

Colonial Entanglements and African Health Worlds

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Abstract

Following Ann Stoler's (2016) idea of colonial and (post)colonial history as recursive, a history which folds back upon itself, emerging in new shapes and forms yet still carrying the formations that they are folded into, and Achille Mbembe's argument that in the (post)colony the 'past and present are entangled in hydra-headed ways' (Mbembe and Hofmeyr 2006), this Review essay puts into conversation three recent publications: Marrku Hokkanen's *Medicine, Mobility and Empire* (2017), Simukai Chigudu's *The Political Life of an Epidemic* (2020), and Luke Messac's *No More to Spend* (2020). I argue that these books help elucidate the transitions from colonial to postcolonial biomedicine in Africa and show what has endured. Focusing on books that look at a small part of south-eastern Africa, the essay examines how detailed historical analysis of the colonial creation of the medical world in the region can allow a temporally entangled understanding of medicine in the (post)colony. In particular, I observe how these three books highlight the impact of colonial logics of spatiality on African medical and healthcare worlds and suggest that paying careful attention to the colonial entanglements of African health worlds is crucial to understanding their contemporary shapes and forms.

Keywords

Mobility, Scarcity, Colonialism, History, Africa, Politics of medicine.

On a hot and rainy day in February 2022, I found myself clinging onto the back of a *boda-boda* (motorbike taxi) as it hurtled up an almost impassable switchback road towards Livingstonia, Malawi. The road had been built in the late 19th century as an oxcart track to bring goods up to the newly established Livingstonia Mission. In 2022, it was still a road that seemed designed for oxen; unnavigable by virtually anything other than the most robust 4x4 vehicle and the highly skilled *boda-boda* drivers, the road makes the trip up to Livingstonia a challenge for anyone. As the rain whipped my face and the *boda-boda* jumped over rocks and gullies, I reflected on the closing chapter of Markku Hokkanen's recent book, *Medicine, Mobility and Empire: Nyasaland Networks, 1859–1960* (2017).

In the closing chapter, Hokkanen describes driving up the same road. For many decades, at the end of the 19th and beginning of the 20th centuries, Livingstonia was the site of one of the most important missions in east and central Africa, as well as of the most significant medical training centre and hospital in northern Malawi. Hokkanen considers how the almost-impassable lakeshore road, leading up a one-thousand-metre escarpment, reflects the 'ramifications of the colonial search for health' on the entire healthcare system which developed in Malawi (idem, 240). The Livingstonia Mission was a powerful nexus of networks that criss-crossed southern and eastern Africa and helped shape those colonial landscapes (ibid.). It also, however, exemplified the power of exclusion—not only through its hard-to-reach locality, but in its role as gatekeeper for education, medical training and provision, and career advancement. The Livingstonia Mission, and later the Overtoun Institute, were built at these impossible heights in order to escape the ravages of malaria, following earlier attempts to establish mission stations on the lakeshore, which had left many missionaries dead. This mission, with its profound impact on the emergence of institutional healthcare in the region, its capacity for the elevation but also the exclusion of Africans, and its shifting in localities to ever-higher ground until becoming almost unreachable, is an excellent exemplar of how questions of health and illness in Africa were intertwined with and built upon colonial logics, particularly of space and race.

The critical postcolonial scholars Ann Stoler and Achille Mbembe have vociferously argued that the postcolonial condition is one in which the tendrils of the past continue to penetrate and shape contemporary life, where 'past and present are entangled in hydra-headed ways' (Mbembe and Hofmeyr 2006, 182). In her work *Duress* (2016), Stoler further suggests African history tends to be conceived of as marked by a linear progression of time, from the colonial to the (post)colonial, sometimes depicted as a 'seamless continuity', or as a history of ruptures between the colonial and (post)colonial.¹ These imaginations, she argues, are problematic,

1 Stoler writes (post)colonial with brackets to show that the 'post'colonial is a reforming of the colonial, not a temporal or ontological period separate to it.

as they allow for the colonial to be something temporarily and metaphysically situated in our past or suggest that aspects of the colonial have continued without change. Stoler offers an alternative conception of colonial and (post)colonial history, one in which history is layered in upon itself. Rather than looking for ruptures in colonial history, she suggests we pay attention to what endures. Hers is a history of recursive continuity, a history which folds back upon itself, emerging in new shapes and forms, yet still carrying the formations into which it has been folded. Histories, rather than being continuous, are here marked by their ‘uneven, unsettled, contingent quality’ that can reveal new surfaces and new planes, where colonial entailments cling ‘vitaly active and activated’ to the conditions of people’s lives (idem, 25–6). Thus, although the colonial may seem to lie temporarily in the past, one ‘cannot simply demarcate a past colonialism from the struggles of the present’ (Pels 1997, 164; see also Mbembe 2001; Stoler 2013, 2019). As Achille Mbembe (2001) states, there is no time ‘after’ colonialism, one marked by an absence of the colonial—colonialism is a feature of long duration, and its tendrils still penetrate the fabric of African life today. Therefore, when looking at contemporary African worlds, these theorists insist that we unpack the colonial endurances that continue to reverberate within those worlds.

While Mbembe and Stoler’s work tends to focus on questions of economics and politics, I argue that being conscious of and actively tracing the lines of these colonial entanglements is equally crucial in the analysis of the worlds of health, illness, and medicine in Africa. Conceptions of health and illness, and the construction of healthcare systems were central to the colonial endeavour in sub-Saharan Africa. And these conceptions and constructions still shape the landscape of health and illness in the region to this day.

Three recently published books unpack the colonial histories of contemporary African health landscapes in exquisite detail: Hokkanen’s *Medicine, Mobility and Empire* (2017), Luke Messac’s *No More to Spend: Neglect and the Construction of Scarcity in Malawi’s History of Health Care* (2020) and Simukai Chigudu’s *The Political Life of an Epidemic: Cholera, Crisis and Citizenship in Zimbabwe* (2020).

Following Stoler’s idea of colonial and (post)colonial history as recursive and Mbembe’s argument that in the postcolony the ‘past and present are entangled in hydra-headed ways’ (Mbembe and Hofmeyer 2006, 182), I suggest that these three texts in conversation help elucidate the movement from colonial to postcolonial biomedicine in Africa, and in doing so, they show what has endured. Focusing on books that examine a small part of south-eastern Africa, we see how detailed historical analysis of the colonial creation of medical and health

worlds² in the region allows for a temporally entangled understanding of medicine in the postcolony. Read together, these works unpack the formations of these southern African health worlds and the ‘durable thread’ (Cooper 2000, 9) of colonial entanglements that continues to run through them into the present.

Hokkanen’s (2017) historically oriented book traces the emergence of a colonial health world in Nyasaland (present-day Malawi). His thesis is that mobility was central to the production of colonial health worlds—an analytical lens which is not only crucial to understanding colonial medicine, but also contemporary medical systems and practices on the continent. A striking aspect of the work is the clarity with which he shows the dependence of the colonial enterprise as a whole on questions of health and illness—particularly on questions of how to safely and healthily travel in and out of colonial territories.

In the 19th century, means and modes of travel featured as perhaps the most prominent colonial health concern in Africa. This, as Hokkanen makes so clear, was because colonialism itself was ‘fundamentally about geographical mobility’ (2017, 8)—penetration into any space required the ability to move both into and out of that space, without falling severely ill or dying. This was the crux of the colonial enterprise: settlers, armies, mercantilists, missionaries, and colonial officials who were sick, dying, or dead could not execute a colonial vision. Colonialism, therefore, fully depended on (moderately) healthy travel. Using letters, newspapers, public debates, and government correspondence, Hokkanen details the ultimate political stakes of colonial medicine—not just the dangers facing the European body but the feasibility of the colony itself.

These spatial logics of mobility infiltrated African healthcare systems and imaginaries. To this day, African healthcare systems are heavily marked by mobility. Most facilities are concentrated in urban metropolises, requiring many patients to travel great distances to access healthcare and thereby often being excluded from healthcare provision. Coupled with this, in many African states some more advanced healthcare provision, such as advanced cancer care, is not available within the country, necessitating patients to travel as far afield as South Africa, India, or even France (Livingstone 2012; Mika 2021).

In later chapters, Hokkanen makes clear that mobility is not, however, confined to the colonists. The medical mobility of African intermediaries and doctors, as well as the mobility of ideas around medicine and healthcare, which travel in both directions between Europe and southern Africa, are much discussed. Although focused on the logics of mobility, Hokkanen’s rich historical analysis also reveals

2 I use the term ‘medical worlds’ to represent those relating to medicine, such as the worlds and lives of doctors, pharmaceutical products, hospitals etc., and that of ‘health worlds’ to describe broader ideas around health and wellbeing.

the colonial genesis of other aspects of healthcare, such as the centrality of missions to rural healthcare provision; the focus on the health of labourers; the positioning of Africa as afflicted primarily by ‘tropical’ and infectious diseases; and the framing of African bodies as having ‘a greater capacity than Europeans to withstand pain’ (2017, 131).

In Messac’s work (2020) we see the temporalities of Hokkanen’s book expanded across the colonial and postcolonial. Here we see how colonial logics were key in the production of scarcity. *No More to Spend* offers an excellent exposition of the colonial underpinnings of contemporary conditions of scarcity in Malawi’s healthcare system. The weight of Messac’s argument rests on the claim that we cannot, and should not, naturalise the scarcity which marks so many African healthcare systems—and nor should we normalise the cost of the toll of human life that this scarcity creates. Messac shows how the assumption that this scarcity is inevitable or normal is the product of the reification and normative acceptance of the scarcity narrative that underpins the majority of global and public health relations with and in the global south, rather than a reflection of any objective reality (Cochrane 2021). In his work, Messac carefully demonstrates how the ‘inevitable’ scarcity—of resources, technology, infrastructures, and capacity, that marks so many African healthcare systems—was firmly colonially produced in Malawi. Tracing the formations of Malawi’s contemporary healthcare system back to the mid-19th century, Messac leaves no room for doubt of the devastating impact of the colonial logics of distribution on Malawi’s healthcare system.

In great detail, we see how Nyasaland (Malawi) was consistently and consciously underfunded as part and parcel of colonial policy. By digging through the minutiae of parliamentary debates, Messac shows how, for much of its existence, Nyasaland was a ‘Treasury controlled territory’, which was intentionally ‘conducted ... on the absolute minimum of expenditure’ resulting in the ‘extreme rigour which limits its medical services’ (Messac 2020, 62). The overall attitude to most British colonies at the time was that they could ‘only have what they themselves [could] pay for’, which in the nature of colonial extraction, whereby much of the colony’s wealth was funnelled into British businesses in the metropole, often meant relying heavily on menial, politically contested incomes such as the hut tax (idem, 98). This fiscal stringency meant that in Nyasaland, health services and infrastructures, particularly those intended for Africans, were grossly underfunded and underdeveloped.

Messac’s description of the development of the Trans-Zambesi Railway, meant to run from the port of Beira to the southern banks of the Zambezi River, is one striking example of the construction of scarcity in the country. The railway was the concoction of a private British corporation, which in 1919 managed to persuade

the British government to take over the role of guarantor for the debt accumulated by the company in building the railroad (idem, 53). Although the British government agreed to guarantee the company's debt, it did not do so from metropole coffers. Without consultation with the Nyasaland administration, the cost for the debt was placed on Nyasaland, and repaying it would come from Nyasaland's own expenditures. The route, as many had predicted, was unable to turn a profit and the whole endeavour collapsed.

As a result of this disastrous failure, by 1937, 44 per cent of Nyasaland's public expenditure went towards servicing the colony's debt (Messac 2020, 7). Malawi is often touted as one of the world's poorest countries with a struggling healthcare sector. Not infrequently this is lamented as an inevitable result of its resource poverty, yet as Messac's account demonstrates, much of this extreme poverty can be traced back to the constricting financial and governance systems of the colonial period. As African taxes went to paying English debts, the fledgling colony was wholly unable to create adequate healthcare infrastructure for its population. Messac shows us how these colonial legacies created the conditions of scarcity in the country, which continue to shackle the healthcare system to this day.

Simukai Chigudu's (2020) book, the third of the titles explored in this Review essay, pulls us firmly into the realm of contemporary African health crises. In 2008, Zimbabwe experienced a devastating cholera epidemic, one that was almost 'unrivalled in the modern history of the disease' (Chigudu 2020, ix). In the course of ten months, 4,369 people died. How did the country's public health system 'flounder ... in response to a straightforward bacterial infection – one that is easy to prevent, difficult to spread and simple to treat'? (Ibid.). This is one of the key questions that lie at the heart of Chigudu's masterful book, *The Political Life of an Epidemic*, in which Chigudu argues that epidemics must be understood as political rather than merely 'natural' or medical phenomena. Doing so, Chigudu suggests, allows us to both more deeply understand epidemics and to see what epidemics and other health crises can teach us about politics. To understand the political life of the cholera epidemic, Chigudu looks at the *longue durée* of Zimbabwe's—and particularly Harare's—political making, unpacking the endurances of health, illness, and disease that shaped the country. In this, his gaze reaches back to the founding of Harare as the colonial settlement of Salisbury in 1890. Here, Chigudu shows us how the spatial logics of colonialism, which were often racially based, doomed Harare from the very beginning.

The site for Salisbury was chosen at very short notice in response to colonial needs. The British South Africa Company was engaged in land grabbing across the region and needed a fort (Fort Salisbury) to help secure these territorial expeditions. Although the fort grew rapidly into a town and became the capital of

Rhodesia (present-day Zimbabwe) in 1923, it was badly located, particularly from the perspective of water and sanitation, as Salisbury was located upstream of its main water supply (Chigudu 2020, 38). This meant that as the town developed, it required a complex network of advanced technology and ‘sophisticated and elaborate infrastructure’ to pump the water upstream and to sufficiently process and treat the water for drinking (idem, 75). Like many colonial towns, Salisbury was founded on ‘racial separateness’, which was articulated in the development of the town’s infrastructures—infrastructures which completely failed to ensure that the non-white residents of the town would be supplied with efficient and safe water access (idem, 43). The town’s water systems were designed to ‘discriminate between white settlers accorded full membership to the polity and Africans for whom the promises of citizenship were deferred or denied’ (idem, 36–7). When the cholera epidemic broke out, it was in part a degraded and inequitable water supply system that could not bring clean water to the city’s poor that sparked the outbreak.

In unpacking the colonial imprints on Zimbabwe’s 21st century political and sanitation landscape, Chigudu’s book clearly articulates how the foundations for the 2008 cholera outbreak were firmly laid in the colonial era, and how the spatial geographies of race and power that were so fundamental to that era continue to underpin the shape of Harare and its healthcare provision. While the Zimbabwe cholera epidemic of 2008 could be rendered as a series of unfortunate events, Chigudu’s historical analysis shows how it was the outcome of decades of structural decay built on a basis of colonial spatialities of race, power, and inequality. Though the book opens with an examination of colonial history, its focus is contemporary, looking at agency, political action, conceptualisations of epidemics and politics in communities in Harare, the engagement and interventions of international organisations in epidemic responses, and the mobilisations of political actors of health crises as part of their own political agendas. In Chigudu’s potent work, we see the importance of a *longue durée* approach to the analysis of contemporary healthcare systems in African landscapes.

One of the themes that most clearly emerges across the three books is the centrality of spatial logics in the colonial constructions of disease and health in Africa. All three books carefully detail the geographies of disease, medicine, and healthcare, articulating how the spatial (and racial) logics of colonialism are central to the construction of African healthcare systems and the production of disease patterns. Colonialism was a deeply spatialised phenomenon, from the very act of penetration into countries and writing borders on maps, to decisions on who can live where. Spatial logics, often racialised, and always oriented towards the needs of settlers and colonial governance, shaped the geographies of southern African countries. As these texts clearly display, this was also the case in the realms of

medicine and health. Hokkanen closes his book with a discussion of his trip to the almost unreachable Livingstonia hospital and mission station. Despite its location, it was one of the key medical centres in Nyasaland for decades—its geography shaped by the needs of the missionaries. Equally, Chigudu shows us how the logics of racial segregation that configured the urban landscape of Harare continued to undergird the politics of the city, shaping who had access to water and in what forms, and thus ultimately who was to die of cholera and who was not.

These three texts make clear that medical and health worlds in sub-Saharan Africa are deeply (in)formed by the spatial and racial logics of colonialism. They show us the importance of paying careful attention to the spatial logics of illness, medical systems, and health when trying to understand southern African health worlds. In closing his book, Chigudu discusses how the Zimbabwean cholera epidemic acts as a window through which to understand politics and power in Zimbabwe at the turn of the 21st century. All three works seek to do the same—to show how questions of health systems are always also questions of politics, and in doing so they consciously and vocally seek to unpack the political stakes of health and illness, and to show how these political stakes are colonially informed and entangled. Reading these works together highlights the importance of having ‘a truly open and honest discussion, historically deep, geographically broad’ (Messac 2020, 187), in which one embraces a ‘long durée analysis’ (Hokkanen 2017, 2) and takes a ‘long range view’ to consider questions of ‘context, of power and of structural violence in shaping patterns of disease and experiences of illness’ (Chigudu 2020, xiii). Chigudu, Hokkanen, and Messac’s works read together make a powerful case for the continued entanglements of colonial logics in African health worlds and for the need to pay careful attention to these to understand and make sense of contemporary African health worlds today.

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References

- Chigudu, Simukai. 2020. *The Political Life of an Epidemic: Cholera, Crisis and Citizenship in Zimbabwe*. Cambridge: Cambridge University Press.
- Cochrane, Thandeka. 2021. 'Luke Messac, No More to Spend: Neglect and the Construction of Scarcity in Malawi's History of Health Care'. *Social History of Medicine* 34 (1): 340–42. <https://doi.org/10.1093/shm/hkaa118>.
- Cooper, Frederick. 2000. *African Since 1940: The Past and the Present*. New York, NY: Cambridge University Press.
- Hokkanen, Marrku. 2017. *Medicine, Mobility and Empire: Nyasaland Networks, 1859–1960*. Manchester: Manchester University Press.
- Livingston, Julie. 2012. *Improvising Medicine: An African Oncology Ward in an Emerging Cancer Epidemic*. Durham, NC: Duke University Press.
- Mbembe, Achille. 2001. *On the Postcolony*. Berkeley, CA: University of California Press.
- Mbembe, Achille and Isabel Hofmeyr. 2006. 'Achille Mbembe in conversation with Isabel Hofmeyr'. *South African Historical Journal* 56 (1): 177–87. <https://doi.org/10.1080/02582470609464970>.
- Messac, Luke. 2020. *No More to Spend: Neglect and the Construction of Scarcity in Malawi's History of Health Care*. Oxford: Oxford University Press.
- Mika, Marissa. 2021. *Africanising Oncology: Creativity, Crisis and Cancer in Uganda*. Athens, OH: Ohio University Press.
- Pels, Peter. 1997. 'The Anthropology of Colonialism: Culture, History and the Emergence of Western Governmentality'. *Annual Review of Anthropology* 26: 163–83.
- Stoler, Ann Laura. 2013. 'Introduction 'The Rot Remains': From Ruins to Ruination'. In *Imperial Debris: On Ruins and Ruination*, edited by Ann Stoler. Durham, NC: Duke University Press.
- Stoler, Ann Laura. 2016. *Duress: Imperial Durabilities in Our Times*. Durham, NC: Duke University Press.
- Stoler, Ann Laura. 2019. 'Colonial Disorders Past and Present: Some Planetary Considerations', Keynote Address, Association of Social Anthropologists UK Annual Conference, University of East Anglia, 3 September 2019.