–19. This exchange and integration is further illustrated in the work of Pernette Danysz, "Oku Ampofu and Phytotherapy in Ghana," *African Environment*, I, 4, (1975); Fikre Worknen, "Traditional Healers and Psychiatry"; P.A. Kitundu, "We can not Afford to Ignore African Traditional Medicine," a paper delivered at the 70th birthday celebration of President Leopold Sedar Senghor of Senegal, (1979); "Traditional Medicine is Good," *Sunday News* (Tanzania); and, Emmanuel Eben Moussi, "Les Médecines Africaines, Populaires et Autochtones," *Présence Africaine*, LIII, (January/February 1965). Carol P. MacCormack, "Health Care and the Concept of Legitimacy in Sierra Leone," in Feierman and Janzen, eds., *Social Basis of Health*, 431–436.

whatever means are at its disposal to control access to national urban and rural markets and the international market place.[35]

In this scenario several issues come to the fore. In systems that are not committed to egalitarian, or even liberal, concepts of social, political or economic process, this approach means greater domination of the traditional sector by those elements deemed "modern." The traditional practitioner becomes the junior partner, with his/her activities controlled and circumscribed by a central authority more than likely not made up of his/her peers. The power of that authority would include the practitioners' licensing as well as the regulation of their profession. Bichman noted that "programs of 'integration' of traditional and cosmopolitan medicine are intended for the establishment of the superiority of cosmopolitan medicine." Indeed, the most current literature on the subject seems incapable of envisioning an "integrated" system in which modern, western elements do not dominate.[36] Benoist expressed the same concept when he wrote that "ethnic pluralism is accompanied by political economic domination and that modern health care personnel belong to the repressive group."[37] Banerji also supports this position:

> The formation of the health service in colonial countries was subservient to the overall imperial policy of exploitation, expropriation and plunder of these countries to promote the growth of the colonial powers. Unlike the industrial European powers, the colonized countries were plunged straight from a preindustrial health culture to a colonial health culture. Large masses of people became even more impoverished and pauperized. As a result they were unable to main-

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[35] Bichman, "Primary Health Care," 12. Benoist, "Patients," 41. Banerji, "Indigenous and Western Health Services," 514. Turshen, "Impact of Colonialism," 30–33. The model that Carol MacCormack suggests in "Health Care and the Concept of Legitimacy," implies the levels at which control over traditional health care might be anticipated. (433–436).

[36] Bichman, 12. Maclean, "Medical Expertise and Africa," 78, 312, 334. Harriet Ngubane, "Clinical Practice and Organization of Indigenous Healers in South Africa," in Feierman and Janzen, eds., *Social Basis for Health*, 374. Mburu, "Social Production of Health," 422; 423–424. MacCormack, "Health Care and the Concept of Legitimacy," 433–436.

[37] Benoist, "Patients," 41. Bichman, "Primary Health Care," 12. Maclean, "Medical Expertise and Africa," 78, 312, 334. Ironically, Mburu illustrates the class conflicts in another way in terms of the manner in which the Kenyan government and ruling party characterized a 1984 strike by doctors in the public sector: 'self-serving individualists' and 'mercenaries' "out to kill the poor." "Social Production of Health," 423.

> tain the health services which they had developed as a component of their overall way of life.[38]

We should note here, that impoverishment and pauperization, though not totally western concepts, are conditions that are further exacerbated by the monied economy and the commercial market for health care.

The modern medical sector's control of access to the market is reinforced by its greater competency in the commercialization of the traditional health care sector. In most cases, commercialization has addressed itself to techniques that were readily marketable such as African pharmacopy.

Another factor in the integration of the modern and the traditional sectors has been the patient. The modern sector has been quick to recognize the fact that the majority of the African population, both urban and rural, patronizes both the modern and the traditional health sectors. As "customers," the African public has forced integration.

Integration, the play of market forces, and the administrative powers of the modern health sector, indicate that health care is a worldwide industry. It is dominated by an international market economy that the African health care apparatus accommodates. The political economy of the dominant health care sector, namely the western sector, draws in labor and raw materials to satisfy the needs of the industry and the expansion of its markets, resulting in the accumulation of capital for the controllers of the dominant sector. This accumulated capital is used partly for market expansion.

The focus here has been the methodological and theoretical premises that have aided in my conceptualization of the historical and political economic factors that have determined the nature of health care in Africa. Health care in precolonial Africa was established within a social and political economic context oriented toward a notion of what some might call "the common good," even though some class status was afforded the practitioners. Even within this notion, the idea of "the common good" can be challenged. It too, is most likely the dictate of class interests within the internalized spaces of these communities. Later, the notion is clearly attributed these communities' interactions with "external" forces. There clearly must be substrata

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[38] Banerji, "Indigenous and Western Health Services," 514.

here that are spoken to by actors who feel themselves to be outside the dominant paradigms. These would include "witches," "sorcerers," "vampires," "werewolves," and the like, conjured up for popular consumption. These actors, and their characterizations, are emblematic of opposition to the status quo and to the prevailing norms that govern the dispensation of health care.

The advent of colonization was advanced by military effort which helped to establish a western oriented medical system. The legacy of this are disparities in the distribution of health care. Most notably among those are the disparities where western oriented practitioners are concentrated in the urban areas while rural inhabitants depend, almost solely, on the services of traditional practitioners. Western medical education has been one means used to undermine the class standing and the relevance of traditional medicine and its practitioners, while at the same time instructing and instituting a new class of "healers" that has paid little attention to preventive medicine.

PART TWO

HISTORICIZING THE POLITICAL ECONOMY OF HEALTH CARE IN SENEGAL

CHAPTER FOUR

THE METAPHOR OF HEALTH: RIVALRY IN PRECOLONIAL SENEGAMBIA

The Metaphor of Health

> Tell me, oh you whom kings mention with trembling, tell me Soumaoro, are you a man like others or are you the same as the jinn who protects humans? No one can bear the glare of your eyes, your arm has the strength of ten arms. Tell me, king of kings, tell me what jinn protects you so that I can worship him also.' These words filled him with pride and he himself boasted to me of the might of his Tana. That very night he took me into his magic chamber and told me all.[1]

The voice is that of Nana Triban, sister of Sundjata Keita, the unifier of Mali. She speaks from the mythic piece, *Sundiata: An Epic of Old Mali.* Her words underline the significance that was given to medicine ("magic," "taboo," "fetish," "divination," "cure"). For the peoples of the West African Sudan, the peoples of the Senegambian region, the magic of the healer was a social and political economic phenomenon. For the chronicler, al-'Umari, (1301–1349 ca), "magic" was a pejorative that described an entire way of being. The Sudan, including Senegambia, rested on a "vivacious . . . pagan foundation" that was its "heart;" it was the "forge of fetishers." Sorcery was "not a metaphor . . . [it was] literally [truth]."[2]

From the era of Mansa Musa onward, there was a continuous struggle to expand the powers of Islam against the "forgers of fetishes." Yet, the tension between an expanding Islam and the traditional religio-political economic forces of the region played in the internal dynamics of the various states that formed the space. Early Islam

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[1] Djibril Tamsir Niane, *Sundiata: An Epic of Old Mali*, (London: Longman Group Ltd., 1965), 57–58.

[2] Shihab al-Din Abu 'l-Abbas Ahmad b. Yahya b. Fadl Allah al-'Adawi (Ibn Fadl Allah al-'Umari), *Masalik al-absar fi mamlik al-amsar* in N. Levtzion and J.F.P. Hopkins, eds., *Corpus of early Arabic Sources for West African History* (Cambridge: Cambridge University Press, 1981), 265. Writing of Ghana and Mali, al-'Umari recorded the account of al-Dukkali:

represented the dynamics that continue to plague political economic distribution to this day—it was initially an urban-oriented force. Even within the court of the Malian state, at the death of Mansa Musa, the dangerous and precarious nature of balancing power between the various religious, and therefore political economic actors was witnessed. Succeeding his father was *Maghan Soma Bourema Kein*. The appellation "*Soma*" identified the Mansa as "Maghan, the Sorcerer."[3]

The person of the healer—the traditional practitioner—was defined by social organization and the practitioner's ability to keep that social organization intact through the maintenance of its institutions. In this context, as I said earlier, illness becomes not only a social event, but a political and economic event as well. The practitioner's ability to cope with illness is directly related to his or her social and political economic standing within the community. The practitioner's charge goes beyond the healing of the individual to the reordering of society itself in times of crisis, flux and uncertainty.[4] The practitioner is a political economic agent.

The Mali of Sundjata ruled Senegambia in the thirteenth century when the Wolof states began to appear. Through this hegemony, the Wolof shared certain cultural attributes with other members of this state. In his "recherches sur l'Empire du Mali au Moyen Age,"

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in the territory of the infidels adjacent to their country the elephant is hunted by magic. This is literally true, not a metaphor. In all of the countries, especially Ghana, sorcery (*sihr*) is much employed. They are forever litigating before their king because of it, saying: "Such-a-one has killed my brother, or son, or daughter, or sister, by sorcery."

Also see, Djibril Tamsir Niane, "Recherches sur l'Empire du Mali au Moyen Age," *Recherches Africaines*, 1 (janv.–mars 1960), 28.

[3] Ibid., 28–31.

[4] For a treatment of this premise in several African societies see John Janzen, "Ideologies and Institutions"; John Janzen and Steven Fiereman, "Joint Committee on African Studies Project on Medicine and Society in Africa", Social Science Research Council (1979), 8; Ludwig Brandl, *A Short History of Medicine in Africa*, (undated); Ivor Wilks, *Asante in the Nineteenth Century*, (London: Cambridge University Press, 1975); Ronald Frankenberg and Joyce Leeson, "Disease, Illness and Sickness: Social Aspects of the Choice of Healer in a Lusaka Suburb", in J.B. Loudon, ed., *Social Anthropology and Medicine*, (New York: Academic Press, 1976), 226, 236; P.A. Twumasi, "Social Aspects of Health and Illness with Particular Reference to Ghana", *Ghana Medical Journal*, 64; Harriet Ngubane, "Some Aspects of Treatment among the Zulu", in J.B. Loudon, ed., *Social Anthropology and Medicine*, 319–323; Una McLean, "Some Aspects of Sickness Behavior among the Yoruba", in J.B. Loudon, ed., *Social Anthropology and Medicine*, 97. All these works, and many more, discuss the social and hence political economic role of the traditional practitioner.

D.T. Niane illustrates the closeness of this "cultural and linguistic unity" by charting the names and genealogy of the ruling houses among the Manding, Bambara, Wolof, and Peuhl, and their corresponding relationships.[5]

The formation of the Jolof Empire by the mid-fourteenth century was based on a political economic, "cultural and linguistic unity" which gave the Wolof hegemony over the region. At its height Jolof control extended over the former Malian territories north of the Gambia River.[6]

The entire Jolof polity was ordered around the "health" of the state. The installation of each *buurba* was accompanied by the ritual bath whose 'supernatural forces would reconstitute the Jolof Empire.' Afterwards, seeds that the *buurba* had held at this baptism were planted. Their fruition was an indication of a prosperous rule.[7] A nineteenth century observation noted that

> the religion of the Pagan Jolofs is pure fetichism; a tree, a serpent, a ram's horn, a stone, scraps of paper covered with Arabic characters . . . are deities with them.[8]

Aside from the views of outside commentators, the religion of the Wolof and its applications (i.e. "fetishism" as a healing device), were in keeping with a political economy based primarily on agriculture. It was in fact the relation between the political economy and the medico-religious sources that ordered the resources of the state. The healers, priests and "fetishers" were consulted before every major action.[9]

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[5] Niane, Ibid., 24. Charles Bird, addressing the observations of both al-'Umari and al-Dukkali, notes that these relations were not simply witnessed among houses of privilege, but they extended to the society as a whole. The "magic" of Senegambia—the key to its health and welfare—were seen in the opening passages of the Sundjata legend with the "magic" of Nare Maghan Kon Fatta, the hunter and provider—the center of the political economy. Bird relates the stuff of legend to the every day practicalities of the "hunters' groups" of the region who crossed ethnic and religious lines to combine their skills and "magic" for a successful hunt. Bird, "Heroic Songs of the Mande Hunters," in Richard Dorson, ed., *African Folklore* (Garden City: Anchor Books, 1972), 276–278.

[6] Nehemia Levtzion, *Ancient Mali and Ghana*, (New York: Africana Publishing, 1980), 10; 97. Boubacar Barry, *La Sénégambie du XV^e au XIX^e Siecle*, (Paris: Editions l'Harmattan, 1988), 30–38. Eunice Charles, Precolonial Senegal: *The Jolof Kingdom 1800 to 1890*, African Research Studies, XII, (Boston: African Studies Center, 1977), 1–3.

[7] Ibid., 14.

[8] Ibid.

[9] Ibid., 18. Charles goes on to suggest that Wolof society may have based its

The tree figures largely in the Senegambian political economic construction. Sundjata determined the extent of his empire through the expanse of the "So" tree and its nourishing, cosmetic, and medicinal product "*karite*," or "shea butter." Al-'Umari also noted the importance of trees as the markers of imperial boundaries. His observation also implies something a bit more ethereal and cosmological:

> The hills are covered with wild trees, their branches intertwining and their trunks extremely thick. One tree spreads out sufficiently to give shade to 500 horsemen.[10]

Mungo Park was among the first Europeans to record its significance. In 1795–96, he wrote of his interpreter Johnson on their journey through Senegambia:

> we came to a species of tree, for which my interpreter Johnson had made frequent inquiry. On finding it, he desired us to stop; and producing a white chicken, which he had purchased at Joag for the purpose, he tied it by the leg to one of the branches, and then told us we might now safely proceed, for that our journey would be prosperous. . . . He meant this ceremony, he told me, as an offering or sacrifice to the spirits of the wood. . . .[11]

In the cosmological sense, the tree joined heaven to earth; it was the resting place of the ancestors. It served as a literal seat of power; from its base the activities of court were conducted. From its leaves came nourishment and healing. Writing of the trees of Mbour in 1852, the Abbe David Boilat spoke of the "immense . . . baobabs":

> This tree is not only extremely useful to the negroes, but it was indispensable to them. From its dried leaves, they make a powder called lalo, which they mix with kouskous. They purged themselves with the roots; they drink a hot infusion of its bark to cure the diseases of the chest.[12]

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religious tradition on a cult of an earth or fertility god, "a common belief in agricultural societies."

[10] Al-'Umari, *Masalik*, 263. Niane, "Recherches," 20. D.T. Niane, *Sundiata: An Epic of Old Mali* (London: Longman Group Limited, 1965).

[11] Mungo Park, *Travels into the Interior of Africa*, (London: Eland Books, 1954), 53. Among the earliest accounts we have that imply the significance of trees are Richard Jobson's work *The Golden Trade*, written in 1623, (Amsterdam: Da Capo Press, 1968), in which Jobson's margin notes and text indicate "We suppose they performe their religious ceremonies under the shady trees", 68.

[12] Abbe David Boilat, *Equisses Sénégalaises*, (Paris: Karthala, 1984), 67–71. Boilat's observations are confirmed over and again by French medical officers practicing in

One half century before Boilat, across the Gambia, the Diola of Niandane gave meaning to their migration into Basse Casamance and their transformation among the Bagnun by referencing the trees of the Bagnun cosmology. This was coupled with the demand that the Diola also adopt healing as a profession in order to live among the Bagnun. The focus on trees becomes an interesting and crucial one in that it links the conflicts between two of the region's political economies and health care systems. The "fetish" attached to trees and stones was powerful and widespread. So much so that there was in the Koran a distinct admonition against those who worshipped the tree and the stone.[13] It is in this context that we begin to see the Islamic incursion into the systems of Senegambian health care. It is here that we also see Islamic accommodation to those systems as well. Though Islam had been part of the Senegambian scene since the ninth century, it was not until the jihads of the eighteenth and nineteenth centuries that it gained political dominance.[14] The road to theocratic hegemony was fraught with accommodation as Islam was viewed by local powers as subordinate to existing traditions.

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the region as was the case with Mr. Beliard who reported on the use of Baobab leaves as a purgative and the sap of trees, "*sambe*" among the Bambara, to cure dysentery. Beliard, "Rapport de Mr. Beliard sur un voyage de l'exploration dans le haut Sénégal", March 26, 1861, H1, ANS, 62.

[13] While this brief exposition has centered primarily on the Wolof there are other peoples of the Senegambian region whose political economies closely follow the Wolof example. Among them are the Peuhl (Fulani) and the Serer, and the Diola and the Bagnun. The Diola/Bagnun relation also emphasizes the theocentric aspects of indigenous Senegambian polities; the interaction and sharing of custom and ritual especially in the area of health care; the alterations to that custom and ritual by the introduction of Islam; and, of course, the importance of trees. See Mark, *Basse Casamance*, 11–19. Interview with Mamadou Tamba, Elder, Niandane, Casamance, Senegal, 1/13/80. Interview with Malamine Dieudhiou, Elder, Niandane, Casamance, Senegal, 1/15/80. Maghan Keita, "Ethnicity, Religion and the Dynamics of Post-Colonial Health Care in Senegal", *Contemporary French Civilization*, XIV, 2, (Fall 1990), 316–317. The question of trees is not restricted to the interaction between Muslims and followers of indigenous religions. The Europeans showed the same disregard and misunderstanding. Patrick Manning refers to this in passing in his work *Francophone Sub-Saharan Africa, 1880–1985*, (Cambridge: Cambridge University Press, 1988), 93.

[14] J.S. Trimingham, *The Influence of Islam upon Africa*, (London: Longman Group Ltd., 1980), 10–17. J.S. Trimingham, *A History of Islam in West Africa*, (Oxford: Oxford University Press, 1962), 20–33; 141–193. Mervyn Hiskett, *The Development of Islam in West Africa*, (London: Longman Group Ltd, 1984), 19–58; 138–147. Nehemia Levtzion, "The Eighteenth Century: Background to the Islamic Revolutions in West Africa", in Nehemia Levtzion and John O. Vall, *Eighteenth Century Renewal and Reform in Islam*, (Syracuse: Syracuse University Press, 1987), 21. Also see Levtzion, *Ancient Ghana and Mali*, 22–25. Charles, *Precolonial Senegal*, 17–20.

Early Islamic proselytizers were so aware of their precarious position that their "adaptation to the local environment emphasized the magical and ritual elements rather than the legal aspects of Islam."[15] This early syncretism among the Wolof led one observer to conclude that the Wolof religion had become a 'sect of fetishism . . . with some borrowings from Islam.'[16] The integration of Muslim clerics into the "African socio-political systems" meant that they "played similar roles to those of traditional priests." While Muslim clerics became accommodated to traditional systems of theology and health care, they also became competitors with indigenous practitioners.[17]

The fact that Islam could be so readily integrated into the health care practices of various Senegambian peoples should not be terribly surprising. Again, the theocentric nature of Islam and these indigenous polities implied certain structural similarities. Yet, more important were the explicit injunctions in both sets of communities that defined the religious nature of the medical enterprise and dictated its use as a fundamentally social one.[18] For Islam, theory and practice in health care were rooted in pre-Islamic conventions that became residual observances in its contact with Senegambian cultures. Therefore, even the most rigid interpretation of Islamic doctrine acknowledged the pre-Islamic principles that were expressed in the social formation that Haissam Aloudat describes:

> The traditions and the customs of the tribe, as well as its mental universe, play a fundamental role in the diagnosis and the definition of sickness. More often this is regarded as the manifestation of an evil sort placed on one of its members or on the entire tribe or owing to an evil action [or] enterprise by one member or one clan of the tribe. . . . In a Bedouin society, medicine is tributary to tribal structure and its evolution depends on changes which occur inside the tribe (*for example the recourse of the chief of the tribe to foreign healers in [the] case*

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[15] Levtzion, "The Eighteenth Century", 21.

[16] Charles, *Precolonial Senegal*, 18.

[17] Levtzion, "The Eighteenth Century", 21. Syncretism as an Islamic construct goes back to the eighth century A.D. when the rationalist school of the Mu'talizites appeared. Fazlur Rahman indicates that though the Mu'talizites were known for "waging controversies with followers of other religions like Christianity, Buddhism and Judaism" they "also imbibed certain influences from them". This characteristic became descriptive of the idea that "Muslims were able to open to non-Muslim communities and people at a cultural level". *Health and Medicine in the Islamic Tradition* (New York: Crossroads Publishing Company, 1989), 4; 17.

[18] Rahman, *Health and Medicine*, 39.

of the failure of the healers of the tribe, opens a way for the acquisition of new understanding). (Italics added)[19]

The "recourse of the chief" could result in conflict. Conflicts on a broader political economic scale were illustrated in competition at the level of health care. The Islamic injunction against the "worship" of stones and trees can be interpreted as an attack on indigenous cosmology and, of course, the health care system which represented it. Yet, in the course of such competition, the Islamic practitioner was able to incorporate and innovate (as did his indigenous counterparts). One example of this was the way in which Islamic healers began to standardize and substantiate incantation, all the while giving it new mysticism through the written word. Their writing gave it a new physical form, and therefore bestowed the cure with an everlasting power (or so it seemed). This new amalgam of the spiritual with the material was seen in the manufacture of the gris-gris. For the Islamic practitioner (and it seems for any literate authority) the new power of the gris-gris was inherent in its written script. Again, Mungo Park was among the first to note the potency and prevalence of the gris-gris or "saphies" as he termed them. He also noted that they were used by Muslim and non-Muslim alike.[20]

The real impact of the gris-gris within the context of indigenous and Muslim interaction was not the idea of Muslim invention. The gris-gris, the talisman, the amulet, had been a source of religious and medical power throughout Africa long before the inception of Islam. The Islamic consequence was the introduction of a new format—script—which universalized the acceptance of this "medicine" and its power throughout the region among disparate peoples whether believers or non-believers. The significance is underscored in the transition of the form from its indigenous roots to a phenomenon of West African Islam. The gris-gris, in the struggle for dominance, became illustrative of Islamic hegemony.

In an interesting commentary on this and the use of gris-gris, J.-B. Henry Savigny and Alexander Correard, shipwrecked on a voyage to Senegal in 1816, compared the prodigious use of these "talismen" [sic] by Africans with the conspicuous show of the crucifix

[19] Aloudat, "L'Islam et la Maladie", 89–90.
[20] Park, *Travels*, 28–29; 57.

by Spaniards.[21] The Frenchmen's observations were tempered by and illustrative of another aspect of the struggles which existed between institutions of health care as religiously oriented devices. Here, fifteen years into the Revolution, the anti-clerical ideology of their own social and political economic space is universalized to encompass the "superstitions" and "fetishes" of all the rivals—domestic and otherwise.

The combination of Islamic and indigenous beliefs concerning health care was not always spurious. Savigny and Correard observed that "the Negroes . . . like all other peoples, have a materia medica, and pharmacopeia of their own".[22] In the hands of Islamic practitioners descended from the same ethnic traditions such "materia medica" and "pharmacopeia" gained a new legitimacy and became much more formidable as agents of an Islamic political economy. As Matt Shaeffer and Christine Cooper write, the *marabout* as an Islamic cleric, came to play "a major role as a healer and a religious counselor" and often as "an expert in plant medicine". Under the aegis of the marabout, as an institution, ethnic medicine became "maraboutic medicine."[23]

The reflections of Messrs. Savigny and Correard are important in so much as M. Savigny was a surgeon in the French medical corps.[24] Savigny's point on the "materia medica" was an acknowledgement of the efficacy of indigenous and Islamic medical practices. It was indicative of the dilemmas to be faced in the act of colonization: the need of the colonizer to neutralize certain institutional forces or, at least, to turn them to the advantage of Empire. The forces of

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[21] J.-B. Henry Savigny and Alexander Correard, *Narrative of a Voyage to Senegal in 1816*, (Marlboro: The Marlboro Press, 1986), x; 192–193. An interesting aside to the remarks of Park and the observations of Messrs. Henry and Savigny is the fact that the amulet or talisman was widespread in Christian society. Henry and Savigny's description of the crucifix and the rosary are simply variations or adaptations on theme criticized within the context of a rising sense of the power of science as a dominant discourse.

[22] Ibid., 129. Jobson supports the idea "materia medica" and specific medical knowledge in his description of the benefits of diet prescribed by the "*Mary-buckes*" (marabouts). *The Golden Trade*, 39–42.

[23] Matt Shaeffer and Christine Cooper, *Mandinko: the Ethnography of a West African Holy Land*, (New York: Rineheart, Holt and Winston, 1980), 18; 34. Richard Jobson's account of his travels in the region is indicative of the importance of the marabout. The bulk of his discussion centers on his interaction and those of his other European colleagues with the marabout of the region. The *Golden Trade*.

[24] Savigny and Correard, *Narrative*, xxvii; 137–138.

Islam in Senegambia had already demonstrated their capacity for such correctives. Indeed, it might be argued that do Sandoval's lament was being heard two centuries later in Savigny's need to know; his need to "master" the knowledge of African medicine and all that that power implied, and his inability to do so. Savigny's lament was an explicit acknowledgement of the power of "superstition" and "fetish"—the power of religion—that shaped Senegambian health care.

It was, in fact, the restrictions on the use of indigenous medical knowledge that were among the characterizations of its Islamization. The proscription against alcohol as a medicinal, and injunctions against calling on the healing powers of ancestors and spirits, and the devices that they inhabited (sometimes trees and rocks!), also distinguished the Islamic health care that dominated the region. Unquestionably, even within the Senegambian context, Islamic health care was heir to a rich intellectual, philosophical and scientific tradition. The splintering of that tradition is not so much an African event as it is a device of the evolution of Islam and its dichotomization as first an urban and later a rural phenomenon. The "populist" tendencies of the later marabouts might be argued as a "vulgarization" of the more refined, urbane and empirical traditions of an urban, elite *ulama* class. The term "class" is also a key operative here as well. The distinctions between marabout and ulama clearly were the result of, and resulted in, contentions over resources and access to them. These contentions also illustrate the internal dynamics of the representative states and the role that health care could play.

These two traditions grew in contention to one another and were certainly witnessed in the Senegambia as early as the formation of the Wolof states and their break with the cities and centralized structure of Mali. There is no doubt concerning the ulama's continued influence during this period. Leo Africanus stated as much when he wrote of Timbuktu at the close of the sixteenth century:

> Here are great store of doctors, judges, priests, and other learned men, that are bountifully maintained at the kings [sic] cost and charges.[25]

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[25] Johannes Leo, *A Geographical Historie of Africa*, [London: 1600], (Amsterdam: Da Capo Press, 1969), 288. Marc Sankale has written that it is implausible to believe that the medical expertise that Leo Africanus alludes to did not exist in the empires of the Western Sudan given their indigenous systems and their extensive contact with and incorporation into the Islamic world. *Médecins et Action Sanitaire en Afrique Noire* (Paris: Présence Africaine, 1969), 30.

However, the marabout represented a break with corruptness; half-hearted adherence to the faith; and, identification with the oppression of the state. Rahman's observation of the Sufi applies to the marabout as well, especially those who initiated the jihads of the eighteenth and nineteenth centuries. Their role was particularly distinguished in the mid seventeenth century with the initiation of the war of the marabouts:

> Being near the masses, as distinguished from the elitist Islam of the 'Ulama, they were intermediaries between the masses and the governments and frequently rose to rebel in the cause of justice and to remove public distress when this became intolerable.[26]

Boubacar Barry writes that the war of the marabouts was a response to a "grave crisis provoked by . . . the European presence in Senegambia." It was also, he points out, the culmination of animosities between adherents of Islam and those whose beliefs personified the traditional Wolof ruling class.[27] It marked the visible crystallization of the three-way conflict that shaped the modern development of the region.

The external dynamics of this three-way conflict were complicated by internal activities. The contention between the ulama and the marabout became symbolic of the dichotomy between urban and rural sectors that has been conventionally written off as a consequence of colonization and "modernization." The events that culminated in the late nineteenth century indicate that these issues existed long before European intervention. Levtzion reminds us that the ulama of nineteenth century Timbuktu and Jenne represented "opposition from old established Muslim communities" to the jihads

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[26] Rahman, *Health and Medicine*, 26–27. Levtzion affirms Rahman's treatment of the Sufi, with a similar reading on the marabout of the region in the nineteenth century and their role in articulating the grievances of the peasantry. This seems to be rather widespread in that Gran makes almost the same observation about the marabout in nineteenth century Egypt and their role in facilitating peasant adjustment to the socio-political economic destabilization of integration into a market economy. Gran indicates that the spiritual role the marabout provided in this adjustment was akin to treatment for psychological trauma—in other words, it was a health care function. Levtzion, "Eighteenth Century", 24. Gran, "Medical Pluralism", 341.

[27] Boubacar Barry, *La Sénégambie du XV^e au XIX^e Siècle*, (Paris: Editions L'Harmattan, 1988), 88–95. Jean Suret-Canale and Boubacar Barry, "The West Atlantic Coast to 1800," in J.F. Ade Ajaye and Michael Crowder, eds., History of West Africa, Vol. I, (New York: Columbia University Press, 1976), 469–473.

of the new reformers. Specifically, "among the Wolof, marabouts of the countryside criticized those who served in the chiefly courts."[28]

In relation to the political economy of precolonial health care practices, more specifically, what is it that we see here? Within the Senegambian context, well before French control, the powers of the health care structures had already been parceled out between indigenous and Islamic forces; between the erudition and elitism of the ulama and the indignation and righteousness of the marabout; between town and countryside. The call for jihad gains additional importance from this perspective. Jihad reflects not simply the desire to purge and purify a religious experience and to rid it of infidels, but it speaks to the establishment of an entire political economy in which the cleansing of religious activity meant the explicit transformation of medical practice as well. The waves of religious revitalization and ethnic concerns coupled with spatial and demographic differentiation became critical pieces of the health care mosaic as Senegambia became Senegal.

On the eve of French incursion into Senegambian space, rivalry played itself out in terms of the strains between different Islamic *tariqas* and ethnic differentiation in an area that was becoming increasingly fractured and hegemonized. This rivalry was also indicative of pluralism within the sphere of Senegalese health care. It was a reflection of competition for scarce resources and clientele. As indicated above, competing health care systems mean competing political economies.[29] Such competition suggests the need for analysis of relations of production and changes in those relations. That analysis points to ways in which health care helped to shape productive and social relations.[30]

The Eve of "Conquest"

Regional and Internal Dynamics

> When ethnomedical boundaries . . . [open,]
> the course of historical change . . . need[s] . . . new
> interpretation.[31]

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[28] Levtzion, "Eighteenth Century," 24–25.
[29] Gran, "Medical Pluralism," 339–41.
[30] Steven Feierman, "Change," 282. Janzen "Ideologies and Institutions,", 317.
[31] Steven Feierman and John Janzen, "Introduction," in Steven Feireman and

> The medicine of government . . . . the government of multiplication and reproduction.[32]

Again, the question of terminology. The word "conquest" is bracketed by quotation marks because I find it to be somewhat elliptical as well. Our evolving notions of Africans as historical agents certainly change our ideas of what "conquest" must mean, and whether it occurred or not in our conventional understanding of the term. And within that evolution, as John Janzen puts it, "the somewhat artificial religion/government or medicine/politics dichotomies are put aside" to reveal that within "historical analysis" issues of health and health care "[take] on more significant stature."[33] With that, we come to understand that 'the struggles for health are tied to a society's central struggles."[34]

Here, paraphrasing al-Umari, the metaphor that is not a metaphor—health and healthcare—replicated the socio-political economic concerns of "pre-conquest" Senegambia. The fourteenth century Mali of Mansa Suleiman, and its tributaries, regarded health as a universal and overarching determinant, far from being simply relegated to the mundane or the unconscious. Health and health care were real concerns. Take the issue of Malian cuisine and health. Ibn Battuta reported that one of the staples of the Malian diet, "rice[,] is harmful to white men." Bridging ethnomedical gaps, Battuta writes of seeking the services of an Egyptian, though Muslim colleague, for a "laxative medicine—*baidar*—made of plant roots mixed with aniseed and sugar . . . beat . . . up in water." He also found that he could make do with regional milk and honey rather than drink the water. Battuta's observations on health, health care, cures and remedies, and the use of imported and indigenous ingredients point to the broad cosmopolitan, and "ethnically" oriented pharmacopies of Senegambia. In Battuta's chronicles of "black" Africa were insightful discussions of injury, illness, and treatment; of diet, doctors, and medicine, and the abilities of travelers and native populations to

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John Janzen, eds., *The Social Basis of Health and Healing in Africa* (Berkeley, Los Angeles, Oxford: University of California Press, 1992), 4.

[32] Ibid., 14. Janzen, "Ideologies and Institutions," in *Social Basis*, 205.

[33] Ibid., 204.

[34] This is the general conclusion of D. Sanders and R. Carver in *The Struggle for Health* (Basingstoke and London: Macmillan, 1985). It is summarized by Feierman and Janzen, "Introduction," *Social Basis*, 10.

maintain themselves on a daily basis as individuals and as collectives. They also point to, quite shrewdly, the ways in which these treatments crossed religious and ethnic lines.[35]

Echoing al-Umari, showing no desire to separate religion from state, or the "medicine of government" from "magic" and "sorcery," Battuta observed that these elements dominated the entire empire in their possibilities of conferring life or death. The symbols of medicine—of magic—made up the most potent imagery of the imperial court:

> they bring two mares saddled and bridled, and with them two rams. They say these are effective against the evil eye.[36]

While Ibn Battuta may have deplored the "magic" and "sorcery" of Senegambian society, it was clear that neither he nor his fellow Muslims were above it. They understood, only too well, the meaning *and* the repercussions of phenomena such as the "evil eye." After all, within this broad, overlapping, contiguous and contentious cultural and political economic space, lots of conceptualizations concerning health had universal currency. The cosmopolitan nature of the region, and the epic/folkloric proportions that initiated the rise of the Malian empire could not have been lost on Battuta and his fellow travelers. Magic was one of its integrative devices, from the magic of the "witches" of Gao (Kukia), to the magic of the ethnically diverse hunters' cults. The essence of the Malian state—crystallized in the battle between Sundjata and Sumaoro—is a struggle between "medicines."

If we refer once more to the founding of the Malian state, then the regional value of that currency takes an even higher relief. Following the observations of Sanders and Carver on the centrality of health and healthcare, and their roles in historical analysis—as Feireman and Janzen inform us—we should expect to see both individual and institutional ramifications. In fact, in the myriad historical interpretations and analyses that are passed to us from just as many

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[35] Said Hamdun and Noel King, eds., *Ibn Said in Black Africa* (Princeton: Markus Weiner Publishers, 1994), 41; 44; 60; 65; 67; 70. Ironically, this "unhealthy" foodstuff became a staple of colonial production, furthering and symbolizing French imperial political economy from Senegal to Vietnam. Senegalese rice was exported on the world market, and what the Senegalese believed to be an inferior rice—"*riz cassé*"—was imported for domestic consumption from Vietnam.

[36] Ibid., 47.

diverse sources over the broadest ranges of space and time, we can see that personal attributes and applications in these treatments are illustrative of, and dictated by the policies of state.

The theocentric nature of the state is referenced obliquely in the myth of Sundjata. The magical and healing aspects of the story and its main characters, however, are blatantly represented. Questions of magic/medicine are rendered in boldface. They begin with the prerogatives of hunters and smiths; and of mothers, and their sons: warrior/magician/sorcerer/kings. The son of a sorceress; a sorcerer himself, defeats a sorcerer. Sundjata is a man of immense magic and "medicine" in a world where healing and sorcery are synonymous in the medical literature.

Sundiata is a tale of the restoration of health and with that, the assumption of "manhood." It also chronicles the reconstitution of the wholeness and the moral and ethical rectitude of the individual adult life, and the life of the state and its peoples. The affairs of state are constituted in the body of the ruler. The state of the body politic, the entire political economic life of a given polity, is enunciated in terms of its "health." As a regional device, there should be no surprise that these elements are replicated in the rise of the Senegambian polities. As Boubacar Barry notes, the structural dynamics of Senegambia show a remarkable similarity across the ethnic spectrum. There is, in his mind, a cultural unity that defines the region.[37]

The Wolof states are indicative of this unity and they help to illustrate the metaphor of health that I have chosen here. Again, the Wolof hegemony becomes the crucial illustration. In the ascendancy of Njaja Njay, the theocentric nature of the Wolof states is much more obvious. The linkages between the spiritual and the mundane are emphasized in the enthronement of the *buurba.*

Both Charles and Barry have described the enthronement of the *buurba.* The ascendancy of Njaja Njay is a crucial feature of the metaphor of health for Senegambia. Charles informs us that Njaja Njay was mistaken for a "water-spirit" when his people first encountered him. His spiritual presence among them was key to their mundane and material survival. His appearance, his bath, his emersion with the seeds—the potential "fruit" of the land—signified the health

[37] Boubacar Barry, *Le royaume du Waalo* (Paris: Editions Karthala, 1985), 21; 45.

of his rule, and the rule of all who would follow him in this space of Wolof political economic and cultural hegemony.

Working with Henri Gaden's very important distillation of the work Yoro Dyao, Charles goes on to cite a passage that relates to the "legends and customs" of the Senegalese and the perpetuation of the Wolof state. The passage centers on the religio-medical status of the state through the person who might rule it.

> [A]ccording to superstitious belief, the people were convinced that supernatural forces reconstitute the Jolof Empire under the *buurba* who could bathe in the waters of the Njasseu stream.[38]

Clearly, the importance of this act was not lost on the other states that made up the Wolof polity. With Jolof's decline and the splintering of the empire, the rulers of Waalo and Kajoor made access to the Njasseu dangerous for any newly enthroned *buurba*. They recognized the religious and political economic significance of the bath and the symbolism and authority associated with the ritual. It was clear that if they were able to disrupt the ceremonies that marked a fortuitous commencement of Jolof reign, there was a lessened possibility that the state would augur well. After all, how could the potential of any ruler be realized if the conditions that might forecast their tenure were unavailable to them. As the "Cahier de Yoro Dyao" indicates, the planting of the anointed seeds, and their growth and normal development were keys to the prosperity of the state.[39]

To outsiders, these religious practices were characterized in cursory fashion. They amounted to little more than "animist" superstitions playing on "popular belief in spirits and sorcery." The regional modes of worship were nothing other than "sect[s] of fetichism" centering on "family gods."[40] As early as 1675, Chambonneau had represented the religious qualities of the region with the terms "totems and taboos," even as they related to Islam. In fact, this was the picture of kind of an indigenous/Islamic amalgam that few observers bothered to separate for its inherent characteristics. Yet, even here,

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[38] Henri Gaden, "Légendes et coutumes sénégalaises, Cahiers de Yoro Dyao," *Revue d'Ethnographie et de Sociologie*, III (1912), 199. Quoted in Charles, *Precolonial*, 14.

[39] Ibid.

[40] R. Rousseau, Le Senegal outrefois: étude sur le Oualo," *BCEHSAOF*, XII (1929), 144n. Abdoulaye Bara Diop, "La Culture wolofe: traditions et changements," *Notes africaines*, 121 (January 1969), 5. Both cited in Charles, *Precolonial Senegambia*, 17–18.

adherence to the past was seen in the religious political economic ritual of the state. Ibn Battuta's description of the court of Mali is repeated in Gaspard Mollien's 1820 *Travels to the Interior of Africa*. The issues had not changed in four centuries.[41]

Boubacar Barry regards reverence to 'Yamsek, maitre des bois', as one of many "real symbioses" between nature and humankind, where the "cult of the ancestors" becomes key to any resistance against interlopers—Islamic or Christian.[42] What is striking about this invocation to the "master of the forests" is the way in which cultural/political economic patterns overlap: a state is demarcated by trees—single trees large enough to shelter entire troops of horsemen; Mungo Park's guide, Johnson, and "sacrifices to the spirits of the wood"; the Abbé Boilat on trees and their life-giving properties. Trees—the wood, the forest—are only one symbol of the complexity of religion's permeation of the Senegambian political economy. Here, the tree gives texture to Janzen's concept of "the medicine of government." References from Ibn Battuta through Boubacar Barry cite "collective consciousness . . . reinforced by the importance of religion." This consciousness clearly under girded class and caste dynamics within Senegambian space. As much as Barry maintains a cultural unity for the region, the class and caste dynamics that were representative of the political economic structure and witnessed in its religious organization, were also critical to its internal discord.[43] The Empire and its composite states were feudal in nature. The disparities in class and caste pitted the peasantry against a warrior aristocracy whose livelihood was based on peasant exploitation. Greater contact with western Europe and the requisite commercial demands on all sides of the equation exacerbated these tensions. The rise of the Atlantic slave trade became another way of speaking of the moral and political economic health of the state.

Of course, the possibilities for internal discord were tied to the complexities and cosmopolitan nature of the Jolof Empire itself. Its "network" as Barry puts it, included not only Wolof speakers, but Serers, Maures, and Peuhls as well. The tangible elements of the

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[41] Barry, *Waalo*, 69. Gaspard Mollien, *Travels to the Interior of Africa* (London 1820), 86, cited in Charles, *Precolonial Senegambia*, 18.

[42] Barry, *Waalo*, 69.

[43] Ibid., 45. Boubacar Barry, *Senegambia and the Atlantic Slave Trade* (Cambridge, New York, Melbourne: Cambridge University Press, 1998), 21.

Empire were fused, in large measure by commerce. It was a commercial prowess that attracted not only regional players, but the interests of Islam and Europe also.

Samir Amin has noted that Wolof imperial formation could never have been achieved in isolation. The commercial network that served as its nexus saw trade from the river regions of the south through the savanna to the Sahel and across the Sahara. And within the context of this trade, the metaphor of health can be exploited again. The consequence of the mixture of peoples and cultures of such vast distances meant the obvious sharing of what Correard and Savigny called the "materia medica" and "pharmacopiea" of a huge region—it implied the sharing of an extended body of medical knowledge, in which, even Europeans were interested. The material trade itself consisted of products that were existential to religio-medical practices, and had their own unifying effect on the region as well. Among them were kola, shea butter, gum arabic, and incense. There was a great market in the trade and acquisition of drugs that underlined the important linkage between religion and medicine. Kola, like salt, was a "strategic product" whose production and trade colored the region's economic activity. Its ritual and medical properties were a source of commercial and cultural unification.[44]

Ironically, a great part of the region's commercial prowess lay beyond the powers of the state. Trade and its networks provided order where empires could not. In fact, in many instances, it was an "order" of a different magnitude characterized by the egalitarian peasant village life and the economic activities of the rivers.[45] This extensive network of trade was, as Mungo Park would find out, a guarantor of the "health" of the state, as well as the health of its white travelers:

> [at] Walli creek, a branch of the Gambia . . . rested at the house of a black woman, who had formerly been the "chere amie" of a white trader named Hewett; and who in consequence thereof, was called, by way of distinction, Seniora.[46]

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[44] Samir Amin, "Preface," in Barry, *Waalo*, 12–14. Barry, *Waalo*, 48; 152. Barry, *Senegambie*, 46–48. Barry, *Trade*, 18–19.

[45] Barry, *Senegambie*, 48.

[46] Park, *Travels*, 19.

Park introduces another element that underlines the complexity of Senegambia, and yet illustrates the ways in which health and health care figured hugely in the political economic structure. "Seniora" Camilla, as Park identified her, was representative of a group of women who had existed since the era of do Sandoval, the *signares*. Their political economic powers were simply too immense to be given justice here. It must suffice to say, however that their skills in forging regional and then international commercial networks were crucial to the future shape of French West Africa and the roles which they and their children would play in that design through independence. Here, however, in the context of Park's brief treatment, the homes of these women became great political economic incubators where the nuances of race, class, and gender gain new and different currency in relation to our conventional understandings. For Park, and other European travelers, the homes of these sophisticated, and at many times, elegant (by Euro-American standards) African women were physically and psychologically associated with the only measure of what might be deemed "hospitable" in their minds. Their homes literally became hospital and hospice for the ailing, weary, and often unfortunate European traveler. They might also become the spaces where those so favored, might find their financial health as well.[47]

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[47] Andrew Douglas Marcroft, "The Signares of Senegambia," (Unpublished Master's Thesis, Villanova University, 1995). Marcroft's work is a reprise of George Brooks' work on the same subject. Marcroft emphasizes the ways in which these women were essential to the process of guarding the interests of the Senegambian polities in international trade. One of the ways in which this was done was in their skill and diligence in overcoming the "*insalubrite*" that Barry indicates greeted most Europeans who ventured into Senegambian space. Macroft uses Brooks citation of Pruneau de Pommegorge. Pommegorge noted that at St Louis, the women on the island are, in general, closely associated with white men, and care for them when they are sick in a manner that could not be bettered.

As the Abbe Boilat observed, these ministrations were carried out in accommodations "built with the finest materials available . . . [which were] perfectly aerated." The "young sailor," Joshua Carnes spoke to the salubrity of the signare household as well: "airy . . . the light breeze . . . made us feel as cool and comfortable as could be desired." According to Boilat, all of these elements were keys to the maintenance of sound health on the part of Europeans. Seemingly, they were only to be had, through the close of the nineteenth century, in the domiciles of the signares. As Marcroft indicates, the hospice and hospitality of the signares, was simply one more way of acclimating the European to Africa—of *assimilating* these white males to the proper ways of behavior within the Senegambian political economy. The signares were the chief regulators of that political economy in terms of the emerging international trade with the Atlantic world. Within the purview of their regulation, health care became simply one more power in the expansion of the regional political economy. 14–15; 24; 27–28.

For centuries to come, these women and their children would control trade where the state could not.

As has been noted, Park was impressed with the elements and the volume of this trade, and its medicinal products did not escape him. Shea butter and kola are noted, as is a product solely of religio-medical manufacture, the "*saphie*." Park understood, with a twist of irony, and of course, disbelief in "superstition," that

> [T]hese amulets are applied to prevent *or* cure bodily disease, *to preserve from hunger and thirst*, and generally circulate the fervor of superior powers under all circumstances and occurrences.[48] The power of the *saphie*, the *gris-gris—the medicine*, was ubiquitous:
>
> I did not meet a man, whether Bushreen [Muslim] or Kafir, who was not fully persuaded of the efficacy of these amulets.[49]

What I find so compelling in Park's observation is the overall political economic conclusion that he brings to bear. By concluding that "it is . . . in the magician that their confidence is placed," Park has signaled that the priest,/magician/sorcerer/healer/*doctor's* place is fundamental to the structure of the societies he describes. He emphasizes that it is not just physical health—"bodily disease"—that is the concern of the physician-priest and his/her charges, but the general well being of the body politic, the political economy, and the state by extension. "To preserve from hunger and thirst, and generally to circulate the fervour of superior powers under all circumstances and occurrences of life" is an endorsement for the powers and maintenance of the commonwealth, and an admonition for those who administer it. Park's acknowledgement of health care in Senegambia from it's most mundane to the most catastrophic—hunger and famine, thirst and drought, warfare and slavery—expresses the concerns of the general body politic within the context of the social metaphor of health.

Park is clear that the administration of health in eighteenth century Senegambia is not all superstition. Drawing a distinction between the "physician" and the "surgeon," Park makes the case for Senegambian health care practitioners as the latter. Their methods of diagnosis and treatment impressed Park:

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[48] Park, *Travels*, 28. Italics added.
[49] Ibid.

> On the whole, it appeared to me that the Negroes are better surgeons than physicians. I found them very successful in their management of fractures and dislocations, and their splints and bandages are simple and easily removed. . . . All abscesses they open with the actual cautery; and the dressings are composed of either soft leaves, shea butter, or cow's dung, as the case seems, in their judgment, to require. Towards the coast, where a supply of European lancets can be procured, they sometimes perform phlebotomy; and in cases of local inflammatory, a curious sort of cupping is performed by making incisions in the part, and applying to it a bullock's horn, with a small hole in the end. The operator then takes a piece of bees-wax in his mouth, and putting his lips to the hole extracts the air from the horn and by dexterous use of his tongue, stops up the hole with the wax.[50]

In spite of these observations and African innovation in the face of new techniques and technologies, it was Park who introduced the term "*mumbo jumbo*" into the discourse on African health care. In so doing, he also alluded to the "inscrutable" elements (from conventional, western standards) of African political economic activity. Again, what Park describes is not just health care but the maintenance of social order as well. All of his observations are related to the restoration of the health of the body politic. "The interposition of Mumbo Jumbo . . . is always decisive." It is a social interposition intended to repair the social fabric and social relations.[51] However, Park's prejudices were clear, the political economy and its body politic were dominated by superstition; by magic.

Here, Park's observations mirror those of Ibn Battuta. They also foreshadow the conflict that emerged between Islam and traditional health care, Christianity and traditional health care; between Islamic and Christian health care practices; and, the contentions between the three. The theocratic implications resonate and suggest the ways in which health care as a resource might be structured and contended for. From Battuta to Park, and all the chroniclers in between,

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[50] Ibid., 210–212. Park's differentiation between "physician" and "surgeon" seems inherent to English (British?) and possibly European dichotimization between physicians and surgeons. Implicit to Park's observations is the notion that the surgeon "practices the art of healing by manual operation." What is suggested is that there is an intellectual difference and sophistication that separate the two. *The Compact Edition of the Oxford English Dictionary* (Oxford, London, New York: Oxford University Press, 1981), 3174.

[51] Park, *Travels*, 29–30.

observations are made on indigenous religious forms and their relation to the social order and the emergence of Islam.

Emergent Islam and the Trade in Slaves

The concerns of early Islamic writers from outside the region were mirrored in the observations of early twentieth century voyagers. What Islam there was, was simply "a sect of fetishism . . . with some borrowing from Islam."[52] Put another way, a great deal of the Islamic experience of Senegambia reflected the ability and the necessity of Islam and its agents to accommodate indigenous religious, social, and political economic forms within a context where Wolof and "Soninke ideology did not tolerate Islam as a basis for political power."[53] The Abbé Boilat made a similar observation in the mid-nineteenth century as he commented on the Wolof warrior-aristocracy: the "lords of war"—as Barry calls them:

> Le mot *thiedo* est l'opposé de marabout; il signifie un incrédule, un impie, un homme sans foie ni probité. . . . La religion d'un *thiedo* ne consiste que dans ses *gris-gris* qui le rendent invulnérable dans les guerres et les pillages.[54]

However, Park noted that the rise of Islam in regions like Bondu could be punctuated by a Muslim population that was "very intolerant towards such of their countrymen as still retain their ancient superstitions."[55] Yet, even his guide Johnson, in a fashion reminiscent of nineteenth century Bagnun and Diola custom, sought the blessings of the "spirit of the wood." Clearly, the inability of the indigenous hierarchies' "ideologies" to accommodate themselves to Islam meant escalating levels of contention in a rapidly changing political economy.[56] That contention, tied to the rise of Islam and intertwined with growing Afro-European commercial activity in the example of the Trans-Atlantic slave trade, points to the difficulties

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[52] Rousseau, "Le Sénégal outrefois," 5. In Charles, *Precolonial Senegambia*, 17–18.
[53] Barry, *Trade*, 23. Also see Barry, *Sénégambie*, 53.
[54] Boilat, *Equisses sénégalaises*, 308–309.
[55] Park, *Travels*, 45.
[56] Ibid., 53.

confronting the region of the "eve of conquest." Take those issues and multiply them by the extreme militarization of state hierarchies throughout Senegambia. This militarization was a cause and a consequence of growing Atlantic trade activities—the slave trade in particular; and a cause and a consequence of an expanding Islam.[57]

In this context, the increasingly predatory nature of the region's military elites made fertile ground for the spread of Islam. This was true not only for people in the less powerful states of Senegambia, but also for peoples within the predatory states themselves. Here multi-layered contentions and resistances were played out. The case of the Serer becomes a prime illustration. Beset by, and resisting both Wolof hegemony and the expansion of Islam, Sine Saloum, according to Barry, was "progressively colonized" by both.[58] Mungo Park observed that throughout the region, Islam "made, and continues to make, considerable progress. But, the body of the people, both free and enslaved, persevere in maintaining the blind but harmless superstitions of their ancestors."[59]

The ambivalent, yet contentious atmosphere that enveloped Senegambia was kindled by a

> fundamental opposition [between] the military class which governed and the peasant class which they dominated accompanied by the . . . existence of old maraboutic families . . . that constituted powerful groups in the religious and economic sectors.[60]

Here the complexity of the Senegambian political economy, with its zones and layers of hegemony; its hierarchies and class distinctions; and, its religious conflicts, was played out. The social and political economic organization that epitomized the Wolof Federation, was replicated, more or less throughout the region.

The complications of the region's political economy are revealed in the emergence of Islam and the growth of Atlantic commercial activities. There are certainly several sets of players here: there are the indigenous interests of the various Senegambian states; there are

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[57] Barry, *Trade*, 22–23.
[58] Barry, *Sénégambie*, 45.
[59] Park, *Travels*, 11.
[60] Barry, *Sénégambie* , 41.

the interests of European commercialists; there is the rejuvenated and historically neglected power of the *signares* and their regional, and soon to be international commercial network; and then, there are the interests of that growing Muslim community.

In Senegambia, Islam initially emerged within "intermediate merchant communities" with their "maraboutic families." At that point in time, these families had no role in the "political power monopolized by the aristocratic" military elites.[61] These religious communities and their followers found themselves enmeshed in a political economic order whose internal ruling class dynamics were based on violence and the inequalities of a caste system that provided for the centralization of religious and political economic power from the "territorial chief" up.[62]

By the end of the seventeenth century, the internalized violence of the region had become a form of political economic control and expansion linked to the precipitously intensifying Atlantic slave trade, and its consequent militarization of the area. In its wake came the rise of a more "militant Islam"—"a vast maraboutic movement" intent on unifying the states of the Senegal River valley and struggling against the slave trade. This conflict, the historical watershed of roughly three hundred years or more, was marked by religious contentions that symbolized the health—in moral, spiritual, and material terms—of the region.

> Opposition between Muslim theocracies and the *Ceddo* powers dominated the history of Senegambia for the course of the 18th century, the era of the slave trade par excellence.[63]

The "Maraboutic Wars" (1673–1677), marked by the emergence of Nasr al-Din, were intent on the overthrow and the replacement of the "traditional" rulers of Waalo, Fuuta, and Jolof with marabouts. These Islamic rulers would be guided by the leadership of the "*buur dyullit*," "the master of priests"—"the spiritual and temporal chief of the muslim community."[64]

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[61] Ibid., 53.
[62] Ibid., 81.
[63] Ibid., 83; 95.
[64] Barry, *Waalo*, 117–118.

Within the context of this struggle began a pattern of shifting alliances that mark Senegambian history in its entirety, and can only be explained by the changing dynamics of political economic control. The alliance between the traditional powers of the Wolof hegemony and the French is an implication of the perceived threat of this militant Islam and its potential to disrupt their established commercial activity. Aside from the trade in gum Arabic, the "hunt for men" constituted the greatest commodity of the region. The "wars of the Marabouts" have been characterized by some as an early attempt of Senegambian agents to "heal" the greatest "wound" to the regional body politic.[65]

Barry goes on to argue that the

> Followers of Islam, all opposed to the powers of the "lords of war," constituted more and more, in the interior of the kingdoms, autonomous communities under the authority of the marabout to protect them against the arbitrariness of the aristocracies and the consequences of the hunt for men.[66]

Barry's analysis makes it quite clear that by the last quarter of the seventeenth century what the French would call "Sénégal inutile" had already emerged. It was a consequence of resistance to the commercial alliance between non-Muslim aristocracies and the interests of European capital. This resistance, in large part, centered on the slave trade as a "curse" or cancer on the body politic that could only be "cured" or "remedied" by the religious, moral, and healing actions of the marabout.[67]

Actions that might be judged "plain and simple" by one account, or as Chambonneau and others put it, "superstitious" and "ignorant." The latter reading is colored by the relations and interests that were shared by the French and non-Muslim powers, and the contention that was inherent in the rise of maraboutic powers. These

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[65] This is implicit in an overwhelming amount of the literature that frames this period. Thomas Powell Buxton makes it explicit in the title of his mid-nineteenth century work, evoking the metaphor of health to describe the political economy of slavery and the slave trade. *The Remedy* (London: W. Clowes & Sons, Stamford Street). An edition cited "not to be published." Photocopy in the author's possession.

[66] Barry, *Sénégambie*, 100; 103.

[67] Ibid., 145; 154–168.

sentiments would carry over, however, and be reinforced and complicated by the anti-clerical sentiments of the Revolution of 1789.[68]

Historiographically, this marks a point where we need to consider and reconsider the writing of African history. This needs to be undertaken in light of notions concerning African and European interaction and the parity of the roles assumed by either side, and the coalescence of goals and the values of the respective ruling classes. There is a certain recognized equality between these parties in the construction and the maintenance of a new political economy and its devices. Issues of African agency need to be addressed on all sides of this historical equation in relation to the "construction and maintenance" of, as well as "resistance" to the new, emerging political economy. Clearly, there is African control of the slave trade in Africa, and the powers of the colonialist are not absolute.

The slave trade and resistance to it were also marked by metaphors of health that were tangible. The displacement of people, either through their abduction or flight had severe repercussions on their health. War, drought, famine, and starvation were clear health hazards in their own right. They were also the precipitating elements of debilitating illness for entire populations. Debilitation could be read in both physical and moral terms that might justify the rise of Islam in Senegambia and the establishment of "Muslim centers where the maraboutic party assured the protection of their disciples."[69]

The predatory nature of the military elites, the avarice of the slave trade, coupled with drought and famine, were clear signs to many of a general sense of social imbalance awaiting correction. The theocentric nature of Senegambian society, whether traditional or Islamic, would interpret these events in terms of the spiritual and physical well being of the state. Among the Wolof hegemony with its military dominated elite, the ritual traditions of Njaanjay were not so far removed as to not have significant impact on the order and legitimacy of the state, and the ways in which that might be interpreted. Barry illustrates the extent of this theocentric structure and the conflicts it engendered by referencing the state of Kaabu.

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[68] Barry, *Waalo*, 70–71; 76; 120.
[69] Barry, *Sénégambie*, 160; 167.

A southern Senegambian amalgam of Bagnun and Manding, Kaabu had a political and military organization that was similar to the Wolof polities. Its

> combined traditions gave Kaabu a distinctive military character, in a culture where the spirits of the sacred forests of *Jalan* also played a key role in political and social institutions.[70]

The Muslim traditions were even closer, historically, in their influence over the ordering of the state. Here, from at least one perspective, the state, the social order, and the body politic need a cure. They need to be purged. Actions that might be conventionally construed as "religious" had clear material consequences. The new Islamic communities, in the physical center of Senegambia—its interior—had centrifugal force. They were destructive and reconstructive; amputating and healing the cancer of a predatory nobility and an emergent capitalist political economy that sought to integrate the region into a reconstituted global system, in large part, through the slave trade. The rise of these religious communities signaled the demise of indigenous Senegambian polities.

Again, "health" can be seen as a dominant imperative. It is the metaphor for the state and its leadership. The right to lead was posited in the ability to "heal." The marabout emerged as priest, leader, and healer. The acquisition and concentration of power in their hands as a class was linked to the struggles of this era and those to come. This is what Barry terms the "conflict of sovereignty" between the French and traditional powers and those of the Islamic states of the region. In the end, this would be the "vast maraboutic movement" that would result in the nineteenth century *jihad* of Shaykh Umar.[71] The political economic language and the ideology of health and health care articulated the nature of the new theocracy.

Senegambia, Europe, and Atlantic Commerce

Insight into the voyages of Mungo Park provide an important segue way into the questions of colonization that came on the heels of these expeditions. They close this chapter on precolonial Senegambia.

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[70] Ibid., 22–23.
[71] Ibid., 189.

Jeremy Swift, in his "New Preface" to *The Travels of Mungo Park*, makes note of three elements in Park's background that lend themselves to my thesis regarding the political economic history of health care in Senegambia.

First, Swift emphasizes what I have stated already: Park saw himself foremost as a scientist and medical doctor in an emerging age of science. He was, as Swift puts it, a "gatherer of scientific information."[72]

Second, whether Park was willing to admit it or not, his benefactor, Sir Joseph Banks' vision of imperial expansion held sway in the wake of Park's initial success. While Park might have "greatly resented the idea that he was a scout for imperialism," Banks was quite clear that Park had 'opened the gate into the interior of Africa.' This was an interior that could be secured with '500 chosen troops' that 'would be able to overcome the whole forces which Africa could bring against them.'[73]

Third, it is clear that after his initial success that the composition and aim of Park's focus changes by the second voyage. With these changes, questions of scientific observation, health, and health care are altered as well. In the "Introduction" to the "Second Journey," "R. M." remarks that "apart from a couple of pages on the ills and diseases of the Mandingoes, one could read Park's journals without guessing that he had medical training." That may be the case for "R. M.," but it appears to me that Park always has an eye on health and health care as they might affect the greater mission of empire. Here, there is the need to be cognizant of Park's "social scientific" bent as well. Park's observations, like so many "explorers," are concerned with social and political economic formation; their structures and institutions; and, military devices and their deployment. Critical to all of this are the locations of centers of commercial activity. Park's observations on all fronts are in keeping with the actions of the medical and scientific officers of the period. Their role was the compilation of data that would advance the political economy, and therefore, the commercial fortunes of their respective states. They were keen on measuring the "*insalubrité du climat*"; they had to gauge—to the best of their abilities—the causes of "fever and delirium," the

[72] Jeremy Swift, "New Preface," *Travels Into the Interior of Africa*, x.
[73] Banks quoted by Swift, "New Preface," x.

"smallest variation in the temperature" in their duty to minister to "sick soldiers."[74]

Two more items draw my attention in terms of the commercial importance of Park's travels and his introduction to Senegambia. Park is introduced to the region by another medical officer, Dr. Laidley. Laidley provided Park with insight and instruction, and "contributed greatly to alleviate [sic] [Park's] suffering." It was Laidley who introduced Park to Johnson, "the Negro servant," and Johnson who interpreted the medico-magical practices of the region for Park. Dr. Laidley, it seems, also aided in the acquisition of the "Negro boy" Demba, Park's other multi-lingual facilitator. The intersection of these four figures—Johnson, Demba, Laidley, and Park—also offer an interesting perspective on questions of slavery, health care, and the commercial penetration of Africa. The perspective is underscored by Park's acquaintance with another African figure: the "Seniora" whose Gambian home on "Walli creek" represented "salubrity" and repose; a space that was both hospice and hospitable. This "*chère Amie*" and her "sisters" played a considerable role in the construction and maintenance of health and haleness of the new political economy. In their households, deals were struck, corporations formed, political entities created, and health restored.

By the second voyage, the racialization of Park's views becomes apparent. Locked with his concern for "sick soldiers" was the issue of "black fellows stealing." Africans had evolved from quaint, esoteric survivors to real and palpable threats.[75]

Changes in Park's narrative from 1795 to 1805 are palpable as well. In 1795, Park showed considerable concern for the ways in which Senegambians coped—in spite of R. M.'s observations. While the methods he witnessed may not have met his scientific disposition, Park exhibited some sympathies for them. In fact, Senegambian technique may not have been far removed from the attitudes and practices encountered in eighteenth century Britain and Europe.

By 1805, however, the context and composition of Park's party shows obvious shifts in the focus of European concerns. Sir Joseph's vanguard was being assembled it seemed. His African counterparts seemed clear on this point. As R. M. points out:

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[74] R. M., "Introduction," "The Second Journey," *Travels into the Interior of Africa*, 282. Park, *Travels*, 307–309.

[75] Ibid., 313.

> While he had no lack of European volunteers, it is ominous that no Africans would go with him.[76]

Why was this the case? Was there the possibility that the Africans and the polities they represented were no longer convinced that Park's intentions were benign. The fact that no Africans would accompany Park, and the fact that Park chose to go without them, illustrated that Park was no longer dependent on Africans and no longer saw them as his primary concern—if they ever were. Park's mission was no longer centered on explorations to their aid.

Park's explorations and the reaction to them—the African refusal to participate—take on a new, adversarial relationship. I would argue that this was the consequence of real political economic change in Senegambia. It was also the consequence of a European attitudinal shift witnessed in the medical doctor's 1795–97 success. It was an attitude that suggested as Sir Joseph Banks had in 1799 that "a conquest of Africa" had been initiated and affected. A medical doctor, a man of science had triumphed.

So here, within the context and composition of Park's second party, the need and the desire for African participation, and their refusal to participate, become another way of divining, defining, and deciphering the political economy of health care in Senegambia. Park has identified Boubacar Barry's notion of the region's collective consciousness and the underpinnings of its theocentric political economy. Park has also affected the challenges to that political economy: the quest of science and the Enlightenment constructs that have colored our notions of health care and religion in Africa. Again, "*Mumbo Jumbo*" as pejorative begins with Park. Yet, it is also Park who tells us that in its dispensation it may lay claim to the ordering of the entire social fabric: "*interposition of MUMBO JUMBO . . . is always decisive.*"[77]

We need to be clear concerning what Park has done for us here. First he has recognized the validity and power of health and health care in African context—he has validated the political economy of health care in Africa. He has acknowledged questions of social interposition and the health of a community. Second, he has charted the

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[76] R. M., "Introduction," 285.
[77] Park, *Travels*, 29–30.

shift in European attitudes toward Africans and their institutions. In the general sense, these institutions will be characterized as "superstitious"—"*MUMBO JUMBO*." Finally the ability of superstition—religion—to hold sway over entire polities, and to do so through systems of health care, was nothing short of dangerous to the enterprise of empire. It was a power that could only be effectively challenged through the use of medicine itself—medicine of the scientific and modern form that men like Park came to symbolize.

CHAPTER FIVE

THE FRENCH, COLONIZATION, AND HEALTH CARE

> The European merchants who have established themselves on all the coast from Cape Vert to Sine think of their health before all else. They spare nothing to have good food and good wine: it is better to make a little less profit than to expose one's health. They provide themselves with a certain quantity of sulfate of quinine against the fevers; they avoid sleeping in the open air during extreme heat. Perspiration is not at all dangerous, whereas a chill produces dysentery; they always carry a flannel shirt and belt. With such prudent measures and a suitable bed, they will be able to live there perfectly and to make a satisfactory fortune.[1]
>
> *Je n'ai pu me procurer sur les médicaments du pays aucun renseignement satisfaisant.*[2]

Over the short-lived history of the "colonial moment" in Africa, there are conventional, yet enduring theories that attempt to characterize the period. In the characterization of French colonial activity in West Africa, the most prevalent of the imperial models engages the notions of "*assimilation*" and "*association*" as vehicles of accommodation to French control.

Senegal was crucial to the cultivation of France's West African orchard. By 1848, the intent of French colonization in West Africa was clear with the advance into the Sudan and the extension of French citizenship to the inhabitants of the towns of St. Louis, Rufisque, Goree and Dakar. As the century closed, the four were afforded the privileged status of *commune*. This status illustrated the conventionally held notions of the development of the French colonial policies of "assimilation" and "association." The two concepts may also be used to illustrate the manner in which health was distributed from this point on.

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[1] Boilat, Equisses Sénégalaises, 40.

[2] Rapport de M. Beliard sur un voyage de l'exploration dans le haut Sénégal, 26 March 1861. Archives Nationales du Sénégal (ANS).

Briefly put, the policy of assimilation was to "gallicize" the savage; to make a Frenchman of her/him. According to Michael Crowder, assimilation was characterized in three ways:

1) political assimilation to France through Senegalese representation in the Chambre des Députés;
2) administrative assimilation through the creation of the General Council; and
3) personal assimilation through the designation of "citizen" for the residents of the communes.[3]

Assimilation, it would seem, despite its limitations, offered members of the communes opportunities that must have seemed substantial in light of the political economic dynamics of the period. In many ways, it simply codified socio-political economic activity that had existed in the two centuries prior to the introduction of the policy, and administratively attempted to turn it to French advantage. The political, administrative and personal possibilities offered to Africans enhanced the opportunities for many to play an influential role in French governance. Those possibilities, coupled with access to French education had profound impact on the psyche and the ambitions of those who became Senegal's new elite.

There were two key provisions that guided the policy of assimilation. The first was the fact that this new elite formation, like all elite formation, by its very nature, was limited. That limitation was reinforced by the limitations of French largesse: it was impossible to extend the benefits of assimilation to all of French West Africa, or even to all of Senegal. It is also questionable if the new elites would have stood for it. The second fact was that assimilation meant the replacement of African institutions with French ones, *where at all possible*. And while those institutions were "profoundly different from what existed on the same level in France itself," there were still attempts within the colonial context to *displace* existing Senegambian structures.[4]

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[3] Michael Crowder, *Senegal: A Study of French Assimilation Policy* (London: Methuen & Co., Ltd., 1972), 2–3.

[4] Ibid., John Bryant, in his work, *Health and the Developing World* (Ithaca: Cornell University Press, 1969) argued that "health issues in Senegal emerge from a long and intimate relationship with France. . . . Still at the heart of the matter remains the issue. . . . Are the attitudes, skills and concepts needed by a physician to direct

The concept of "association" spoke directly to the limitations of metropolitan France to meet what became an overwhelming desire for the rights of citizenship. It also spoke to the need to limit the power and influence of the new elites of the communes. Association, in short, involved the two-faced concept of respect for "custom, religion and manners" while adhering to the idea that Africans were culturally inassimilable, and that the uselessness of African institutions required direct French intervention.[5]

The policy that led to the creation of the communes introduced and exacerbated the differences between the communes and the interior, between urban and rural populations, and between the communes and metropolitan France itself. Colonial policy further demarcated the distribution of resources in Senegal and reinforced the concept of what was "useful" ("*utile*") and what was not in both the geographic and demographic senses. It also helped to crystallize a new set of class differences and antagonisms. It was along these lines that colonial health care policy was formed.

These notions are conventional *if* the element of reciprocity is not entertained. As I have attempted to illustrate—possibly, too much by implication—and as Marcroft points out directly, through the nineteenth century, those who entered Senegambia were "assimilated" by it, and drawn to it by various modes of "association." It was these interlopers who accommodated themselves to its space, climate, and culture. It was their accommodation to Senegambia; their inability to resist it, that posed the greatest dangers to company, and to colonial mission. Official French policy, it might be argued, was a direct reaction to *this* assimilation and association. As both Park and Boilat noted, the early European inhabitants of Senegambia were only too willing to place their health ahead of profit; to even argue that profit was dependent on health, and indeed, that the liaisons in which they were involved with Senegambian women were "calculated effort[s] to ensure a loyal local elite with French blood flowing

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the health affairs of a sector of Senegal sufficiently different from those required for France. . . . The result has been serious discrepancies between the physicians produced and the roles to be filled". While, in this passage, Bryant seems to work on the assumption that the French institution is transferred to Senegal unaltered, he does, nonetheless, note the disparity in outcome, and from there goes on to detail the systematic inequities of the system which emerges from the colonial construction. 64–66.

[5] Crowder, *Senegal*, 3–4; 83–85.

in its veins, *and yet a natural immunization against the diseases fatal to Frenchmen.*"[6]

Within this context, the issues of health care allow for the reformulation of these concepts from the standpoint of the peoples of Senegambia and their encounters with both the forces of Islam and the French imperial mission. This reformulation recognizes the reciprocity inherent in these interactions and the agency these interactions imply. Within the context of health care, the fears of several actors are realized as well. We would do well to recognize that these fears have different manifestations that range from group to group, and over time. The fears of French commerçants in the initial years of this contact—indeed, even those of the French administration and the military—were not those shared by the Company, or later administrations. As the previous chapter illustrates, some of those fears were ameliorated by European recognition of, and accommodation to, Senegambian forms of health care. The same can be said of the entrance of Islam into the region.

However, it is just as clear, that as time progressed, and new hegemonic structures were established, the ways in which these fears were managed, and their relationship to the requisite powers of the various political economies of the region evolved. They changed. Those changes reflected the need to dominate and were clearly marked by contention between the various parties that I have described as "traditional," Islamic, and French. Those contentions, and the moves to dominate, particularly on the part of the French, led to our conventional understanding of the French colonial process.[7]

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[6] Rita Cruise O'Brien, *White Society in Black Africa: the French of Senegal* (Evanston: Northwestern University Press, 1972), 33. Italics added.

[7] The leading authority here is Michael Crowder. His work, *Senegal: A Study of French Assimilation Policy*, is quite useful in summarizing conventional views. 2–4. Jean Suret-Canale's *French Colonialism in Tropical Africa: 1900–1945* (New York: Pica Press, 1971), is very important in deciphering the official French considerations concerning policy. However, it is Suret-Canale's essay, "Colonisation, Decolonisation and the Teaching of History: The Case of Black Africa," in *Essays on African History: From the Slave Trade to Neocolonialism* (Trenton, New Jersey: Africa World Press, Inc., 1988), that is one of the keys in my rethinking questions of "*assimilation*," "*association*," and the multiple ways in which the various parties in this historical and political economic scenario accommodated and were accommodated. Here in relation to conventional notions of the colonial process as history, Suret-Canale apprises us of the fact that the histories to which we are accustomed are histories that primarily satisfy the conditions of European imperialism. We are not expected to see, let alone to analyze, the "other side."

In the struggle to consolidate hegemony and build empire in Africa, from the mid-nineteenth through the early to late twentieth centuries, what is witnessed is a reconfiguration in the global market and in participation in the accumulation of capital. The Senegambian experience through the opening two decades of the twentieth century—and possibly beyond for certain indigenous forces that were able to consolidate their own political economic power, and to grow within the context of French colonialism—confirm J.E. Flint's observations on Africans' abilities to keep pace with global political economic change from the middle of the nineteenth century onward.[8]

Here, African "elites" were part of the political economic process, though capital was becoming consolidated in fewer and fewer hands. At the same moment, in concurrence with global dynamics, more Africans were being incorporated into the capitalist economy as workers—as various types of labor; as proletariat of some sort.[9] This consolidation of capital, and the expansion of the workforce laboring under the aegis of a global capitalist market, had repercussions on the reconfiguration of health in Senegambia. In that regard, paramount among the issues presented here, are the ways in which health care was used to achieve French hegemony in the region; and of course, the resistances to that hegemony. As important, from the theoretical perspective, are the possibilities that the examination of health care pose for the reconstitution—the reformulation—of colonial historiography.

Again, the epigraphs that open this chapter refer to the problems enunciated by do Sandoval in 1627. Almost two and a half centuries later, the lament remains. M. Beliard has already articulated it in his inability to grasp the healing powers—"*les médicaments du pays*"—of the region. In almost the very same moment, Boilat acknowledges the accommodations made by a French population seeking its

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[8] J.E. Flint, "Economic Change in Nineteenth Century West Africa," in J. Ade Ajaye and Michael Crowder, eds., *History of West Africa, Vol. II* (New York: Columbia University Press, 1973).

[9] Lucy Behrman, "Muslim Politics and Development in Senegal," *Journal of Modern African Studies*, XV, 2 (1977), 261–265. Samir Amin, *Neocolonialism in West Africa* (Great Britain: Penguin Books, 1973), 9–11; 14. D.B. Cruise O'Brien, *The Mourides of Senegal* (Oxford: Clarendon Press, 1977), 234–236; 300–302. Andre Gunder Frank, "The Development of Underdevelopment," in Robert Rhodes, ed., *Imperialism and Underdevelopment* (New York: Monthly Review Press, 1970), 6–7.

fortunes. It is a population concerned with—worried about—its health; a population willing to sacrifice profit for health.

Such a position on the part of Senegambia's early European population, suggests the power of the region and it's peoples. In the most pejorative way we are treated to Curtin's "White Man's Grave."[10] Carried a step further, French colonizing forces would conclude that the people themselves, with their culture, customs, habits, and religion, were the carriers of disease. The Senegambians became vectors from which European society and political economy needed to be segregated except under the most desperate of circumstances.[11] Senegalese resistance would be characterized as disease; its cure—its "pacification"—could only be achieved through the process of colonization. In that regard, health care, and the war for health care supremacy, were pivotal. Marc Sankale is clear on this count. In the "medical penetration" of Africa

> the military columns which launched the conquest of the continent counted among them the major doctors and aides who healed the troops as well as the indigenous peoples . . . one could say that after the military stage and before that of economic development, *there is the medical phase of colonization.*[12] (Italics added)

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[10] Philip Curtin, "The White Man's Grave: Image and Reality, 1780–1850," *Journal of British Studies*, 1 (1961).

[11] Even the liaisons with African women—the signares, in particular—can be read in this light. Indeed, this is one of the interpretations that might be given to Rita Cruse O'Brien's observations concerning the Frenchmen's hopes, wishes, and expectations of the physical fruits of such unions. These children were the "innoculatory" product—the future—of French commerce and empire in West Africa. See Rita Cruse O'Brien, cf. 3.

[12] Médecins, 29; 31; 35; 46. Also see John Carman, *A Medical History of Kenya* (London: Collings, 1976), 13; 16. Dr. Rene Collignon, Interview, Dakar, Senegal, February 12, 1980. Dr. Alain Froment, Interview, Philadelphia, PA, July 9, 1981. While there were health services provided by the missionary bodies, this treatment centers on the role of military health care providers because of the pervasive nature of their function. Ironically, the limitations of missionary health care services were restricted by denomination in that the bulk of care seemed to be provided by Protestant rather than Catholic missionaries from a metropolitan state that was predominantly Catholic. The work of Catholic missionaries in health care seems so scarce that Suret-Canale only mentions it in passing and Manning indicates that while "Catholic missionaries gave strong emphasis to doctrinal training. . . . The Protestant denominations [sic], in contrast, put relatively great effort into medical facilities . . . to show the superiority of Western medicine, and to undermine African religion by invalidating African religion". *Francophone Sub-Saharan Africa*, 96. Suret-Canale, *French Colonialism*, 355–366. However, Virginia Thompson and Richard Adloff noted that in 1947 Catholic medical missionary work divided between the

Boilat's remarks provide a causal linkage between health care, commerce and the general political economy of the French colonial enterprise. In similar fashion, the conflict one hundred and eighty years earlier that sparked the maraboutic war of 1673–1677 was a political economic one. It was a conflict over the control of the region's resources that centered on the French presence at St. Louis. The French realized early in the construction of their empire how important health care was. As early as 1747, there was an inspector and director-general for hospitals in colonial territories. In that year, the Inspector/Director-General, M. Pospournier, delivered his report on the state of health care facilities in the colonies. While the report was a general summation of health care activities with some specific references to colonies in the Americas, it was indicative of the role the French assigned to health care. By 1673, the precursor to the Corps de la Santé, the Corps of doctors and surgeons of the Royal Marines was created.[13]

However, French health care was severely limited in its own conceptual and curative approaches. The real significant advances in health care had only occurred by the turn of the nineteenth century. And even then, the benefits of those advances were only realized in the most halting fashion. Advances in health care during this period were tied primarily to new efforts in public health and sanitation; and not to great medical discoveries. While "medicine had advanced sufficiently that Europeans need not expect to die in the Tropics. . . . Nonetheless the death rate was still very high";[14] and as William Cohen has indicated, "both in the middle and at the end of the [nineteenth] century, colonies were synonymous with death."[15]

Fathers of the Holy Spirit, the White Fathers and the African Mission of Lyon for the whole of French West Africa totaled seventy dispensaries and approximately 1,754,000 consultations per year. *French West Africa* (New York: Greenwood Press, 1969), 583.

[13] M. Pospournier, "Rapport de M. Pospournier, Inspecteur et Directeur General des Hopitaux", circa 1747, National Archives of Senegal (hereafter referred to as ANS). Sankale, *Médecins*, 33.

[14] Christopher Harrison, *France and Islam in West Africa, 1860–1960*, 2.

[15] William Cohen, Malaria and French Imperialism, *Journal of African History*, 24 (1983), 24. Also see Philip Curtin, "The White Man's Grave: Image and Reality, 1780–1850", *Journal of British Studies*, 1 (1961). Philip D. Curtin, *Disease and Empire: The Health of European Troops in the Conquest of Africa* (Cambridge, New York, Melbourne: Cambridge University Press, 1998), 1–28; 74–112. Philip Curtin, *Death by Migration: Europe's Encounter with the Tropical World in the Nineteenth Century* (Cambridge, New York, Melbourne: Cambridge University Press, 1995).

This, according to Jean Suret-Canale, was due to the fact that even by the early twentieth century, western medicine had "only recently advanced beyond the stage of empiricism."[16] Here again, are the observations of Savigny and Correard, reiterated through Beliard. Throughout this interaction is the crucial desire to know and to understand the "*medica materia*"; "to obtain the healing powers of the land." And, at the same time to inoculate the political economy from the sources of that power.

The inoculation of the political economy. At first this seems an oxymoron to the observations of the Savignys, the Correards, and the Beliards of the imperial enterprise. Theirs is a begrudging respect; an acknowledgement of the skill, the science, the power inherent to this space. At the same time, however, the acquisition of this medical knowledge, of this power was clearly for the advancement of French empire. The ambivalence would be reconciled through the goals of policy. The goals of that policy accommodated and used the views of practitioners like Dr. Barot.

For all those who wanted "new understanding" there were overwhelming numbers of Frenchmen who feared what they could not understand. Writing in 1902, Dr. Barot summed up the French disease in the face of traditional practices and practitioners:

> Among the fetishist peoples whom we are conquering we have to struggle against the enormous influence of witches. . . . In the countries still to be explored we cannot count on anything except luck and chance; for the griot bought one day with the price of gold will declare against us the next day if the white rats, kolas, or the other oracles give an unfavorable opinion. Many explorers have been the victims of the idiotic capriciousness of fetishers.[17]

The ambivalence between the desire to understand and the fear of what could not be understood also occupied the French fixation with Islam in Senegambia. To be clear, however, as our observers implied earlier, Islam among the Senegambians was considered to be only a shadow of its actual self. According to these observers, the true

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[16] Suret-Canale, *French Colonialism in Tropical Africa* (New York: Pica Press, 1971), 403.

[17] Dr. Barot, *Guide practique de l'européen dans l'Afrique occidentale*, quoted in Harrison, *France and Islam*, 32. Harrison underlines Barot's concern by stating that

> For the early European administrators worried about their health and generally impatient to return to the metropole, animist beliefs and rites must have been not only incomprehensible but also at times terrifying.

actualization of the faith required more than the clutching of prayer beads and the recitation of Koranic incantations. In fact, among such "childish" and "ignorant" peoples—Africans, in general, and Senegambians as specific types—Islam became a real danger. They could be misguided and manipulated by barely lettered and insufficiently tutored individuals willing to take advantage of popular naïveté—the marabouts. Islam among the Africans was, in effect, a sacrilege. And for the French, initially, it posed problems for their sacred quest—empire.

Barot's ideas were based on at least two, if not three, centuries of chauvinism, racism and advanced ignorance that became the basis for many of the French conclusions about indigenous and Islamic health care in Senegambia. More importantly, such ideas served as rationale for the development of French health care delivery in the region; a rationale which tied health care delivery tightly to the goals of empire and made it a tool for the realization of political economic hegemony. Barot also identified the resisters to this political economic hegemony and its health care. His injunction against "fetishist peoples," "kolas," "oracles," and "fetishers" bring us back to the theocentric political economy of health care arrayed against the French. These were "fetishers" whose craft, as al-'Umari indicated, had been refined over four centuries.

The Medical as Military

Here, we need to return to Sankale's observations on health care and imperialism. How is the imperial design achieved? What is the vehicle of initiation? Sankale informs us that the military is crucial to this design; and, of course, we are not surprised. However, the emphasis that Sankale places on medicine should give us pause. "There is the medical phase of colonization" with its "major doctors and aides who healed the troops.[18] The institutional introduction of health care to the region under the aegis of the French military was through the Corps de la Santé. The pervasiveness of the medical corps' relation to the armed forces is, in fact,what Marc Sankale described as the "medical penetration" of Africa by the military. It marked the emergence of imperialism's medical face.[19]

[18] Ibid.
[19] Sankale, *Medecins*, 29; 31; 35; 46.

The correspondence of the nineteenth century certainly substantiates Sankale's observations. The reports of medical officers and travelers to the region provide a great deal of insight into the role of the medical officer. That insight is illuminating in that it shows that the functions of medical corpsmen exceed our conventional ideas of health care personnel. In that regard, the correspondence forces us to rethink the role of medical personnel a) as military officers; b) in the provision of health care; c) in defining health care; and, d) in neutralizing opposing institutions. This implies a revisioning of the institution of health care.[20]

Conventionally, the medical corpsman's primary duty was to provide for the health of the troops under his charge. It was only after they were tended to that he might give attention to colonial administrators and members of the civilian population. This hierarchy of treatment among Europeans was quite rational in light of the role attached to the military. In a colony where military personnel came to dominate strategically, if not demographically, it was not surprising that disease took a devastating toll on French troops. In an arena in which the physical contest for territorial domination, the securing of routes, and the opening of new commercial venues were the province of the military, it is only logical that the military leadership would see disease as *first* a threat to its own efficacy and existence, before looking to the needs of other members of the colonial population.

If the military received priority, it should be underlined that it was "treatment among Europeans" which became the real issue, though among European troops a class dichotomy prevailed as well. The standard of living, the requisite health care, and consequently health itself, were much higher among officers than enlisted men.[21] African troops and then the indigenous populations were given ter-

[20] Here the voyage of Savigny and Correard is instructive. The crew included five surgeons, two hospital doctors, two apothecaries, and a physician as members of an expedition that numbered 365. Savigny and Correard, *Narrative*, x; xxvii; 127–128.

[21] David Macy's biography of Frantz Fanon is insightful. French colonial health care policy well into the twentieth century still functioned on the premise of pacifying the racially inferior peoples of the overseas territories. Macy reveals this in his analysis of Fanon's treatment of the "north African syndrome" as a central element of a racialist and racist health care policy. The focus of this policy was the notion that Islam was a "pathogenic agent," 'a contagious epidemic,' a 'mental pathology.' Macy, *Frantz Fanon: A Biography* (New York: Picador, 2000), 217–227.

tiary considerations. Yet, these considerations, along with those given the European civilian community, were crucial dynamics in the pursuance of French colonial policy. In a report written in 1829, the author noted that the hospital at St. Louis saw inhabitants from the city and the interior everyday. That function gave the hospital and the health care it provided "political" significance in any "country where the human heart was not foreign to sentiments of generosity and recognition.[22] The author had identified one of the key policies of pacification: "winning the hearts and minds." Winning hearts and minds through the provision of health care was a crucial factor in the colonial process; it was also a way of demonstrating power to both white and black populations.

As a military officer responsible for advancing the fortunes of the state, the medical corpsman was decisive in determining strategic and logistical positions for the army and navy. It was clear that health conditions and the ability to deal with them influenced the penetration of the region as well as the ability to administer it. So, we find that the duties of the medical officer, Mr. Thorval, were not only observations on how diet, topography, and climate contributed to the overall well-being of the men in his troop, but also included notes on the positioning of fortifications that would be beneficial from the commercial and military standpoints as well as from the vantage of health. Mr. Thorval's concern was whether considerations for health should take precedence over commercial and military interests. His position was supported by other officers who argued, as Lt. Colonel Borgnis-Desbordes had, that the "nature of their occupations" and their exposure to the "rigors of a dangerous climate" made such proscriptions possible.

As military men, they could moderate their questions concerning the subordination of military interests to medical priorities by arguing as Doctor, First Class Palmade did that

> from the first day to the last, the question of the state of health has been a fundamental question for us, everything has been put in place to give the troops the highest [level of] well-being possible.

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[22] Dr. Beaujeau, "Rapport du Docteur Beaujeau sur le poste d'Assinie—1847–1848," H1, ANS, 85–87. "Rapport sur la situation du service de santé et les hôpitaux de la colonie au 19 avril 1829," H6, ANS, 7. Thorval, "Grand Bassam—rapport du Mr. Thorval" (May 1845), H1, ANS, 29.

However, from the commercial side, questions of hygiene v. profit and the policies that ensued signaled the emergence of issues that would illustrate that unanimity on the process of the colonial enterprise was fragile.[23] A number of outbreaks of epidemic proportions taxed the relationships between military and civilian populations, both of which had come to Senegambia to make their fortunes and their careers. The Yellow Fever epidemic that marked the last two decades of the nineteenth century illustrates the strains placed on the French community by health care considerations. It also shows the attempts to remedy those strains through the creation and enforcement of new health care policy.

In brief, those policies were perceived by members of the merchant community as obstacles to their pursuit of their livelihood. The resulting conflict saw a number of attempts on the part of the merchants to circumvent military policy through breaking quarantines, running blockades and the like. In May 1889, the governor of the colony was informed by the president of the chamber of commerce of the cities of Rufisque, Gorée and Dakar, of the disastrous effects of the quarantine on commerce. The president argued that the quarantine was an ill-conceived "measure destined to neglect public health . . . and . . . to restrain commerce." The president went on to state that the government and the merchants needed to work out a plan that would reconcile business interests with "the indispensable precautions for the preservation of the colony.

It could be questioned if the "precautions for the preservation of the colony" which the merchants endorsed, had little if anything to do with the state of health in the region. The Department of Health acknowledged that the quarantine was useless. It was useless because it was not extensive enough. The suggestion was that it needed to be expanded to the Gambia and Sierra Leone, if British cooperation could be gained, and that the status of health of their major cities should be monitored. There were serious reservations that the Department of Health was overstepping its bounds. The gravity of the situation was underlined when two soldiers were arrested and

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[23] Lt. Colonel Borgnis-Desbordes, "Colonne expéditionnaire du Haut-Fleuve" (circa 1847), H1, ANS, 221. Doctor, First Class Palmade, "Rapport médical de Mr. le médecin de 1ere classe Palmade sur la colonne expéditionnaire du Fouta," June 10, 1881, H1, ANS, 232. Thorval, "Grand Bassam."

imprisoned for breaking the quarantine.[24] The dynamics witnessed in the Yellow Fever Epidemic, which began in the 1880's, also epitomized tensions between the métropole and the colony. The instructions to the colonial administration were that metropolitan France was to be spared the potential catastrophic consequences of the ravaging ailments of the overseas territories. The colony was, in effect, a *cordon sanitaire* for the imperial power, and health care policy was constructed to keep it that way.

The hierarchy imposed on the distribution of health care had a distinctive racial overlay as well. And the racism involved in the construction of French health care policy in Senegambia had a certain irony to it. Within the context of military medical initiatives designed to aid "the success of [our] arms," medical personnel were appalled by what the Commandant Particulier Hesse termed the "difference of proportion and . . . the form of death" for so many soldiers. The Commandant was dismayed that the majority of his troops were succumbing to disease rather than to gunshots, arrowheads or spears. What was overlooked in such wailing on the untimely and not altogether soldierly demise of so many men-at-arms was the fact that the overwhelming percentage of these soldiers was African.[25]

The low percentage of European deaths was due to the prodigious use of Africans. However, numerous medical officers, in their best medical judgment, concluded that their black troops were, themselves, disease carriers. So Africans were sequestered from their European counterparts for reasons of health as French authorities heeded injunctions which were characterized by Medical Officer Doublet's assertion in 1860 that

> the mixing of whites and blacks is already a cause whose importance cannot be overlooked for destroying the health of the former.

Yet, those same officers also argued that the African was best suited for military action because of certain inherent immunities.[26]

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[24] Cabinet du Gouverneur, Le Gouverneur du Sénégal et Dépendance à Monsieur le Directeur de l'Intérieur, "Au sujet des quarantaines imposées aux provenances du sud pendant la période du 1e juin au 15 dbre," No 139, 27 mais 1889, H8, No. 35, National Archives of France (hereafter referred to as ANF), 1–2.

[25] Ibid., Cabinet du Médecin en Chef, St.Louis, 21 Juin 1889, "Médecin en Chef de la Santé au Gouverneur du Sénégal et Dépendances," H8, ANF. Also see Nos. 30–34, June 19–25, 1889.

[26] Hesse, "Copie d'un rapport adressé le 25 Août 1830 par M. le Commandant

The contradictions of the French encounter with Africans and their systems of health care witnessed both positive and negative responses. On the positive side was the acknowledgement of the need for Africans in various capacities to sustain the life of the colony.[27] There was a similar acknowledgement of African medicinal treatments because of their capacity to sustain the life of the colonists. On the negative side were the fear of treatment and the fear of those who treated or served in any capacity as the bearers of afflictions that the European population sought to avoid. The contradictions of this need resulted in the formation of policy designed to keep both those who were feared and those who were needed beyond the pale. This policy was physically visible in the actual construction of colonial communities and the creation of the cordon sanitaire.[28] In many ways this was a functional decision dictated by the struggle for control of the region. In the ongoing battle to neutralize the opposition and, if possible, to turn them to one's own advantage, French action was contextualized by two conclusions that became exceedingly difficult to refute. Carried into the realm of health care the conclusions read thus: French health care was superior; African health care was inferior. It stood to reason that this was a measure of contact at every other level of interaction as well, both personal and institutional.

Notions of superiority caused the French to make assumptions about the efficacy of their own health care vis-à-vis that of the Senegambians. The presumed appeal of "European" health care caused writers like Anne Raffenel to state that "medicine it is said, is an excellent passport for the European who travels in Africa. As Sankale put it, from that point on, the French were willing to accept the idea that the African saw every Frenchman to be "more or less a doctor" based on the fact that many Africans were willing to avail themselves to French medicine. This idea became obvious as early

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Particulier sur le terme de l'Epidémie qui règne à Gorée du 14 Juin jusqu'à la fin de Juillet", H6, ANS, 4. William Cohen, "Malaria and French Imperialism", 30–33.

[27] Mr. Doublet, "Rapport de Mr. Doublet sur le navire l'Etoile—1860," H1, ANS, 40–41. "Correspondance Départ du Service de Santé," No. 40, 41 ANS. Also see Cohen, "Malaria and French Imperialism".

[28] Gwendolyn Wright, "Tradition in the Service of Modernity: Architecture and Urbanism in French Colonial Policy, 1900–1930," *Journal of Modern History*, 59 (June 1987), 299–301; 303; 309–312. Also see Philip D. Curtin, "Medical Knowledge and Urban Planning in Tropical Africa," *American Historical Review*, 90 (1985).

as the journeys of Mungo Park.[29] French medical officers underlined the point and expanded on it in terms of the discharge of their responsibilities. Yet, we are forced to temper these observations by reflecting on "how many" and "which" Europeans Africans encountered and *what* their functions were, and what was the level of their preoccupation with health care and their own health. Clearly, however, the political economic role of health care is reiterated.

The upshot of conclusions concerning the superiority of European medicine was the assumption of the inferiority of African health care. Health care in the indigenous setting was plagued by "ignorance and superstition" according to medical officers like Dr. Phillipeaux. Dr. Beaujeau supported Phillipeaux's assertion by stating that indigenous medicine was "reduced to a variety of fetishes." All this was exacerbated by what Surgeon Dessables noted was "the torpor of intelligence" and "the most degrading vices . . . generally found among all Negroes.[30] Race and racism were clearly articulated points of colonial diagnosis.

The changes in French perceptions from the observations of Savigny, Correard, and Beliard to this point were witness to the pragmatic response on the part of Africans to the available resources. And while in many ways, the French did the same, they seemed totally unprepared for such rational behavior on the part of Africans. Yet, in their desire to meet the disparate health care needs of the colonies, the French sought to co-opt various health care agencies, or at least to pit them one against the other. In effect, this was what happened at the outset of the War of the Marabouts. French efforts were seen as altering the balance of power in favor of indigenous forces, especially those of the traditional Wolof hierarchy. In these early years, the French argued that Islam was a corrupting force that held the potential for thwarting French advances in the region.

French hegemony began to shape the nature of health care delivery in the Senegambia. However, the process was not without conflict or contradiction. The establishment of French health care facilities

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[29] Quoted in Sankale, *Médecins*, 39. Ibid., 29; 31. Park, *Travels*, 41–42.

[30] Dr. Philippeaux, "Epidémie de Variole à Gorée en 1846", 24 Juin 1846, H1, ANS, 4; 6. Beaujeau, "Rapport du Docteur Beaujeau", 80. Menu Dessables, "Rapport du Chirurgien de la Marine Mr. Menu Dessables attaché à l'expédition de Senou-Debou pour la formation d'un comptoir dans le royaume de Bondou (Haut Galam) adressé à Mr. le docteur Salva médecin en chef du Sénégal et dépendances," 26 Mai 1846, H1, ANS, 15.

was clearly distinguished by the line of march. Running north to south from St. Louis to Mbacke, Koungheul and Kolda through Ziguinchor, the area west of this line and to the north of the Gambia was designated as "*le Sénégal utile.*"[31] The line of march was itself, indicative of conflict and contradiction. As a military boundary, it illustrated conflict between the French and indigenous forces, and particularly the forces of Islam. One way of explaining the line of demarcation is to view it as an area beyond which the French could not successfully venture. "*Sénégal inutile*" was "useless" not only because of the "marginal" value of its land and people, but also because it could not, in many ways, be pacified. In fact, it might be speculated that it was the French inability to pacify this space and its peoples that made it "*inutile.*" The fact that French health care could not breach the line was indicative of the power of the institutions which confronted it, even though many concluded that health care could do what guns could not.[32]

Along the line, at the same time, was the consolidation of power among Islamic reformers bent on the establishment of their own spheres of rule and on limiting that of their rivals. From the early nineteenth through the twentieth centuries the reformist forces of the Tijaniyya contended with the representatives of the status quo, the Qadiriyya. The conflict evolved to include not only issues of faith, but also class dynamics as well. In the end, the political economic power that would accrue to either group and to the later rival, the Mouridiyya, would be key in determining the distribution of health care services in colonial and post-colonial Senegal.

The jihad of the reform movements of the period was propelled by some of the same concerns that dominated the French exercise. Success could be dictated by the health of their forces. The inability to prevent illness through proper diet, preventive care and timely medical intervention "were the major causes of death in the community." The practice of medicine played a crucial role in the jihad

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[31] Maghan Keita, "Ethnicity, Religion and the Dynamics of Post-Colonial Health Care in Senegal," *Contemporary French Civilization*, XIV, 2, Summer/Fall, 1990, 308.

[32] As Sankale concluded, "medicine is the best agent of 'pacification,'" 35. George Vincent, former president of the Rockefeller Foundation stated 'that for the purpose of placating primitive and suspicious people medicine has some advantages over machine guns.' Vicente Navarro, "Social Class, Political Power and the State and their Implications in Medicine," *International Journal of Health Services*, VII, 2 (1977), 259.

and in the lives of its leaders. A personality such as al-Hajj ʻUmar illustrated this importance. Like his indigenous predecessors, the shaikh was invested with divine powers and wisdom that were indicative of his sacred appointment to "purify Islam in the western Sudan under the aegis of the Tijaniyya tariqa." These powers became manifested in his service to Muhammad Bello of Sokoto in prescriptions of medicines (gris-gris) "which were considered instrumental to some of the victories the Sokoto army scored." These elements helped increase his following throughout the western Sudan as he moved to consolidate his own position.[33] The powers of his medicine were adduced as proof of his right to leadership in the holiest crusade of the region and the period.

Al-Hajj ʻUmar was also central to one other crucial element in the historical development of the region. Like the forces of the Wolof states which preceded his movement and those of the Mourides which followed, al-Hajj ʻUmar showed real flexibility in the exercise of options which might guarantee power. Among those options for all these parties, was alliance with the French at one point or another. As French hegemony became the dominant force in the region's political economy, those forces that found themselves most closely allied to the French during the colonial epoch were in the best position to dictate the apportionment of the spoils of such an alliance. In some instances, those spoils were expanded access to health care; in others, it was the power to place systems of health care beyond the reach of colonial administration. In many ways, however, it was indicative of the ability to dictate the terms of health care distribution in the colonial and post-colonial periods.

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[33] Murray Last, "Reform in West Africa: the *Jihad* movements of the nineteenth century," in J. Ade Ajayi and Michael Crowder, eds., *History of West Africa*, II (New York: Columbia University Press, 1974), 8. B.O. Oloruntimehin, *The Segu Tukulor Empire* (New York: Humanities Press, 1972), 39; 41; 43.

CHAPTER SIX

COLONIAL HEALTH CARE

> For the colonial doctors, there is no indigenous medicine, only that of 'witch-doctors' and 'quacks' exploiting the credulity of their fellows. Medical aid . . . is our duty. . . . But it is also, one might say, our most immediate and matter-of-fact interest. For the entire work of colonisation, all the need to create wealth, is dominated in the colonies by the question of 'labour'.
>
> Albert Sarraut, quoted by Jean Suret-Canale

Sarraut vividly illustrated the essential nature of colonial health care. His pronouncement was borne out in Suret-Canale's analysis of health care delivery for the whole of French West Africa in *French Colonialism in Tropical Africa*. Their observations, along with those of others cited here bring us to the indisputable conclusion that French medical penetration was key to the entire process of colonization. In regard to the goal of colonization to generate wealth, Sarraut stated that health care in the colonial setting helped in promoting the "'necessity, in a word, of conserving and increasing human capital to make financial capital work and bear fruit.'"[1] Sarraut's was the "orchard" metaphor for French West Africa.

Bringing fruit to bear demarcated the distribution of resources in Senegal and reinforced the concept of what was "useful" and what was not in both the geographic and demographic senses. It also helped to crystallize a new set of class differences and antagonisms. It was along these lines that colonial health care policy was formed.

As mentioned, the distribution of health care services, aside from its geographic and demographic particularities, was hierarchical. Its initial distribution was based on lines of race and class. Those lines were replicated and to them were added issues of ethnicity and religious affiliation. The policy that led to the creation of the communes

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[1] Suret-Canale, *French Colonization*, 403; 407.

introduced and exacerbated the differences between the communes and the interior, and between urban and rural populations. Yet, within the health care profession in the colonial arena, race certainly was the key determinant of access, post and status.

Colonization provided a model for health care among Africans that was characterized by at least three distinct elements. The *cordon sanitaire* was one operable dynamic. That was reinforced by a new consciousness among the new African elite that bound them even closer to France. This was complicated by the fact that even within the framework of French colonialism, the Senegambia was still a contested area: contested among the forces of Islam; and between Islam and the powers of indigenous institutions.

The *Cordon Sanitaire*

Colonial policy, through administrative design, emphasized the dichotomy between urban and rural. The city, in many ways, became synonymous with colonization. It separated the European and those who would be *European* from the rest of the population. In her discussion of the *cordon sanitaire*, Gwendolyn Wright speaks of "urban planning" as being of "central importance in consolidating political power." For the French, she goes on, this was realized in Hubert Lyautey's idea of the 'dual city'.[2] The "two cities" or two parts of the same city suggested "health precautions" with the designation of the 'sanitary corridor.' Within the French Empire, indigenous cities were routinely separated "for reasons of health" as well as for political and military control. For some colonial officials, "urban planning represented the essence of modern urban planning" where "health seemed to depend on the separation of populations".[3] This is exactly what medical officer Doublet and his colleagues had in mind in 1860.

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[2] Ibid.

[3] Wright, "Architecture and Urbanism," 299. There is little, if anything, original about Lyautey's "dual city." The concept in the Western Sudan goes back to the very first contacts between indigenous African polities and the agents of Islam. Muslims were segregated in separate enclaves that became the dual cities written of in the chronicles. One can argue, given the theocentric nature of both indigenous and Islamic communities, that this *cordon sanitaire* was also a barrier against ill health, politically, spiritually and physically. In Lyautey's case, his designation may indicate that he was a shrewd observer of the African condition.

Urban design was directed at "protecting the health of the European population." Where the *cordon sanitaire* had successfully separated the two populations, it unwittingly created new health problems. Some, like tuberculosis, once thought non-existent among Africans was found among 43.3% of African school children tested in Dakar in 1927. One doctor noted that the catastrophic rise in diseases such as tuberculosis was tied to the French process of urbanization: unsanitary housing and overcrowding in the African quarters.

> Faced with these indestructible sordid ruins, true parodies of hygiene, one begins to regret the old straw huts. Inside, one finds rigid division into dark boxes; these house a whole population.[4]

In cases such as this, where the European population was threatened as well, the cordon sanitaire became even more operative. As Suret-Canale noted, urban sanitation could be improved by destroying the homes of Africans "situated next to the European quarters . . . and their occupants moved to the outskirts." This was "medicine for the masses" under the name of "Services d'hygiéne".[5]

Mass medicine as "native medicine" became a real fixture of colonial health care in Senegal with the establishment of the program for training the *médecin africain*. The program was a consistent part of French health care policy from 1900 through 1960. That policy was designed to mobilize the masses to meet colonial labor and military needs.[6] A key feature of the program was inaugurated by the French military in 1918 with the establishment of the Ecole africaine de médecine; ostensibly, because there were no Africans qualified to receive university medical education. By 1953 when the school closed, 582 "African doctors" and 87 pharmacists had been trained. This cadre was educated to provide limited health care services to the African population of all of French West Africa and to meet colonial needs in supplying subordinate personnel. Their posting was primarily to rural areas.[7]

Francis Snyder is clear that the utilization of the African medical auxiliary and the promotion of the *médecin africain* were designed to

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[4] Ibid., 311.
[5] Suret-Canale, *French Colonialism*, 400–401; 407.
[6] Ibid., 407.
[7] Francis G. Snyder, "Health Policy and Law in Senegal," *Social Science and Medicine*, VIII, 1974, 11.

control what Sarraut defined as 'human capital.' In preparation for World War I and in meeting the existing pressures for labor, Snyder writes that the French realized the need to improve the African population both qualitatively and quantitatively. The provision of health care services was explicitly directed toward this goal. "The provision of health care services in Senegal complemented taxation and military force as a means of facilitating minority control of the largely rural population of West Africa.[8]

The insertion of these African personnel into the health care equation as agents of French colonial policy was indicative of two characteristics of the development of Senegalese health care. First, it underscored the ongoing process of the integration of the region's health care systems. Second, as a part of elite formation, the creation of African cadre helped the evolution of new attitudes that became part of the rationale and driving force behind the colonial health care structure. It was an attitudinal formation that was so formidable that it, in fact, became the basis for the post-colonial distribution of health care services.

Those attitudes were the essentials of a new health care practitioner. As such they removed this practitioner from identification with indigenous practitioners and their charges, yet left him (in all cases through the colonial period the position was occupied by males) with no opportunity to join the ranks of his European colleagues. Yet the aspirations of this new class of medical practitioners were clearly products of their training and the implicit and explicit perspectives of the system that provided their training. In effect, the "African doctor" finished his training with an apparent disdain for traditional medical practices and personnel, both indigenous and Islamic. The orientation of these new health care agents was a recognition of the fact that the more they could approximate the French practitioner, the more satisfaction and happiness they would receive. This accompanied an inclination toward urban, and later curative and technologically overwhelming health care. These were as much elements of prestige as they were tools in the fight against disease. They also limited access to western health care for the majority of the Senegalese population.

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[8] Snyder, "Health Policy," 12. Andre Prost, *Services de Santé en Pays Africain* (Paris: Masson & Cie., 1970), 125. John Bryant, *Health and the Developing World* (Ithaca: Cornell University Press, 1969), 62–63.

The education and attitudes that it engendered divorced the "African doctors" from the community they were to serve. So much so, that they viewed the community and its institutions in much the same way as their European counterparts: backwards, ignorant and superstitious. In the end, in a system that placed the bulk of its facilities in cities like Dakar and which, as a consequence, devoted the bulk of its health care budget there, Senegalese health care workers felt woefully inadequate. Unable to function in the city because there were no positions for them there, and unable to cope with the countryside because of attitude and training, they were cast in much the same manner as a colleague in the post-independence era described when asked how he responded to traditional practitioners and their skills:

> [D]uring our studies we receive a hospital directed training. We are taught modern hospital techniques, with teachers who have been trained in the Ecoles Supérieurs d'Infirmiers. Once assigned to a locality, all we can do is apply what we've been taught.[9]

The Male Nurse

> Sogolon initiated her son into certain secrets and revealed to him the names of medicinal plants which every hunter should know.[10]

Throughout Senegambia, the power of women is known. Men of heroic proportions come to their fate by way of their mother's milk and counsel. Women are the intermediaries between their peoples and the ancestors; they are the basis for much of the region's economic production; and, in some areas, they hold the key to the political process.

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[9] Massamba Diop, "An Experience in a Rural Dispensary," *African Environment*, I, 4, 1975, 111. Bryant, *Health*, 64–66.

[10] D.T. Niane, *Sundiata: An Epic of Old Mali* (London: Longman Group Limited, 1965), 23. John William Johnson has noted that within the Mande culture which provides the broader context for life in Senegambia, magical powers are transferred from mother to son. It is through the mother's ancestry that power is acquired. This magic applies very specifically to the power to heal. Johnson, quoted in Thomas Hale, *Scribe, Griot, and Novelist* (Gainesville: University of Florida Press, 1990), 21. The economic powers of women in African society are well documented. In the political arena, among peoples such as the Diola of southern Senegal, women exercise the equivalent of the veto in that issues cannot be voted upon in the community's male-only franchise unless women agree to the issues and the vote.

As healers, women have always occupied prominent positions within the various indigenous communities of Senegambia. Those positions have not been held in opposition to men, but in congruence with them. In the professional sense, female healers were recognized for the efficacy of their craft, which could in many cases be the same as their male counterparts. They were also recognized for their powers as spirit mediums and their very special skills in dealing with psychological disorders. In this area, researchers such as H. Collomb, P. Martino, B. Diop, R. Guena and others provide substantial detail on the role and power of women in the Wolof and the Lebou cultures of Senegambia. These works specifically speak to women's roles in the resolution of individual conflict *and* in the restitution of social order.[11] H. Gravand recorded similar observations in his research on the Serer of Senegal and the psychiatric ailment known as "*lup*." Gravand stated that the role of healer in this therapy could be assumed by male or female.[12]

The negative aspect of the power possessed by women is personified in the *doma* or witch. Like the power to heal, the power for evil was passed from mother to son in Senegambian society.[13] This was the basic image that French colonizers chose to emphasize. In an era when psychotherapy was almost unheard of; where the "frenzied" state of women of all cultures was to be expected, the spiritual possession of Senegambian women must have pointed to their primitive frailty and must have underlined what already had been known in France: women were unfit for the rigors of duty in the colonies. Even if this was not the case, this medicine as part of Senegambian

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[11] H. Collomb and P. Martino, "La Possession chez les Lebous et les Wolofs du Senegal: Sa fonction de regulation [sic] des tensions et des conflits," *Bulletin Mensuel de Faculte Mixte de Medecine et de Pharmacie*, XVI (1968), 127. B. Diop, R. Guena, and H. Collomb, "Detection et Prevention des Maladies Mentales au Senegal," *Bulletin de la Societe de Medecine d'Afrique Noire de Langue Francaise*, XIII (1968), 933–936. Morton Beiser, Winthrop Burr, Jean-Louis Ravel, and Henri Collomb, "Illnesses of the Spirit among the Serer of Senegal," *American Journal of Psychiatry*, 130:8 (1973), 882; 884.

[12] R.P. Henri Gravand, "Le 'Lup' Serer: Phenomenologie de l'emprise des Pangol et psychotherapie des 'possedes'", *Psychopathologie Africaine*, II, 2 (1966), 216. In his "Le Symbolisme [sic] Serer," *Psychopathologie Africaine*, IX, 2 (1973), Gravand writes of the "harmonics" of Serer society which are the "principal note concerning the feminine cycles"; the cycles which regulate "fecundity," the "lunar cycle" [time], and life itself. 250.

[13] David Ames, "Belief in 'Witches' Among the Rural Wolof of the Gambia," *Africa*, XXIX (1959), 265.

religious culture was a challenge to the anti-clerical, anti-religious tone of the French Republic. The healing therapies of these women (and their sons) were characterized much as Jean Suret-Canale noted in the Sarraut epigram that opens this chapter:

> for colonial doctors there was no indigenous medicine, only that of 'witch doctors' and 'quacks'.[14]

This is a rationale that needs to be remembered when the impact of Islam is considered in relation to the development of the *infirmier*. Suret-Canale's observation becomes important when it is understood that Islamic therapies were regarded in very much the same light as other indigenous therapies. In fact, as Christopher Harrison noted, the French brought their anti-clerism with them and applied it liberally to the Islamic marabouts.

Like the village priest, the marabout was accused of obfuscation and of leading a life-style which essentially exploited the mass of believers. The role of the supernatural—in the form of amulets and special magic formulae—was seen to be as common a feature of rural French Catholicism as it was of popular Islam in Africa.[15]

However, in spite of French hostility to Islam, some writers have speculated that the patriarchal nature of Islamic society and its view of the role women must have been, in part, responsible for the emergence of the African male as the most visible element of the colonial health care apparatus. Donal Cruise O'Brien has argued that the Islamic attempt to impose patrilineal succession on Wolof society had significant repercussions.[16] Historically, this view might be justified in the emergence of the male-dominated *ulama* and the later rise of the marabout that dominated rural Senegambia. The rise of these two Islamic classes was key to the demise of indigenous leadership. The implication is that their activities helped to erode the power

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[14] Jean Suret-Canale, *French Colonialism in Tropical Africa, 1900–1945* (New York: Pica Press, 1971), 403.

[15] Collomb and Martino, "Possession," 130. Christopher Harrison, *France and Islam in West Africa, 1860–1960* (Cambridge: Cambridge University Press, 1988), 42. The accounts of J.-B. Henry Savigny and Alexander Corread, two French naval officers shipwrecked in Senegambia in 1816, also illustrate this distaste for religion in general when they compared the prodigious use of amulets worn by Africans for religious and medical purposes with the conspicuous show of the crucifix by Spaniards. *Narrative of a Voyage to Senegal in 1816* (Marlboro: The Marlboro Press, 1986), x; 192–193.

[16] Donal B. Cruise O'Brien, *Saints and Politicians* (Cambridge: Cambridge University Press, 1975), 3; 24.

of women. Working on this assumption, the same might be said of other Senegambian societies that recognized the specific powers of women and their contact with Islam. This seems to be the basis for John Bryant's assertion that "Senegal is almost entirely Moslem, and this has influenced nursing. Nursing is a predominantly male profession in Senegal.[17] In this thinking, Islam becomes the critical qualifier for the emergence of the male nurse and the "subordination" of women within the arena of Senegambian health care.

The fact is there seems to be nothing in Islamic or Senegambian society that would inherently exclude women from healing. In his work "L'Islam et la Maladie," Haissam Aloudat notes the specific role of female healers in pre-Islamic society and their incorporation into Islamic tradition and their "important role in the transmission of the Hadith."

> The female healers [*guérisseuses*] worked in the oases, the villages and the cities. Their functions were multiple and varied. They would be qualified in our days as paramedicals. They were midwives, pediatric nurses and they assisted in the dressing of wounds in the time of wars and in raids.[18]

Aloudat goes on to say that in the early period of Islamic development, these women were "numerous" and they "played an important role in the wars of conquest and influenced the position of Islam concerning the participation of women in combat, and in its attitude vis a vis medicine." Care giving among pre-Islamic and Islamic women had practically the same attributes as the profession did among the women of Senegambia: it was religious with an overlay of the supernatural; there was the practice of magic and the use of amulets for healing. In this regard, it became the "medicine of the good women.[19]

In his nineteenth century travels in the Arabian Desert, Charles Doughty alluded to what Manfred Ullmann described when he wrote that

> the practitioners of medicine were called *tabib, asi* or *nitasi.* The care of the sick lay in the hands of the women who themselves carried out the treatment and to do so took refuge in magic incantations.[20]

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[17] John Bryant, *Health and the Developing World* (Ithaca: Cornell University Press, 1969), 153; 154.

[18] Haissam Aloudat, "L'Islam et la Maladie," (unpublished doctoral thesis), Paris (1983), 73.

[19] Ibid., 73–78.

[20] Manfred Ullmann, *Islamic Medicine* (Edinburgh: Edinburgh University Press, 1978), 3–4.

These ideas are supported by Fazlur Rahman in terms of the custodial privileges that women seem to have had over health care in pre-Islamic and Islamic society, and in the concept that an actual branch of health care which could be identified as "nursing" (*timardari*) could be traced and passed down through the vast compendium of Islamic health care sciences.[21]

What Aloudat, Ullmann, and Rahman suggest of pre-Islamic and Islamic societies and the role of women as caregivers holds true for what is known of religious syncretism in African societies. In this regard, scholars of religion in Africa have argued that the appeal of Islam was, in part, its ability to absorb some of the variation manifested in the African cultures with which it had contact. By extrapolation these ideas might be summarized in the concepts of synthesis and symbiosis that imply that female health care givers functioned within the context of Senegambian Islam on the basis of their efficacy in the indigenous sector. The key to that efficacy is seen in the ritual nature of their healing and the relation of that healing to ethnic devices, more so than the religious overlay of Islam.[22] However, there does seem to be the notion in Islamic intellectual circles that healing as performed and preserved by women is a "folk-medicine." Interestingly enough this is the same designation that Europeans applied to *both* indigenous and Islamic medicine in Senegal.[23] The designation becomes reflective of the inability, or the refusal, to differentiate between the two. It is, nonetheless, an emphatic declaration that both are beneath, and therefore subject to, the powers of western, empirical medicine and the health care institutions that administer it.

> [T]here are certain distinctions within nursing that can be directly attributed to Ghana itself and these have an historical . . . influence. . . . At present, the great majority of nurses are females; but this has not

[21] Fazlur Rahman, *Health and Medicine in Islamic Tradition* (New York: The Crossroad Publishing Company, 1989), 33; 79–80.

[22] Collomb and Martino, "La Possession," ibid. Diop, Guena, and Collomb, "Detection et Prevention," ibid. Gravand, "Le Symbolisme Serer," ibid. Keita, "Ethnicity," 318–319.

[23] There is, in general, a reluctance to make the differentiation between indigenous and Islamic health care even in contemporary literature. The notion of "traditional" medicine includes both Islamic health care as well as the vast array of indigenous treatments that demand categorization in their own right. This is best illustrated in the interchange of the terms "marabout" and "healer." See Collomb and Martino, "La Possession," 130.

> always been the case. It was difficult for the early colonial administrators and missionaries to recruit females into nursing, so *in its inception nursing was primarily a male occupation.*[24] (Italics added)

The circumstances of a place far removed from Senegambia, colonized and administered in a fashion that could be distinctly differentiated from colonial Senegal, present a key to the puzzle of male nursing in Senegal and in Africa in general. The Ghanaian experience to which Patrick Twumasi refers is key to understanding the Senegalese question in that it places the issue of the male nurse for both Senegal and Ghana in a more universal context. What Twumasi exposes is that the institution of the male nurse in Africa is a construction of colonization. Twumasi's observation might be taken further with the assertion that nineteenth and early to mid-twentieth century colonization was a male *and* capitalist fabrication.

Early colonial interaction was constructed in the minds and the activities of the period, and therefore perceived primarily as relations between males. Colonization was equated with "conquest," and conquest in the romance of the age was a male preoccupation. In the conventional sense colonization was the act of confiscating the property and goods of indigenous males—the "natives." This often included their women. The romanticism that accompanied the colonial process and its subordination of women to items of property was well summarized by Friedrich Engels in *The Origin of Family, Private Property and the State*. There, Engels noted that male supremacy had become the hallmark of capitalist life. With notions of "men's work" and "women's work," and the cloak of chivalry, European women could be overtly excluded from the process of colonization. And nurses, of necessity, in this process, would be men. Here, we need to seriously consider—again—the role and *hospital*-ity of the signares as a critical feature of the colonial political economy.[25]

The empirical data on this exclusion in an area such as the Senegambia is related to the actual number of European women

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[24] Patrick A. Twumasi, *Medical Systems in Ghana: a Study in Medical Sociology* (Accra-Tema: Ghana Publishing Corporation, 1975), 79–80.

[25] This assertion is made with the full understanding of the role which women like Anne Raffenel and Flora Lugard played in furthering the process of imperialism. While their contributions are real and critical, they were regarded by their male contemporaries, and to a large degree by the historians of the period, in much the same light as the male nurse—as anomalies.

who took part in early colonization. Rita Cruise O'Brien argued that the "absence of European women in the trading post and colony until well into the twentieth century had an important effect" on the colony's internal dynamics. One of the most visible effects was the creation of a mixed French/African population, the *metisse, who became critical to the establishment and expansion of the colony*.[26] While the social, and the *political economic* imperatives of the liaisons between French men and African women are fairly clear, the O'Brien citation provides a medical rationale for "*metissage*" that is both astounding and *fantastical*, and yet, is one of the clearest revelations of how the French felt about the Senegambian environment and how they might safeguard their *fortunes* in it. The creation of a "mixed" community was

> a calculated effort to ensure a loyal local elite with French blood flowing in its veins, *and yet a natural immunization against the diseases fatal to Frenchmen*.[27]

In an environment where the French viewed every disease as a potential epidemic; in a venture whose predominant military ethos precluded European women and yet was marked by a significant population which gave witness to the numerous unions between white men and black women, how is the insertion of the African male explained here? On the side of speculation, it might be argued that

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[26] Marcroft, "The Signares," 14–15; 24; 27–28. Aside from the data that can be assessed concerning the political economic origins and power of the signares, two notes need to be posited concerning Engels' observations. Firstly, the source of Engels' analysis was fundamentally European. As such, the source and its analysis provide significant clarity on the preoccupations of European males *and* females. However, secondly, as much as we might wish it otherwise, the application of Engels' analysis "whole-cloth" may cause us to miss the differences and nuances at work in Senegambia as they relate to the agency of certain groups of women, and the activities of those women within the broader political economy.

Observations on the professionalization and attempts at the exclusive gendering of nursing, particularly through the emergence of republican France, speak to struggles not just between church and state but between genders as well. See Maghan Keita, "Disease, Gender and Imperialism: the Evolution of the Male Nurse in Senegal," (unpublished paper 199_). Jacques Léonard, "Les Médecins et Les Soignants: Femmes, Religion et Médecine—Les religieuses qui Soignent, en France au XIX^{e} siecle", *Annales*, 32, 5 (September/October 1977), 887–888. Jacques Leonard, *La France Médicale au XIX^{e} Siècle* (Mesnil-sur-Estree: Archives Gallimard/Julliard, 1978), 14. Jacques Leonard, *La Médecine entre les Pouvoirs et les Savoirs* (Paris: Editions Aubier Montaigne, 1981), 1; 7–8.

[27] Rita Cruise O'Brien, *White Society in Black Africa: the French of Senegal* (Evanston: Northwestern University Press, 1972), 33. Michael Crowder, *Senegal: A Study of French Assimilation Policy* (London: Methuen & Co. Ltd., 1972), 2–11; 21–23; 32.

the French perception was one that saw only males at risk (and specifically French males at that). The instance of unions between French men and African women could also be built into a postulate which would read, rather crudely, that "only males got sick". While this was obviously not the case, both French and African males within the context of colonial Senegambia had to regard themselves at greatest risk by virtue of *their exposure to one another*. This conclusion can be drawn from the "male-ness" of colonial medical reports in regard to the care-givers, the ill, and *the carriers of disease* themselves. In this context, the "native" is always implicitly *male*; and the native is the carrier of disease.

The French health care system was replicated to the degree that it could be through the establishment of the *Corps de la Sante*. In this way, the French attempted to effectively use their military medical personnel in the process of colonization. This meant that every level of the military health care establishment would be transported to the colonies. This included those French men who would serve as *infirmiers*. However, like the doctors they served under, their numbers could have hardly been sufficient to meet the work at hand; and, like those same doctors, they were victims to racism and the maladies of the region. Their numbers would have to be augmented.[28]

It is here that the French logic of the "surrogate" is rationalized (again). The *metisses* are created as surrogates to safeguard the fortunes and future of France's colonial merchant class; the male nurse becomes the surrogate in the battle against disease. And ironically,

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[28] Pospournier, "Rapport de M. Pospournier, Inspecteur et Directeur General des Hopitaux," circa 1747, ANS. "Gouvernement Général de l'Afrique Occidentale Française/Colonie du Sénégal/Service de Santé/No 201/Le Médecin Principal, Chef du Service de Santé a Monsieur le Gouverneur Général de l'Afrique Occidentale Français/St. Louis," (9 July 1897), Archives National Français (hereafter referred to as ANF), 3. Marc Sankale, *Médecins et Action Sanitaire en Afrique Noire* (Paris: Présence Africaine, 1969, 33. As the African was introduced into the ranks of the *infirmier*, those male nurses of European origin were promoted nominally to supervisory roles over Africans. These positions have sometimes been referred to as "aides," though the terminology has been used to describe Africans as well. In his letter to the Governor General of West Africa, the Chief of Health Services wrote that the 1897 decree establishing "indigenous male nurses" (these are assumed to be for use in civilian facilities, and were predated by African *infirmiers* in military service) would provide European "aides" with a sense of professionalism given "the important role that they must play *vis-à-vis* our indigenous personnel." "Gouvernement Général de l'Afrique Occidentale Française/Colonie du Sénégal/Service de Santé/No 201/ Le Médecin Principal, Chef du Service de Santé a Monsieur le Gouverneur Général de l'Afrique Occidentale Française/St. Louis," (9 July 1897), ANF, 3.

those who became the overwhelming victims of disease and who defended and expanded the frontiers of the colony and the Empire were surrogates themselves: African troops.

The use of African troops suggested three things. First, as surrogates, they might reduce the number of European casualties. Second, as Africans—the "natives", so to speak—they might also be the traffickers of illness themselves. And third, if this were the case, precautions had to be taken to guard against any possible contamination.

As William Cohen relates, after 1857, the African became a standard feature of French colonial expansion on the continent.

> In colonial expeditions troops recruited from the colonies usually outnumbered Europeans by 4:1 to 10:1. . . . If death rates were quite high, what made them somewhat tolerable is that the total number of European casualties were [sic] low.

In fact, as has been mentioned, it was the lamentations of medical officers such as the Commandant Particulier Hesse[29] that caused General Faidherbe to drastically alter French colonial military policy by recruiting African troops.

Yet the very troops that were to defend and expand the Empire were also the cause of great concern. The notion that *these* "natives" might be disease carriers became the basis for policy concerning the care and maintenance of African troops. So Africans were *racially* sequestered from their European counterparts for reasons of health as French authorities heeded injunctions which were characterized by Medical Officer Doublet's previously mentioned assertions of 1860. Doublet's argument may have been one of the earliest espousals of the French policy of the "*cordon sanitaire*".[30] Yet, those same officers

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[29] Hesse, "Copie d'un rapport adressé le 25 Août 1830 par M. le Commandant Particulier sur le terme de l'épidémie qui règne à Gorée du 14 Juin jusqu'à la fin de Juillet," H6, ANS, 4. William B. Cohen, "Malaria and French Imperialism," *Journal of African History*, 24 (1983), 30–33. Myron Echenberg, *Colonial Conscripts: The Tirailleurs Sénégalais in French West Africa, 1857–1960* (Portsmouth: Heinemann Educational Books, 1991), 21.

[30] Mr. Doublet, "Rapport de Mr. Doublet sur le navire l'Etoile—1860," H1, ANS, 40–41. "Mesures prises par le Corps de Troupes pour la dissémination en cas de Maladie Contageuse à Podor," (14 February 1892), ANF, 3. Miguel, "Service de Santé/Assanissement du poste et construction d'une infirmerie ambulance/Le Médecin 2e Classe des Colonies Miguel à Monsieur le Médecin Principal Chef de Service Sanitaire de 2e Arrondissement du Sénégal/Sedhiou," (15 Octobre 1895), ANF, 4–5. "Note Circulaire/No C.123/portant instruction pour la préparation de dissémination en 1902: Afrique Occidentale Française/Commandant Supérieur/Etat Majeur," (27 March 1902), ANF, 1–6.

also argued that the African was best suited for military action because of certain inherent immunities; and in the same sense, the *infirmier indigene* was equally well suited to cross the *cordon sanitaire*.[31]

Epidemic and Profession

The scarcity of Sanitary Corps officers is very large in Senegal.[32]

From this point it seems necessary to extrapolate on the importance of the *infirmier*. The extrapolation is based, primarily, on French reaction to the Malaria and Yellow Fever[35] epidemics that continually plagued them during the colonization of Senegambia. To do this however, some attention needs to be given to the late colonial and early independence periods in Senegal.

The proposition at work here is this: the French constructed the colony of Senegal on several premises: there was the implication of "conquest" as a gender-determined prerogative of men; there were notions of the inextricable linkage of disease and race which permeated health care; there was the idea of biological determinism in the apportionment of tasks. All of these premises placed certain limitations on French colonization, the most evident of which related to demography. The modest size of the European population and its fear of further depletion were cause for the establishment of policy that both repelled and embraced the African. It seems safe to speculate

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[31] Gwendolyn Wright, "Tradition in the Service of Modernity: Architecture and Urbanism in French Colonial Policy, 1900–1930," *Journal of Modern History*, 59 (June 1987), 299–301; 303; 309–312. Also see Philip D. Curtin, "Medical Knowledge and Urban Planning in Tropical Africa," *American Historical Review*, 90 (1985), 594–613. M.A. Kermorgant, *Epidémie de Fièvre Jaune au Sénégal du 16 Avril 1900 au 28 Février 1901* (Paris: Imprimerie Nationale, 1901), 3; 89; 92.

[32] "Correspondence Déepart du Service de Santé," No. 40, ANS. Kermorgant, *Epidémie*, 21. In the Yellow Fever epidemic of 1900/1901 in Senegal, the statistics indicated that African troop mortality was considerably less than that for Europeans: 29 out of 225 deaths. Numbers such as these supported the notions that Africans were less susceptible to some diseases than others; and particularly to those to which Europeans readily succumbed. Kermorgant, 44–45. Cohen, "Malaria," 32. Marcovich reports that the same ideas were prevalent in Algeria and applied to the Arab population: "Natives seem to be genetically adapted." "French Colonial Medicine," 107.

[33] Dodds, "Sénégal et Dépendances/Commandant Supérieur des Troupes/le Colonel Dodds, Commandant a Monsieur le Gouverneur du Sénégal/No 689," (28 June 1891), ANF, 2. See Cohen, "Malaria," 23–35.

that in no place was this more evident than in the area of health care and with the promotion of the position called "male nurse."

As Marcovich has pointed out, the dominant medical practice in the French colonies could be summarized in the notions of the 'contagionist school.' This school mandated that Europeans protect themselves from epidemics by healing "diseased natives." One crucial problem here, was the shortage of health care personnel. The literature of the period is replete with requests from the field for doctors and other medical staff. It can only be assumed, in the very real sense, that the overwhelming number of these requests could not be honored.

What probably did occur was more in keeping with the report of Doctor, Second Class Miguel for the third trimester of 1895. Dr. Miguel reported that he had established three secondary health posts along the southern line of march in the Casamance region. One was in an area along the Casamance River where life was very "difficult for Europeans"; and another at a camp of African troops.[34] In all probability, at least two of the secondary health posts were staffed by an *infirmier*. Though there is no certainty that the staffing of these outposts took place before 1897 with the call for the formal establishment of *infirmiers indigènes*, they might have been staffed by Africans given that military policy usually outpaced civilian administration, often by decades, and sometimes by centuries, given the military nature of colonization.

The degree to which Africans were used as male nurses in the military is suggested by the campaign against sleeping sickness in Togo. Suret-Canale has written that the Togo operations began in 1924–25 with ten doctors, "twenty European assistants" and "150 male nurses." It seems prudent to assume that the "male nurses", in contrast to the "European assistants" were African. By 1931, the staffing for this project had increased to 18 doctors, "36 European

[34] Marcovich, "French Colonial Medicine," 108. Borgnis-Desbordes, "Colonne Expéditionnaire du Haut-Fleuve," (undated), ANS, 218–221. "Le Médecin en Chef, Chef du Service de Santé a Monsieur le Gouverneur du Sénégal et Dépendances, No 656," (21 Mars 1889), ANF, 1–3. "Sénégal et Dépendances/Service de Santé/No 295, Au Sujet du Service Sanitaire de la Colonie/Le Médecin en Chef de 2eme Classe de Colonies, Chef de Service de Santé à M. le Gouverneur Général de l'Afrique Occidentale Française," (27 Novembre 1895), ANF, 1–4. Miguel, "Service de Santé/ Rapport Trimestriel/3e Trimestre 1895/poste de Sedhiou/Le Médecin 2e classe des Colonies Miguel, à Monsieur le Médecin Principal Chef du Service Sanitaire du 2e arrondissement au Sénégal/Sedhiou," (10 Octobre 1895), ANF, 1–3.

agents" and "400 male orderlies." The ratios of European to African may be an indication of the level of importance assigned to the African *infirmier* throughout the colonies.[35] The military campaigns, and in particular, the epidemics which occurred almost seasonally as one observer reported[36] proved that the African male nurse was indispensable; if nothing else, the number of patients he would have to treat made this so. In his work on the Yellow Fever epidemic of 1927, Inspector General Lasnet, harkened back to one of the underlying rationales for the use of the African in a medical capacity. As Lasnet surveyed the morbidity and mortality lists of this epidemic he noted that for the reported cases of 190 infected and 123 dead, there were no Senegalese. He then recalled that an 1836 thesis concerning the 1830 epidemic on Goree, pointedly titled, "*Role des Indigènes*" related that the African population on Goree "had not suffered." In subsequent bouts with Yellow Fever in 1882, 1900, 1911–12, and 1926, Lasnet reported that there was not a trace that the indigenous peoples had presented the suspected manifestations which seriously held the attention.

Lasnet's conclusions on African resistance to Yellow Fever did not preclude his arguing that when "guarantees for hygiene" demanded, wherever practical, "the segregation" of indigenous populations should receive the highest priority.[37] Yet the dualism of his arguments illustrated the contradictions in French health care policy as it reflected on the danger *and* the utility of the African male. Again, the fragility of the French situation can be illustrated demographically. In 1889, St. Louis had a total population of 20,000; Dakar and Goree each had estimated populations of 2,000; and, Rufisque had approximately 7,000. By 1927, Lasnet commented, there were over 20,000 Africans *alone* resident in Dakar "in a part of the city pell mell with European houses." He was forced to conclude that in a place like Senegal, it was almost impossible to segregate the infected.[38] His predecessors

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[35] Suret-Canale, *French Colonialism*, 409.

[36] Etienne Lafaure, *Considérations Pathologiques sur les postes de M'Pal et Louga (Sénégal): Précèdes d'une Notice Géographique, Ethnographique et Climatologique* (Thèse: Faculté de Médecine de Montpellier, 9 Février 1892), ANF, 41–43. Suret-Canale, *French Colonialism*, 413.

[37] Lasnet, *Relation de l'Epidémie de Fièvre Jaune au Sénégal en 1927* (Paris: Office International d'Hygiène Publique, 1929), 4; 17.

[38] Lasnet, *Rélation*, 33.

seemed to have drawn similar conclusions with the establishment of the *infirmiers indigènes* in 1897.

It is clear that the later conclusions of medical officers such as Lasnet were based on the historical circumstances of epidemics in Senegal *and* racist assumptions concerning infection and treatment. The circumstances and assumptions always placed the French in close proximity to their worst fears because of their need for Africans to perform the major tasks of colonization. The Yellow Fever epidemic that began in 1882 and lasted sporadically through the turn of the century becomes a fitting final example of this.

At the outset of this period, the two essential elements of French colonial life, the military administration and the commercial class, were in contention with one another. Each side was preoccupied with the idea that the activities of the other were, at least in part, responsible for the transmission of the disease and the inability to suppress it. The conflict began over a quarantine of Senegal's major commercial centers. This meant restrictions on traffic in and out of these centers.

The commercial sector battled the military over the nature and duration of the quarantine. In 1888, when the epidemic seemed at its height, one of several quarantines went into effect. The four communes of St. Louis, Rufisque, Dakar, and Goree were the areas most immediately effected. They were the centers of trade. Delegations from these cities were caught in a barrage of cable traffic that described the conditions of the quarantine and its consequences. It was clear that the quarantine would effect everything including transport and the disembarkation of troops. Concurrent with this was a decree establishing the *infirmier indigène*. By May 1888, the powers of the commercial sector were being felt. In May of 1889 the President of the Chambers of Commerce of Rufisque, Goree and Dakar complained to the Governor of the colony that the quarantine had placed undue strains on commerce and was ineffective, and should therefore be lifted. The Governor, relaying these complaints to the Director of the Interior, noted that the provisions of the quarantine were much more stringent than those imposed in 1884. The Governor requested that the Director of Health be consulted and that a policy be constructed which would reconcile business interests with "the indispensable precautions for the preservation of the colony." The response of the Director of Health was that the quarantine should be extended, and where at all possible, there should be cooperation

with the British to quarantine their colonies as well. The Director had clearly overstepped his bounds. In August 1889, the council of Gorée voted to lift the quarantine over the objections of the medical officer.[39] In December 1891, the Commissioners of Health for Dakar, Rufisque, and Goree countered by establishing a rigorous quarantine on rail traffic between St. Louis and Dakar, and a cordon sanitaire around the rail service.[40]

In the midst of this was the military, forced to police the quarantine and to monitor its own actions within these restrictions. Soldiers who had been on detail beyond the limits of the communes were quarantined outside the cities at what were considered reasonable distances. They were also sequestered from African villages for fear of contamination.[41] In the fear of the disease there was the fear of the soldier himself.

The numbers of troops quarantined were not insignificant. In one instance, the Commandant Supérieur had to ask how 360 troops arriving from Brest might be quarantined; in another, cable correspondence described the quarantine of 80 African sailors along with an undisclosed number of troops who had been prepared to embark on the ship *Mytho*.[42] They all were at risk either through their attempts to enforce the quarantine or as victims of it themselves.

They, above all others, were suspect. In the uncertainty of the ways in which the epidemic was transmitted, medical authorities looked at every possible vector no matter how implausible. Kermorgant noted in 1901, that the principle ways in which epidemics had spread included troop movements. The epidemic of 1900 had struck a number of commercial houses which lead him to speculate that Yellow Fever might, in fact be carried in merchandise, particularly

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[39] Rita Cruise O'Brien, *White Society*, 43. Lasnet, *Rélation*, 33; 44.

[40] "Cabinet du Gouverneur/Le Gouverneur du Sénégal et Dépendances au Directeur de l'Intérieur/Aux Sujet des Quarantaines imposées aux Provenances du Sud pendant la période du 1e Juin aux 15e [sic] Dbre [sic]," (27 May 1889), ANF, 1–3. "Mairie de Gorée/A Monsieur le Directeur de la Santé/Gorée," (29 Auot 1889), ANF, 1.

[41] "Procès Verbal de la Séance du 31 Décembre 1891," H5, ANF, 18.

[42] Nivard, "Nivard, Médecin Principal, Chef du Service de Santé, 2eme classe au Capitaine Gossot, Sous-Directeur d'Artillerie/Dakar," (21 August 1891), ANF, 2–3. "Commandant Supérieur des Troupes/Le Colonel Badens, Commandant Supérieur des Troups à Monsieur le Gouverneur du Sénégal et Dépendances/No 132–3," (4 October 1892), ANF. Even among the military, the quarantine was not always respected. "Service des Postes et des Télégraphes/Bureau de St. Louis/

clothing. He theorized that many of the bales of clothing which were now appearing in the warehouses of the major centers were, in fact, items that had been contaminated by tailors (presumably Africans) who had then passed the infected woolen garments on to the African troops. Within the framework of this epidemiology the Africans were perfect choices as carriers of disease.

Yet the real question here is who would see to the medical needs of these men while they were in quarantine? That was answered by the decree of 1897. In many ways the decree was an acknowledgement of the efficacy of the service of those Africans who served the military medical corps. The creation of a civilian counterpart recognized their work and estimated their worth as a *human* cordon sanitaire between the French and their subject peoples. As the decree went on to state, the case had been proven in Algeria in a preventative vaccination campaign, the *infirmier indigène* would "assist the indigenous peoples and favor the work of colonization.[43]

> They [the doctors] are in effect doctors for 'the whites' and very secondarily doctors for 'the niggers'.

Rene Trautman's quote, from the novel *Au Pays de Bataoula*, coupled with Colonel Dodds' assertion of the scarcity of doctors in Senegal underlines the necessity of the male nurse. The two statements provide some clarity on the expansion of Africans in health care positions from 1897 through independence. In March 1913, on the eve of World War I, the Medical Inspector of the Health Services suggested to the Governor General that the establishment of a corps of "*agents indigènes d'hygiène*" was "necessary and indispensable to the maintenance of a good state of public and private health and therefore to the normal economic movement of the colonies.[44]

The African male in health care had become the "norm." The process of increasing the number of Africans in the Senegalese health

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Télégramme," (13/9/1892), ANF. Badens, No 132–3. "Ministère des Postes et des Télégraphes/Bureau de St. Louis/No 2433/W-56," Dakar (2 November 1892), ANF.

[43] Kermorgant, *Epidémie*, 13; 24. "Rapport sur l'Application au Sénégal du Règlement du 10 Mars 1897 sur le Fonctionnement de Hôpitaux/No 164," ANF, 4.

[44] Rene Trautman, *Au Pays de Batouala*, quoted in Suret-Canale, *French Colonialism*, 407. "Gouvernement Général de l'Afrique Occidentale Française/Services Sanitaires Civil Inspection/No 52F/Analyse: Organisation d'une Section des Agents Indigènes du Service d'Hygiène du Sénégal/Le Médecin Inspecteur des Services Sanitaires à Monsieur le Gouverneur Général de l'Afrique Occidentale Française (Personnel)/ Dakar" (5 Mars 1913), ANF, 1.

service continued well into the Independence period. Aside from the sector devoted to midwives, women began to make headway in the nursing profession, though their numbers still seem negligible. Curiously enough, the interventions of "progressive" non-governmental organizations, multi-lateral institutions and various agencies advocating "development" all seem wedded to the fictions that have emerged from the colonial period in relation to "men's work" and "women's work" ("men's work" is to make money; "women's work" is to make food). To that degree, USAID could write in 1980 that the problem it encountered in one project in the selection of health care staff (*secouristes*: first aid workers) was not that their selections were male, but that they did not have roots: married men with families, substantial fields being worked, probably thirty years old or more, and similar evidence of village attachment.[45]

That a project conceived in the later part of the twentieth century could make the same assumptions of the last century is somewhat unnerving. Yet, it is indicative of the fact that there is still very little real understanding of the evolution of the male nurse and the relationship of that development to the status of women in Senegalese society or in the greater global political economy.

In the conventional literature on health care the nurse is absent. In the literature on French colonial health care the *infirmier* is absent as well. Neither of these points should come as a surprise. The struggle for supremacy in health care in France and the attitudes of military medical personnel spawned by that struggle precluded all but the most cursory examination of the male nurse and his role domestically (in the metropole as the nurse in black face) and as an agent of colonialism. That must be coupled with the fact that one of the tasks of the colonial health system was the defeat of indigenous and Islamic systems of health care.

Yet, these men were, at times, the only entrée that their people had to health care. And though their training and profession marginalized them, in many ways their accomplishments were amazing and essential.

The desire to limit contagion and the transmission of disease demanded greater and greater precautions, "surveillances" and treat-

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[45] "Richard F. Weber, Graham B. Kerr, Herbert B. Smith, and James M. Seymour, *Senegal: The Sine Saloum Rural Health Care Project: A.I.D. Project Impact Evaluation Report No. 9* (Washington, D.C.: Agency for International Development, 1980), 8.

ment of the "native" population. The task could only be accomplished through the expansion of the role and the numbers of the indigenous health care worker. This amounted to the utilization of one segment of the African population to keep the remaining segment at bay.

In this explanation there is a *partial* understanding of the evolution of the male nurse. The links to capitalism and imperialism seem quite clear in the Senegambian context. The relations to gender are less distinct in that their origins, again within the Senegambian context, are clouded. In this regard, for the male nurse, gender within the framework of colonialism is tied to European phenomena more so than any African features that can be determined within the scope of this inquiry. Race, as a rationale for colonial conduct in certain areas, is also, in part, the rationale for the status of the *infirmier*. Race may have allowed French attitudes to fold back on themselves as they related to the struggle to wrest the nursing profession from women in metropolitan France by the early nineteenth century.

The nurse in black face. Race becomes utilitarian: it is to be used and avoided. In colonial Senegal, race very well may have become class, especially as it was articulated professionally in 1897. If race under these circumstances replicates the questions of gender in the Europe of the time, that is another question. It is complicated by the fact that the *infirmier* did not spring full-blown from Senegalese soil; he was a European import. In Senegalese life, as in European, the male nurse was representative of the displacement and replacement of women in the political economic sphere. However, within the political economic context of colonialism, no conclusions can be drawn from the existing data that might verify a notion that African men as nurses became "women" in the eyes of the French. Again the presence of European males in the same or similar positions seems to preclude that idea. The idea is also diminished by the fact that in the presence of the European woman, the best African male nurse would have been conceived as her lesser, not her equal. These men became, and for sometime remained, "niggers." What nursing did for these men was to further their integration into a political economy dominated by the French, and in that they further facilitated the integration of Senegambia, and all French West Africa. To this process, they were indispensable.

Yet, even here a certain irony remains. The daughters of Sogolon Kedjou were not silenced. We need to return to the questions posed

by the "salubrity," the "hospitality," and the "*métissage*" associated with women—*signares*—who might also come from a tradition of, and be recognized by outsiders as, "*guérisseuses*." The "maleness" of what would become "professionalized" health care in colonial and post-colonial Senegambia could not escape the powers of women healers. That there was power is illustrated in the attempts at the diminution of the powers of the women of Senegambia, and in particular, those of the *signares*. The early injunctions of the Company against "*mariages à la mode*," and the wealth, power, sophistication, and "*salubrité*" of the *signare* households, families, and their corporate structures, also spoke to health—the health of the individual *commerçant*, or company official, or military officer who engaged in these types of "*liaisons financières*"; and the political economic health of the colony as a whole as the *signares* and their progeny wielded increasingly more power. The secrets of Sogolon's children would not be lost on her. The "medicine of good women" might remain as well.

PART THREE

SOGOLON, HER DAUGHTERS, THEIR CHILDREN

CHAPTER SEVEN

POST-COLONIAL HEALTH CARE

All we can do is what we've been taught.

Massamba Diop

Contention and Agency

The fundamental question of this assessment, so far, rests on considerations of how the social product of pre-colonial and colonial Senegambia—*cum* Senegal—might be defined. If we go back to do Sandoval and accept his lament as one entrée into an analytical discourse on the political economy of this space, then it becomes clear that we open both the space and its history with *contention*. If this is acceptable, then that contention is the product of the *agency* of the various actors of the region and its history.

This contention and agency are illustrative of the processes involved in the construction and maintenance of political economic units—of polities constructed to control discrete segments of the region's resources at the levels of material, intellectual, and human interaction. For the sake of convenience and, I hope, clarity, I have defined several sets of players through designations of "traditional," "Islamic," and "colonial" ["French," "western," "modern"]. These designations have been complicated through a recognition of the internal dynamics that are inherent to each category and the ways in which internal players interact with one another and then across the wider political economic and historical landscape. So here, we experience not only the contention between the traditional powers of the *ceddo* and the forces of Islam, but within the Islamic "world" of Senegambia we also see the struggles between the *marabout* and the *ulama*.

The emerging European colonialism of the 17th through the 20th centuries—complicated by Islamic expansion and resistance to both these forms—had its own internal contentions. They are witnessed throughout the historical period by the wrangles between the Company and its agents, and then between later commercial interests and the state itself.

All of this, ironically, is linked and sometimes orchestrated, and backgrounded by the powers of women, real or putative. Those powers are seen in the emergence of the states of the region and their imperial designs. The mythistories of Mali and the Wolof states are instructive here, as are the actual interactions of women in the political economies of these states: the women of the complexes that will be identified as *signare*, and those not so readily recognizable who held and *hold* sway in the political economy of health care in their own communities. We are also treated to these dynamics in the expansion of Islamic patrimony, at the expense of women, and the European "professionalization" of occupations as male domains within the colonial context.

In the language of development theorists, these people—these *agents*—occupied the *margins* of this political economic discourse in relation to the hegemony of French imperial design, and to a similar degree in relation to competing *Islams*. The degrees of contention and conflict, the definitions of *marginality*, and its *definers* mark the ways in which we might approach the issues of the political economy of health care in the *emerging* post-colonial state.

This political economy clearly has history; there is a bequest—a legacy. Calculating the effects of this legacy—or legacies—is not a straightforward proposition. It must give way, again, to the recognition of agency in many, many quarters, at both the center and the margins. Conventionally, one obvious attribution of the colonial process was the creation of new demographies related to *new or renewed* urban structures. In the language of French colonization in Senegambia, demography, urbanization, and therefore the distribution of health care services were predicated on the concept of "utility"—hence the notion of "*le Sénégal inutile*."

At first blush, the conceptualization seems quite logical. Demographics were defined by the "push/pull" of the "new" colonial cities; these two, in great part determined the distribution of health care services and access to them. The other corollary was the necessary access, maintenance, and expansion of those areas that might be termed useful. The economic priorities that are witnessed on the part of French policy emphasize a utility that is tied to Sarraut's metaphor of the "orchard" of colonialism. Utility—"usefulness"—became a key barometer of the placement of people, structures, and services. Those areas that did not lend themselves to use were defined

as "*inutile*." These were the margins. These were the "unconquered" lands and the people who occupied them. Lands and people who might, in fact, be deemed "unconquerable." Lands, peoples and cultures that would continue to shape Senegal from pre-colonial through colonial into the post-colonial—producers of culture whose impact, as yet, have hardly been measured. Culture, including medical culture, that might *seep* in from the margins, "*infecting*," transmuting the health cultures of imperialism.

The analogy holds true for the "*Islams*" of the regions. The spaces of "infidels" and "heathens" were beyond their pale. So here, their terminology might be rendered in terms of what might be useful to each *tariqa*, recognizing the contention and competition between each of them; between them and non-believers; between them and the various European interlopers—in particular, the French. Complicating the picture from the "pre-colonial" through the colonial to the post-colonial, were issues of religion and ethnicity that characterized demography, structural dynamics, and the access to resources such as health care. These were historical, and overlapping layers of activity, all of which shaped health care in post-colonial Senegal. To these, class, gender, and conceptualizations of "modernity" (e.g. "the western") must be added.

Dynamics

Clearly the dynamics of the construction of Senegal's post-colonial political economy and its institutions of health care move well beyond the characterizations of colonial structures and attitudes. In fact, this analysis begs a much more nuanced interrogation of all the agents in a critical reassessment of the colonial as well as the periods that precede and succeed it. Yet the colonial becomes a fit starting point for moving into an analysis of the post-colonial. Within the space of French hegemony, French structure and attitudes certainly dominate. Those structures and attitudes have become the putative marker for the institutions and functions of the post-colonial state. Our assumptions for that state are the same that we project on conventional imperialism and colonization—there is little critical analysis of the absoluteness and ubiquity that are attributed to the state in either period. There is little assessment of the agency and dynamics of the margins.

Having said that, the bequest of the colonial state offers a snapshot of one segment of the political economy of health care in contemporary Senegal. Here, "*Senegal inutile*" becomes the illustrative device: people, structures, services. The opening of the post-colonial period found approximately one-half of Senegal's geographic area and one-quarter of its population outside of the range of the state's health care services. The anomalies in this pattern are in areas that have the potential for economic development. Utility. A utility defined by colonial political economy and the region's continued and subsequent integration into a broader, deeper global economy. In a global, capitalist political economy—perhaps in any political economy—the logic of this should come as no surprise; nor should it be attributed solely to colonization. The logic in the marshalling of resources in the attempt to maximize their productive potential is standard economic policy—the crux of sound political economic theory. At issue are the ends of such theorization. In this regard, the "usefulness" and "utility" of the post-colonial political economy is understood. And in this, to a large degree, it is rationalized as well.

So here, in the attempt to marshal resources and to insure the greatest level of production, a prime illustration of the anomalies spawned by the notion of "utility" as a colonial bequest is seen in the Fleuve region. Fleuve has a relatively high level of health care facilities in relation to a fairly low population. The region has three hospitals, two of which were constructed in 1977, and five health centers, also built in 1977. The massive development of the region's health care infrastructure was tied to the fact that the Fleuve was pinpointed as the center for a massive hydroelectric and irrigation scheme. The irony of both the heavy outlays in capital and health care development was that by 1980 most of these health care facilities were inoperable because of the lack of funds for equipment and personnel.

> Health posts are numerous. . . . However, most of these posts are not operational because of insufficient personnel and medicines. . . . At times the remoteness of the health posts is one of the motivations that cause people to consult a traditional practitioner.
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> . . . In most centers there is an acute problem in securing proper health care personnel. But in the regions of Fleuve and Senegal Oriental, the problem of sparse population

> dominates the distribution of health there. . . . These centers cannot carry out their assigned functions because of the lack of personnel and medicine.[1]

The situation of the Fleuve region rests in stark contrast to that of Louga. In 1975, Louga had only three health posts, one private clinic and nothing else.[2] Data collected in 1980 and 1982 showed a marked increase in facilities, yet, the ratio of health worker to the general population still remained in the area of three doctors to approximately 418,000 people.[3] To underline this disparity, by comparison, Louga had only one doctor for every 139,245 persons to one doctor for every 4,102 persons in the region of Cap Vert where the capital city of Dakar lies. Along the same lines, Sénégal Oriental had no hospitals, one center for major endemic diseases and thirty-one health posts.[4]

These differences also reflect the priority given to the health care sector and its relation to national development. This is illustrated by the national budget. In the 1963–64 budget, health care allocations totaled 9% of all expenditures. In 1976, the public health allocation was only 5.3%, a total of five million francs CFA. Moreover, widely differing amounts were distributed to the urban and rural sectors. In 1974, the St. Louis-Dakar-Thiès area, which contains 25% of the population, received 60% of the medical budget.[5]

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[1] Lionel Robineau, "Environnement Africain: Approche cartographique de l'environnement médico-sanitaire au Sénégal", *Environnement Africain*, I, 4, 1975, 1; 6.

[2] Ibid., 8–9. Of course, the questions of "usefulness" and "utility," and Robineau's empirical data and its analysis are compounded by the theoretical propositions that frame this work. In the broader frame of political economy, the works of Ake and Amin should be revisited as they are presented in the opening segments of this work. Rati, Schultz, Vengroff, and others, comment on the optimization of human capital, particularly on questions of labor productivity and the provision of "services" such as education and health care. Contributors to journals such as the *International Journal of Health Services*, including Vincente Navarro, round out considerations on the political economy of health care itself. Again, in this regard, we are treated to the theoretical propositions that allow for the analytical treatment chosen here and illustrated in the very specific and discrete analysis of Senegal and its particular communities and their interactions in the post-colonial.

[3] Ibid., *nos. 4; 5.*

[4] Ibid. Ministère de la Santé Publique, *Etude du Plan Directeur de Santé Du Sénégal: Bilan Diagnostic des Formation Sanitaires: Région de Louga* (Dakar: République du Sénégal, February 1981), 18–52. (hereafter referred to as MOH *Etude: Louga*).

[5] Robineau, ibid., nos. 4; 5.

While little more than 5% of the national budget is allocated to health care, the average Senegalese spends at least 11% of the household budget on health care. The expenditures are probably greater than the 11% indicated. Costs are multiplied by forces which include family income; the ability to purchase medicine before an illness progresses; difficulties in communication between physician and patient; the lack of facilities to conserve prescribed medicines; and the psychological and infrastructural barriers that force patients to seek help elsewhere. The fact that help can be sought elsewhere is an indication of a widespread support for indigenous medicine.[6]

Various international organizations, such as the World Health Organization, favor the promotion of traditional health care practices in Africa. Those practices are seen as a fundamental way of utilizing existing, but often unrecognized, health care personnel, techniques and delivery systems. This can also be interpreted as a call to the margins; a recognition of their potential and power.

In Senegal, the western trained medical community admits the efficacy and widespread use of indigenous health care. They also indicate that they are neither in a position to promote or retard this process. They express pragmatic reasons for the wide-scale dissemination of traditional health care practices: the lack of infrastructure and its relatively inaccessible nature; the lack of trained personnel; and the inadequate distribution of medical supplies.[7]

Western trained professionals have noted that their education and attitudes have inhibited their ability to positively deal with indigenous health care. Massamba Diop's observation, first introduced to illustrate the professional limitations that faced western-trained African practitioners bears repeating. It gains a new refraction when it is measured in relation to the *practical* application of such training and skill.

> during our studies, we mainly received a hospital directed training. We are taught modern hospital techniques, with teachers who have been trained in the Ecoles Supérieures d'Infirmiers. Once assigned to a locality, *all we can do is apply what we've been taught.*[8] (Italics added.)

A study of the Dakar suburb of Pikine indicated that 9% of the population consulted traditional practitioners before seeking the help

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[6] Ibid., pp. 9; 30–31; 32.
[7] Ibid., p. 2.
[8] Ibid., pp. 42–43.

of a western trained practitioner. 96% of the Pikine population used traditional medicine solely or in conjunction with western medical treatment. Modest estimates are that at least 80% of Senegal's population uses traditional medicine, and that number is growing.[9]

In spite of legal prohibitions, people continue to use traditional medicine. To that another irony must be added. Many western trained physicians claim that traditional health care not only furthers the interests of the state but also those of the modern sector and international capital.[10] Western trained professionals and market analysts are assessing the potential of traditional pharmacopiea at both domestic and international levels.

This interest explores a number of issues. For instance, there is discussion of the general consequences that the "packaging" of traditional health care services might have on the Senegalese economy. There are questions of its potential profit margins, its impact on worker productivity, and the areas where such health care operations might be most effective. In the review of traditional health care as a viable market commodity, there are also questions of the nature of the domestic market, and how best to control it.[11]

These considerations are not lost on government planners.[12] The scheme for increasing groundnut production in the Fleuve region is indicative of the ways in which potential profits might motivate government planning. Planners implicitly and explicitly assigned some importance to the role of health care when the increase in medical facilities for the region is examined. Where there were, in the recent past, no hospitals, the region now boasts three; one less than Senegal's most populous region, Cap Vert, which contains twice the population.[13]

This is part of the Senegalese government's attempt to bring its marginalized population and areas into the economic mainstream.

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[9] Massamba Diop, "An Experience in a Rural Dispensary", *African Development*, I, 4 (1975), p. 111.

[10] Robineau, ibid., pp. 43–47; Interview with Lionel Robineau, Doctor of Medicine, Professor, Faculté de Médecine, University of Dakar, 11/12/79, Dakar, Senegal; Interview with Issa Lo, Doctor of Medicine, Director of Pharmacy, Professor of Pharmaceutical Medicine, University of Dakar, 11/8/79, Dakar, Senegal; Interview with Kaousou Samba, Researcher, Institut Fondamental d'Afrique Noire, 10/24/79, Dakar, Senegal.

[11] Robineau, ibid.; Lo, ibid.; Samba, ibid.

[12] Interview with Guy Maynard, Professor of Botany, University of Dakar, 12/5/79, Dakar, Senegal.

[13] Maynard, ibid.; Samir Amin, *Neocolonialism in West Africa* (Great Britain: Penguin Books, 1973), pp. 12–16.

The idea is to make them more productive and, at the same time, more receptive to market forces. The integration of traditional health care practices with those of the modern sector is an important part of this strategy.

The Integration of Traditional Health Care

Integration. The point has been alluded to above, and it will be treated with greater detail in a following chapter. International bodies, including the World Health Organization, the Organization for African Unity and its Center for Scientific and Technical Research, the Economic Commission for Africa, and the Conseil Africain et Malgache pour l'Enseignement Supérieur, have pressed for a broader role for traditional health care in Africa. Centers researching traditional health care dot the continent; various European countries, the United States, and the Peoples Republic of China have also expressed interest.[14] This interest can be translated in basic political economic terms that concern lessening dependency on outside medical interventions and increasing productivity through good health.

However, there is another debate that centers on one very important question: is it possible, within its present political economy, for a country such as Senegal to pursue a health care policy that will lessen dependency, and at the same time increase productivity? Theoretically, the answer is yes; but what are the real probabilities?

Senegal's move towards a new federalism in the late 1970's can be viewed as an attempt to improve various services through the process of decentralization. Yet, in light of the numerous ways in which decentralization or federalism can be interpreted, this option might also be seen as an attempt to lessen the financial and administrative burdens that the central government must carry.

The abandonment of these services by the central government is explained in part by one of the historical dynamics of Senegal's evolution. These dynamics are seen in the power held by various ethnic and religious groups and what these groups might hope to gain in the process of decentralization. That power and the goods and services that might accrue to it also affect the distribution of health care in the regions.

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[14] Lyons, ibid.

These dynamics and the agencies inherent to them can be illustrated by two discrete examples. First, the questions of the "Islams," contention, resistance, and accommodation to French hegemony, and its post-colonial dynamism can be seen in the rise of the Mourides. In a set of almost diametrically opposed dynamics, the Diola of Niandane in the region of Casamance are witness to interaction and integration as elements of the contention, resistance, and accommodation that emerge as the historical functions of relations not only between indigenous religious and ethnic entities, but between those entities and the "Islams," and then between the region and the colonial and post-colonial Senegalese states.

The Mourides of Sine Saloum

Several authors have identified the political and economic considerations that may have prompted the move towards decentralization in Louga, Diourbel, Sine Saloum, Fleuve and Sénégal Oriental. Lucy Behrman, D.B. Cruise O'Brien and others have used the Islamic Brotherhoods (tariqas) to illustrate the economic and political role that various religious and ethnic groups have played in Senegalese history. The Mourides have been extremely successful in parlaying religious allegiance into political and economic opportunity.[15]

Historically, Mouride dominance has meant opposition to various infrastructural developments including the establishment of western educational and medical facilities. However, the Mouride experience shows their ability to make use of a number of innovations introduced by the colonial government in order to enhance the power and the prestige of the marabouts. For example, Cruise O'Brien identified the Mouride acceptance of electricity, tarmac roads and borehole wells as evidence of this fact. Especially interesting was the widespread adoption of western agricultural techniques through which the colonial government used the sheikhs as the medium of dissemination. The acceptance of these innovations increased the political and economic position of the sheikhs and marabouts, individually and collectively. By independence, the growth of the brotherhoods'

[15] This assessment is one of global proportions. As the 21st century unfolds, the potentials and properties of "traditional" health care are no longer under debate. They are viewed as accepted, if even, unknown commodities. In fact it is their *commoditization* that becomes the paramount issue.

political and economic power allowed them to oppose any government policy that threatened their socio-political economic position. Samir Amin suggests that the sheikhs formed a distinct landed class which, though feudal in its outlook, realized that its interests were best served where it could accommodate and profit from its connections to capitalist modes of production and marketing.[16]

Writing in 1969, Cruise O'Brien stated that:

> the passing of electoral competition, finally and most importantly, has already weakened the political position of all Mouride leaders in depriving them of a large part of their power concessions from politicians.

However, he pointed out that the power of the Mourides might be reinforced "if the government came under challenge and was ready to make concessions to religious leaders in return for their support.[17]

Postcolonial history has shown Cruise O'Brien's analysis to be astute. The most important example of this was the carefully orchestrated dominance of Senegalese politics by former President Leopold Senghor's political party, the Union Progressiste Sénégalaise (UPS). This was done by ostensibly opening the political process to all parties in 1978–79; an act that foreshadowed the resurgence of Mouride influence. The UPS turned control of the regions over to Mouride leadership and their followers, who traditionally have voted the UPS line.[18]

The economic implications of these actions were twofold. It was estimated that the Mouride following produced one-third to three-fourths of the Senegalese groundnut harvest.[19] However, prior to 1973, there was a continual decline in production because of a depressed market and low prices from the government marketing board. This combination caused a large number of peasants to boycott production.[20]

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[16] Lucy Behrman, "Muslim Politics and the Development of Senegal," *Journal of Modern African Studies*, XV (1977), 261–277; D.B. Cruise O'Brien, *The Mourides of Senegal: The Political and Economic Organization of an Islamic Brotherhood* (Oxford: Clarendon Press, 1971), 214–236; 262–284; Amin, ibid., 3–40; G. Wesley Johnson, "African Political Activity in French West Africa, 1900–1940," in J.F. Ade Ajayi and Michael Crowder, eds., *History of West Africa* (New York: Columbia University Press, 1971), 482; 545; 552; 562.

[17] Amin, ibid., 3–33.

[18] Cruise O'Brien, ibid.

[19] Behrman, ibid.; Cruise O'Brien, ibid.

[20] Cruise O'Brien, ibid.

Before the nationalization of the groundnut trade, marabouts, traditional chiefs and Lebanese traders controlled the marketing process. With nationalization, the traditional and Islamic elements were cut out. However, there is reason to believe that the marabouts, as exemplified by the Mourides, still exert considerable influence by the sheer weight of their levels of production.[21] Production in Sine Saloum and Diourbel is controlled by the brotherhood as are an enormous number of votes. The level of production also provides the government with an important revenue base as well.

The cases of Sine Saloum and Diourbel pose serious challenges to the improvement of health care in Senegal within the present political economic framework, and within conventional notions of "development." Given government interest in the regions' economic status and political numbers and the fact that both are centers of powerful Islamic influence, it might be assumed that the regions would have health care systems that rivaled that of Cap Vert. However, this is not so. Sine Saloum and Diourbel suffer for two reasons. First, the control of cash crop production by the Mourides has allowed them to resist development initiatives deemed contrary to their interests. Second, faced with such explicit economic and political force, the government has been content to abdicate its responsibility in pursuit of a federalism that expects little of it by way of public expenditures, yet politically safeguards the government for the same reason.

Sine Saloum and Diourbel have a combined population of roughly 1.5 million people. Their area, approximately one-eighth of the country, is served by two hospitals (one in each region), twelve health centers, one center for major endemic diseases (in Diourbel), and eighty health posts.[22] It might be concluded that these regions have fared well. However, in 1977, the United States Agency for International Development (USAID) project for the establishment of village health huts in Sine Saloum made that conclusion questionable.[23]

The Mourides have resisted outside interventions into health care and education by the state, bi-lateral partnerships, and the international

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[21] Amin, ibid., 12–13; Interview with Malamine Dieudhiou, Elder, 1/15/80, Niandane, Casamance, Senegal; Interview with Aruna Sané, peasant, 1/21/80, Niandane, Casamance, Senegal; Interview with Assane Ndiaye, Elder, 1/22/80, Niandane, Casamance, Senegal.

[22] Amin, ibid., 12–14.

[23] Robineau, *Approche cartographique*, nos. 4; 5.

community. Koranic principle is the foundation on which both institutions stand in Islamic society. The acceptance of European, western, or secular concepts would undermine Koranic teachings and the power of the marabout and the sheikh. As the Isalmic health care practitioner, it becomes clear that the Mouride marabout seems compelled to resist change that might be imposed through the introduction of western health care. Behrman has argued that for the Mourides, modernization is equated with secularization. As such, it has been resisted by the upper echelons of the brotherhood because it would be detrimental to their religious and socio-political economic positions as well. The distribution of health care has been retarded in the very areas where they are strongest.[24]

The Diola of Casamance: "Going to Senegal"

By comparison, the history and institutions of Casamance have been shaped by different geographic, ethnic, economic and religious considerations. These have had significant impact on the distribution of health care in the region.

Geography has had a profound influence upon the political and economic development of Casamance. Separated from northern Senegal by the nation of Gambia and the Gambia River, the region is divided into "upper," "middle" and "lower" Casamance. The Gambia River serves as the east-west axis for trade and communication; a factor that has reinforced the region's isolation and blunted outside influence. This isolation has resulted in talk of secession among the more militant, while the moderate still refer to a northward crossing of the Gambia as "going to Senegal.[25] Geography has also helped to reinforce ethnic and religious differences.

Yasmine Marzouk has pointed out that:

> colonization, the peanut trade, the introduction
> of the market economy, whatever the consequences,
> were decisive factors in the constitution of the

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[24] Lyons, ibid.; Richard F. Weber, Graham B. Kerr, Herbert B. Smith, and James M. Seymour, United States Agency for International Development, *AID Project Evaluation Report No. 9, Senegal: The Sine-Saloum Health Care Project* (Washington, D.C.: USAID, October, 1980), ii.

[25] Behrman, ibid., 263; 266–270; Cruise O'Brien, ibid., 228–229; 215; 218–219; 232–236; 278.

> national economy. In avoiding these, Basse [Lower] Casamance from the first became a deviant in the life of the country that became independent. . . . Thus the end of colonization coincided with the entry of the region into the market economy which had happened much earlier for most other regions of Senegal.[26]

Production of the Senegalese cash crop, the groundnut, has been marginal, and its commercial nature has meant that Casamance has not been a significant sector of Senegal's economy.[27]

The Diola, who numbered some 300,000 in 1981, are key to this phenomenon. The Diola are composed of at least ten different subgroupings spread throughout Casamance.[28] These variations can be attributed, in part, to the periods of migration and invasion of Diola territories. In this regard, the Diola provide an interesting example of people who, in the late nineteenth and early twentieth centuries, were still the object of religious and political conquest.[29]

Indigenous religious practices were a source of resistance against the encroachment of Portuguese and French Catholicism and Islam.[30] This resistance provided another way of distinguishing between northern and southern Senegal religiously and culturally. The north was "Wolofic ized" (under the cultural and political economic hegemony of the Wolof), while the south practiced indigenous religions, Christianity, and Islam with considerable Manding influence. This differentiation is quite significant in the determination of the distribution of resources and power in Senegal today.

The historical significance of the Diola and the conquest of Casamance should not be overlooked. Islam among the Diola is a fairly recent phenomenom.[31]

The control of resources and their distribution has been a prime factor in Senegal's historical development. Increased interaction with

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[26] Yasmine Marzouk, "A Social Economic Study of Agriculture in Lower Casamance" (unpublished, 1979), 1.

[27] Ibid.; Cinam Seresa, *La Casamance: Etude Régionale* (Dakar: Grande Imprimerie Africaine, 1961), I, 17–19.

[28] Marzouk, ibid., 2–3; Cinam Seresa, ibid., I, 18–20.

[29] Cinam Seresa, ibid., I, 17; IV, 2; Francis G. Snyder, "Labour Power and Legal Transformation in Senegal," *Review of African Political Economy*, 21 (May-September, 1981), 26.

[30] Philip Curtin, *Economic Change in Precolonial Africa* (Madison: University of Wisconsin Press, 1975), 69. Charlotte Quinn, *Mandingo Kingdoms of the Senegambia*, Evanston: Northwestern University, 1972), 173–174.

[31] Cinam Seresa, ibid., I, 18–20.

the French north of the Gambia in the late nineteenth century gave way to a great deal of maneuvering by the various ethnic powers. Within this increased interaction, the control of the commerce in groundnuts became crucial. The Manding dominance of the southern bank of the Gambia should be seen in light of the quest for such control and the international, inter-ethnic and inter-religious rivalry that it spurred.

The importance of inter-Islamic rivalry is crucial here in that the Manding as adherents of the Qadiriya sect of Islam found themselves in conflict with the Tijaniyya dominated Wolof who were a part of the period's Islamic revival.[32] The spread of Tijaniyya was a threat to states both north and south of the Gambia who were neither Wolof nor Tijaniyya. Therefore, it proved convenient for the Manding to declare jihad on the Diola.[33] In this context, Mandingization and the spread of Qadiriya, as with Tijaniyya and the Wolof Muridiya, became important religious and cultural prerequisites to the distribution of resources and the sense of identity between Senegal north and south of the Gambia. The ethnic and religious rivalries of precolonial Senegal have persisted into the twentieth century and survive as the basis for contention over the distribution of resources in the post-colonial period. They also affect the way in which health care has been distributed in Casamance.[34]

Health Care in Casamance: The Case of Niandane

The introduction of Islam had a profound effect on Diola social structure and its institutions.[35] Martin Klein has noted that there is a "high correlation between Islamicization and socioeconomic change." The result has been the evolution of the institution of the marabout as a hierarchical structure that transformed the chieftaincy,[36] and consequently the role of the traditional healer.

The disparities in the distribution of health care in the era of independence and the changes that occurred through Islamicization and

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[32] Ibid., IV, 3; Quinn, ibid., pp. 170–174; Marzouk, "Lower Casamance," p. 1; Interview with Mamadou Tamba, Elder, Niandane, Casamance, Senegal, 1/13/80; Dieudhiou, ibid.

[33] Quinn, ibid., 110–111.

[34] Ibid., 173–174.

[35] Klein, ibid., 225–227; 235–236.

[36] Marzouk, ibid., 1–2; Cinam Seresa, ibid., IV, 17–23; Klein, ibid., 229.

colonization can be summarized in figures for the distribution of hospital services in Casamance in 1980. Casamance ranks the lowest of all regions with one hospital providing only surgical services and ninety-two beds.[37]

The village of Niandane provides a case study of the distribution of health care services in Senegal. In 1980, the population of Niandane was 307 persons; 18% of the population was non-Diola. From Niandane's founding in 1802 until its Islamicization in 1902, indigenous religious and medical practices continued. These practices were based on a spiritual world share by the Diola with the first inhabitants of Niandane, the Bagnun. These indigenous systems reflected an empirical knowledge of medicinal plants and herbs. Even the adoption of the name Tamba by the head Diola family was directly related to the practice of healing.[38] Islam became a principal factor in the breakdown of traditional health care practices among the Diola and the institutionalization of new forms.[39]

Although syncretism is a fundamental characteristic of Islam in Africa, it appears that no such tolerance was shown to traditional Diola health care. There seems to have been no chance of mixing indigenous Diola health care practices with those of Islam, though the only real difference was apparently the ability of the marabout to use Islamic text in the healing process.[40] Yet, a transition occurred between traditional Diola practitioners and the marabout who now dominate health care in the Casamance. This is seen in the recruitment of marabouts.

Islamic healers come from the same families, or are trained in the same families as were a number of traditional healers.[41] This represents an integration of the two health care systems. However, Islamicization of the health care sector has resulted in the loss of skills, techniques, remedies and even personnel. It has displaced the indigenous practitioner by replacing him/her with the marabout as the new symbol and embodiment of religious and medical authority.[42]

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[37] Klein, ibid., 228.

[38] Ministry of Health, Republic of Senegal, *Etude d'un Plan Directeur de Santé du Sénégal* (Dakar, 1982), 369.

[39] Cinam Seresa, ibid.; Marzouk, interview, ibid.; Babacar Tamba, ibid.; Mamadou Tamba, ibid.

[40] Babacar Tamba, ibid.

[41] Ibid.

[42] Interview with Khalidou Tamba, Marabout, Niandane, Casamance, Senegal, 1/23/80.

In a region like the Casamance, access to health care within the colonial period was provisional at best. Alongside melding with Islamic practices, traditional Diola health care persisted in some ways. Informants from Niandane argue that what traditional health care remained at their disposal had greater efficacy than Islamic practices. Yet, they also acknowledged that it left a great deal to be desired when it was compared to twenty years of "European medicine." The elders of Niandane and the young men who had become their marabouts all expressed a desire for access to western health care, if not a wish to work with it.[43]

In contrast to the pattern of Mouride resistance to western health care, the marabouts of Niandane welcomed it as a possibility to broaden their own careers and influence. There was general agreement on referral, joint diagnosis and the use of equipment and facilities to expedite traditional technique within the confines of the western medical establishment. Even collegial relations were envisioned under certain circumstances that recognized the stature and the skill of the traditional and Islamic practitioners and would afford them consonant remuneration. It is clear that the integration which they envisioned was not one in which they would be regarded as junior partners.

However, the most vivid example of the desire to promote this integration came from the community at large. That desire centered on the construction and staffing of a village clinic and maternity ward. The construction of a clinic at Niandane was to be compensation for the villagers' participation in the building of a dam. By early 1980 the government had not honored its commitment, so the people of Niandane began collecting funds for the building and staffing of a clinic. 50 CFA was collected from each family for each child for the purchase of medicine and food to supplement their diets. The balance of these funds was put aside for the construction of the clinic and the training of personnel to staff it.[44]

The people of Niandane were quite clear in their course of action given the lack of government response. Their explanation for the lack of response centered on the political economic relation of Casamance to the rest of Senegal. They argued that they were neglected

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[43] Mamadou Tamba, ibid.; Babacar Tamba, ibid.; Klein, ibid.; 219–220; 228.

[44] Mamadou Tamba, ibid.; Babacar Tamba, ibid.; Khalidou Tamba, ibid.; Interview with Mamadou Dramé, Mamrabout, Camasour, Casamance, Senegal, 1/19/80.

by a government that cared little about their welfare because of the level of groundnut production in the region. The new regionalism seemed to provide a case in point where the individual village was expected to construct, staff, equip and stock its own health care facilities that in other areas might be underwritten by the government.

The Islamicization and "conquest" of Casamance and its late entrance into the Senegalese political economy worked against it in terms of the distribution of national resources. This also means that there has been no real voice within the national ruling circle or the Wolof elite to plead or defend the Casamancaise case. The Casamancaise see themselves as subjugated ethnically, religiously, and in terms of class. Klein underlined this when he pointed out that "new loyalties created new dimensions of conflict . . . struggles between the major tariqas were superimposed on old particularisms" and the fact of ethnic/state rivalry has persisted into the twentieth century.[45]

The class interests of the Mouride sheikhs and others point to the conflicts that exist within Senegalese society. However, there are class interests that are somewhat more international than those of the Mouride hierarchy; they are represented, in part by the modern medical establishment. As the government has, this group realizes the power and the importance of the Islamic brotherhoods. It also realizes that within the traditional health care sector there are two types of health care that overlap: one that can be termed traditional or indigenous and the other Islamic. As modern, western trained practitioners, their goal has not been to resist traditional health care practice, but to assist a merger based on the interests of the dominant parties within each group.

Such a merger would enhance the position of the modern health care sector both nationally and internationally. Integration would give the modern sector control of all health care personnel and facilities. As the middlemen in the distribution of international pharmaceuticals, they would increase their market. With this goal of commoditizing, the traditional sector, its personnel, practices and pharmaceuticals, the modern sector's dominance in the Senegalese market would be complete, and modern sector input into the international market would grow as a result of this.

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[45] Marzouk, "Lower Casamance", p. 14; Interview with Abdou Tamba, Responsable, Président, Communauté Rural, Niandane, Casamance, Senegal, 1/14/80; Interview with Bakary Djiba, Peasant, Health Cadre, Niandane, Casamance, Senegal, 1/22/80, nn. 353, 363. Klein, ibid., 223; 235–236.

Integration, specifically in the area of traditional pharmaceuticals would need massive doses of foreign capital. Some parties believe that capital is waiting in the wings. Others indicated that the outcome of such a venture gives control to multinational pharmaceutical corporations. Their control would make the enterprise something other than traditional medicine.

Traditional practitioners are also divided on the issue. While the efficiency of modern medicine was undeniable, several, particularly the elderly, stated that they would not engage in a joint undertaking with *toubab* (European or European-trained) practitioners. Those who were in favor felt the idea had to be pursued along lines that were advantageous to them as well as the government.

However, all agreed that there were a number of things that the government could and should do. The elder practitioners felt that in spite of the government's promises, cooperation had historically seen them on the losing end of such agreements. In relation to this very point, a published interview with a traditional healer sums up their arguments. When asked if he was ready to participate in a collaboration with western-trained practitioners, the healer replied: "No, because I wouldn't benefit in such a case. The Toubabs always trick us.[46]

Structures established during the colonial period insured a certain integration of the indigenous and modern health care sectors and maintained western dominance over both. However, what has been overlooked in rather conventional analyses of health care and its dilemmas in spaces like Senegal are the possibilities of measuring that integration in a variety of different ways. In particular, gauging integration from the standpoint of the perceived "junior" partners—the recipients and practitioners of "traditional" and Islamic health care. Within that context lay the permutations caused by internal contention, and then the struggles between indigenous and Islamic polities; none of which would readily yield to the forces of French colonialism, or to a post-colonial state that had not yet fully recognized the power inherent in any of these sectors.

Attitudes and the actual distribution of government-sanctioned health care attest that even in independence, ethnic and religious

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[46] Lo, ibid.; Interview with Jean-Louis Pousset, Professor of Botany, University of Dakar, Dakar, Senegal, 11/13/79; Maynard, ibid.; Robineau, interview, ibid. Khalidhou Tamba, ibid.; Drame, ibid.

differences can be exploited to the advantage of the state and complimentary class interests. Yet, there is no certainty to whose advantage some of the most important aspects of this struggle accrue. Certainly the honored arguments of upper/ruling class hegemony over the process, layered by religious and ethnic affiliation, have some credence. But there appears to be a permeable nature to the resource of health care that can neither be checked by the forces of ethnicity, religion, state, or even "modernity." There is a certain agency at work here witnessed in suburbs like Pikine, or remote villages like Niandane, that illustrate the ways in which common, almost forgotten people become the forces in their own lives, compelling fundamental, and overall systemic changes in political economic activity.

"The Toubabs always trick us"

The statement should not always be read from the vantage of a disadvantaged voice. It is the voice of wisdom; one that expresses choice and agency. The voice argues that the only possible relationship to be had is one of equal partnership. It does not necessarily say when, but there is a certain clarity concerning how. Here, it references health care.

Realization of the moral and ethical limitations of "*toubabs*" also gives way to their practical handicaps. Over three hundred years later, those handicaps are heard in another lament: "all we can do is what we've been taught"; yet, this is a belated expression of a failure to learn the lessons of the land. Massamba Diop inadvertently laments the cause of colonial projects gone unfinished; of dreams of independence unrealized because the arrogances of race and religion and class and modernity failed to account for the "*medica materia*" of this space; because they failed to recognize that there might be powers at hand that were and are, if not equal to theirs, at least as *capable*.[47]

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[47] Sané, ibid.; Babacar Tamba, ibid.; Dieng Mbaye, "Interview d'un Guérisseur Sénégalais Originaire du Pays Serer (Senegal)" PHAREV 5 ENDA—Programme Formation pour l'Environment—IDEP-UNEP-SIDA et UNCTAD, July, 1977, 6. J.-B. Henry Savigny and Alexander Corread, *Narrative of a Voyage to Senegal in 1816*, 129. Richard Jobson. *The Golden Trade*, 39–42. Rapport de M. Béliard sur un voyage d'exploration dans le haut Sénégal, 26 Mars 1861. (ANS).

CHAPTER EIGHT

HEALTH CARE AND INDEPENDENCE: "TRICKERY" AND "DEVIATION"

"*Toubabs*"

deviant[s] within the life of the country that became independent.

Yasmine Marzouk

Refusing "Development"

The complications of this project become apparent once more. Throughout this work, I have played with the international aspects of the political economy of health care in Senegal. Sometimes I have done this quite overtly; at other times the manipulation has been implicit. Within the context of a political economic history, one of the major theoretical constructs presented here, underdevelopment theory—and of course, development theory—relies heavily on the argument of intervening powers from beyond the borders of the given nation-state to illustrate the ways in which both international and national class interests combine to promote dependency in the "underdeveloped" state. National class interests—the interests of the ruling classes, in particular—no matter how they are constituted, or how we might wish to portray them, by definition, must defend themselves against the interests of other classes—domestic and international. Such defense and aggression are indications of agency; an agency that has hardly been explored.

In the case of Senegal, certainly the notions of "center-periphery" dynamics can be extended and illustrated. Yet, even here, they, along with terms like "dependency," "development"/"underdevelopment," and even "independence" need to be redefined and re-contextualized. It occurs to me that the intellectual and conceptual parameters that marked the initiation of this project over twenty years ago have been expanded and refined. The critique that has ensued—critique of some of the icons of development/underdevelopment theory—reveal what, in fact, has been missed—gone unrecorded—in

the histories of this space and the development studies they supposedly ground.

The clarity of my own epiphany is lodged in two readings. The first is an examination of the possible meanings of the title of Axelle Kabou's *Et Si L'Afrique Refusait le Développement.* The second is found in John Thornton's "Introduction" to his work, *Africa and Africans in the Making of the Atlantic World, 1200–1800.*

What I find intriguing, and *possibly* unintentional, in Kabou's work begins with its title. This intrigue is underscored given that her work—though incisive, and an often scathing critique of Africa's post-independence leadership and its inability to confront and solve the problems facing it—seems trapped in the dynamics of "elite" formation and their rationales for their lapses in leadership. Yet, it still raises the possibility that "development" might be defined in ways other than those that receive the greatest currency now. The title implies that there is another agency—or *other agencies*—lurking about, that need to be exposed and examined. The implication is that the *margins* may indeed form, and inform the *center.*

If Kabou's title implies this, Thornton stridently tells us what is wrong with what was once the "radical" work of dependency theorists—many of whom I have quoted here.

However much they were committed to the study

> of the non-Western world, or however sympathetic they were to its people, they still agreed that the the non-Western world, including Africa, had played a *passive* role in the development of the Atlantic. . . . the effect was simply to reinforce the tentative conclusions of the French pioneers [the Annalistes] that Africa was a victim, and a passive victim at that, for it lacked the economic strength to put up an effective resistance.[1] (Italics added)

Again, what I think Kabou alludes to, and Thornton references directly, is African agency—the power of various groups of Africans to act on their *own* behalf. In part, those actions are not simply phys-

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[1] Axelle Kabou, *Et Si l'Afrique Refusait le Développement?* (Paris: Editions l'Harmattan, 1991). John Thornton, *Africa and Africans in the Making of the Atlantic World, 1400–1800* (Cambridge and New York: Cambridge University Press, 1999).

ical manifestations, but from my perspective, more importantly, conceptual and intellectual. In part, what is spoken to here is the power to define *and* then act. That power, in the conventional wisdom of the development/underdevelopment discourse, is *deviant.*

In this vein, this chapter addresses dynamics of international intervention in Senegal and brings together examples of, and allusions to that intervention that are cited throughout the work. This chapter also highlights "deviant" activity—activity that moves in contrast—in opposition—to conventional definitions. While the re-definition of the development/underdevelopment theses needs fine-tuning, that is not my task here. I simply point to this issue through the actions of the peoples of Senegambia.

The historical development of the Senegalese health care sector has made discussion of international intervention inevitable. What might be construed as the humanitarian character of that intervention has been highlighted: health care and therefore, better health for the "less-fortunate"; support for medical education; the provision of trained personnel; the provision of medicines and equipment; USAID in the conceptualization and design of health care systems; and, funding for the construction and maintenance of those systems.

What is seen as the humanitarian nature of this health system is also essential to the creation of a structural dependency that characterizes the other side of that intervention. If "empire" is a "structure," then its construction never could have proceeded without medical intervention. The French understood this three centuries ago.[2] The supports that USAID provided, in many ways, it has been argued, are another element of the continued outside domination of Senegal's system of health care.[3] Through independence, and well after, medical activity in Senegal has been dominated by France, but other international players also have significant roles.

Yet, what appears to be "inevitable" in terms of "outside" and international intervention must be measured against a variety of internal responses; measured against the various quarters from which

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[2] Thornton, ibid., 4; 5–7.

[3] Pierre Pluchon's monumental yet conventional edited volume, *Histoire des Médecins et Pharmaciens de Marine et des Colonies* (Toulouse: Editions Privat, 1985) on the establishment of the Corps de Santé des Troupes de Marine, underlines the historical dimensions that under gird the *medical* construction of empire. This volume, along with the primary sources cited here for Senegambia, magnify the relations between health and the construction of empire.

those responses and the agency that propels them has emerged. Here, is a dictum of contemporary, English-speaking popular culture: "What do the common folk do?" The measurement might be ascertained by re-visiting the structural devices that under gird post-independence health care in Senegal and then juxtaposing those devices with the initiatives of "common folk"—the actions of people outside the "official" sectors—and the pressures they bring to bear on reconstituting and controlling access to health care.

Education

Dr. Marc Sankale states that the infrastructure and attitudes of Senegal's "official" health system are built on the fact of western medical penetration. The result is a model illustrative of French (and other European and American) influence; and a model that expects such influence to be forthcoming.[4]

The formal medical training of "African doctors" or "doctor's aides" in Senegal began with the establishment of l'Ecole Africaine de Medicine de Dakar, founded by Emil Le Dantec in 1918. Its sole purpose was the training of African personnel to meet the medical needs of the African population. Between 1918 and its closing in 1953, the Ecole produced 582 "African doctors" and 87 pharmacists who were posted throughout French West Africa.[5] These professionals were among the opening keen of Massamba Diop's lament. The context of their training lay outside of that provided at a much earlier date for Africans exclusively assigned to service military personnel. Nonetheless, the intention remained the same.

The Faculty of Medicine at the University of Dakar was officially inaugurated in 1960, at a time when there were only six medical schools in all of sub-Saharan Africa. The medical program was and is decidedly French in its orientation, so much so that one could not "properly speak of 'African medicine' within the confines of

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[4] Immanuel Wallerstein, "The Limited Possibilities of Transformation Within the World Capitalist Economy," *African Studies Review*, XVII (April, 1977), 1; Vincente Navarro, "Social Class, Political Power and the State and their Implications in Medicine," *International Journal of Health Services*, VII, 2 (1977), 283–287; James O'Connor, "The Meaning of Economic Imperialism," Robert Rhodes, ed., *Imperialism and Underdevelopment* (New York: Monthly Review Press, 1970) 166.

[5] Sankale, *Médecins*, 29.

University training."[6] Yet the establishment of the Ecole and later the Medical Faculty were indications of a slow recognition of the propriety in giving a European medical education to an African elite. It should be noted that such medical education had already been formalized in France's colonies outside of Africa.[7]

In 1976, 24 of the 56 faculty members at the Centre Hospitalier were French.[8] The school and its curriculum, it might be argued, could only be structured on the principle of reciprocity between metropolitan facilities and those in Africa. This was a feature that served to "aggravate dependency.[9] As John Bryant states, the Senegalese medical school was "nourished by the French academic system"; admission was determined by the same examination provided French students; the curriculum was designed in France, and was "under the auspices of the French academic system.[10]

Senegalese students went to France for specialization. There, many came to the realization that, educated in France or Senegal, their training was not fundamentally different in that it was fundamentally inadequate.[11]

Personnel

The reluctance of qualified students to enter medical training and the inordinately high rate of failure from the medical school illustrate the personnel needs of Senegal's state-run health care sector. Sankale has argued that Africa's poverty in the health care sector is an indication of the lack "not so much of capital as of technically qualified personnel."[12] A dropout rate of 25%–50% at the Faculty of Medicine and Pharmacy at the University of Dakar makes this abundantly clear.[13] This catastrophic dropout rate is a side effect of French domination of the Senegalese medical education system and the fact that French students, usually with better pre-medical preparation, also

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[6] Prost, *Service*, 125; Sankale, *Médecins*, 39.
[7] Prost, ibid., 127.
[8] Sankale, ibid., 38.
[9] Robin J. Menes, *Syncrisis*, 76.
[10] Prost, ibid.
[11] Bryant, *Health*, 63–64.
[12] Sankale, *Médecins*, 267.
[13] Groupe de Réflexion et d'Action Sanitaire à l'Afrique, "Pour une Education Sanitaire en Afrique," *Présence Africaine*, 124, IV, 1982, Paris, 43.

attend the University of Dakar medical school in relatively large numbers. Their presence and the competition it induces are key factors in discouraging Senegalese students from pursuing medicine as a vocation and in accounting for the small number who complete their medical education.[14] The inability to recruit, retain and graduate sufficient numbers of Senegalese medical students underlines a problem inherent to all post-colonial societies. Faced with the lack of personnel in key sectors, the only sensible solution relies on the good will of the former colonial power in the supply of the necessary personnel. In 1964, Senegal's Department of Public Health listed 3,857 persons in categories from doctor to laborer as the total of the department's personnel. The list did not include the medical faculty of the University of Dakar, private practitioners or military medical personnel. Nor were the medical personnel attached to Hôpital Principal de Dakar, which was administered by the French military, listed. There was also no indication of the French technical agents attached to the Ministry of Health.[15]

In 1968, 214 doctors were recorded as practicing in Senegal. 97 or 45.3% were French.[16] By 1974, the number of physicians in both the public and private sector was 281, of which 162 were foreign, the majority French. Of that number, 37 were military and another 24 were part of the Technical Assistance program.[17] 1979/80 figures from the *Etude d'un Plan Directeur de Santé du Sénégal* lists 163 doctors practicing in Senegal; 46 were listed as foreign. It also provides figures on pharmacists; a total of 9, 3 of whom were "foreign"; and 13 dentists, of whom 3 were listed as "foreign." There is no breakdown of expatriate staff among the other medical positions.[18]

The *Corps de Santé des Troupes de Marine* is responsible for a significant percentage of French medical personnel in Senegal. The Corps, created in 1673, had established its medical corps by 1683. In 1901 the Health Service for Colonial Troops was established. Since 1963, the students of the Corps have done mandatory duty in the Medical Technical Assistance Program oversees.[19] In one argument—certainly

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[14] Menes, *Syncrisis*, 95, 103.
[15] Ibid.; Prost, *Service*, 15.
[16] Sankale, *Médecins*, 268.
[17] Prost, *Service*, 76.
[18] Menes, *Syncrisis*, 98. Ministry of Health, Republic of Senegal, *Etude d'un Plan Directeur de Santé du Sénégal* (Dakar, 1982), 64.
[19] Ibid.

considered conventional—the largess of the Corps might be underscored, from its earliest inception right through its present incarnation. The colonial medical officers of the 19th century were clear on this point. They understood the necessity of "winning the hearts and minds." This was clearly a lesson that was not lost to late 20th century policy makers as well.[20] They would argue that the humanitarian act involved in the provision of health care could yield enormous political economic benefits.

This reasoning is exactly the other side of the equation. The "humanitarian" impulse was not so humanitarian after all. Health care was a recognized resource and as such its distribution could be controlled to the advantage of certain parties within the broader political economy. So here, the question of health care in general; its institutional formation and the vehicles for its provision—its personnel—are all resources that may be controlled and distributed. The questions surrounding the composition of health care personnel across the board, and their regulation are issues broached in the previous chapter in regard to the "*integration*" of the traditional and modern sectors; issues posed by questions of Islamic doctrine and hierarchy; issues seen in the training of Senegalese in the modern sector. These are the questions that arise from the remarkable number of ex-patriots in the health care sector, and they all speak to questions of control and contention over control.

Equipment, Pharmaceuticals and Funding

The contention over human resources anticipates the ways in which other resources related to the provision of health care might be distributed. Senegalese dependence on foreign technology can be seen in the procurement of medical equipment. This too is an issue of resources, their distribution, and their control. Virtually all medical equipment is imported. The impact of that importation is witnessed in the fact that there has been little talk of disengagement and manufacture within Senegal is negligible, if not non-existent. From the official sector there is only the complaint of the lack of standardization for equipment procured throughout the world.[21] Here, the

[20] Sankale, *Médicins*, 33; 365.

[21] Again the precursors for 20th century observations on the importance of health care as policy that could further the interest of capital and empire are seen in the

diversity of sources is not indicative of sufficient equipment, or the ability to procure equipment at the best possible rates within a market economy. What is indicated is the way in which health care in Senegal fundamentally illustrates the theoretical paradigms that open this work. In the case of equipment, it points to equipment with similar function yet dissimilar use. It points to an inability to exchange parts, and from there to the general disuse of many items because of the inability to repair them.[22] The Senegalese situation is an example of Michael Bader's findings on the international transfer of medical technology.[23]

The procurement of pharmaceuticals is also illustrative of the position of a Senegalese medical structure dominated by international capital. There is no state sponsored or regulated research and development in the production of pharmaceuticals in Senegal. In 1982 there was one pharmaceutical laboratory that engaged in the "fabrication," i.e. the production of pills and other medical supplies from imported products for all West Africa. A number of private and public pharmacies and pharmaceutical distribution houses exist as well.

The major question I posed to informants in the area of pharmaceuticals was whether Senegal could overcome its dependency on foreign suppliers.[24] There is the general understanding that even with its wholesale embrace, traditional pharmacopiea would be dominated by the multinational pharmaceutical corporations.[25]

A consideration of these areas—education, personnel, equipment, and pharmaceuticals indicate that the health care costs for the Senegalese state are considerable. "Senegal is largely dependent

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documents provided by imperial medical officers. As a "universal" policy supporting a "ubiquitous" notion of "empire," the humanitarian righteousness of colonial aims, and, even, "the white man's burden," the rationales for policy were reiterated in remarks as temporally disparate as 18th century explorers, 19th century medical officers, and 20th century officials with multi-national and philanthropic organizations.

[22] MOH, *Etude*, 52–54.

[23] Bader, "The International Transfer."

[24] Menes, *Syncrisis*, 88.

[25] Pousset, Interview; Ntonzoo, Interview; Marcelle Maynard, Interview; Issa Lo, Interview; Robineau, Interview; Gay Maynard, Interview. Clearly the position held by these informants has been substantiated by the global discourse on the preservation of the sources of traditional pharmacopiea, and a cataloguing of the knowledge of traditional practitioners. All of this is taking place within the context of how both might be controlled and regulated by international public and commercial concerns.

upon . . . assistance in meeting these costs." As in other areas, French aid, both public and private, is significant.[26] So another level of contention arises. In this case, it references the debates of post-coloniality: can an independent Senegal escape its former colonial relationship. Can the relations of a colonial past be fashioned into anything that might approach equality, or even equity, between the two parties?

Again, theoretical imperatives extend themselves here. As much as I might hesitate to use the terms "development" and "underdevelopment," given my own questions of their present utility, the health care situation of the Senegalese state does, in many ways, present a case study of the effects of "underdevelopment" and its function as *process*. Here, one of the prime illustrations is seen in the successive four-year plans from 1973 through 1985.

The *Fourth Four-Year Plan* for 1973–1977 listed a total health budget of 3,594 million CFA, of which the Senegalese government only expected to cover 979 million CFA. 1,191 million CFA was to be covered through multilateral assistance. Another 1,424 million CFA was to come from bilateral assistance. It should be noted that the Senegalese portion is representative of an increase on the part of the government over previous quadriennia.[27] Yet, if we take this as the point of comparison for the subsequent plans, the issue of underdevelopment—better put, dependency—is clearly articulated.

The *Fifth Four-Year Plan* for 1977–1981 listed a total budget of 9,400 million CFA, an almost 200% increase over the fourth four-year plan. The contribution of the national government almost doubled, 1,710 million CFA. External funding was listed at 7,030 million CFA. The shortfall was unaccounted. However, between 1960 and 1981, the health care budget declined 3.4%. The *Sixth Four-Year Plan* for 1981–1985 showed a significant decrease in the combined budget for "Health and Social Welfare." The total cost for the Sixth Year Plan was 7,715 million CFA, a total decline of almost 2,000 million CFA compared to the 1977–1981 Plan.[28] The fluctuations in, and the reductions of, the health care budget overall in relation

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[26] Menes, *Syncrises*, 117.

[27] *IVe Plan Quadriennal de Développment Economique et Social du Sénégal, 1973–1977* (Dakar; Les Nouvelles Editions Africaines, 1973), 208.

[28] *Fifth Four-Year Plan for Economic and Social Development* (Dakar-Abidjan: Les Nouvelles Editions Africaines, 1977), 257.

to the total national budget since independence[29] are signs of the difficulty Senegal faced in meeting its health needs. These, in turn, underscore its dependence on the largess of other nations, international bodies and multinational corporations. That largess—that dependency—often allowed external parties the freedom to experiment on the Senegalese system and its recipients. One of the most powerful examples of international intervention in the Senegalese health care sector is the Sine Saloum Project of the United States Agency for the International Development (USAID).

USAID as an Example

The USAID Sine Saloum Rural Health Care Project, initiated in 1977, is a key example of the problems confronting international health care in Senegal. The Mouride hierarchy has been particularly hostile to any programs that seek to "democratize" the sociopolitical economic process for the Senegalese peasantry,[30] the USAID project for Sine Saloum suffered from both that hostility and its own lack of planning.

The USAID project was specifically designed to coincide with the decentralization plan carried out by the Senegalese government. Along with the goal of establishing 600 village health huts, the first stage in the health referral process, and the provision of primary health care at the village level, was USAID's admission that that "Sine Saloum Rural Health Project is in many ways more about management and administration than it is about health. The project's *Impact Evaluation Report* raised several questions. In the management and administration phases, USAID stated that health huts were to be administered, at least in part, through community participation and "sustained largely by villagers' payment for services.[31] The *Report* went on to say that some of the "most critical elements" of the plan had not been carried out, "notably the establishment of a functioning Project Executive Committee and the appointment of

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[29] *Sixth Four Year Plan for Economic and Social Development: Guiding Principles and Sectorial Programs (1981/1985)* (Dakar: Nouvelles Imprimeries du Senegal, 1981), 92–93. MOH, *Etude*, 70.

[30] Cruise O'Brien, *Mourides*, 228–229.

[31] *USAID: Sine Saloum*, 1.

a Project Director. Instead, the Regional Governor apparently had taken direct personal charge of project administration.[32]

USAID also found other problems with the project. These problems were divided into two groups: major and secondary. The major problems included financial viability, adequate support and supervision, and the re-supply of medicines. The financial viability of the project was dependent on what the *Report* termed "bottom-up village participation." This meant that villagers would pay for their treatment at what seemed to be nominal fees.[33] This assumption was made in spite of the fact that per capita income was falling following the decline in groundnut prices on the world market, the cut in prices paid by the state marketing monopoly, and the reluctance on the part of Senegalese peasants to participate in the cash crop economy. This was coupled with the depletion of arable land in a region like Sine Saloum, which one writer has stated should have been used for no more than grazing area.[34] Possibly, the most telling factor is a point the *Report* made and then chose to overlook: the village health huts comprised the initial level of the health care infrastructure for which every level of care that occurs above it is free.[35] People who understand that their government has pledged the right of free health care services to them might find more fundamental things to do with their money given the economic situation. In any event, they might seek ways to circumvent this "outside" administrative invention by leap-frogging to the next level, leaving the health huts without the requisite financial support that USAID mandated as illustrative of a "successful" project. USAID may have been thwarted by the "deviance" of local agency—a "*grassroots*" agency that became the vogue—at least in theory—among many planners. The problem, it appears, was that they were incapable of seeing it, even when it stood *plainly* before them. Here, it was identified as the inability of "peasants"—people in "*Third World*" countries in general—to deal with the exigencies of modern life. Never once did it seem to occur that these might be logical choices made by logical people.

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[32] Ibid., 4.
[33] Ibid., 5.
[34] Ibid., 6; Lyons, Interview, 11/6/77.
[35] Malamine Dieudhiou, Interview, Niandane, 1/15/80; Sané, ibid.; Assane Ndiaye, Interview, Niandane, 1/22/80; Amin, *NeoColonialism*, 4; 11–14; 25; Behrman, "Muslim Politics," 265.

Logic. The question of economic viability also speaks to one of the secondary problems that the *Report* identified: the location of the health huts. As an example of the problem the *Report* cites this case:

> In Nioro Department 50 percent (54) of the huts which were opened are within five kilometers of a Health Post or eight kilometers of the Nioro Health Center.[36]

This particular illustration indicates not only why the huts might not be financially feasible but also why they might complicate the case for the Senegalese government and outside organizations, such as USAID, in providing adequate health care.

The questions raised concerning the issues of support and supervision relate to the over-extension of a health care apparatus that already lacked adequate personnel in terms of training and numbers. The *Report* states "most of these support and supervision shortcomings could probably be sorted out with time."[37] It needs to be asked how much time the authors of the *Report* thought was necessary in order for Senegal to develop the kinds and numbers of health care personnel the *Report*'s authors thought might be adequate to the task? In light of this fact, the *Report* notes that this lack of support and supervision is tied to the dwindling national health budget that recorded a high of 9.2% of the national budget in 1969–70 and dropped to 6% in 1978–79. The *Report* concludes that "in absolute terms the amounts for health do not appear to be keeping pace with inflation."[38]

This was an *economic* observation concerning the Senegalese *national* budget. Again, little consideration seemed to be given by the planners at USAID to the ways in which *Senegalese* economic planners had skirted the substance of this issue. Herein lay the secondary problem of the payment of village health workers in the USAID project that was linked to the national health care budget. The health workers were to be paid from revenues that came into the health huts. In many cases where there were revenues, they were either inadequate or inequitably distributed.[39] However, the policy of payment for the village health workers was in keeping with the gov-

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[36] *USAID: Sine Saloum*, 4–5.
[37] Ibid., 9.
[38] Ibid.
[39] Ibid., 7.

ernment's policy of decentralization in which Rural Community Councils were supposed to establish the salaries of health teams.[40] The national government had neatly shifted much of health care, its costs, and their inflation to local and regional authority. In doing so, some apologists might argue, it had begun not only to "*democratize*" the Senegalese political but to "*rationalize*" and "*modernize*" it, as well. For other critics, the Senegalese government had abdicated its responsibility to provide health care nationwide.

"Deviation"

This chapter began with an allusion to the complexity of the subject and various contextual referents that might make the issues of health care in the period of independence somewhat more nuanced. In the realm of complexity and variation, the political economy of health care in Senegal may be treated to several types of "independence." The typology of independence[s] also can lead to new considerations of colonization and the interdependencies that made it possible. In that light, what has been regarded in conventional circles as a unified and ubiquitous system, appears to be little more than the "spatch-cocked," "gimcrack" series of unstable facades that we've assigned as an inviolable and almost all-powerful colonialism.[41] While the considerations of Robinson and Gallagher might be dismissed as "dated," they do point to what might seem to be an "unintended" consequence of their analysis. In a consideration of the political economy of health care in a space like Senegambia, the persistence and adaptability of various polities in meeting their political economic needs in the face of imperialism—in this case, health care—serve to clearly indicate the "cracks" in the system. The cracks themselves are witness to why certain geo-political space might be defined as "*inutile*" in the face of an ostensibly "invulnerable" and overarching colonialism.

This is *deviation.* It is the modification of systems in the face of power. Those modifications are tantamount to the abilities of the people in question to exploit the colonial system, and then the powers of an independent state that does not respond to their needs.

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[40] Ibid.
[41] Ibid., 9.

In this vein, Kabou's title comes into play again, and the possible ways in which "development" might be defined, and by whom. This is the historical dynamic seen in Thornton, and in J.E. Flint as well, in his groundbreaking piece on African resilience and adaptability in the face of a European onslaught, in "Economic Change in West Africa in the nineteenth century."[42] The varied independences and interdependencies give witness to contention and the construction of alternatives within that contention. The alternatives are another take on Marzouk's "deviant": an alteration, and therefore, a deviation in the face of the "expected," the conventional, the western, the "modern."

In the newly independent state, there would be deviations to western structural devices—to the bequeathed institutions that characterized "official" and "national" health care and its policies. Notions and actions that might be depicted as "backward" or "obstructionist," coming from disparate camps such as the Mourides, or suburban Pikine, or rural Niandane, might impart new understanding in this light. "Deviation" as change, alteration, or adaptation, signal a break with the conventional—even with "*tradition.*" This deviation may also signal a change in the ways that *we* think of Senegambia and regions like it; in the ways in which we theorize and plan its "development."

Deviation becomes symbolic of agency. And in its actualization we are forced to do what many Senegalese have done and continue to do: they have re-thought and re-conceptualized "development"; and in that, are re-thinking and re-conceptualizing the control of the political economy. These are not grand, sweeping acts. They are incremental and practical; and they show a theoretical and practical application on the part of the participants that might force *us* to re-consider the theoretical perspectives from which we've approached these problems and composed their solutions.

Here, we return to the "deviates" of Niandane for our primary illustration. In the previous chapter where Niandane was referenced,

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[42] Ronald Robinson and John Gallagher, "The Partition of Africa," in F.H. Hinsley, ed., *The New Cambridge Modern History* (Cambridge: Cambridge University Press, 1962), Vol. XI, 639–40. Cited here Robert O. Collins, ed., *Problems in the History of Colonial Africa 1860–1960* (Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1970), 47. J.E. Flint, "Economic Change in change in West Africa in the nineteenth century," in J. Ade Ajayi and Michael Crowder, eds., *History of West Africa* (New York: Columbia University Press, 1973), Vol. II, 380–401.

I deliberately neglected to speak to the issues of Diola women in relation to health and health care. Before using them as an example, let me reiterate the pivotal role that women have always played and continue to play in the region's health care. There are the mythic figures that emerge from shared regional epics; these must be tied to the very real, and quite often misunderstood powers of women in a myriad of health care fields from "traditional" psychotherapy, to plant pharmacology, to forms of osteology. The historical proportions of women's roles and powers—across the ethnic and religious spectrum—are illustrated in writings that range from the era of Mungo Park and the Abbe Boilat to the writings of Boubacar Barry. Here, we need only underline the "*salubrité*" and hospitality (in all senses of the word) of the signares. What we come away with by way of contextualization are women in the promotion of health as primary intermediaries in the processes.

A close reading of Niandane, then, positions Diola women in both their relation *and* response to the *national indicators* of the health of women *and* their children. In this regard, take both the colonial and the [outmoded] developmental notions of "women's work."

Engaging Flint's thesis, the political economy of rural Niandane is a sophisticated, complex, and diversified apparatus that defies any notion of simplistic, mono-crop subsistence. Women are critical to the functions of this political economy, again in ways that might defy even the most deft gender analysis. Diola women are property holders. Within a political economy that may appear to be characterized by gendered occupations, women control the means and the modes of certain production, *and* they control the distribution of the wealth they produce. They *even* hire men to carry out tasks that may appear outside their realm for whatever reason.

In the construction of policy, while the franchise is solely a male prerogative, women hold the power of the veto. No civic issue in Niandane can reach the floor for debate, let alone the vote, without the consent of its women.

So here the interesting story of government service and reciprocity work themselves out. It is a story in which the people of Niandane may very well have regarded the actions of the government as "trickery," and the government itself as filled with "*toubabs*." Yet, even before the government failed to honor its commitment for the construction of a clinic-*maternité* as compensation for their work in the building of a dam—possibly in anticipation of the government

reneging on its promise—the decision concerning compensation was largely directed by women. When the government proved unable to meet its part of the agreement, the people of Niandane, led by their women, decided that they would undertake this project on their own. The health of the women and children of the community mandated this action, and who better to compel it than the women themselves. The monies from their rice cultivation and their oil pressing became the capital engine of the project and its maintenance. Their monies supported the *infirmier* and the provisioning of the clinic.

The Casamançaises speak of "going to Senegal" when they make northward passage across the Gambia. The data of the 1980s clearly show the disparity between officially sanctioned health care in Casamance and that in the region of the capital. It clearly suggests that "Senegal" is a different place. What the data could not relate are the bindings between deviance Casamancaise style and the questions and definitions of development. What could not be fathomed in official and scholastic pronouncements and theories were the ways in which peasants—let alone peasant *women*—might take development upon themselves and make it their own. So here, USAID's pronouncement concerning the failure of its Sine Saloum project might be rethought. Certainly the structure of the Senegalese health care system may have been a mitigating factor, and certainly questions of compensation and local public financing of staff and medicines may have been a far-fetched proposition in desperate economic times. Yet even the generalized element that USAID believed the Senegalese lacked most,

> married men with families, substantial fields being
> worked, probably thirty years old or more, and similar
> evidence of village attachment,
> for the women of Niandane seemed of little consequence.[43]

Axelle Kabou's indictment of "official" Africa may, indeed, be fundamentally sound. To that must be added a much larger body of criticism, and a much more important critique. These are the crit-

[43] Richard F. Weber, Graham B. Kerr, Herbert B. Smith, and James M. Seymour, *Senegal: The Sine Saloum Rural Health Care Project: A.I.D. Project Impact Evaluation Report No. 9* (Washington, D.C.: Agency for International Development, 1980), 8.

icisms and critiques found "*en brousse*" and in the "*medinas*." These are the actions that impel the actualization of health care and health policy at both the micro- and macro-levels. Here, in the villages and the *quartiers* of the cities the right to health is being appropriated.

CHAPTER NINE

A POLITICAL ECONOMY OF HEALTH CARE IN SENEGAL RE-VISITED

> No colonial power and no independent African state has ever intervened decisively to destroy popular healing . . . healing . . . organically bound up with the basic political and economic processes.
>
> Feierman

> an historical continuity uninterrupted by the most complicated and radical changes in political and social forms
>
> Gramsci, quoted in Feierman

> Health care for all by the year 2000
>
> Alma Ata Declaration
> *WHO*

Contention

The epigraphs that open this chapter signify contention and struggle through ascending levels of assumed power, through differing and "progressive" temporal and geo-political economic space. The most explicit points of contention illustrate this in relation to religious, ethnic, national, and colonial stresses. Yet, they hardly address the trans-national organizations constructed to oversee the "new world order" of the post-colonial/post-imperial era through a type of seemingly beneficent hegemony. Nor have the issues of contention with these structures and the agency that such contention implies been entertained. In that light, an analysis replete with complexities leads us beyond the conventions of the engagement of the singular African state with the supra-statal structure to an examination of how both state and international policies and structures are re-oriented, re-articulated, and re-directed by agency at the base. Re-oriented, re-articulated, and re-directed by 'an historical continuity uninterrupted' yet highly adaptive and innovative—an historical continuity that is "organically intellectual."

The recognition of the seemingly beneficent hegemony of the new world order of post-colonialism elicits questioning, analysis, and critique of the ways in which such structures work, and for whom: "Toubabs always trick us. . . ." Who and what do this hegemony benefit? What might be belatedly realized in national and international policy circles has already been realized on the "ground." What is realized at the base is the source of contention and evidence of the endurance of agency.

In relation to health and health care, it is clear—if only belatedly—that the World Health Organization did not and would not achieve "health care for all by the year 2000." In spite of catastrophic, pandemic manifestations—of which HIV-AIDS is the most recent and prevalent example—and a myriad of human-made tragedies, the very parties that John Bryant thought so necessary to solving the crises of health care in spaces like Senegal in this model of new hegemony would not coalesce around the issue. The national strategies that were to serve as the basis for a global mobilization of a coalition of major international donors such as the United Nations Development Program, the World Bank and the International Monetary Fund, coupled with the most affluent of bilateral donors and private voluntary organizations have, by and large, been inadequate to the task. The focus on the possibilities and potential of health care as the medium to address equity and social justice with national and international institutions as the sole arbiters has proved itself lacking.[1]

Within this new post-colonial order, as Bryant envisioned it, there are contentions over policy at the highest theoretical and pragmatic levels. These contentions are actually lived by peoples who are the subjects of the policy debates. In an age trumpeted as the "New Economic Order," "social development is unacceptable without par-

[1] John Bryant, "WHO's Program of Health for All by the Year 2000: A Macrosystem for Health Policy Making—A Challenge to Social Science Research," *Social Science and Medicine*, 14A (1980), 381–384. *The World Health Report 2000* revisits and reiterates the shortcomings of the policies that were to be initiated by the notions of "Health for All." For the authors of this report, 100 years of the "evolution" of modern health systems—nationalized and internationalized health care—has resulted, in part, in the significant "perversion" of medicine and health care, and its knowledge and skills. While the *Report* uses "uninformed participation in experiments, forced sterilization, or the forced expropriation of organs" as its examples of this "perversion" certainly the disparities in access to health care might also rank as a perversion as well. 4.

allel economic development." Here the abstract and concrete forms of the economy take precedence over humans and their interactions. The "economic" has become the motive and deciding force.

Bryant's remedy is health care at the service of economic forces—another configuration of health care as a "political economic device."

> Health care can contribute on one hand to development in the purely economic sense of increased productivity and on the other hand, to social justice and the meeting of basic human needs.[2]

Bryant's thinking, revisited and critiqued in 2002, finds its way into Ann-Louise Colgan's denunciation of the World Bank and the International Monetary Fund and their participation in the "perversion" of health as "a fundamental right." Colgan has indicted these multilaterals as "hazardous to [the] health" of African states and peoples.[3] The African response here is both official and "un-official." It is also the official versus the "un-official." This response, in part overlooked even by thoughtful "progressives" like Colgan, centers on who initiates and sustains social policy, and therefore "social change."[4]

Here, Steven Feierman is incisive in his acknowledgement of the "ideological role of those who control therapy" and the ways in which "therapy shapes ideology." The conclusion is that such therapeutical and ideological contentions affect "the outcome to control society's overall direction."[5] Such an acknowledgement allows for the recognition of the closeness of Colgan's analysis with that of Kabou. Kabou suggests alternatives to the new post-colonial order, and in doing so, she re-articulates skepticism turned to activism *en brousse*—"they always trick us. . . ."

Yet the fact of an activism in these spaces tells us that at no point is there resignation among these people. It is an expression of the realization of the historical prospects and how peoples might contend with them. Through these ascending voices—at least as we might hear them—from the bush to Kabou to Colgan is critique and criticism of the new multi-lateralism and globalism; critique and

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[2] Ibid., 385.

[3] Ann-Louise Colgan, "Hazardous to Health: The World Bank and IMF in Africa," Africa Action Position Paper (April 2002), http://www.africaaction.org.

[4] Steven Feierman, "Struggles for Control: The Social Roots of Health and Healing in Modern Africa," *African Studies Review*, 28, 1/2 (June/September 1985), 83.

[5] Ibid., 75; 85.

criticism of the IMF and World Bank, even of the WHO. This is also the refinement of the critique of development/underdevelopment theory from the base. It is, at heart, a critique of the ways in which those who "do policy" at the top have failed to take people into account. It is a critique that underlines the very historical nature of a political economy of health care in Africa, and in Senegal in particular.

Theory Revisited and Refined: Feierman

The concepts that frame this work: contention, historical dynamism/materialism, political economic analysis through health care, and the agency of those who contend, are summarized for Africa in general by Feierman. If we return to one of the epigraphs that open this chapter:

> No colonial power and no African state has ever intervened decisively to destroy popular healing.

We might ask "how," "why," or more importantly," what is the significance of this fact?" Feierman's observation echoes the 1627 concerns of Alonzo do Sandoval. Do Sandoval's lament is exactly what Feierman has identified: the inability of the state—any state—to destroy—to absolutely control—the institutions of health care. Together, do Sandoval and Feierman underscore that these institutions, and the individuals and groups that they serve, are representative of interests that are valuable and are, therefore, the objects of contention.

Feierman amplifies my thesis. His notion that there is a "struggle for control" in relation to health care in Africa is clearly related to the thesis of a political economy of health care in Senegal. It is this fundamental quest for the control of the distribution of health care resources that is central to the discussion. This is the ability to grant or deny access to such resources, in which the "history of health care is inseparable from the total history of communal organizations and the economy." The political economic thesis reiterates this and supports the interrogation of the "link between the broad political economic forces and the distribution of health or disease." Feierman tells us that "healing [is] . . . organically bound up with basic political and economic processes." There are broader implications for

those "who control therapy" which include and then move beyond ideology.[6]

Feierman's illustration of the broader concept by citing the Zande example, and John Janzen's work on the Lemba,[7] exemplify issues of linkage and control. These examples also underline and complicate the structural dynamics of pre-colonial African space. Ironically, in so doing, they also provide dynamic complexity and complication to both the colonial and post-colonial as well. Again, contention and agency become focal devices: as a healing art, Feierman informs us that among the Zande, divination served to support the domination of aristocrats over the common people.[8]

All of these observations lead us to begin any examination of the political economy of health care in Africa with these notions: there is structure here; that structure is indicative of interests that must be maintained and defended. In their maintenance and defense, it is safe to speak of and identify class categories that are contiguous with those interests. Those classes and the interests that they maintain and defend continuously and rigorously reinforce the "culture's basic premises in a most powerful manner." Within the context of this discussion, one class that might be identified—a group of professionals—are healers. Yet even within this class, complexity, complication, and contention dominate in the "competition among alternative sets of healers." This particular dynamic is replicated and expanded when the overlays of colonialism and "modernity" are imposed.[9]

The question of contention makes an analytical imposition of its own. Again, Feierman begins this with the allusion to the "struggle for control," the possible "struggle to create alternatives" that are, *in part*, dictated by the "relation of the healing occupations to power." Here, the question that Feierman poses relates to the role of healers in society as "mediators" capable of identifying issues and seeking "allies."[10]

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[6] Ibid., 73; 75; 116.

[7] John M. Janzen, "Ideologies and Institutions in the Pre-colonial History of Equatorial African Therapeutic Systems," *Social Science and Medicine*, 13B, 4 (December, 1979), 317; 321–325. John Janzen, "Ideologies and Institutions in Precolonial Western Equatorial African Therapeutics," in Feierman and Janzen, eds., *Social Basis of Health*, 204–211.

[8] Ibid., 75.

[9] Ibid., 75; 114.

[10] Ibid., 105; 113–114.

To some degree, my inquiry is an inversion of Feierman's observations here. An inversion in that not only are healers mediators sought as "allies" because of their *own* powers, professionally and in the socio-political economic milieu; but their powers are, in many ways granted, and then contended for by the very populations that they serve. If as Feierman maintains—and I believe that the historical record of Senegambia bears him out—the "control over healing carries with it power over other *practical* matters," then those "practical matters" are also key to any analysis of the subject and history in question. (Italics added) In the broadest view, how are health and health care *not* "practical?" In that regard, how are they addressed in the most "practical" senses?

This question moves to an inquiry of our most fundamental assumptions—assumptions that Feierman promotes, mostly by implication, when he writes of the "control of therapy" by "health specialists, whether physicians or popular healers." Though Feierman alludes to the notion that the "control of therapy" is not the sole purview of the "health specialists," it is the work of the psycho-therapists, like Collomb, Martino, Diop, Guena, and Gravand, that provides the leverage for understanding the powers of the "client" population in insuring the success of those who control therapy. Their works show the intervention of various "care-givers" who are not members of the established professional classes. The necessity of their intervention suggests their agency, and the possibilities of their contention with professionals over what might be defined as healing and its therapies. These works are contextualized by Senegambian political economic and cultural space.[11] Again, both Feierman and Janzen's observations on the Zande and Lemba, respectively, go to the heart of the matter: in the context of political economic analysis, the questions of class and the interests that any given class might represent and defend, provide the stage for contention in both the internal

[11] H. Collomb and P. Martino, "La Possession chez les Lebous et les Wolofs du Sénégal: Sa fonction de régulation [sic] des tensions et des conflits," *Bulletin Mensuel de Faculté Mixte de Médécine et de Pharmacie*, XVI (1968), 127. B. Diop, R. Guena, and H. Collomb, "Detection et Prevention des Maladies Mentales au Senegal," *Bulletin de la Societé de Médécine d'Afrique Noire de Langue Française*, XIII (1968), 933–936. Morton Beiser, Winthrop Burr, Jean-Louis Ravel, and Henri Collomb, "Illnesses of the Spirit among the Serer of Senegal," *American Journal of Psychiatry*, 130:8 (1973), 882; 884. R.P. Henri Gravand, "Le 'Lup' Serer: Phénoménologie de l'emprise des Pangol et psychothérapie des 'possédes'", *Psychopathologie Africaine*, II, 2 (1966), 216. "Le Symbolisme [sic] Serer," *Psychopathologie Africain*, IX, 2 (1973), 250.

and external arenas. The psychotherapists bring the Senegambian example into high relief.

If these people who are not members of the professional medical classes are engaged in care-giving, then the struggle for and the formation of alternatives "reshaping and reinterpreting . . . values"[12] moves beyond Feierman's "health specialists"; beyond conventional assumptions of who controls and participates in the construction of a political economy of health care and access to its resources. The interrogation moves to the "base," and its role and agency in "reshaping and reinterpreting values," creating alternatives, and solving health care problems no matter how tentative.

So, in the end, does the analysis support the notion that *only* "healers make alliances which empower the healthy to improve their own health?" (This is certainly not Feierman's conclusion, but it is where he leaves most of us).[13] Or is there a tension—and therefore, contention—between health specialists and the clientele and communities they serve that might be another source of empowerment in meeting their own health care needs? There is a possibility that in both the historical and contemporary senses, these communities have been more dynamic, and much more successful than we would believe.

But here, as Feierman concludes, this analysis points to a "history [or histories] of the fundamental social institutions which control therapeutic choice."[14] If this is the case, then the work of Collomb, *et al.* suggests that the "control of therapeutic choice" is not the sole provenance or province of the health care professional. The clients they serve and the communities from which they emerge also contend for control as well. If we take this analysis a step further, Feierman is re-phrased here. These are also histories of the fundamental political economic institutions that, through health care, dictate the course of society.[15]

Let me underscore another possible course of analysis that Feierman has provided for me. The "possibilities for change" that he speaks to are not only contextualized by the present and the future, *but* their potential and probability are witnessed in the *long* historical

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[12] Feierman, Ibid., 75.
[13] Ibid., 115.
[14] Ibid., 83.
[15] Ibid., 73–75.

view of health care in Africa in general, and Senegambia in particular. The long view—the *longue durée*—is *seen* in the adaptability that has allowed for the continuity of power *as* class and professional privilege, and *in* class and professional privilege. In spite of conventional analyses, this has been the maintenance of power within the "popular" sectors and in contention with the various powers of the state.[16]

This provides at least one answer to Feierman's question concerning the abilities, possibilities, and probabilities for popular health care practitioners to create alternatives that empower communities to "improve their own health." The answer is that wherever the "proper" incentives for change are encountered in relation to this class, then the "reshaping and reinterpreting of values" become a real possibility. What has been missed in the vast majority of analyses, is the power of the "base"—the clients and communities served—in providing the "incentives" that reshape, reinterpret, and therefore re-orient the actions of health care professionals at all levels of the health care arena.

Through a series of questions, observations, and implications, Feierman leads us to the need to recognize and analyze the agency of Africans. That recognition is almost tenuous in that that agency almost seems *dependent* on European and American "technical knowledge." This is seen in Feierman's query on the "independence" of popular healers and their actions and the ways in which they are manifested in "concert with established political and economic power holders" and their ability to "take socially effective action to promote health." It is the implications of the question that concern me here; a concern that implies that the only "power holders" are those who move in "official capacities," and that it is their movement that can only result in "socially effective action" that will "promote health." I am not asserting that this is Feierman's conclusion, or that it is the only way of reading Feierman. I do, however, maintain that it is the most conventional way of viewing Africa and the health care issues that affect it.

The questions of agency that issue from Feierman's query begin with when and in what system are health care professionals—"heal-

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[16] Again, the Zande analogy comes to the fore: "Healers . . . defending [sic] their own interests . . . exercising their authority to defend their interests" which are neither "impartial *or* class neutral." Ibid., 75; 118. (Italics added).

ers," *et al.*—"independent?" and, "independent" from what and whom? In the same light, when and where does the nature of their relationships preclude their ability to take socially effective action? It should be clear that such situations and circumstances do occur. The question is what are the ameliorating actions on all sides of such an equation? As Feierman points out, a great deal of the efficacy in health care delivery is predicated on "circumstance"—on context—yet, context itself does not preclude agency.

And here, the allusions to agency are strong, though they are rooted in a "professional" class: the possibilities of "healers [to] use their knowledge to shape the public distribution of health and disease."[17] Yet, the possibilities are also historical. The contexts are contentious; the contention is, in many ways, a reflection of efficacy, or the lack thereof. Contention is a manifestation of agency. It is its product.

This protests the notion of the ubiquity assumed of colonial power and then the powers of the post-colonial state, and the new global hegemonic structures that surround it. The contentions related to health care illustrate that "colonial conquest" is never secure and power is always contended for. Here is Gramsci's 'historical continuity uninterrupted'; an example of the fact that

> No colonial power and no independent
> African state has ever intervened decisively
> to destroy popular healing . . . healing
> organically bound up with the basic political
> and economic processes.

Historical Continuity Recognized

The tendencies that characterize this section are broadly outlined in works that appeared in 1975 (Banerji; Kerharo) and 1988/89 (Fassin and Fassin). These pieces carry the insights of a substantive body of analytical and theoretical reflection and their complementary activities that chart and chronicle "popular" agency. They also underline the historical analysis that has preceded them: the inquiries of the late 19th through the mid 20th centuries are reiterations of observations of an explorer like do Sandoval.

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[17] Ibid., 113; 118.

Debebar Banerji's "Indigenous Medicine in India," re-emphasizes and underscores the global nature of the argument. It articulates the agency (and resistance) inherent to and sustained by indigenous medical practices. By implication, his work speaks to the same constructions and dynamics extant throughout the world among peoples facing similar circumstances. The crises in health care and its provision are seldom met by those least advantaged with simple resignation.[18]

Specifically on the case of Senegal, Eric and Didier Fassin published two pieces in 1988/89 that spoke to the agency that stemmed from colonial contentions and which found its way into the inadequacies of the post-colonial, "independent" state. "La santé publique sans l'état," (1988) anticipated the arguments of both Axelle Kabou and Ann-Louise Colgan. Building on do Santos' 17th century deprication, they offer a solution, in part, that Feierman has already generalized: the colonial power has been ineffective in absolutely curtailing the powers of the "traditional" medical sector. The Fassins' work leads us to this conclusion in their discussion of the contentions surrounding the legitimization of traditional medicine in Senegal.

While the work's tone emphasized the healers' dependence on the largess of the state, it also implied the continued existence of individual healers as *agents* of health care—a health care that differed from that sanctioned by two states—the colonial and the independent. The collective agency of traditional healers was also identified in that the Fassins' focus was the *organization* of traditional healers into "associations," that secured access to and control over certain medical epistemologies. Those healers' requisite therapies constituted leverage in suing for state recognition. This, historically, was the "medica materia" of Correard and Savigny's early 19th century observations, and the consternation of other French colonial medical officers.[19]

The Fassins surmise that such suits for "legitimacy" usually have their origins among the weakest of traditional practitioners. But, their

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[18] Debebar Banerji, "The Place of Indigenous and Western Health Services in India," *International Journal of Health Services*, IX, 3 (1979). Also see Philip Singer, ed., *Traditional Medicine: New Science or New Colonialism* (New York: Conch Magazine Limited, 1977).

[19] J.-B. Henry Savigny and Alexander Corread, *Narrative of a Voyage to Senegal in 1816* (Marlboro: The Marlboro Press, 1986), 129. Rapport de M. Beliard sur un voyage d'exploration dans le haut Sénégal, 26 March 1861 (ANS).

observation here also leads to the conclusion that the "strongest" of those practitioners already have an agency and autonomy based on the power of their knowledge and therapies, and the communities that they serve. They also conclude that the reciprocal benefits of seeking such legitimacy—even among the weakest—allow certain powers to accrue to those who advocate for them.

The historical implications of such "legitimacy seeking" indicate an historical presence that consistently thwarted colonial laws and the laws of the independent Senegal; an historical and contemporary presence that challenges the "objective domination of western medicine over other medicines." The contention and tensions underline the existence, prevalence, and to some degree, the efficacy of "parallel medicines."[20]

The observations of the 1988 piece clearly presage the focus of their 1989 work. In the 1989 work, their fundamental question centers on the possibilities of health and health care in a "nation" without the aegis of the state—within the context of a state incapable of providing such services. The Fassins bring their focus to community organizations, and in doing so link two elements of *organized* agency through these two pieces: traditional practitioners and the communities they serve—the communities that empower them. In addressing the "veritable absence" of the state, the Fassins ask who assumes responsibility for health care. The question makes it clear that a vacuum is filled, and it is done in a variety of ways that defy conventional and orthodox assessment of the socio-political economic landscape of Senegambia. Their analysis is book ended by Gramsci's "historical continuity" on one side, and Axelle Kabou's theoretical musings on African options for development outside of the arena of multi-lateral hegemony on the other.[21]

Didier and Eric Fassin recognize that the quest for "understanding" the "medica materia" of the 19th century has its own historical continuity in the "Encyclopedia[s] of Traditional Medicine" compiled in the late 20th century. The quests and their compilations are witness to medical epistemologies with socio-political economic bases and

[20] Didier Fassin and Eric Fassin, "Traditional Medicine and the Stakes of Legitimation in Senegal," *Social Science and Medicine*, 27, 4 (1988).

[21] Didier Fassin and Eric Fassin, "La santé publique sans l'état?: Participation communautaire et comités de santé au Sénégal," *Revue Tiers Monde*, XXX, 120 (Octobre–Décembre 1989), 883.

practitioners that are already institutionalized, and that enjoy "legitimacy" in quarters outside of the official jurisdiction of the state. Here is evidence of bodies of knowledge and practice that constitute power for those involved in their activities.

This is chronicled in a series of papers written in the first decade and a half after independence. Writing in *African Environment* in 1975, J. Kerharo looked at the questions related to "Traditional Pharmacopoiea and Environment." Here, Kerharo engages the obvious—what had been historically acknowledged for quite some time—the relation between traditional practitioners and the bodies of knowledge that informed their practices: one of them being their pharmacology. Kerharo enunciated the plea of 19th century colonial medical officers: there was a vast body of knowledge and practice whose "vestiges must be patiently sought" by "winning over" healers.[22]

In 1976, Kerharo writing for the United Nations through the Dakar-based ENDA (Environment and Development in Africa), stressed the need to identify at least "some of the aspects of African Phytotherapy" within the context of a "study of Traditional Pharmacopy" and it applications. Kerharo's work stemmed from a WHO recommendation that suggested that traditional practitioners might be used as auxiliaries.[23] In many ways, the "legitimacy" that the Fassins discussed thirteen years later had imposed itself in the 1970s in a recognition of the knowledge, skills, and professional numbers present in the traditional sectors.

The analysis, and then the assessment of the practicality of these conclusions came from an examination of Senegalese health care practices in both the rural and urban sectors. The analysis spoke to an urgency (and the possible ameliorations) in dealing with new ideas related to problems concerning African health and health care without becoming bogged down by *a priori* conceptualizations. Here were "rich possibilities" that were very often ignored. The work also recognized, again, yet with a slightly different nuance, the interplay between religion and health care.

However, here, the analysis became bogged down in overlooking, if not dismissing, the possible efficacy of traditional agents. The "mys-

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[22] J. Kerharo, "Traditional Pharmacopoeia and Environment," *African Environment*, I, 4 (1975), 30–34.

[23] J. Kerharo, "Quelques aspects de la phytothérapie africaine," Pharev 4, ENDA-Programme Formation pour l'Environment-IDEP-UNEP-SIDA-UNCTAD (June 1976), A; 2.

tical," "religious," "spiritual" aspects of this health care were incomprehensible to researchers. Their assumed "superstitious" nature rendered them un-scientific.[24]

Again, Kerharo's work had been anticipated as well; approximately a decade earlier. The January/February 1965 edition of *Présence Africaine* carried a piece written by Emmanuel Eben Moussi, "Les médecines Africaines, populaires et autochtones." Not only did "African doctors" have a popular following and mass appeal in 1965, they were also "independent." Astoundingly, Moussi concluded:

> Si leur magique et leur religieux sont souvent décevants, leur réalisations sont quelque fois remarquables et inattendues.[25]

In this context, Moussi argued that "certain healers merit being called 'doctors.'" From his assessment, traditional medicine as a whole merited better understanding. Without such an understanding, certainly on the purely practical plane, its co-existence with western clinical therapeutics poses a real problem.

> Where traditional therapeutics have proven effective, they must be used.[26]

Five years into the post-colonial, in the period of independence, a clear historical hindsight is reiterated, and then repeated consistently in the half century that follows. Yet, it seems that it received scant attention. Within a context of reluctance and inability, neither the state—colonial or post-colonial—nor the requisite international bodies were capable of meeting the health care needs of the majority of Senegal's population. Within such a context, that population, with all its variation and vibrancy, was hardly dormant or stagnant in regard to those needs. Breaches were being filled as they always had: through "professional" innovation propelled and compelled by community initiative and intervention. "Public health without the state" was and had been an historical fact for the vast majority of Senegalese. And in many ways they had risen to the challenge.

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[24] Ibid., 8–9.

[25] Emmanuel Eben Moussi, "Les médecines africaines, populaires et autochtones" *Présence Africaine*, LIII (Jaunuary/February 1965), 194.

If their magical and religious [context] is often disappointing, their practical realizations are sometimes remarkable and unexpected. [my translation]

[26] Ibid., 204–205.

In 1975, Guy Belloncle and Georges Fournier would write of the government of Niger's attempts to involve the local populations in an appraisal of "their own health situation and their traditional practices against disease." These activities enlisted chiefs, "notables," marabouts, and "*hokas*" (traditional practitioners).[27] In the end, however, the contention between two groups of practitioners and the organs of the state, and those they supposedly were to serve scuttled the effort. Belloncle and Fournier placed the onus on western-trained government health agents whose interests and attitudes were so clearly aligned with former colonial exigencies that they became the "main obstacles to the implementation of [this] policy." The government and its agents were so distant from the populations they were to serve that "most officials no longer [knew] how to talk to peasants."[28] The situation that Belloncle and Fournier describe is illustrated theoretically in much of the discussion of the previous chapters and underscored by the introductory analysis of this chapter and Feierman's particular insights. This situation is substantively reiterated in numerous ways in the specific case of Senegal in the voices of both traditional and western-trained practitioners. The loss of the ability to speak to the people is not simply a vocal dysfunction; it is reflective of cultural dissonance. It is the contention between disparate political economies and the interests they represent.[29]

In spite of these setbacks, the powers of the skill and knowledge posited in the popular sector continue to seep into "official" and formal deliberations and institutions. This is witnessed in the numerous studies and reports that analyzed and recorded the efficacies of various forms of traditional medicine. The most prevalent of these researches were those of the Dakar-based ENDA (Environment and Development in Africa), and the cadre of Senegalese and French doctors and researchers associated with the University of Dakar (Université Cheikh Anta Diop).

By and large, Correard and Savigny's consideration of the "medica materia" of the region, and Medical Officer Beliard's "need to know"

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[27] Guy Belloncle and Georges Fournier, "Santé et développement en milieu rural africain," *African Environment*, I, 4 (1975), 127.

[28] Ibid., 130–131.

[29] I. Mbaye Dieng, "Interview d'un Guérisseur Sénégalais Originaire du Pays Serer (Sénégal)" PHAREV 5 ENDA—Programme de Formation pour l'Environment—IDEP-UNEP-SIDA et UNCTAD, July, 1977. Massamba Diop, "An Experience in a Rural Dispensary", *African Development*, I, 4 (1975), p. 111. These are only two examples of the many that move throughout this text.

were realized in ENDA's work. Recognizing the inadequacies of modern, western health care practices, ENDA turned to the personnel and therapies of the traditional sector. In a series of pamphlets, ENDA identified various traditional pharmacopiea, and instructed in and advocated their use. Researchers associated with University of Dakar, in conjunction with the Ministry of Health, focused on the possibilities and the potential of traditional pharmacology and its marketing.[30]

And here, *in spite of* their achievements, the efforts of the ENDA group were reflective of three elements that underlined the inability of the official agents of the state to effect comprehensive and effective health care:

1) the state, its agencies, and agents could not resolve the contentions over health care. The struggle over health care, access to it, and control over it in relation to the various peoples that populate Senegal remain. This is illustrated in questions as far flung as "legitimacy" and "phytotherapeutic" cataloguing.
2) These elements of contention have been translated into distrust and frustration in those segments of the population that deem themselves most needy and most deserving of effective government action.
3) These combined deficiencies and the grievances that they provoke speak to the inadequacies of the state and its international partners.

In the inadequacies of the state and its international partners, as a prelude to their own studies, rests the question of popular intervention. While the need for popular intervention has been recognized across the board by official and "non-official" sectors, its actualization and effectiveness have, for the most part been speculative—at best, anecdotal. And in this, from the standpoint of policy analysis and implementation outside of the popular sector, the fundamental problem became the identification of the most effective agents of "popular" health care and its therapies.

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[30] Dr. Kassou, Interview, Dakar, Senegal, October 24, 1979. Dr. Issa Lo, Interview, Dakar, Senegal, November 8, 1979. Dr. Lionel Robineau, Interview, Dakar, Senegal, November 12, 1979. Dr. Guy Maynard, Interview, Dakar, Senegal, December 12, 1979. Mme. Marcelle Maynard, Interview, Dakar, Senegal, December 19, 1979. Dr. Jean-Louis Pousset, Interview, Dakar, Dakar, Senegal, November 13, 1979.

HIV/AIDS: Agency—Sogolon, her Daughters, their Children

> On the frontlines. . . .
>
> "African Civil Society Statement" June 26, 2001
>
> Women and children carry the burden
>
> Stephen Lewis
>
> What they have done proves that where there is a will to achieve, it can work
>
> Zephin Diagne UNDP

The 'historical continuity' that Gramsci found 'uninterrupted' is in many ways due to the multiple forms of agency that exist in historical and contemporary Senegambia. Their multiplicity also implies their complexity. Their forms and functions can be underscored and illustrated by the efforts of women and their children. Here again, I fall back on myth, folklore, and epic as entrées to the case I wish to make. There is Sogolon, my paradigm of the power of women and healing in the broader cultural context of this region, and her bequest of the knowledge and power of healing to her daughters and sons. That bequest, in the real sense, is contextualized here in relation to activities that have been institutionalized by professionalization and "modernity."

Possibly, one of the most effective ways of illustrating agency in health care outside of official quarters is seen in the crisis of HIV/AIDS and the roles of women and youth. In an interview in 1980, Yasmine Marzouk spoke of the issues confronting the community of Niandane in relation to health care. Here, she described the process at the local level and the issues of contention that existed at various strata of Niandane's socio-political economic fabric—issues and contentions that seem to have resonance throughout Senegalese society.

At the annual village congress, the perennial problems of social conflict emerged: the contentions between youth and elders; contentions between the well-to-do and the poor; conflict over "*tradition*." These were village and intra-village issues.[31]

Marzouk's analysis and observations spoke to activity at the base. In another work, Marzouk identified another force that demands attention, and that has both contemporary and historical resonance: the women of Senegal. Deferring to Marzouk underlines a proposition

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[31] Yasmine Marzouk, Interview, Dakar, Senegal, February 21, 1980.

that has been prominent in this exercise: clearly in the historical, mythistorical, and in the aspects of epic literature (oral and written), women have been referenced. However, the references themselves—the *sources* of their *voice*—can be interpreted as having left the analysis of the roles of women to the proportions of myth and epic—to allusion and the anecdotal, even where they are assumed historical. Marzouk's work provides an entrée that allows for the voices of women to substantiate their own concerns and agency.[32]

Feierman fixes the question of women within the context of the overall political economy. His point of reference are the "social costs of production" and who pays for "their distribution." Within a contextualization that is derived from colonization, "westernization," and "modernization," the tendency emerged of "defining . . . women's work . . . as . . . neither labor nor production." From this notion it could be concluded that women, as illustrated in the "*value*" of their work, were and are systematically excluded from access to health care, and decision-making concerning that access. In such acts, however, are the ignition of a considerable and formidable force of caregivers, in which disease, health, and access to health care collide to "create structures within which women shape their daily work."[33] These women become the initiators and articulators of policy—at least in Senegal, if its Niandanes and then the issue of HIV/AIDS are any examples.

The example of Niandane dates to the early 1980s, but again, it has mythistorical and historical resonance that I have attempted to illustrate throughout this work. Writing in 1975, S. Sane and B. Diop analyzed the "Contribution de la femme Sénégalaise a l'amélioration de la santé familiale."Again, they begin with mythistorical and historical proportions—Sogolon and her daughters are involved implicitly. The role of Senegalese women in protecting their families and communities against sickness and death is never contested. They are the keys to the "promotion, the conservation, and the amelioration of family health." This is all realized within the context of a society whose demography is overwhelmingly rural. In this, given thoughtful analysis, the foregone conclusions should be derived—should have been derived—from the fact that the first line of health care within

[32] Yasmine Marzouk, "A Social Economic Study of Agriculture in Lower Casamance" (unpublished, 1979). Also see Cinam Seresa, *La Casamance: Etude Régionale* (Dakar: Grande Imprimarie Africaine, 1961).

[33] Feierman, ibid., 95; 105.

the household; the first order of diagnosis, and then consultation, is given to the senior women of that household.[34]

Beyond the household was the "professionalization" of women's specializations in popular/traditional medicine: maternal/infant and child health care; questions of female sterility; traditional contraceptives; and, psychological illnesses associated with women. Their roles and actions were preventative as well as curative. Historically, they have been elucidated in the works cited earlier here: Mungo Park, Abbe David Boilat, and Haissam Aloudat, are prominent examples that span the historical discourse. What they suggest of women's power and agency is augmented by the analysis and conclusions of Feierman: these are powers and proclivities that cannot be destroyed.

In that regard, taking note of women's roles and powers seriously, Sane and Diop argued for a multidisciplinary approach that speaks to the integration of their agency within the much broader context of the integration of popular/traditional health care under the aegis of state-controlled structures. Such an integration in relation to women would emphasize maternal/child health, sanitation, and nutrition. All this, according to Sane and Diop, could only be achieved through very serious educational effort among women.

Key to this education for health would be the matron/nurse as the most effective link between traditional and modern health care; these professional women would be both representative and symbiotic in their relationship to and as mothers and wives. Their efficacy would be measured, in large part, in their abilities to engage and span different cultures—"modern" and "traditional"—and to re-articulate primary health care and its concerns to the degree that they might speak to, for, and from Senegal's various ethnic orientations. These women's "insertion"—insinuation—into the broader body politic is witness to women exploiting—in the most positive senses of the term—their own multiple roles as women.

Yet, as a reflection of the resources expended on health care in general, and then in relation to women and their concerns specifically, these cadres of women professionals, with their own very specific tasks, only numbered 61 in 1973; and they are lost from *my* researches from then on.[35]

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[34] S. Sané and B. Diop, "La Contribution de la femme Sénégalaise à l'amélioration de la santé familiale," *Medecine d'Afrique Noire*, XXII, 12 (1975), 785–786.

[35] Ibid., 786. The *Etude d'un Plan Directeur de Sante du Sénégal-Bilan Diagnostic des*

However, in spite of the inadequacies of my own research, this particular group of women provides another significant layer of legacy and agency. They—or more appropriately and precisely, women like them—reappear at the end of the millennium. They are not necessarily, or solely the agents of the government or multi-lateral organizations; but they do represent a continuum of women's agency in the face of a national health care crisis: HIV/AIDS.

We can contextualize and re-focus this analysis by returning to Colgan's trenchant declarations concerning the World Bank and the International Monetary Fund. Colgan's analysis is underscored by Africa Action's analysis of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).[36] Within this framework, UNICEF points to the multi-lateral and bi-lateral relations that must give these women impetus in its "State of the World's Children 2002 Report." Here the report notes that "industrialized nations have 'markedly failed to show the requisite global leadership.'"[37]

The deficiencies cited in these analyses are placed in graphic relief alongside of African states strapped for cash and resources. African leaders provide a litany: "the fragility of our economies"; "cancellation of Africa's debt . . . to enable us to fight the scourge of HIV/AIDS"; "our health systems are over-stretched." All this in light of the "lack of political will among some rich countries and corporations," and "global patterns of poverty and debt and the shameful and immoral prices demanded for drugs."[38]

Now, compound this with the acknowledgement that "weak health care structures" are also emblematic of "gender inequalities" in which the "struggle will fail if women and their rights are not brought to the forefront." And bear in mind that the UN has reported that "globally women and girls are disproportionately affected by HIV/AIDS."[39]

Formations Sanitaires: Rapport de Synthèse (Fevrier 1982) specifically lists 281 "*sage-femmes*" [sic], after that the categorizations for "*infirmiers*" and "*aides infirmiers/ères*" are compressed. There are no indications that these professional categories assume any of the tasks described by Sané and Diop. Also see David Warren Rinaldo, "An Economic Analysis of the Health Care System of Senegal," (unpublished doctoral dissertation, 1980).

[36] http://www.africaaction.org/docs02/gf0204.htm. http://www.globalfundatm.org. (April 22, 2002).

[37] "UNICEF's State of the World's Children 2002 Report," http://www.africapolicy.org (September 2001). [?]

[38] "African Leaders on AIDS," http://www.africapolicy.org. http//www.un.org/ga/aids/statements/. (June 26, 2001).

[39] Ibid. "UN Declaration, June 27, 2001," AIDS Assembly Summary 2,

Such observations force the historically obvious: "young women and men must occupy positions of leadership in the global fight against AIDS." Within this demand are calls for the affirmation of "young people's rights" to "sexual and reproductive health information, care and services," and the "rights of children and young people orphaned by AIDS."[40] The Youth Caucus may have different notions of where "leadership" is housed, nonetheless, their point is critical: women and youth continue to lead, and Senegal provides a striking example.

Here, the speculation begins in light of the fact: Senegal has one of the lowest incidences of HIV/AIDS infection in Africa, if not the world. How is this achieved in light of such inadequacies and deficiencies? In part, and possibly in disproportionate ratio to the resources expended, the Senegalese success is due to the voices and the actions of "Sogolon, her daughters, and their children." Their actions and critique have forced a reconsideration and re-articulation of the most conservative institutions, not only as they relate to the most pressing issue of HIV/AIDS, but also as they relate to the exercise of basic rights on the part of women and young people throughout society.[41] It might be argued that the response of women and youth to the crisis of HIV/AIDS is revolutionary; part of a revolutionary continuum—at least in light of conventional historiography and epistemology—that may revolutionize society. It might be argued that out of this crisis possibility might emerge. And that pos-

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http://www.africapolicy.org. http://un.org/adna/ung0106c.htm. "HIV/AIDS and Civil Society: Africa's Concerns and Perspectives," http://www.africapolicy.org/adna/ung0106d.htm. "A Civil Perspective on the UNGASS Declaration of Commitment," http://www.africapolicy.org/adna/ung0106.htm.

[40] "Youth Caucus Position Paper," http://www.africapolicy.org. (July 3, 2001). "Young people have and will continue to serve on the frontlines in the fight against AIDS . . . governments and civil society must recognize the value of investing in young people." "African Civil Society Statement," June 26, 2001, http://www.africapolicy.org. (July 3, 2001).

[41] This is witnessed across the continent in the responses of religious leadership to the issues posed by HIV/AIDS and the consequences for young people in particular, and women, in large part, tangentially. Women were only alluded to, and then quite circumspectly. Religious leaders were "compel[led] . . . to act" to "support stakeholders and affected persons . . . working in partnership with all sectors of our societies." "HIV/AIDS is not just a health issue, but a development issue as well." Possibly women were the subtext of remarks concerning respect for "sexual integrity." "African religious Leaders on National Policy Advocacy Strategies on Children and HIV/AIDS—11 June 2002," http://www.africaaction.org. (June 14, 2002).

sibility, seen in the engagement of women and youth, may signal a transformation of the overall political economy.

If, as the "Declaration for a Framework for Action" asserts, "successful local and community responses to HIV/AIDS prevention and treatment are synergistic" and "good quality care requires . . . traditional healers, religious and community leaders and volunteers," then where are women in this synergy? As the Declaration states, effective action against HIV/AIDS occurs at the "local and community" levels. Here women are critical and indispensable. In many instances, they have been the initiators and sustainers of community institutions and the care they provide. Yet their roles in policy formation and the distribution of health care resources up to the moment of this very crisis illustrate the inherent nature of gender inequality and the assumptions that accompany women's positions in most societies, including those of Africa. However, within this crisis are also the possibilities for the democratization of health care. Again, the Senegalese case becomes most instructive here.[42]

Senegal and the actions of Senegalese women and youth are documented extensively in the "UNAIDS Best Practice Case" for Senegal, and in Ofeibea Quist-Arcton's seven-part series for AllAfrica.com on combating HIV/AIDS in Senegal.[43] The UNAID report begins by addressing the successes of the post-colonial health care structure of Senegal, particularly in relation to issues of reproductive and children's health. The report indicates that between 1970–1996, "infant mortality and under-5 mortality rates dropped dramatically." Within

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At the June 11, 2002 meeting in Nairobi focused on "children and HIV/AIDS," Stephen Lewis, Special Envoy of the UN Secretary-General for HIV/AIDS pointedly noted the omission of women in the basic discussions at all levels including those of religious leaders:

> We know that there are internal struggles around the leadership roles of women—not to be taken lightly when gender is such a visceral part of the pandemic.

"African Religious recommendations on National Policy and Advocacy Strategies on Children and HIV/AIDS—11 June 2002," http://www.africaaction.org. (June 14, 2002). "Address by Stephen Lewis, Special Envoy of the UN Secretary-General for HIV/AIDS to the African Leaders Assembly on Children and HIV/AIDS Nairobi Kenya, 10 June 2002," http://www.africaaction.org. (June 18,2002). http://www.africaaction.org/docs02/debt0206.htm. http://www.hopeforafricanchildren.org/.

[42] "Declaration for a Framework for Action: Improving Access to HIV/AIDS Care in Developing Countries," (1 December 2001) http://africapolicy.org. (December 10, 2001).

[43] "UNAIDS Best Practice Case," UNAIDS/99.34E, http://hivinsite.uscf,edu/Insite.jsp?page=pa-05–01&doc=2098.470e. (hereafter referred to as "UNAIDS").

the same context, the report noted that "the country's STD control programme will soon enter its fourth decade. Safe motherhood is actively promoted . . . with the advent of AIDS [the STD control programme] also provides a solid infrastructure" for "sexual health education" and "monitoring the spread of infection." It must be emphasized, emphatically, that all of this occurs within a context in which "40 percent of spending on health care comes out of family budgets. Poor families in Senegal spend more on health than anything else except food." The health care actions that occur in this context are augmented and reinforced by the emergence of non-governmental organizations in Senegal. Again, the emphasis here is placed on indigenous NGOs that are reflective of the initiative of the Senegalese people and their "active [role] in rallying public support for health campaigns."[44]

The UNAIDS study continues as a largely sociological study that re-covers much of the ground already explored in the early chapters of this work. In that regard, however, it does take up and reiterate the roles of two important sectors: women and youth. The point that I wish to emphasize, particularly in relation to the health gains that have been achieved since independence, is that many of these gains can be interpreted as the result of the exercise of women's agency on their own behalf and those of their children, and not necessarily the largess of a beneficent state in the colonial or post-colonial eras. Such an interpretation is in keeping with both the historical record and women's immediate involvement in Senegal's current battle against HIV/AIDS.

Take the conventional wisdom on women and their access to power in any given structure. Add to that the complication of women who work in the sex industry. In this analysis—an analysis of those women least likely to have access; to have a modicum of the respect necessary to negotiate the most mundane elements of life, let alone the maze of a state and professional bureaucracy—is a clear indication of the kinds of agency inherent in women in general in Senegal. Interestingly enough, while the infrastructure exists for the monitoring of STDs, and there were "dramatic falls in the infection rates," between 1991 through 1996[45] that in the "fight against HIV/AIDS

[44] Ibid.
[45] Ibid.

stands out as a beacon of hope," the vehicle for such achievement has been the women and youth of Senegal.[46]

The program in STD monitoring and prevention that centered on the sex industry, and that in large part depended on the cooperation of the women who worked in the industry, formed the crux of an "early awareness and prevention campaign" on HIV/AIDS that "dates back to the late 1980s." In coupling these institutional devices and the agency of these workers, the Senegalese government could marshal resources for education, prevention, and treatment that would give it considerable leverage in the international community. Here, the key example was its ability to become the "first [state] on the continent to negotiate a 90 percent cut in the price of AIDS drugs."[47]

Social resources are critical in these considerations. In the Senegalese case, there was a renewed engagement of Muslim clerics. Like the roles of women, an historical paradigm was invoked that rejuvenated the role of religious institutions in the political economy of health care in Senegal. Here, "some Imams . . . now broach the subject of AIDS and condoms in mosques." "Imams and health workers acknowledge that they have difficulty convincing some Senegalese that AIDS is not a curse from God for human lapses on earth." Yet, the very fact that they undertake such efforts is indicative of the new ways in which religious/spiritual leaders are mobilized as arbiters of health care.[48]

However, the aggressive actions of women, youth, NGOs, and clerics, and "a healthy budget which compares favorably with other African countries," has not kept some segments of the Senegalese population from concluding "that the government may have failed local communities."[49] And, here again, the focus shifts to the agency of women and youth. Senegalese president, Abdoulaye Wade noted that the success that Senegal now enjoys in its struggle against AIDS is

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[46] Ofeibea Quist-Arcton, "Beacon of Hope in Africa's fight Against AIDS," June 26, 2001. http://alafrica.com/stories/printable/200106260446.html. (Hereafter referred to as "Beacon").

[47] Ofeibea Quist-Arcton, "Living with AIDS—Mabeye's Story," June 27, 2001. wysiwyg://35/http://allafrica.comstories/printable/200106270171. (Hereafter "Mabeye's Story").

[48] Ibid. Ofeibea Quist-Arcton, "'This Is My Whole Life'—A Scientist's Dedication to Defeating AIDS," July 4, 2001. wysiwyg://47/http://allafrica.com/stories/printable/200107050030.htm. (Hereafter "My Whole Life").

[49] "Mabeye's Story."

> in inculcating the notion in every single Senegalese, that they must not transmit the disease . . . [was/is] all about information. . . . *And the most important element is youth and women.*[50]

The metaphor of Sogolon's daughters and their children continues in an analysis of youth leadership and the role of pop culture in the battle against HIV/AIDS. Here, Baaba Maal and Daande Lenol ("Voice of the People") and DJ Amadi, a Senegalese rapper, and the youth leaders Regina Diompy and Boubacar Sagna, epitomize the role of youth: with "one voice, one message . . . the youth of Senegal" take "the threat of AIDS very seriously." They argue that "the challenge is to make people understand" that "AIDS is a real disease." Their engagement suggests that they have kept step with, if not moved beyond their American and European counterparts.[51]

Regina Diompy and Boubacar Sagna are members of the anti-AIDS club at the lycée Malick Sall, they are "youth advocates on HIV/AIDS in Louga." Diompy has articulated the need for Senegalese youth to challenge the taboos associated with AIDS in the struggle to "break silence and shatter . . . myths." For Diompy, these are the multiple myths of Senegal's cultural diversity: the myths of Catholic and Muslim culture; the myths of "Senegalese" culture in general. In this particular facet of the struggle against AIDS, popular culture and liberation coalesce. In that coalescence there are curious and interesting amalgams: Islamic themes in rap. Then again, the uses, the expectations, and the possibilities of these blendings and their possible vehicles are seen in the evolution of epic forms like *Sundiata.* They come together—they are brought together—to meet political economic exigencies.

DJ Amadi's raps illustrate this. Is *Sundiata* replicated here? Is this Sogolon to MariDjata? Mother to Son?

> Listen Son. . . . Listen Son. . . . Listen Son. . . .
> Vicious virus. . . . It's serious. . . .

This could very well be the daughters' voices to their sons—all their children. As in the epic, Baaba Maal asserts, it is the reiteration of youths' obligations to society. The responsibilities and the demands

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[50] "Beacon."

[51] Ofeibea Quist-Arcton, "Pop Stars and Youth Break Taboos to Spread AIDS Message," AllAfrica.com (June 28, 2001), http://allafrica.com/stories/printable/200106280576.html. (Hereafter, "Youth").

that they impose are national and international: "give us the right to produce anti-retrovirals!"[52]

I am at pains to make the case of women's agency here, and to reinforce it within the cultural contexts constructed by myth, epic, tradition, and history. Sogolon and the Mande epic are simply illustrations that are played out in the roles of women and health and health care in the Wolof polities. The examples are witnessed in the consecration and legitimization of rule in the various Wolof monarchies; in the historical depictions of the Wolof, Serer, and other women who would become known as signares; and in that vast group of women the French simply called "*guérisseuses*." So, I believe that the chosen metaphor of Sogolon, her "daughters" and their children, works well here. DJ Amadi's mother's letter, "Listen Son," Regina Diompy's willingness to challenge taboos and stereotypes for the health of Senegalese society carry on the theme. Then, there is what Quist-Arcton has identified as the "Frontline of the War to Contain HIV—Prostitution."[53]

Sex is legal in Senegal. As an industry, it is recognized and regulated. Its regulation has become a central instrument for calibrating sexually transmitted diseases, educating the public about them, and then in controlling and eradicating them. All this is achieved through the agency of its women workers—"prostitutes." They too, are an essential and conspicuous element in the army Senegal has assembled to combat HIV/AIDS.

The critical role assigned to these women in this health care struggle helps to re-contextualize and then to unpack the politically and culturally-laden implications of a term such as "prostitute." That re-contextualization and analysis also force a re-evaluation of gendered constructions, and this also implies the need to critically examine the role of women within the general political economy, and within the political economy of health care in Senegal, specifically. In short, we are treated to a tremendous irony in the role that *these* particular women play in addressing the most catastrophic health care crisis the world has seen.

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[52] Ibid.

[53] Ofeibea Quist-Arcton, "Prostitution—Frontline of the War to Contain AIDS," AllAfrica.com (June 29, 2001) wysiwyg://41/http://allafrica.com/stories/printable/200106290227.htm. (Hereafter "Frontline").

If there is a political economy of health care, there is also a political economy of prostitution. This political economy of prostitution lends itself to our understanding of the central issues that plague access to health care: the political economics of prostitution are driven by poverty; yet even this agency is displayed in numerous ways, among which is the organization of sex workers and their advocates in the fight against AIDS. This is seen in such groups as the AWA (Association for Women at risk from AIDS), and the SWAA (Society for Women against AIDS in Africa).

Among sex workers, agency is more immediate, if not more intimate—the insistence on condom use. Over the past decade, the increase in condom use has been at least ten-fold. This increase has not been simply a question of reproduction; it is the issue of health. And here it has been at the insistence of women.

The relation of Senegal's STD control program to the recognition and regulation of the sex industry has allowed it to be a "pioneer on the continent to *integrate STD care into its regular primary health services, in response to AIDS.*"[54] "Medical doctors and AIDS specialists," Ibra Ndoye and Souleymane Mboup argue that "Senegal's long practice of registering commercial sex workers" has meant that "'when HIV/AIDS came, it was easy to organize this core group of people, evaluate them and *train* them.'" Sex workers have become health care cadre, many act as "outreach trainers and educators."[55] These women's actions epitomize President Wade's observations on the ways in which Senegal's women 'strengthen and improve our efforts at prevention.'

> Take any given woman in any given neighborhood . . . if she gathers ten or twenty women and she talks to them—without fanfare, without drums or trumpets—and explains the problems of AIDS so that it sinks in, then we will make progress. *And that is possible in Senegal.*[56]

From the president of Senegal, recognition of the power and potential of women; recognition of a mythic and historical past; recognition of contemporary agency. These are the voices and actions of women hailed from villages like Niandane in Casamance to the south,

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[54] Ibid. Italics added.

[55] Ibid. Quist-Arcton, "My Whole Life."

[56] Ofeibea Quist-Arcton, "Women—Vulnerable but Vital Campaigners Against AIDS," AllAfrica.com (July 2, 2001) wysiwyg://44/http://allafricacom/stories/printable/200107020491.htm. (Hereafter "Vital Campaigners"). Italics added.

to Niomre in the north; and the cities such as Dakar and St. Louis. In Niomre, Aminata N'diaye speaks for the Association of Women of Niomre. She is its vice president. Her organization's concerns focus on AIDS and religion. The women of Niomre recognize the need to confront a political economic and "cultural dilemma" that is exacerbated by traditions of male migration—now to Europe—and the subordination of women through cultural and religious devices. Central to all this is the socio-cultural tradition of "wife-inheritance"—a social welfare device in which a widow becomes the wife to the brother of her deceased husband. HIV/AIDS and its prevention pose new challenges to tradition, in particular to the institution of wife-inheritance. Again, President Wade sides with these women and their agency. At the very least, there is the need to 'convince the wives of these migrants that they must take even more precautions.'[57]

Yet, even though "discussion of AIDS and HIV remain[ed] taboo" within the context of space like Niomre, "the women's groups in Niomre . . . have concluded that they must put pressure on their menfolk," and it is not just the president who has heard them. Not far away in the town of Louga, popular culture shows its power and potential again. This time it is a theatrical performance. The performance is an educational tool and a catalyst for an audience described as "young, Muslim and committed to the fight against AIDS." To them the "*griot*" sings: 'Open your eyes before AIDS closes them forever.'[58]

With this the cultural circle—the traditional and the contemporary popular—is closed. Young Boubacar Sagna, of Lycée Malick Sall's anti-AIDS club, clearly understands the intersections between culture, tradition, the political economy of health care in Senegal and the need to seek new *social* as well as political economic solutions. In an age of AIDS, Sagna argues that his generation has moved beyond the particular traditional stricture of wife-inheritance. And beyond to the recognition that the "only way to avoid AIDS is to be informed and to share this information with others."[59]

Sagna's observation from Louga resonates to the capital city and to international agencies. Yasmine Fall, Senegalese, and regional

[57] Ibid.
[58] Ibid.
[59] Ibid.

director of UNIFEM (United Nations Development Fund for Women), notes that the incidence of HIV/AIDS is growing faster among women who, in large numbers, have no idea of how the disease is contracted. Their exposure, Fall argues, is related to the broader issues of women's agency in Senegalese society: women's rights, and the questions of violence against women. Fall goes on to state that 'sex education about HIV infection should not just be dealt with in the school curriculum.' That too, it seems, is part of 'the courage [required] to address the issue of traditional practices that go against human rights and women's rights.'

In the same manner that multinational corporate proscriptions hinder the manufacture and distribution of anti-retrovirals, Fall argues that the same actions hindered women's agency in Senegal and the ways in which they might protect themselves against HIV/AIDS. Her example is the female condom. Fall noted that before its Senegalese manufacture, its high cost was "a form of discrimination against women 'denying them the ability to access and negotiate safe sex and [to] decide how to protect themselves.'"[60] The female condom—a 'critical tool'—is "beginning to empower Senegalese women." Senegal is "ahead in the battle against AIDS in Africa because of the 'tremendous' work" that Fall says has been done to "sensitise both men and women." Yet, it is a battle that has "not yet been won."[61]

The battle has "not yet been won"; 350 years of political economic activity in health care in Senegambia. 350 years that are illustrative of agency; agency and its contentions. 350 years that become a way of re-writing the history of the peoples of the region, and a source in anticipating their future; a way of understanding that some are not simply awaiting our charity. 350 years of a political economy of health care that are punctuated by people actively moving to address their own crises; to solve their own problems.

From Michael Crowder's *Senegal: a Study in French Assimilation Policy*, through the works of authors such as Boubacar Barry, the historiographies and histories of Senegambia from the 1960s to the close the last century, have witnessed a clear shift in perspective and analysis. Within the last decade or so, there has emerged a subtle yet dynamic perspective which examines questions of African agency within the region and then posits the implications for recasting and

[60] Ibid.
[61] Ibid.

reconstructing the historiographies and histories of its temporal and geo-political spaces. This is done on both sides of the colonial spectrum, and at it very center.

The subjects of the historical discourses and analyses have changed as well. Within these changes—from the "conventional" to the "radical"—a wealth of material has been mined that has allowed for much richer readings of the region. This work is another foray into the Senegambia by way of a different vehicle whose political economic history throws light on one of the most critical issues facing all of Africa today—health care.

This agency indicates that the "bankrupt" or "failed" state thesis is not the accurate barometer of these people's potential. It is a theoretically blunt instrument in the light of 350 years of historical analysis. While governments may await aid for chronic problems, certain segments of their populations are moving on those problems.

Over 350 years of contention over health care—access and denial of access to it; health care as a metaphor of state and commerce; and as a real physical manifestation—become one more way of examining the history of the region, recognizing its complexities and sophistication, and opening them up for examination. It becomes another way, as well, of understanding how the people of Senegambia cope; of understanding their great capacities for innovation; and of understanding their courage and their abilities to face and to act on the most daunting of situations. Their capacity to act is readily revealed in political economic history.

This is not simply a history of the "development" (or "underdevelopment") of health in Senegal. The emphasis on the contending systems and institutions of health care that have over time shaped the choices of Senegambia's peoples make it something altogether different. It is a *political economic* history and as such, requisite consideration is given to the ways in which the people of the region have shaped those systems and institutions. These systems of health care are political economic institutions. Their actions under gird, maintain, and expand the broader political economies in ways that are overlooked or taken for granted.

The theoretical and historiographic approach of this work calls into question what most conventional analyses have described as the state of health care in Senegal, and in Africa in general. It concludes that the peoples of Africa—historically, and in the contemporary—have had a "say"—and they continue to have a "say," an

agency—in constructing the institutional frameworks and dynamics that might function for their common good.

While this approach cannot *predict*—the layers, multiplicity, and diversity of actions are too dense, even when the actors appear to be finite—it can, however, offer the kind informed speculation that Bogumil Jewsiewicki deems so crucial to the construction of African histories. That is inherent in almost every page presented here.

If there are conclusions to be drawn from this analysis, they should in no way lead to the notion that the state of health or health care in Senegal—or the rest of Africa, for that matter—has been satisfied by the agency of local actors. That is clearly far from the case.

However, what is abundantly clear and magnified as a product of historical consequence is that the people of Senegal have not sat idly by dwindling and dying because of the lack of health care. They have innovatively created alternatives to and from the systems of health care that have presented themselves over the span articulated here. In doing so they have challenged various imperialisms and colonizations. In some cases, they have been co-opted and assimilated by the practices of colonizers and imperialists. In other cases—cases that conventional theorists might find truly remarkable—the people of Senegambia have co-opted and assimilated their colonizers and their institutions. They have shown remarkable resilience and ingenuity. And even in their adaptability—like young Muslim boys in Niandane who can recite the names of Bagnun spirits living in trees—they have managed to maintain some semblance of institutional integrity.

In the end, it may be integrity that leads the people of Senegambia to contend. They contend for what is rightly theirs, against the scourge of disease and the capriciousness and greed of those who would seek to oppress them. They contend for the right to adequate health care. They recognize that where the state cannot deliver, they must do for themselves. This is the lesson of the least among them: women and youth.

In their work, *Afro-Optimism: Perspectives on Africa's Advances*, Ebere Onwudiwe and Minabere Ibelema seize upon this and its implications. The scholars they have brought together in their volume attempt to move the discussion away from the dire body of work that has dominated African Studies and the questions of Africa's future by providing alternative insights on post-independence history. An addendum to their analyses is the long historical dynamic of a political

economy of health care in Senegal and the implications that it casts. If health care can be used as a political economic device in an historical analysis of Senegambia, then there is a certain inevitability that there must be positive stories to tell and instances to relate. The peoples of the region have struggled to make it so. *A Political Economy of Health Care in Senegal* is part of a growing body of work that seeks a deeper and more balanced treatment of Africa.

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