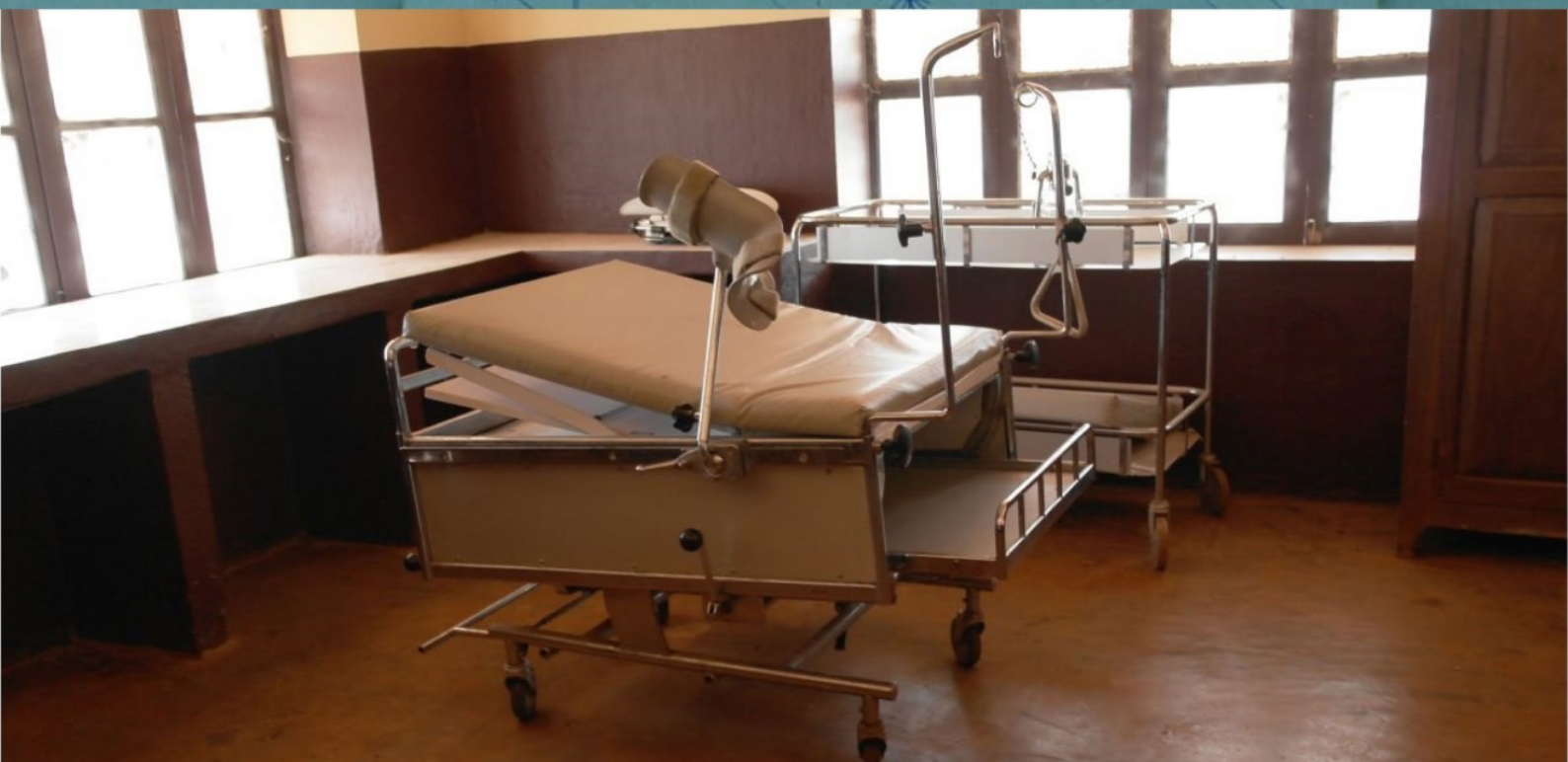
DREAMING OF HEALTH AND SCIENCE IN AFRICA

AESTHETICS, AFFECTS, POETICS AND POLITICS



Wellcome Trust Conference Center, Hinxton Hall, Cambridgeshire, UK
June 13th to 15th 2015

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Dreaming of Health and Science in Africa

Aesthetics, Affects, Poetics and Politics

Hinxton Hall, Wellcome Trust Conference Center, UK

June 13th to 15th 2015

Keynote Sessions held in Chestnut Suite, Parallel Sessions held in Chestnut Suite and Green Room

Saturday 13th June

10.00-10.30 Welcome

10.30-11.30 Opening Keynote: Simon Schaffer - The silent trade: reveries of global sciences

Chair: Noemi Tousignant

11.30-12.00 Tea

12.00-13:30 Parallel sessions

A. Archives of Dreams (Chestnut)

Chair: Alison Bashford

Guillaume Lachenal - Colonial doctors in paradise. The history of the Haut Nyong utopia, Cameroon

Noémi Tousignant - Things that did not happen: archive, resurrection and dreams of public health in Senegal

John Manton - Medical forgetting and musical memory at Uzuakoli Leprosy Centre, Nigeria

B. Governing Dreams (Green)

Chair: Jeremy Greene

Rasheed Olaniyi - Memory and Politics of Colonial Medical Services in Ogbomoso, 1907-1970

Erick Nyambedha - Forgotten People: Challenges of accessing basic health services by Indigenous Populations in Kenya

Hannah Brown - Managerial relations in Kenyan health care: Empathy and the limits of governmentality

13.30-15.30 Lunchbreak

15.30-17.30 Parallel sessions

A. Imaginaries of Care and Welfare (Chestnut)

Chair: Gabrielle Hecht

Claire Wendland - Starter kits and easy blessings: dreaming possibilities in everyday maternity care in Malawi

Ruth Prince - The past futures of a public hospital in Kenya

Noelle Sullivan - Imagining a Hospital Future: An Archaeology of Performative Engagement in Tanzania

Ramah McKay - Mourning Alma Ata: Public commitments and humanitarian temporalities in Mozambique

B. Progressive tools (Green)

Chair: Carlo Caduff

Nolwazi Mkhwanazi - A living laboratory? Medical male circumcision in Swaziland

Marine Al Dahdah - Health in Africa: mobile phone is the cure

Iruka Okeke - Evolved molecular biology laboratories in West Africa

Ann H. Kelly -Sensing Cellular Debris: Traces of a Soviet method in a Tanganyikan Laboratory

17.30-18.00 Tea

18.00-19.00 Keynote: Nancy Rose Hunt - Dreams and Dream Collectors in African History

Chair: Guillaume Lachenal

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Sunday 14th June

8.30-9.30 Keynote: James Fairhead - Ebola nightmares: Where dreams and the imaginary fill a social void

Chair: Alice Desclaux

9:30-10:30 Radio Programme: Uzuakoli in Music and Medicine (2015; by John Manton, produced in collaboration with the Arts and Culture Unit for Resonance 104.4fm, engineered by Vivien Jones)

10.30-11.00 Tea

11.00-13.00 Parallel sessions

A. Freedom and dependence (Chestnut)

Chair: Nancy Rose Hunt

Helen Tilley - The Wisdom of the Peoples' - African decolonization, Global Governance, and Cold War Constructions of Traditional Medicine

Wenzel Geissler – Field station as stage: acting science, forgotten scripts and the violence of mimetic dreaming

Johan Lagae - "Il ne peut être question de faire une politique, basée sur la couleur de peau". Postwar hospital architecture in the Belgian Congo and the dream of a new colonial society

John Harrington - Staging the Nation: Blood Donation, Ethnicity and Terror in Kenya

B. Divergent dreams (Green)

Chair: Alice Street

Catherine Burns - The Invention of the Birthsuit: Dreams, Fiction and Techno-Science in Apartheid South Africa

Freya Jephcott - Formal and informal systems of response to outbreaks emerging infectious diseases in Ghana

Luce Beeckmans- Imagined disease and racial segregation: multiple dreams of open space in Kinshasa and Dar es Salaam

Mathieu Quet - Security Dreams: Fighting against illicit medicines and shaping pharmaceutical markets in Kenya

13.00-14.30 Lunch

14.30-16.30 Parallel sessions

A. Quests for pharmaceutical effect (Chestnut)

Chair: Bob Simpson

Rene Gerrets - Malaria control dreams in colonial British East Africa: tracing remnants of cinchona-based industrial production in Tanzania

Rebecca Marsland - The Standardized Dream of the Insecticide Treated Mosquito Net

Kirsten Moore-Sheeley - Visions of 'Community Based' Malaria Control: The History of Insecticide Treated Nets in Kenya

Anne Pollock - Hope in Synthesis: iThemba Pharmaceuticals and dreams of South African Drug Discovery

B. Hope, death and wellbeing (Green)

Chair: Christoph Gradmann

Aimé Kakudji Kyungu - « Une femme ne peut pas mourir pour avoir aimé» Les rêves brisés des parturientes dans les salles d'accouchement de l'hôpital Sendwe de Lubumbashi

Benson Mulemi - Quest for health beyond hospital treatment of cancer in Kenya

Patience Mususa - Dreaming beyond a blanket and a roof: Visions of dwelling and wellbeing in an HIV/AIDS proje7ct in Zambia

Tamara Giles-Vernick and Fabienne Hejoaka - Healing dreams and hepatitis B in Burkina Faso

16.30-17.00 Tea

17.00-18.00 Keynote: Gabrielle Hecht - Toxic Tales from the African Anthropocene

Chair: Ferdinand Okwaro

19.30 Dinner

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Monday 15th June

9.00-10.00 Keynote: Filip De Boeck - Searching Kinshasa, or how to heal the city

Chair: John Manton

10.00-10.30 Tea

10.30-12.00 Parallel sessions

A. Transformative science (Chestnut)

Chair: Benson Mulemi

Gemma Aellah - Human-landing catchers, science-workers and AIDS orphans: the art and science of hustling to crossing the border between poverty and stability among the post-AIDS generation of 'youth' in rural Western Kenya

Lloyd Akrong - (Re)configuring visions of biomedical research in Africa: clinical trials as imaginative and transformative spaces

Johanna Crane - Administrative dreams, administrative nightmares: Indirect costs, inequality, and the economies of global health science

B. Engendering capacity (Green)

Chair: Anne-Marie Moulin

Peter Mangesho - Forgetting "Africanization" in East Africa

Branwyn Poleykett - Formatting the future: dreams and desires in capacity building

Ferdinand Okwaro - Collaborations in transnational medical research: aspirations, aims and dreams of African scientists and institutions

12.00-13.00 Lunch

13:00-14:00 Keynote: Steve Feierman - Imaginary Care in the History of Eastern Africa

Chair: Wenzel Geissler

14.00 -15.30 Parallel sessions

A. Targeting infection (Chestnut)

Chair: Ruth Prince

Fanny Chabrol - Dreaming of safer blood donation and transfusion amidst a ruined hospital in Cameroon

Alice Desclaux - Tensions between humanistic and sanitary projects in the Ebola outbreak

Julia Cummiskey - Stylish Men: Promoting Male Circumcision for HIV Prevention in Uganda

B. Seeking engagement (Green)

Chair: Peter Mangesho

Tracey Chantler - Becoming part and parcel of KEMRI-CDC': Hopes and expectations undergirding stakeholder engagement in health research

Birgitte Bruun - Daily trials: Lay engagement in transnational medical research projects in Lusaka, Zambia

Crystal Biruk - Blueprints and minor dreams: The polyrhythms of survey research projects in Malawi

15.30-17.00 Closing Drinks

Abstracts

Archives of Dreams

Guillaume Lachenal - Colonial doctors in paradise. The history of the Haut Nyong utopia, Cameroon

Between 1939 and 1945, the French colonial administration of Cameroon attempted an experiment in government. It decided to hand over an entire region of Eastern Cameroon, the Upper Nyong, to doctors from the colonial troops. The Upper Nyong was transformed into a "Région médicale" exclusively and entirely governed by medical doctors. The aim: experiment a radical approach to public health, by giving free reins to doctors for the transformation of "native" society. Led by a military doctor named Colonial David, a handful of young doctors presided over unprecedented efforts in the development of infrastructure, agriculture, education and medicine.

After briefly retelling the story of an experiment which turned, in many respects, into disaster, I will present my recent fieldwork on the remains of that medical utopia – the traces left in local memories, landscapes, official and familial archives. My aim is to move beyond a Conradian narrative of colonial hubris, isolation, failure and madness. By presenting the diverging, open-ended, looping tracks which I followed in the last months, I try to bring in wonder, laughter, fear, nostalgia and ecstasis in this history of colonial medicine, working through love stories, tales of death and violence, children songs, crashed cars and abandoned trees.

Noémi Tousignant - Things that did not happen: archive, resurrection and dreams of public health in Senegal

After the first post-independence decades, many of the actions and institutions of government, science and care that seemed banal elsewhere became fantastical in Africa. Things that had been planned but did not happen come to manifest as bitter jokes, dismissed dreams, awkward omissions or regretted failure. Yet such plans keep and make other forms of material and affective presence. Documents from the past were written, and can be read, as if were perfectly plausible for a proposal for an institution, a blueprint for a lab, a pilot for a national programme, a budget for research grants. As these futures vanish as plans for those who awaited them, and for historians leafing through records, what becomes of this archive of the plausible? Is it a reminder of past and future possibility, or does it break up into forgotten fragments and residue of the utopic? And what should one make of recent echoes and revivals of past developmental plans in the time of global health?

This paper is about how scientists and historians do and can deal with the debris, reversals and opportunities that form in the wake of changes in the plausibility of public health. It is not about conditions of possibility per se, but about the ways in which dreams survive, or not, as traces in archives, fantasies and resurrected projects. I explore these questions by describing the partial survivals of three public health plans that did not happen in Senegal. In 1966, Pierre Cantrelle announced a near future of accurate and comprehensive vital registration in rural Africa. In 1974, a proposal for a national medicinal plant research institution written by Joseph Kerharo was approved by the Directorate of Scientific and Technical Research. In 1973, Georges Gras suggested the creation of a national poison control centre to the Senegalese authorities.

Decades after these plans had been abandoned, I observed various ways in which they maintained some presence as (im)possible futures on old paper, in jokes and celebration, or in new and ongoing projects of public health action and research. At an anniversary symposium, Cantrelle's legacy of demographic monitoring was reclaimed and celebrated as a global health infrastructure. Kerharo was remembered in his university lab without his planned institute as a colonial prospector. Gras was forgotten, but a new national poison control centre was under construction. Through these different cases, I ask whether the plan that did not happen can ever be reached through the archive, the dream and the resurrection, or whether, after becoming fantasy, its past plausibility must remain ungraspable.

John Manton - Medical forgetting and musical memory at Uzuakoli Leprosy Centre, Nigeria

This paper counterpoints cultural currents and commemorative enterprise with destroyed and degraded remnants of medical and scientific research, located together at the Leprosy Centre, Uzuakoli, Nigeria. This centre, once a key location in global leprosy research, has largely been neglected since the beginning of the Nigerian Civil War in 1967. In its heyday, it was a charismatic scientific and cultural site, and its architectural remnants, while still in use, are haunted by the material persistence and the melancholic afterlives of massive institutional mechanisms for leprosy control in Eastern Nigeria, evident both in degraded and destroyed paper records, and in the dissemination and performance of the choral compositions of its most famous former patient, Ikoli Harcourt Whyte.

The paper interrogates the remains of the recording apparatus at the Leprosy Centre and Research Unit. It considers the ruination of these records as an active political process, interpreting their scattering, heaping, their (literal) consumption and excretion as an agent in productions of the memory and trajectory of the African state. Focusing on the story of a recent choral performance held at the Chapel of Hope, at the Leprosy Centre, it contextualises this political process in relation to stories, histories, and trajectories of musical performance, where performance and its demands elicit and crystallise the ethical and ultimately redemptive potential of an alternative folk historiography of leprosy, its control, and the Nigerian encounters with science which it mediated.

Governing Dreams

Rasheed Olaniyi - Memory and Politics of Colonial Medical Services in Ogbomoso, 1907-1970

From the early 20th century, colonial medicine was received with great enthusiasm in Ogbomoso town southwestern Nigeria. This paper discusses the politics of colonial medicine and its memory in Ogbomoso town, in order to understand how colonial modernity changed and improved health care in a traditional Yoruba town from the early 20th century. It highlights the alliance and antagonism between the Baptist Mission, colonial administration and the people of Ogbomoso in the development of the hospital. The politics of land acquisition for the building of the hospital, how colonial medicine became socialised through missionary activities, the politics of colonial government to medical missions and memorialisation process of colonial medicine in Ogbomoso are discussed. Modern medicine at the Baptist hospital, Ogbomoso incorporated aspects of Yoruba cultural values and social relations. It raises the question of how Baptist hospital and related health institutions have been transformed and memorialised since independence in 1960. The survival of popular healing, the spread of competing popular therapies and the introduction of biomedicine, Christian healing, and Muslim healing combined to create a profusion of therapeutic forms and aesthetics. Many kinds of practitioners co-exist to provide healing. From the humble beginning in 1907, the healing ministry developed over the years to include the following constituent parts of the Medical Centre-Baptist Hospital, Ogbomoso; Baptist School of Nursing, Ogbomoso; Kersey Children's Home, Ogbomoso; Baptist Health Service (Leprosarium), Ogbomoso; Baptist Dental Clinic, Ogbomoso; School of Midwifery, Ogbomoso and Staff Nursery and Primary School, Ogbomoso. All these institutions remained memorable in Ogbomoso as it raised the standard of living and provision of health care services. Nearly all the missionaries and medical doctors in Ogbomoso were immortalised through naming of churches, schools, hospital wards and clinics after them. Annual lectures are organised to commemorate the invaluable efforts of Dr. George Green in medical mission. As much as possible, the colonial state kept financial commitment to the hospital at the lowest ebb. Government sought collaboration with the Baptist Hospital regarding the Ogbomoso Leper Camp. Government expected medical missions to expand their medical and health work from their own resources. Even though medical services at the Baptist Hospital was considered valuable, it was treated as rival institution and there were fears that grant-in-aid and other income could be used for missionary purposes. Despite lack of government support, Ogbomoso was designedly omitted from the list of places to be provided with a dressing station owing to the existence of the Baptist Hospital. The full implementation of the Nigerianisation process posed several challenges in terms of funding and qualified personnel.

Erick Nyambedha - Forgotten People: Challenges of accessing basic health services by Indigenous Populations in Kenya

Attempts to attain elusive dreams of equality in access to healthcare in the developing world buoyed with global concerns for the equitable access to basic services have led to attempts by the Kenyan government to introduce deliberate measures to provide basic health services to indigenous populations. A qualitative study was done among 13 out of the 22 Indigenous groups to explain the challenges and existing opportunities for addressing problems of inequality and exclusion in access to healthcare as well as the value that the indigenous populations attach to western medicine. The results of the qualitative study show that stigma particularly for HIV/AIDS services, cultural practices such as FGM, use of long nails as surgical blades for home delivery and language barriers between health workers and Indigenous populations have shattered the dreams of attaining equitable healthcare. Health care delivery system that is considered insensitive to cultural beliefs and practices, gender issues, poor infrastructure and absentee health workers form an important part of the inadequacies in the health system that perpetuate marginality in healthcare by indigenous populations. The results of the study have important implications for medical anthropologists and preventive medicine as future dreams for health equity among indigenous populations.

Imaginaries of Care and Welfare

Claire Wendland - Starter kits and easy blessings: dreaming possibilities in everyday maternity care in Malawi

In discussions of their everyday work with pregnant and childbearing women, both Malawian clinicians and informal-sector care providers often referred to the possible envisaged in dreams, in wishes, in imaginations and fears. Delvecchio Good has claimed that the medical imaginary is a global phenomenon, and that it engenders a political economy of hope with sometimes troubling effects. The alternate pasts, alternate futures, and alternate selves that appeared in narratives of the possible from Malawi suggest a medical imaginary that is less focused on biotechnical cures and more on social and political care.

Ruth Prince - The past futures of a public hospital in Kenya

In 1960s Kenya, dreams of a postcolonial public health focused on health infrastructures, the most impressive being the building of modern, state-of-the-art public hospitals. These solidly built structures materialized an anticipated future, of medical modernity, public service and a modern state, and an associated civic politics of entitlement and belonging, international solidarity and equality. Fifty years later, these buildings are ambivalent symbols of past utopias and dystopias, being materializations of both progress and decay, places haunted by both hope and failure. This paper engages with this ambivalence. Focusing on a Soviet-built hospital completed in 1968, it explores the dreams of its Kenyan planners and Soviet architects and their problematic remains in the present-day efforts of government doctors and civil servants who no longer associate medical progress with public health institutions. The question of which publics are served and imagined by the hospital continues to engender controversy as efforts to give and receive care evoke both a past of civic commitment and a present of privatization, commodification and class inequality.

Noelle Sullivan - Imagining a Hospital Future: An Archaeology of Performative Engagement in Tanzania

Tanzania's long history of biomedical scarcity has largely been exacerbated by structural adjustment programs that required the health sector semi-privatise, and over a decade of highly targeted global health interventions that value some lives over others. Global health interventions have thereby introduced new inequalities onto a landscape that today is remarkable as much for its dearth as its potential as a development partner.

This paper ethnographically traces the work by staff at one government hospital in northern Tanzania to engage and expand the confines of donor, state, and foreign volunteer intervention. Marketing fifteen years of successful compliance with reporting burdens and narrow global health values, staff at this hospital have, over the past two years, attempted to make the relatively strict boundaries of global health intervention more porous

in order to envision new hospital possibilities. Based on ethnographic research over approximately 18 months from 2008-2014, this paper traces the materiality of a hospital's past, its present, and its envisioned future.

This archaeology of a hospital future begins in the office of the head administrator. On its walls hang certificates of appreciation and acknowledgement, and photos with well-known political figures visiting the facility. In this office, global health successes are juxtaposed with the hospital's "5 year master plan"—a topographic map layering the hospital's structural present onto an imagined infrastructural future. Existing buildings are surrounded by aspired-to edifices: multi-storied buildings including a new maternity ward, library, radiology department, nursing school, and mortuary with 12-drawer cadaver fridge. If, as Timothy Mitchell suggested for Egypt (2002:201), donors' topographic representations of intervention sites naturalize particular interventions, then here we see a Tanzanian hospital administration adopting a similar tactic in order to engage NGOs, donors, state representatives, and even foreign students beyond the targeted enclaves of development characteristic of global health's present. The map suggests a hospital not-yet-come—a beacon of potential for biomedicine imagined, but as yet unseen.

The materiality of the administrator's office is a space of attempted engagement. A mere three years ago, such a hospital future would have been unimaginable. Today, it is a hope that no longer seems fleeting. The hospital's reputation as a good development partner has grown among donors, NGOs, state representatives, and foreign volunteers. These new actors within the hospital have encouraged the staff to imagine that some among these visitors—just maybe—might become potential benefactors, seeing fit to invest in their collective vision. Guided tours of the facility are thus geared towards showcasing the aesthetics of the hospital's present success, in order to argue for its aspired-to infrastructural future.

Attentive to the material politics through which the hospital claims itself as a worthy space of investment, as well as strategic and performative attempts at engagement with visitors, this paper highlights both the burdens and excitements that characterize work at the interstices of historical scarcity, global health inequalities, and institutional imaginaries of the present.

Ramah McKay - Mourning Alma Ata: Public commitments and humanitarian temporalities in Mozambique

In 1978, the World Health Organization recognized Mozambique as a model of primary health care, citing successful vaccination campaigns, the mobilization of community health workers, and the construction of primary care clinics. Today, as much as seventy percent of Mozambique's health resources are provided by donors and primary health care competes with humanitarian orientations to the provision of care. As a result, many public health actors (and anthropologists) locate contemporary global health interventions in the aftermath of socialist aspirations to public and primary health care – what anthropologist Lawrence Cohen has described as the dream of the clinic (2012). Yet while ethnographies of global health have contrasted the urgent present tense and short term temporalities of these humanitarian interventions with the enduring nature of the state and public health, many patients, program recipients, and some medical actors in emphasize the entangled histories of public and nongovernmental and the longevity of humanitarian action in Mozambique.

In this paper, I explore the temporalities, public and humanitarian, that animate two medical projects in Mozambique as a means of understanding the medical practices that transnational interventions make possible and the forms of collectivity and care that they enable. Alongside the dream of the clinic and its demise, I suggest, there are other orientations to the temporalities of medicine, care, and survival that inhere in humanitarian medical practice. To understand this, I draw from ethnographies of African cities, which have emphasized how provisional and mobile encounters between "objects, spaces, persons, and practices" also enable "new forms of solidarity" through "participation in makeshift, ephemeral ways of being social" (Simone 2004:426). Attention to the makeshift, ephemeral, provisional, and mobile, I suggest, can also illuminate the experiences and effects of transnational medical interventions in Mozambique, for patients and practitioners alike, and can highlight the collectivities and potential solidarities that emerge around and through transnational intervention. These urban analytics, even and perhaps especially in rural places, show how transience and ephemerality can make available important resources for wellbeing. In contrast to distinctions between the enduring and expansive qualities of public and primary health care and the temporary nature of transnational intervention, attending to the ephemeral and transient qualities of medical projects, both public and nongovernmental, highlights the horizon of possibilities in which wellbeing, collectivity, and medical practice are

constituted. Ultimately, I ask whether medical dreamtimes – in which past, present, and future coexist – might be sites in which to ask broader questions about the politics of transnational intervention (and ethnographic approaches to it).

Progressive tools

Nolwazi Mkhwanazi - A living laboratory? Medical male circumcision in Swaziland

Based on the 'successes' of male circumcision clinical trials in Kenya, Uganda and South Africa, in 2011 the kingdom of Swaziland became the site for a medical male circumcision accelerated saturated initiative called Soka Uncobe (circumcise and conquer). The aim of Soka Uncobe was to circumcise 80% of HIV negative males (152 000 males) between the ages of 15 and 49 years in a year or less. The benefits of this initiative were calculated in terms of averting 88 000 new infections and saving 650 million US dollars in care and treatment costs. Towards this end, PEPFAR donated 30 million US dollars in support of the initiative, and the Centre for Disease Control (CDC) and USAID came forward to lend their expertise. The intervention was planned with military precision in Washington. Maps were drawn up. Sites were chosen and the advancement of the campaign was charted. The dream of the triumph of medicine and science was however short-lived. In the first six months of the campaign less than three per cent of the projected 152 000 males underwent circumcision. In the second half of the year, increasingly desperate attempts were made to try to reach the projected target. This paper speaks to the persistent dream of Africa as a 'living laboratory'. Through a discussion of the kinds of planning that went into the campaign, I show the assumptions the campaign was based on and how utterly unsuitable they were for Swaziland. The paper thus charts the unpreparedness and delusions behind the medical male circumcision accelerated saturated initiative called Soka Uncobe.

Marine Al Dahdah - Health in Africa: mobile phone is the cure

In 2014, almost seven billion people were mobile phone users, thus propelling mobile phone ahead of all Information and communication technologies (ICT). Whether it be Mobile Personal Health Record or confidential clinical data send via SMS, those devices are increasingly used to provide "better" health services in a context of reduced health expenditure and of increased involvement of patients. Substantial research has been conducted on eHealth – health on the Internet - in recent years, mainly regarding the nature and the value of health information on the web (S. Adams et Berg 2004; Eysenbach et al. 2002), the redefinition of the roles of lay and expert in health, the subsequent transformation of the patient-caregiver relationship (Akrich et Méadel 2010; Henwood et al. 2003; Wyatt 2005). Yet, very little *research has been conducted on the use of mobile phone and wireless technology within health programs, called "mHealth" or mobile health, and especially in the global South, or in development contexts. However, the impact of mobile technologies on health care in such contexts raises critical questions that become particularly acute* in the context of increased access to mobile phones in Africa.

This new wave of mobile technology applied to health thus raises complex issues in terms of economic organization, governance, and control. Especially when millions of dollars are being invested in mHealth projects in developing countries where poor health systems are failing to meet the needs of the population and where the lack of legal framework may leave the door open to experiments (Petryna 2009; Rottenburg 2009; Geissler, Rottenburg, et Zenker 2012). It calls for anthropological and geopolitical questioning on the implementation in developing countries of projects that are sometimes entirely designed and funded by developed countries, programs within which the types of collaboration of developing countries, that is more or less voluntary, more or less committed, deserve to be further studied. These mobile technologies point out important issues in terms of data safety, confidentiality and "privacy" in the context of collection and analysis of health data that is "globalized"(mHealth Alliance et al. 2013; Rodrigues et al. 2001; Patrick et al. 2008). They also highlight the dynamics of how foreign ethical and financial practices adapt – or not - to local economic and political contexts, customs and traditions, health organizations and health professionals. Furthermore, *mHealth* participates to the economic and technological reconfigurations of Global health (V. Adams, Novotny, et Leslie 2008; Biehl et Petryna 2013; Atlani-Duault et Vidal 2013; Brown, Cueto, et Fee 2006; Fassin 2012). It raises major issues at the intersection of research on ICT, Anthropology of health and STS studies.

The recent multiplication of mHealth worldwide illustrates the overall trend towards the globalization and technologization of biomedicine. The widespread idea that digital technologies improve the quality of care, reduce health disparities and optimize health systems takes shape in a diverse set of technical devices : mHealth, telemedicine, big data, etc. This communication offers an overview of this new field of mHealth and the various ways it contributes to the emergence of new global healthcare spaces and trends. It also aims to explore how mobile connectivity gives rise to new forms of power, of control and friction (Tsing 2005) through the study of a particular maternal mHealth project, we've conducted in Ghana. Finally, we propose to focus more specifically on the perceptions of the end-users - health professionals and pregnant women- of this technology as an expression of its effects.

Iruka Okeke - Evolved molecular biology laboratories in West Africa

Molecular methods developed from the 1960s made it possible to ask and answer precise questions and were introduced into most biology sub-disciplines by the 1980s. The 'molecularization' of biology occurred during the years that Nigeria, Ghana and many other African countries were cash strapped by imposed Structural Adjustment programs, and in which academic, clinical and research laboratories became moribund. At the start of the current millennia, a few African biomedical scientists had begun to use molecular methods. Many began with de novo laboratories or laboratory out-posts set up with start-up support or technological aid. A handful of laboratories staffed by African principal investigators however re-imagined and reconstructed existing laboratories through other means. This paper looks at three of these laboratories, how their equipment was compiled, the ad hoc ways in which they are supplied and maintained, and their extraordinary accomplishments. These small bacteriology research laboratories were equipped by a combination of coalescing and refurbishing existing materials, small equipment donations from laboratories abroad and collaborative projects that brought in occasional pieces. The investigators that work within them also use facilities in neighboring, shared or even distant laboratories to supplement their own. The productivity, flexibility and longevity of the laboratories suggests that what might appear at first glance to be cobbled-together facilities actually represent viable means investigator-led laboratories in resource-limited countries that deserve explicit support mechanisms.

Ann H. Kelly - Sensing Cellular Debris, Remembering a Soviet Method

A microphotograph of a mosquito taken in the 1962 in a mountain laboratory in what was then Tanganyika provides a prompt to consider the socio-political salience and affective power of scientific images. Drawing inspiration from anthropological work on photographic practices, the paper excavates the context of the image's production—both the geopolitical machinations of the global malaria eradication program and the domestic research station—to apprehend the relationship scientific work and lives. As much souvenir as 'epistemic thing', the microphotograph provides new directions in thinking about the materiality of memory in tropical medicine

Keynote: Nancy Rose Hunt - Dreams and Dream Collectors in African History

I will move a step or two toward a history of dreaming, less in everyday African life perhaps, than in African anthropology and history, paying special notice to dream collectors and their attentions to therapeutic (or pathological) dimensions. The examples may hop around a bit: with say southern Africa, lower Congo, Ghana, and Mbembe's maquis dreams from Cameroon, and from say mid-19th century to the present. I will keep one eye open for "dreaming of science" kinds of African dreams, while pressing for better disaggregating vernacular therapeutics. The need to distinguish night dreams (and nightmares) from reverie (or daydreams) is critical, just as Bachelard's concept served me well in identifying repetition in eviction reverie in A Nervous State

Keynote: James Fairhead - Ebola nightmares: Where dreams and the imaginary fill a social void

Médecins Sans Frontières were shocked in June 2014 when the President of the Republic of Guinea accused them of making money on the back of Guineans. They were shocked, too, when villagers in the Ebola-hit Prefecture of Gueckedou organised to fell trees and demolish bridges to keep out the ambulances, contact tracers and

educational teams attempting to bring them succour. Violence and threats against the new medical order escalated, and in the small town of Womey the men's and women's initiation societies enjoined in the orchestrated and brutal murder of a delegation of politicians, doctors and journalists. Violence and active resistance continues, as do the everyday forms of resistance. The epidemiology of the disease follows social resistance. The outbreak would have been contained long ago were it not for this social rift.

MSF were delivering health in Guinea divorced from the social in a world shaped by memories of the slave trade, of colonial wars and apartheid administration, and of Stalinist modernist iconoclasm, and in a world shaped by current experiences of neoliberalism and colossal global corruption that alienates youth from gold and diamond reserves, and everyone from income promised from their Iron mountain, Simandou.

MSF have been reflecting on their role in the deepening crisis. Did they project too much confidence? No. Had they overly monopolised Ebola response? Yes. Here I consider the existence of this monopoly in the hands of an organisation that admits that whilst it 'does health', it does not 'do society'. What is the effect of delivering 'humanitarian health' divorced from the social worlds of the ill? How is it experienced? In particular, how do dreams and nightmares substitute for everyday social interaction? What work has to be done to maintain the social divorce and associated dream-worlds. How is this dream associated with the social production of amnesia in the health establishment? Both MSF and WHO had long and painful experience of the centrality of 'community relations' in Ebola response acquired in the previous 20 years, so what led to its neglect?

Radio programme

Uzuakoli in Music and Medicine (2015, 59 Minutes)

Dating from 1932, the Leprosy Centre at Uzuakoli, Nigeria, was a medical site of global significance, offering home and shelter to its rejected residents, and carrying out groundbreaking research into drugs still used to treat leprosy, until interrupted by catastrophic civil war in 1967.

Today housing a much reduced medical and rehabilitation programme, it is renowned as home to Ikoli Harcourt Whyte (1905-1977), a leading choral composer who transformed his experience of suffering and segregation into songs of worship and wonder, and whose school at Uzuakoli attracted choirmasters from across Nigeria.

In this programme, historian John Manton explores the story of Uzuakoli, of visionary and hopeful science, of pain and dislocation, and of musical transcendence.

Blending documentary, feature and sound art, Uzuakoli in Music and Medicine draws upon and assembles found and field recordings including original vinyl as remastered recordings of Harcourt Whyte's choir; contemporary recordings of Harcourt Whyte's work arranged by his scholarly biographer Achinivu Kanu Achinivu; oral historical testimony; and field recordings of sung and spoken passages of Harcourt Whyte's music.

This programme was authored by John Manton, and co-produced with The Arts & Culture Unit; it was engineered by Vivien Jones.

It is broadcast as part of the first series of *Modulations: Broadcasting Research in the Arts, Humanities and Social Sciences*, on Resonance 104.4fm.

Freedom and dependence

Helen Tilley - The Wisdom of the Peoples' - African decolonization, Global Governance, and Cold War Constructions of Traditional Medicine

This talk presents select evidence from my current research project, which seeks to explain the ascendency of *traditional medicine* within global and pan-African institutions in the twentieth century by situating it in the wider context of decolonization, the rise of ethnoscientific research, and the global Cold War. When European, American, and Japanese empires were dismantled following the Second World War, endogenous therapeutic practices that had been so widely denigrated in the imperial period were granted a new hearing. Political independence in India in 1947 and China's communist turn in 1949 prompted both countries to valorize Ayurvedic and Chinese medical traditions in the ensuing decades. Yet had it not been for simultaneous efforts

within dozens of newly independent African countries, Chinese and Indian leaders might have been lobbying in support of "traditional medicine" at the international level in isolation. In fact, prior to 1973, when the People's Republic of China was officially admitted to the UN system, it was largely African rather than Asian delegates who raised questions about "traditional" medicine in global venues. In 1965, for instance, scientists with the Organization of African Unity (OAU) encouraged it to foster pan-African research networks that could investigate African healing and pharmacopeia as valid alternatives. Over the next decade, the OAU sponsored a series of pan-African conferences and, in 1972, forged stronger links with the African office of the World Health Organization in Brazavillle. The OAU's persistent effort between 1965 and 1976 helps to explain why the WHO used the African expert group's definitions of traditional medicine when it announced its program to the world in 1978.

Wenzel Geissler – Past future and present tense: living in the remains of a dream institute

This paper is about people's lives, in 2015, in the remains of a once world-leading scientific institute on a mountain in the East African rainforest - Amani Hill Research Station. Seemingly well-insulated from the 20th century's social and political contradictions and transformations, the institute was during its 1960s apogee famed as a home for "scientists in the clouds", promising scientific freedom and the pleasures of an out-of-the-world sociality - a dream institute.

In 2015, the century-old station has been in a suspended state for more than a generation. With little research since the 1980s, declining staff and no infrastructure investments, its laboratories stand as left in the late 1970s, its large library collection ends then, its vehicles stopped moving little later, and its residential housing, spread over 250 acres, is crumbling. This paper asks how the remaining 32 staff - most of whom are watchmen and caretakers, who have not seen scientific work for decades – and the 252 people who reside on institute land, live in the remains of a scientific institution.

Exploring the lives of those who live on an iconic site of mid-20th century African science reveals the ruin as lived-in landscape, and shifts attention from contemplation of temporality and memory to matters of usage, decomposition and waste. For 21st-century visitors, including ethnographers, Amani's traces of the future titillatingly intertwine nostalgia for progress with postcolonial discomfort. Similarly focused on temporality, and biographical experience, Amani's elderly retirees – British and Tanzanian alike – who left the station long ago, mourn loss and express pain when visiting the sorry remnants of their past lives.

But Amani is not 'dead enough' to be merely a ruin, a landscape of remains, infused with connotations of temporality. 90% of Amani's contemporary population were born after the institute's 1960s post-colonial heyday. Rather than being about the past, for them the place is of the past, but for the future. To be used, surveyed for opportunities, and laid to waste. Used as relatively stable social and spatial position for manifold productive activities – providing professional legitimacy and routines, housing and limited cash incomes – and exploited as resource-rich terrain that can be rendered fruitful by using or purveying its spaces and tools, by farming and gardening, or harvesting timber, medicines and grass. And, if necessary, to be used up and left behind with little respect for a past beyond living memory.

The resulting futures are very different from the comprehensive past futures of mid-20th century modern science, built on durability and predictability, and embedded in visions of progressive civic expansion: it is precarious, speculative and short-lived, like so many contemporary African futures. Only very rarely, or upon the ethnographers' stimulus, Amani's inhabitants are given to dreams of return and restoration; and their considerable everyday suffering is not framed as loss of a better past – although it bears the traces of enduring colonial violence. And yet, their actions remain framed by and draw upon the remnants of a spectacularly modernist past, continue to obey and rely upon some of its rules and boundaries; while, perhaps most importantly, converting forms and materials of an ancient past future into both waste, and resources.

Johan Lagae - "Il ne peut être question de faire une politique, basée sur la couleur de peau". Postwar hospital architecture in the Belgian Congo and the dream of a new colonial society

The Ten Year Plan for the Social and Economic Development of the Belgian Congo, launched in 1949, put large emphasis on investments in housing, education and health care. As such, it formed the framework for the large scale building operation resulting in a whole new physical infrastructure of satellite cities, schools and hospitals. The pages of the book Investir c'est prospérer, which was published in 1959 and presented the first overview of the results of the plan, are filled with photographs of impressive complexes most often designed in a modernist style, that testify of the introduction of a particular form of a welfare society in the Belgian colony. Today, almost all of this infrastructure still is standing and functioning, despite the often degraded state of the buildings. In particular in terms of health care, the DR Congo is in many instances still relying on infrastructure dating from colonial times, despite recent investments in new hospitals and local dispensaires by the Congolese government or Chinese partners. As such, postwar colonial hospital infrastructure forms an object of current "Politics of Nostalgia" (Lachenal & Mbodj, 2014).

In this paper, I will discuss how the hospital complexes built in major cities of the Belgian Congo during the 1950s speak of an era of promise and development, which is explicitly reflected in their innovative architectural language. Through their urban location and internal distribution of spaces, these medical complexes simultaneously illustrate a continuation of earlier policies of racial segregation that had informed colonial building and planning practices since the interwar period. The "segregation mania" that spread across colonial territories rapidly (Nightingale 2012) also struck the Belgian colony. The introduction of a "colour bar" in the spaces of Congo's urban spaces, especially from the late 1920s onwards, was largely informed by considerations of health and hygiene, even if its spatial implementation was often challenged by particular local physical and societal conditions.

By discussing the hitherto overlooked role of doctor Albert Duren in the postwar debate on hospital infrastructure, I will demonstrate that within the colonial establishment some dissonant voices were already emerging from the late 1940s onwards. Duren, who from 1946 onwards acted as Inspecteur Général de l'Hygiène within the Ministry of Colonies, tried to reorient the earlier approach of erecting separate hospital complexes for Africans and Europeans on different urban sites, and made an explicit plea for a rapprochement, not only because of considerations of economy or efficiency, but also on ethical grounds. Or as he would state it in 1951, in a discussion of the planned urban location of two new hospitals in the city of Lubumbashi, "Il ne peut être question de faire une politique, basée sur la couleur de peau". Yet, Duren's dream of a new colonial society, that was partly informed by the emerging political discourse on the communauté belgo-congolaise, remained an unfulfilled project, as I will demonstrate through a critical investigation of several examples of postwar hospital infrastructure, located in different Congolese cities.

John Harrington - Staging the Nation: Blood Donation, Ethnicity and Terror in Kenya

The attack on the Westgate shopping centre in September 2013 in which 61 civilians were murdered was accompanied by an exceptionally large wave of blood donation in Nairobi and other Kenyan cities. National leaders and prominent NGOs made high profile pleas for donations. In official speeches, opinion columns and on social media, blood donation was figured as a fitting response to the presumed intentions of the Al-Shabaab militants who had seized the centre. In word and image blood was represented as a unifying substance capable of physically crossing the 'tribal' divisions which were seen to have provoked mass conflict after Kenya's disputed elections in 2007-8. This 'staging' of the Kenyan nation-state needs to be understood with reference to the consequences of that conflict, in particular the trial of the current President and his deputy for crimes against humanity at the International Criminal Court. Drawing on an ongoing review of secondary sources and interviews with blood donation mobilizers this paper sets the official rhetoric of unity against a more heterogeneous landscape of multiple particular donation intiatives. The latter are often driven by specific ethnic groups, such as the Asian and Somali communities, or by faith groups and 'on-line communities'. The strategic goals of many of these groups and the practical effects of their initiatives tend to run counter to the ideal of a national, anonymous and wholly altruistic system of donation as championed in post-war Britiain by Richard Titmuss and promoted internationally by the World Health Organization.

Divergent dreams

Catherine Burns - The Invention of the Birthsuit: Dreams, Fiction and Techno-Science in Apartheid South Africa

This paper is a history of the decompression Birthsuit – an obstetric technology and a clinical application process designed and patented by Professor O. S. Heyns, a renowned professor of obstetrics and gynecology in South Africa, active from the late 1920s to the late 1960s. After developing and publishing research based on African women in his early career, Heyns' ambitions widened and he turned to the invention of devices and techniques for birth labour, drawing on the access he had to patients as a powerful academic head of Department and a consulting specialist to two major hospitals in the city. Heyns' Birthsuit was tested first on black women at the Bridgman Memorial Hospital in Johannesburg and later white women at the Queen Victoria Maternity Home. The patent process was relatively smooth, given the lack of ethical oversight and consideration required today. The results were announced on radio, in local newspapers and overseas broadcasts, and only later in academic papers. The invention, a rubberized vacuum-based Birthsuit, was designed to relieve pressure on a labouring woman's spine and to obviate pain, from the onset of labour. In 1964 the current Queen of England's personal physician, Sir Peel, was curious enough to communicate with Heyns, and arrange for a demonstration. So impressed was he with Heyns, the device, and the evidence before him, that he recommended its use. Soon claims for genius children born of this birth process were made, and the notoriety of the Birthsuit spread widely. The equally dramatic process of its de-legitimation and then the rapid purging of O. S. Heyns' professional positions and reputation, was as rapid.

There is hardly any published work on obstetric science in Southern Africa and this paper examines the complex interplay of race-based maternal birth labour, iniquitous research contexts, as well as highly motivated researchers with relatively well funded medical research projects in the first decade of Apartheid. Drawing on medical archives, medical autobiographies, scientific journal papers, patent records, photographs and technical drawings, popular works on childbirth, and oral accounts, the paper argues that by 1960s South African medical science was energized, and possibly transfixed, by dreams of global possibilities from local invention. The paper places the history of the Birthsuit in the wider context of obsessions with modernity and technology in the South African scientific and medical academy of the 1950s and early 1960s. Many published works have traced the South African technological and clinical drive necessary to perfect the world's first successful heart transplant in Cape Town. O. S. Heyns dreamed that his invention would transform obstetric medicine globally, and initially his conceit garnered support. The spectacular collapse of this device in all global obstetric settings, bar Eastern Europe – where its reputation and use survives in a few isolated clinical setting – is discussed and analyzed as a dream turned nightmare, a morality tale about hubris in a setting shot through with race and gender power.

Freya Jephcott - Formal and informal systems of response to outbreaks emerging infectious diseases in Ghana

In 1998 the Member States of the World Health Organization's Regional Office for Africa (WHO/AFRO) adopted the Integrated Disease Surveillance and Response system (IDSR); a single template for domestic infectious disease control infrastructure developed by the US Centres for Disease Control and Prevention (CDC) and the WHO. IDSR provides a rigid hierarchical framework for outbreak responses in West Africa. In the wake of the ongoing Ebola outbreak, there is talk of strengthening the IDSR in countries such as Sierra Leone as an insurance against similar outbreaks of emerging infectious diseases (EIDs). In this paper, I contrast this global bureaucratic vision with the domestic system of response that manifested itself during the early stages of a particular EID outbreak in Ghana in 2011.

I will draw on the case of a supposed emerging zoonosis outbreak that occurred in the Brong-Ahafo Region (BAR) of Ghana in 2011. The outbreak failed to satisfy the criteria necessary for international assistance under the revised International Health Regulations (IHR, 2005) and thus the investigation and response remained solely the remit of the national authorities. The system that emerged through the course of the outbreak, whilst referencing the IDSR scaffolding, existed almost entirely outside of it. The system utilised instead was a social network composed of carefully engineered social ties across various actors within the Ghana Health Service, Veterinary and Wildlife Division and specialists laboratories.

This unofficial system had largely been established through the course of a 2007 Avian Influenza outbreak in Ghana, but was apparently actively developed as a default system for similar outbreaks by senior officials in the relevant national agencies. This system involved a hierarchical cross-disciplinary network of vetted and beholden individuals who cultivated personal ties to actors working in relevant international agencies – intertwined with access to resources – which was often referred to as 'capacity'. This unofficial system provided a speedy flow of information, meaningful oversight and access to specialist knowledge and diagnostic technologies, all pertinent in relation to EID outbreaks and the established weaknesses in the formal IDSR system.

The informal system was forged from a familiarity with the practical demands and challenges of responding to an outbreak of an unfamiliar pathogen in a resource-limited setting. It acknowledged and utilised the nature and varying strengths of social ties in a way that many bureaucratic structures fail to do. Through tracing the response in the BAR case study, I demonstrate that investing in standardised rigid systems of surveillance and response, such as the IDSR, in developing countries may seem safer than working with the more flexible informal responses that take place, perhaps the latter are better primed for early containment of EIDs.

Luce Beeckmans- Imagined disease and racial segregation: multiple dreams of open space in Kinshasa and Dar es Salaam

It is strange to encounter an open space in the middle of Tanzania's congested capital, Dar es Salaam. Similarly, one might wonder why there exists a golf course and a zoo besieged by traffic jams in the bustling city centre of Kinshasa, capital of the Democratic Republic of the Congo. The key to understanding the intriguing anomalies in the urban geographies of these capital cities lies in tracing back their histories.

After the First World War colonial governments in British Dar es Salaam (1924) and Belgian Kinshasa (1931) dreamed of implementing a physical separation between Africans and Europeans. Although the British indirect rule/association, in fact provided an excellent basis to legitimate racial segregation, the British in Dar es Salaam just like the Belgians in Kinshasa, who applied a policy that was greatly inspired by both British and French rule, but was nonetheless overtly racial, felt forced to legitimate racial segregation with a sanitary discourse. In both colonies similar explanations underpinned the sanitary discourse, such as the statement that a physical distance would prevent malaria mosquitos flying over from the African quarter to the European quarter, or that it would prevent the contamination by germ-ridden rats 'as these are less likely to move from area to area over an open space' – all explanations which were far from scientifically proven, and were even broadly contested by empirical observations. This shared use of a sanitation discourse thus shows the controversial character of the planned intervention, but also suggests a certain transnational exchange with regard to the implementation of racial segregation in sub-Saharan Africa.

Indeed, a remarkable similarity exists in the place-naming of the separation zones between Africans and Europeans in both capitals: the 'Neutral Zone' in British Dar es Salaam and the French equivalent 'Zone Neutre' in Belgian Kinshasa. With regard to the 'neutral zones' several archival records highlight both in Dar es Salaam and Kinshasa the powerful influence of British and South African sanitation experts (in South Africa already in the beginning of the 20th century a sanitary discourse was used as a pretext and legitimation of racial segregation, a phenomenon that has been called a 'Sanitation Syndrome' by Maynard W. Swanson), as well as a significant transnational dialogue between the colonial powers. Through influential manuals, international and above all inter-continental conferences such as the *Conference of Principal Medical Officers and Senior Sanitary Officers* in Lagos in 1912, the *Inter-Colonial Conference on Yellow Fever* in Dakar in 1928 and the *Sanitary Conference of Chief Health Officers* in Cape Town in 1932, these 'all-purpose experts' turned racial segregation, and in particular the implementation of 'neutral zones' in the urban fabric, into a legitimate sanitary measure, with considerable impact on town planning. Moreover, under the influence of the discipline of Tropical Medicine racial segregation also evolved from a temporary solution in the battle against infectious diseases, to a permanent prevention measure. Therefore, even though epidemics are foremost medical phenomena, in the colonial context they clearly also functioned as political constructions and ideological instruments. This was clearly the case in Dar es Salaam and Kinshasa where imagined diseases formed the basis for racial segregation, as both cities, in contrast to for instance Dakar in 1914, never even faced an outbreak of infectious disease.

Although the 'neutral zones' became only partly implemented, today they form one of the rare open spaces in the congested city centres of Dar es Salaam and Kinshasa. Only now they seem to fulfil their legitimising

sanitation objectives by operating as a lung for the congested city. However, the 'neutral zones' still mark a segregation in the urban fabric (albeit more socio-economic than racial nowadays) and are highly inaccessible to most citizens. Moreover, today these rare open spaces stand under high real estate pressures to develop the sites for high-standard commercial and housing purposes. Considering the enormous lack of open space in city centres of Dar es Salaam and Kinshasa, as well as the segregation these open spaces still embody, many more valuable projects could be imagined to turn these open spaces both into sites of encounter and healthy environments accessible to all urban dwellers.

Mathieu Quet - Security Dreams: Fighting against illicit medicines and shaping pharmaceutical markets in Kenya

Illicit medicines – or Substandard, Spurious, Falsified, Falsely labelled, Counterfeit Medicines according to WHO's terms – have given raise to growing concerns in international organizations, governments, firms and foundations during the last two decades. Global initiatives have been set up to fight against bad and dangerous medicines, and have been sometimes largely criticized since they mix up health concerns and marketing strategies. In Kenya, debates upon the fight against illicit medicines have been particularly fierce since an anti-counterfeiting law was passed in 2008 whose definition was conflating generic medicines and counterfeit medicines. Protests occurred and a lawsuit eventually dismissed the law in 2012.

In that context, I have been working since 2011 upon the securitization of the Kenyan pharmaceutical market – through a socio-anthropological approach mixing interviews with pharmaceutical actors (regulatory authorities, firms, civil society groups) and the analysis of a large corpus of press articles.

What I intend to present in this talk is an analysis of how pharmaceutical security has been framed and defined by actors. How do they imagine security and who produces such dreams? What are the differences in the conception of security between today and twenty years ago? What kinds of technologies are envisioned to ensure pharmaceutical security? The hypothesis is that to understand the multiple security dreams that are historically evolving and superimposing, one has to connect them to the larger discourses upon security in Kenya (civil, military, political) but also to the growth of pharmaceutical markets and to the context of increasing circulations between India and Kenya in a changing industrial context. The dreams of security articulate aspirations to consumption with relationships of industrial dependence ; they also bring social actors to mobilize technological and legal tools and to shape the market – defining both the value of health goods, the way they are controlled and creating pharmaceutical flows.

In conclusion, I will interrogate these dreams of security as they bear primarily upon commodities – medicines. To what extent the securitization of the flows of goods can be understood as a foucauldian principle of governmentality? Foucault was studying securitization processes bearing on individuals and populations ; what does it change if the analysis bears on commodities? Furthermore, what are the consequences of conceptualizing securitization in terms of "dream" for such foucauldian analysis?

The talk will be empirically grounded in interviews with actors of the fight against illicit medicines and in the analysis of press articles regarding pharmaceutical issues in Kenya.

Quests for pharmaceutical effect

Rene Gerrets - Malaria control dreams in colonial British East Africa: tracing remnants of cinchona-based industrial production in Tanzania

A remote and impoverished village overlooking the vast Maasai Plain one kilometer below, Mikwinini is one of the few remaining traces of the vast cinchona plantations that gave the surrounding Eastern Usambara Mountains (in northeast Tanzania) a key place in the imperial malaria control strategy during the British colonial period. Mikwinini, the Swahili name for cinchona, arose at the edge of a former plantation where these trees used to be cultivated for their bark – the principal source of quinine, the main treatment for malaria through the 1950s when synthetic substitutes gradually replaced it.

Combining ethnographic and archival research, this paper examines British colonial era plans and aspirations about making affordable cinchona-based malaria treatments widely available to native populations in (East)

African territories. An integral aspect of interbellum aims at justifying and revitalizing colonial rule, this colonial initiative to address the enormous malaria public health problem was inspired by similar undertakings in British India and the Netherlands Indies yet greatly shaped by (overly optimistic) expectations about synthetic antimalarials, and by fretting about the powerful Dutch "quinine monopoly." The 1942 conquest of Java, which ended the Dutch monopoly and severed Allied access to quinine, suddenly propelled Tanganyika and its cinchona plantations to the center of British imperial malaria control policy, and set the stage for local industrial production of antimalarials that were distributed in East Africa and far beyond. This production scheme existed until the 1950s and today the oldest houses of Mikwinini, constructed from the stems of cinchona trees harvested from abandoned plantations, are among the most tangible material traces that recall this short-lived industry in Tanganyika, whose rise and fall illuminates (illusory) British colonial dreams about reducing the public health impact of malaria in its East African possessions.

Rebecca Marsland - The Standardized Dream of the Insecticide Treated Mosquito Net

A well-worn quotation in the anthropology of witchcraft is Monica Wilson's 1951 assertion that she saw 'witch beliefs as the standardized nightmare of the group'. Her argument was partly based on her 1930s fieldwork in Bunyakyusa, a region of Tanzania (now Tukuyu and Kyela Districts) where I researched the introduction of Insecticide Treated Nets (ITNs) to protect against the transmission of malaria in the years 2000-2002. I observed at the time that the rationale that lay behind these ITNs was a dream of medical science to separate mosquitoes from humans and end the millions of deaths due to malaria across the world. As has been well documented, this dream was haunted by nightmares: of the re-emergence of mosquito resistance to insecticides, and of the 'rebound effect' in which a temporary elimination of mosquito transmission of malaria could also eliminate an acquired partial immunity to malaria and thus result in a resurgence of severe malaria. Medical science also has its standardized nightmares. In 2000-2002, these nightmares were put aside, indeed my questions about them were unwelcome, because of the urgency that Tanzanians should be convinced that they should live apart from mosquitoes. It was clear that ITNs save lives, and that they should be 'rolled out' with great speed. As I documented in Kyela District, people who were generally indifferent to mosquitoes, seeing them as part of the environment, were taught that they should pay attention to how they might live apart from them. In Kyela, fathers and mothers learnt to put aside their fears that the insecticide used to treat the nets might harm their children, and began to use ITNs as a matter of routine. By 2009, women mourning at funerals even took ITNs with them under which to sleep with their children, an act that would have been unthinkable earlier in the same decade. Fifteen years since my first fieldwork in Kyela District, the nightmare of mosquito resistance to the insecticides used to treat nets is returning, and the question of the rebound effect has reappeared in the medical journals. Much as Monica Wilson asked of witchcraft, in this paper I ask what are the social conditions which produce a general belief in the dreams of medical science, and cause the nightmares to be brushed aside.

Kirsten Moore-Sheeley - Visions of 'Community Based' Malaria Control: The History of Insecticide Treated Nets in Kenya

While an insecticide treated bed net (ITN) may appear to be a coherent object, it is actually a constellation of relationships, values, and practices that is constantly being reconfigured. Multiple different actors, infrastructures, and technologies have been essential to making this simple object work as a biomedical technology. It should come as no surprise, then, that bed nets have been the subject of different visions of large scale malaria control as these elements have changed. This paper will trace the co-evolution of these visions, their larger historical context, and the ITN as a health technology by looking at the history of bed nets in Kenya. In the late 1980s, bed nets were one of many personal protection measures incorporated into calls for 'community-based' health care programs adapted (partly) to local circumstances. Due to strained resources and the shift towards decentralization of health services in the country, this vision placed responsibility for sustainable malaria control at the door step of impoverished 'communities.' As alternative methods for malaria control became less financially, biologically, and politically feasible in the 1990s, bed nets became more central to plans for global—though still "bottom up"—malaria control. The Kenya Medical Research Institute and the US Centers for Disease Control (KEMRI-CDC) conducted the largest of a series of ITN trials to help substantiate this plan, hoping to show ITNs were efficacious in any setting regardless of transmission pressure or weak health

infrastructures. Since becoming a 'community,' rather than just personal, interventions through the ITN trials, bed nets have been procured and distributed in bulk by donor agencies, NGOs, and other private organizations. Finally, agencies such as the President's Malaria Initiative are now supporting the creation of 'community-based,' continuous ITN distribution channels in order to meet demands for sustainable, universal ITN coverage in malaria endemic areas of Kenya. 'Community' health infrastructures and practices, in other words, are being made to fit the ITN. By unpacking these visions, their contexts, and their conceptions of 'community-based malaria control' this paper offers a unique way to examine the relationship between biomedical public health technologies and the neglect of health systems.

Anne Pollock - Hope in Synthesis: iThemba Pharmaceuticals and dreams of South African Drug Discovery

This paper draws on ethnographic research at iThemba Pharmaceuticals, a small South African startup pharmaceutical company with an elite international scientific board, which was founded with the mission of drug discovery for TB, HIV, and malaria. The name 'iThemba' means 'hope' in Zulu, and most of what I describe are aspirations. So far, iThemba does not make any drugs. It may never do so. Much of the bench scientists' time has been spent generating revenue by synthesizing molecules on contract for pharmaceutical companies elsewhere, and most drug discovery efforts fail. Yet although drugs are the ultimate objects of knowledge, the product is not just a potential pill. The aspiration is also to build capacity so that South Africa could become a place not only of pharmaceuticals' raw materials, clinical trial subjects, and end users, but also of fundamental knowledge-making.

One of the slogans that came up in many of my interviews was the idea of "African solutions for African problems." South Africa is of course a problematic stand-in for the continent as a whole, but that moniker does important work. It is strikingly flexible, able to incorporate South Africans of diverse ethnicities, as well as (black) Africans from other parts of the continent who are working in South Africa. iThemba's organic synthesis methods are indistinguishable from what might be done in well-equipped labs anywhere else, and the work is informed by a network of advisors comprised of global experts. Yet, it is tied to place. The scientists talk about the motivation to do this work coming from personal experience with disease, a sense of democratic citizenship, and the opportunity to have a job at home. These scientists are trying to make indigenous pharmaceuticals of a very particular kind: not autochthonous, but meaningfully their own.

In iThemba's work, the importance of space and distance is both palpable and reconfigured. In interviews, references to the 'map' came up all the time. This 'map' is partly metaphoric: iThemba provides 'an opportunity to put the country on the research map'. And yet the map is also importantly literal. South Africa's simultaneous distance from and proximity to Europe shapes the capacity for research. On the one hand, South Africa is in the same time zone as Europe, and the ability of European scientists to speak to South African scientists during the day has advantages: the capacity for virtual connection collapses some distance between north and south. On the other hand, South Africa's geographic isolation from concentrations of the pharmaceutical industry poses real material constraints. The delays in delivery of reagents slow down South African research capacity relative to other developing countries with more robust pharmaceutical sectors. Challenges of securing supplies of reagents underscore the materiality of pharmaceuticals: intellectual property can exist in abstract forms, but in order to become drugs, it must be materialized with ingredients and processes that are unevenly distributed in space. Part of the hope in South African drug discovery is an aspiration that the map of pharmaceutical geographies can be redrawn.

Hope, death and wellbeing

Aimé Kakudji Kyungu - « Une femme ne peut pas mourir pour avoir aimé » Les rêves brisés des parturientes dans les salles d'accouchement de l'hôpital Sendwe de Lubumbashi

Basée sur quelques études de cas réalisées dans les salles d'accouchement de l'hôpital Sendwe entre 2006 et 2010, ce projet de communication relate la manière dont la combinaison de certains facteurs (pauvreté, nombre de grossesses, âge à l'entrée dans la vie reproductive, fécondité élevée, inaccessibilité aux services de l'hôpital, etc.) participe à la construction de la maternité à risque et contribue à briser les rêves de parturientes et de leurs

familles dans un environnement où la procréation demeure encore une de grandes aspirations de la femme et une affirmation de la féminité.

Depuis la Conférence mondiale sur la Maternité sans Risque (Nairobi, 1987) et la Conférence internationale sur la Population et le Développement (Caire, 1994), l'accès pour les femmes à des services de santé est reconnu comme un droit. Mais la situation des parturientes en RD Congo contraste drastiquement avec ces aspirations.

L'observation des pratiques dans les salles de naissance de l'hôpital Sendwe et l'analyse du discours des acteurs (soignants, parturientes et leurs proches) révèlent qu'au-delà des considérations « simplistes » qui stigmatisent la pauvreté des parturientes et leur analphabétisme pour justifier la mortalité lors des accouchements, il existe des facteurs humains et sociaux (comme être connu ou non par les professionnels, avoir des relations avec des notoriétés dans la ville, etc.) qui « pavent le chemin vers la mort maternelle » (Pruel 2009). Celle-ci peut résulter, bien sûr, des problèmes de moyens. Mais elle est surtout le fait des rapports interhumains (accueil différencié, violence verbale, catégorisation des parturientes, etc.) et des problèmes organisationnels qui façonnent le continuum accueil-prise en charge des parturientes.

Dans un univers précaire comme l'hôpital Sendwe, ce qui paraît comme un détail sans importance, peut en effet se révéler déterminant pour sauver des vies. Des situations « banales » comme le manque d'aiguille pour réaliser une perfusion, le manque des poches de sang ou le fait d'être obligé d'user d'un tensiomètre défectueux, le manque de linge qui retarde une césarienne urgente ou encore les difficultés de joindre un médecin responsable qui doit prendre une décision importante, etc. se sont révélées très néfaste et ont contribué à arracher aux nombreuses parturientes leurs rêves de devenir mères.

C'est dans ce contexte que nous nous interrogeons sur la manière dont les rapports interhumains et les contraintes qui structurent le continuum accueil-prise en charge des parturientes participent à briser les rêves des parturientes et déçoivent les attentes des femmes dans un contexte où la procréation est perçue comme un acte d'affirmation de la féminité et de préservation du mariage pour la femme.

L'essentiel de cette communication va reposer sur un matériau empirique – basé sur une ethnographie articulant observation, entretiens semi-directifs et récits de vie – collecté dans les deux salles de naissance de l'hôpital Sendwe entre 2006 et 2010, dans le cadre d'un doctorat défendu en 2010 à l'Université libre de Bruxelles. Si les résultats présentés dans le cadre de la thèse se fondaient sur l'ensemble de l'hôpital, considéré comme une unité d'analyse, la présente communication, elle, s'appuie fondamentalement sur une éthographie réalisée au mois d'avril 2007 pendant trois nuits de garde dans les deux salles de naissance de l'hôpital.

Benson Mulemi - Quest for health beyond hospital treatment of cancer in Kenya

Increasing incidence of cancer and poor treatment outcomes in Africa belie the hope in biomedical science that hospitals embody. Available medical expertise and technology fail to abate the helplessness that cancer engender in Kenya and other Sub-Sahara African countries. The experience of cancer further contradicts the assumption many people have held that hospital treatment guarantee restoration of health or 'getting better'. Late diagnosis, treatment interruptions, inadequate medical facilities, and shortage of cancer care personnel shatter the expectation that hospital interventions would restore health and quality of life. This paper draws on ethnography in Kenya to examine cancer patients' experience of recovery after provisional or final exit from a public referral hospital. The absence of professional cancer care support services and inadequate access to essential medicines contribute to the growing disillusion regarding the power of biomedicine and the health promotion role of hospitals in the Kenyan health system. The end of each hospital treatment session usher cancer patients and their families into new phases of life that require continuous material, social, emotional and informational support. However, hospital departures exacerbate the challenges to cancer management, such as, treatment interruptions and bleak recovery prospects and unmet care needs. Livelihood, social and physical difficulties undermine cancer patients' wellbeing beyond the hospital. This compounds the mutual negative effect of disease burden and socio-economic marginalization on the performance of the health system. The aim of this paper is to show how the disjunctures in hospital and home care affect cancer treatment, patients' quests for wellbeing and aspirations for health in a typical African health system. The experience of cancer management in a public hospital and at home in Kenya highlights two important aspects in sustaining aspirations for health in the public system. First, the government should recognize cancer as a development priority. Secondly, despite

the challenge posed by cancer to biomedicine in both developed and developing countries, the quest for health in the face of this threat calls for equitable access to affordable essential medicines, screening, diagnosis and treatment technology.

Patience Mususa - Dreaming beyond a blanket and a roof: Visions of dwelling and wellbeing in an HIV/ AIDS project in Zambia

HIV/AIDS projects in southern Africa have tended to focus on the body as a locus of biomedical intervention, often linked to mainstream development discourses around 'behavioural change'. Material and environmental aspects of illness are often neglected in favour of an emphasis on social dimensions, including the social and cultural practices supposedly conducive to high transmission rates. In contrast, interventions on malaria and tuberculosis have built on frameworks that explicitly connect persons and their environments – poor health in this context is conceived not only in social terms, but also with reference to material conditions and inhabitation.

A large international aid programme in Zambia, which I took part in 2011-2012, sought to establish community based home care for lowest income people with HIV/AIDS. It also attempted to broaden its focus by experimenting with an initiative that addressed the shelter needs of its beneficiaries. The latter went beyond the narrow utilitarian logic of programme evaluation – best exemplified by a key criterion which framed the basic dwelling needs of its beneficiaries as consisting of a blanket and a water-proof roof over their head. The initiative provocatively put forward the idea that design creativity for housing and neighbourhood was not just a privilege of the wealthy, and that persons living in low income neighbourhoods too wanted aesthetically pleasing suburbs and homes to foster psychological wellbeing.

As an anthropologist and architect, I was hired to develop and run this initiative. In partnership with a Zambian housing movement, I run several workshops and practical demonstrations on shelter and community design. The paper presents my reflections on this experience and the kinds of discussion and issues that emerged from drawing on design to imagine and dream better futures beyond the narrow confines of behavioural change discourses and technocratic conceptions of material needs.

Tamara Giles-Vernick and Fabienne Hejoaka - Healing dreams and hepatitis B in Burkina Faso

Drawing from Tim Ingold's meditations on dreaming as a metamorphosis that "opens up the world" and from Nancy Rose Hunt's reflections on reverie and temporality, this paper explores the diverse ways in which people afflicted with hepatitis B (HBV) imagine and seek out "healing" in Burkina Faso. Hepatitis B, a viral infection afflicting the liver, manifests as an acute or chronic illness and exposes those with this infection to a substantially elevated risk of cirrhosis or liver cancer. Affecting some 350 million people worldwide, HBV is a major public health problem in Africa, yet rendered invisible by entangled political, biological, economic and socio-cultural processes. These very processes not only shape what Margaret Lock calls "local biologies", but they have also generated a plethora of dreams (and techniques and practices) around "local healings". For those diagnosed with HBV, pathways to "healing" are multivalent -- idealized quests for a "complete" cure; nightmarish peregrinations fraught with disappointment; and for a select few, long, costly journeys to keep at bay the infection's nefarious effects. We evaluate how "healing dreams" sharpen tensions around patients' present lives, as they project into the past and future different ways of being.

We base our presentation on field research conducted among people diagnosed with HBV in urban centers of Banfora, Bobo Dioulasso and Ouagadougou between 2012 and 2014. We pursued 80 in-depth individual interviews among people with HBV, their families, medical personnel in hospitals and blood transfusion centers, healers and pharmacists; we also conducted participant observations of diagnostic announcements and consultations in one hospital, two blood transfusion centers, a community association, and among "traditional" healers and phytotherapists.

We first describe the therapeutic itineraries of people living with HBV, tracing the itineraries' diverse forms and modalities and associated dreams of "healing", as well as their imagined and elusive temporalities and bodily and social consequences. The paper's second section explores a historical genealogy of these proliferating "local healings" and their attendant dreams. Two crucial developments have framed them. First, for over a decade,

GAVI and the Burkina state and medical authorities have channeled resources into routine infant vaccination against as a sole means of controlling HBV, itself sustained by a dream of full vaccination. Yet this preoccupation with routine infant vaccination against HBV has resulted in the neglect of generations of people who never received the vaccination; and inattention to a therapeutic landscape with poor medical infrastructure for the complex and costly follow-up of HBV patients and with health workers who know little of this illness. Second, global politics of HIV and its control have cast a shadow over patients' understandings of HBV, and have simultaneously cultivated their dreams of free access to therapies (tenofovir, lamivudine) – currently readily available at no cost to those diagnosed with HIV, but not to those living with HBV.

Keynote: Gabrielle Hecht - Toxic Tales from the African Anthropocene

A term first popularized by earth scientists to signal a new geological epoch in which humans shape our planet's materiality, the "Anthropocene" has become a node of interdisciplinary conversation among humanists, artists, and natural and social scientists. Yet these conversations falter when critics observe that the notion obscures massive inequalities by attributing the unfolding planetary catastrophes to an undifferentiated "humanity." So how can we theorize temporal and spatial scales that allow us to hold the planetary and the particular in the same frame? How can we gain purchase on the dynamics of waste, toxicity, and violence at the heart of the Anthropocene? From the slow violence of modernist dreams in postcolonial Gabon to unrealized expectations of modernity in post-apartheid South Africa, I use the colliding temporalities and unruly materialities of production and waste to explore the analytic possibilities offered by an African Anthropocene.

Keynote: Filip De Boeck - Searching Kinshasa, or how to heal the city

Drawing on ethnographies of divinatory systems and of urban life in Central Africa, this presentation unravels the complex weaving and knotting together of forms of sociality and survival in urban Congo. As will be shown, older medical technologies such as divination continue to be used to make sense of the city as limit-experience.

Transformative science

Gemma Aellah - Human-landing catchers, science-workers and AIDS orphans: the art and science of hustling to crossing the border between poverty and stability among the post-AIDS generation of 'youth' in rural Western Kenya

What hopes and dreams unite a paid human-landing catcher sitting outside his hut late at night sucking mosquitoes off his legs, a medical research fieldworker developing a model tree farm in the village where he works and the members of an impoverished community-based organisation laying a physical foundation-stone for a million dollar dream AIDs orphanage that never comes?

In a group of small villages in Western Kenyan medical research and intervention has been an everyday feature of the social, physical and economic landscape for more than 30 years. Extremely high HIV prevalence, an ongoing health and demographic surveillance project and associated research programme based on transnational medical research collaborations ensures that medical research and intervention activities are the biggest provider of formal employment, material resources, new infrastructure and cash-flow in an area otherwise characterised by an informal and subsistence farming economy. Exposure to the city, to cosmopolitan living and the wider world is carried into the village through these flows of people, resources, ideas and styles. Residents engage with medical research across a spectrum of formality and temporality including formally contracted science-workers, community link persons who have represented their villages to scientists for over 30 years, long term and short-term research participants and recipients of intervention and training. Medical research and intervention, therefore, provides a reference point for endless potential opportunity and opportunity-out-of-reach that interplays with the dreams and ambitions of the majority of youth in these villages who dream of, but can't access, either medical research's formal economic opportunities or former avenues to stability through education and government/industry employment.

Here, the rural component of the so-called post-internet 'digital' generation of Kenyan youth who were transitioning into adulthood in the midst of an HIV epidemic and who experienced perhaps the greatest rapid dip and then recovery in life expectancies in the country's history are busily engaged in trying to cross the border between abject poverty and economic stability by entrepreneurial efforts that place in medical research and intervention engagements in the same schema as riding motorbike taxis, poultry-keeping, micro-financing schemes and road-building initiatives (here glossed as the Kenyan English word 'hustling'). This paper focusing on the attempts of rural youth in Kenya to hustle - to make a life and make-a-living in their home villages in a way that meets changing intergenerational expectations and new possibilities for what can and what does make a good life, whilst not being able to quite shake the feeling they will not live to see past 40.

Lloyd Akrong - (Re)configuring visions of biomedical research in Africa: clinical trials as imaginative and transformative spaces

Biomedical research continues to expand across global borders as underscored by the proliferation of international clinical trials. Originally limited to western settings, in recent years there has been an increase in the amount of clinical trial activities taking place in a number of developing countries like those situated within the sub-Saharan African region.

Along with the shift of research activities, there has also been a parallel movement of a seemingly universal assemblage of tools, including standardized protocols, regulations, guidelines and documents, meant to prescribe the proper conduct of biomedical research as well as providing a mechanism to control the contexts, boundaries and ways in which such activities are conceptualized, developed and carried out. This has had a significant impact on the way the public has come to envision links between global health, notions of treatment, biomedical research and its potential trajectories. Discourses pertaining to biomedical research, particularly in the developing world, have primarily been framed under the rubric of bioethics, placing a strong emphasis on the ethical processes involved in biomedical research, the challenges therein and the implications for participant protection. This has left little room for the exploration and discussion of the imaginative space presented within the arena of clinical trial research where actors, constructed relationships and trial activities are (re)envisioned in novel and transformative forward-looking ways.

As part of my work on the internationalization of biomedical research I explore how the clinical trials arena in the African setting can be viewed as this imaginative space where stakeholder's visions of current and future biomedical research, the circumstances in which it does (and can) occur, and perceptions of the politics embedded in scientific experimentation are articulated. Through the completed and ongoing fieldwork that I have conducted in Ghana and Tanzania, consisting of interviews with clinical trial participants, clinical trial investigators, sponsors and trial Principal investigators, as well as extensive observation of the everyday activities and interactions within and between stakeholder groups I present how visions are constructed, (re)shaped and offered through verbal and non-verbal mechanisms and how they affect the space and context in which trials occur. Ghanaian trial participants for instance use visions to question, construct, or change the boundaries of authority and power relations in the trial setting in accordance with their expectations and desires to influence the future course of African biomedical research. In Tanzania, trial investigators use visions of desired research futures to inform the type of research they participate in and collaborations necessary to achieve this. While conceding that their visions are currently not realized, they suggest that having visions for where they want to be is an important step to achieving this goal. The way visions are constructed and how they relate to potential realities have important implications for the progressions of African biomedical research. They can inform discussion between local stakeholders and sponsors, experts and the general public about how to go about transforming the envisioned research landscape to reality.

Johanna Crane - Administrative dreams, administrative nightmares: Indirect costs, inequality, and the economies of global health science

Many U.S. researchers enter global health work in Africa with dreams of a career devoted to ameliorating the health the poor. However, much of the labor of global health science is, in fact, administrative. In this paper, I attend to this "boring", shadow side of global health science (Lampland and Star 2009), where stakes are

measured not in life and death, but in paperwork and conference calls. I do not mean to suggest that the life-and-death aspects of the field do not exist or are not important. Rather, I want to focus on the side of global health that does not figure into popular imaginaries but does, ultimately, have the power to make or break the partnerships that make global health possible.

This paper focuses on the evolving fiscal administration of a U.S.-Ugandan HIV research partnership. I follow the evolution of this project's fiscal administration from a petty cash system, to subcontracting, to a 'shell NGO', and, finally, to the establishment of a central grants office – the first to exist in a Ugandan public university. In this case study, 'dreams' of philanthropic science co-exist with the administrative 'nightmares' that come with negotiating multiple incommensurable bureaucracies across continents, nations, and institutions. U.S. staff often attribute these 'nightmares' to African inefficiency. This attribution renders the African administrative labor that sustains global health projects visible only in the negative, and erases the ways in which U.S. government funding mechanisms—and particularly the reimbursement of 'indirect' costs—underfund African partner institutions. In telling this story, I focus on the experiences of American and Ugandan researchers and staff as they struggle to transform NIH grants administered in Bethesda into "money on the ground" in Mbarara. Ultimately, I argue that this story sheds new light on the paradoxical relationship between global health science and global inequality.

Engendering capacity

Peter Mangesho - Forgetting "Africanization" in East Africa

'Africanisation' was many African nations' policy between 1960s and 70s, aiming to replace European (and Asian) professionals and officials with African ones. As part of research on history and anthropology of medical science in East Africa (1950s to present) we conducted two reunions of now elderly scientists and technicians who had worked together in the formerly British, later Tanzanian, medical research institute at Amani, Tanzania, between late 50s and 70s. The first of these gatherings, held in Cambridge, brought together those who had retired in Europe. The second took place in Amani, assembling Tanzanian and other East African retirees. Both reunions elicited shared themes: visions of progress, satisfaction with shared research, and pleasures of work and life in a well-resourced and beautiful research station. The participants dwelled upon the social innovations and scientific advancements of their time and the delight at transgressing colonial roles of gender, class and race. That shared sense of political possibility and even radicalism was offset by nostalgia for the material and aesthetic qualities of colonial architecture, the drive of scientific programs and quasi-militaristic order of an imperial administration. The ambivalence that undercut these events – articulating hopes and disappointments that both cut across and tracked along colour lines – casts into relief the challenges of Africanization in transforming the socio-political context of scientific work.

Branwyn Poleykett - Formatting the future: dreams and desires in capacity building

This paper tracks across time, between colonial and postcolonial institutions and European and African contexts in order to understand how flows of 'capacity' shape the skills and desires of African scientists and technicians and lead them to shape their futures in particular ways. The conflicts of the past and the attempts of African scientists to mitigate, predict and negotiate change is, I argue, a way into understanding the unstable scientific values of the present. This research explores experiences of – and potential limitations to – dreaming and ironising and explores the ethical and political content of dreams. Between Africanisation and 'capacity building', between an idiom of restitution and an idiom of 'excellence', between dreams of automation and desires for autonomy, this paper considers how these contradictions are experienced along the lines of lives.

Ferdinand Okwaro - Collaborations in transnational medical research: aspirations, aims and dreams of African scientists and institutions

This paper examines the possibilities, labours and occasional anger and frustrations that collaborations in transnational medical research engender for African scientists and their institutions. It emerges from ethnography of African scientists working conditions in selected institutions in one African country.

'Collaboration' is today the preferred framework for the mechanisms by which Northern institutions support research in the South. The concept signals a shift away from the legacy of unequal (post-) colonial power relations, although, amidst persisting inequalities, the rhetorical emphasis on equality might actually hinder critical engagement with conflicts of interest and injustice. Collaborations have obvious manifest benefits for scientists in African institutions who, in the absence of funding from their governments, have come to depend on resources generated through these partnerships. Most thriving research institutions in Africa depend solely on funding derived from collaborations, which has led to the popular casting of collaborations- justifiable in most cases - as an unproblematic and straightforward social good. In reality however, as evidenced by observations of African scientists working conditions, discussions with scientists and from media reports, collaborations are anything but straightforward and harbour room for conflicts and frustrations. Indeed, for collaboration to work out, they involve hard labour, negotiations across several layers, between local and international scientists and their respective institutions and between local scientists and their local collaborators, employees and participants in the medical trials. In order to 'collaborate', African scientists engage various strategies: they establish a qualified but flexible, non-permanent workforce, diversify collaborators and research areas, source complementary funding to assemble infrastructures, and maintain prospective research populations to attract transnational clinical trials. Through this labour of collaboration, they sustain their institutions under prevailing conditions of scarcity.

Keynote: Steve Feierman - Imaginary Care in Eastern Africa

This paper asks a very basic question that is largely ignored in the study of medicine in eastern Africa and its history: how effective has the formal system been in providing everyday care to the majority of the population? When we look at the development of medicine in the region, we tend to focus on dramatic interventions, notable advances, and remarkable contradictions, but not on how medicine has (and has not) provided what most people want from it. This issue is invisible in both the records of medical departments and even to a large extent in scholarly practice. The question is crucial to my own interest in the burden carried by patients' relatives and other supporters at each stage, and in how the essential activities of these people came to be woven into the region's practices of formal medicine. We are all familiar with the story of the missionary physician who arrives among diseased people, cures them and earns their eternal gratitude. Perhaps through his healing acts he wins their souls for Christianity. When it comes to the history of medicine in Africa we rarely ask what was this care that they provided. In eastern Congo, on a single tour in 1937, one British missionary physician examined 47,000 people. Other mission doctors claimed similarly outlandish numbers. In Tanganyika in the same year, fewer than 20% of districts had a missionary physician and almost half the districts had no physician at all. The fantasies of the region's medical authorities held that something called "prevention" could serve as an effective medical system. The exceptions (the places where care was provided) existed in enclaves. In some periods the vast majority of the population got no biomedical care at all; at other times the lowest ranks of African auxiliaries played a mediating role. Even when medical provision expanded from the early 1950s, the system's major strengths were urban, at a time when more than 90% of the population was rural. Care (even in hospitals) was often outsourced to laypeople. At the time of independence international financial institutions argued that prevention ought to be able to take the place of care in rural medicine. After 1970 formal health systems were undermined by economic crises and political dysfunction, followed by the disasters of AIDS and Structural Adjustment. Seen from the point of view of patients and their care-givers, there has never been a stable normal situation in which even barely adequate care took the pressure off families. The result of all this is that for the majority of the region's people most care of the sick has taken place outside the boundaries of biomedicine. The open question here is whether today's authorities continue to imagine the possibility of effective medicine without care.

Targeting infection

Fanny Chabrol - Dreaming of safer blood donation and transfusion amidst a ruined hospital in Cameroon

In the course of an ethnographic study of the management of viral hepatitis in Cameroon in the context of the HIV epidemic I was particularly interested in the concomitant differentiation – in terms of policies and drug

access – and the juxtaposition of these two iatrogenic epidemics. I thus investigated the management of blood donation and transfusion in one of Yaoundé's biggest hospitals and at a national level.

While clinicians and public health officers are fully aware of the unsafe character of blood transfusion and the nightmare it represents since decades, they dream of a better system of blood collection. Most recently, the newly appointed national program for blood transfusion imagine a system that would be able to detect and triage infected donors from healthy ones and to retain them. How could we interpret such dreams?

A prominent feature of African biomedicine, contemporary blood management reveals the corrosive power of the ruin (Stoler 2012), of costly and iatrogenic healthcare and the imaginative power of selfless, regular and infection-free citizens who would give their blood in an altruistic fashion. From these considerations about hopes and reality I will extrapolate and look at current projects around convalescent blood therapies for the treatment of Ebola virus disease infected patients in Western Africa.

Alice Desclaux - Dreaming health or avoiding a nightmare? « Getting prepared » towards Ebola and caring as an everyday practice for a safe future in Senegal

May we consider that the on-going Ebola outbreak in West Africa revealed, betrayed or reinforced 'dreams of health' in science and medicine for actors at the 'front line'? Did it engender new 'public health dreams', hegemonic or diverse, agonists or antagonists?

This presentation will be focused on two levels of the Ebola response in Senegal, a country that experienced an outbreak – happily ended after the only case got cured without any secondary transmission. Based on data collected through a multi-sited ethnography going on since the beginning of the epidemic in late August 2014, it will consider national and frontline levels. At national level, response plans were elaborated and managed by committees composed of international and Senegalese experts, inspired to some extent by evolving global recommendations. At 'front line' level, we consider the people who perform community surveillance, named contact tracers by WHO. These follow-up agents are supposed to visit twice a day contacts — the people who had a direct or indirect physical contact with an Ebola case or his/her body fluids — to diagnose any symptom during a 21-day period, in order to refer the person rapidly towards a specialised health facilities where isolation and virological diagnosis will be performed.

At both levels, anticipations and expectations are shown in individual narratives, meetings discussions and reports. However concerns depend on temporality and are partly diverging. During pre-epidemic and epidemic phases, discussions at national level do no rely on previous experiences, and the situation created by Ebola outbreak is considered radically new. Without noticeable reference to previous dreams of health, anticipation is introduced by experts through pessimistic estimates, reinforcing the nightmare vision of thousands of cases, as in neighbouring countries, and conjured by verbal precautions during meetings. After the end of the outbreak, this anticipation of a nightmare is maintained by global experts' interventions to support preparedness, using present fear to reinforce the building of future trust, a symbolic configuration embedded in Western perceptions of risk and safety considered paradoxical in Senegalese culture pervaded with Islam.

At the front line, follow-up agents also anticipate a nightmare, partly due to their trainers who have used pedagogy based on fear predicting their rapid contamination and the extension of the epidemic if they do not individually comply with maximalist biosecurity precautions. They face dilemmas in micro-social situations when the application of a recommended precaution may result in contacts' leaks during the follow-up period. They must sometimes make the difficult choice of neglecting compulsory biosecurity precautions in order to provide care to contact subjects. For them, building a secure future requests maintaining a link between contacts and health services, which is possible only if care is provided through many everyday practices besides data collection and symptoms screening. However, empirical findings show that in the building of national dream for Ebola response to future outbreaks, global preparedness made local leaves little space to lay workers' experience of turning everyday dream into care practices.

Julia Cummiskey - Stylish Men: Promoting Male Circumcision for HIV Prevention in Uganda

Male circumcision is the most promising recent development in HIV prevention strategies in sub-Saharan Africa. In Uganda, the Rakai Health Sciences Program (RHSP), one of three sites to conduct the large-scale randomized trials that established the scientific evidence in favor of the intervention, promotes safe male circumcision and trains providers from across the continent in the procedure. The endorsement of male circumcision as a critical component of HIV control efforts has been characterized as part of the medicalization of HIV prevention efforts in the wake of decades of largely unsuccessful attempts to curb the epidemic through education and behavior change. However RHSP's methods are deliberately designed to "de-medicalize" conversations about HIV prevention and following observations that men were far less likely than women to engage in such discussions and activities. The material culture of RHSP's efforts to generate demand for circumcision is bold and bright – a far cry from the aesthetics commonly associated with medical interventions. Gospel-style music videos in English and Luganda and a media-savvy campaign called "Mwami Mulembe" or "Stylish Man" attempt to persuade men and their partners that circumcision (along with sexual fidelity and attention to one's health) characterizes stylish, modern, and desirable men. Using material from several months of participant observation in Rakai District, oral history interviews with RHSP staff and residents of the District, and published and unpublished literature, this paper considers the variety of methods employed by RHSP to effect their mission to expand the provision and uptake of male circumcision services and the possible effects of these strategies on the way men's bodies, male sexuality, and appropriate behavior are understood. In this paper I will consider the factors that led RHSP to identify what they have termed the "problem with men" and their lack of health-seeking behaviors and the evolution of a campaign to de-medicalize community perceptions of HIV/AIDS treatment and prevention. I aim to historicize the circumcision-related activities of RHSP in the context of previous interventions tested by the RHSP as well as earlier public health research and interventions in Uganda and elsewhere in Africa. The paper builds on the work of historians and anthropologists such as Nancy Rose Hunt, Robert Morell, Daniel Jordan Smith, and Shanti Pratikh who suggest a variety of ways in which gender, masculinity, and intimacy have been imagined and represented in the context of public health concerns. Furthermore, the paper will consider the way in which the Mwami Mulembe campaign fits into the evolution of HIV prevention efforts from those focused on behavior change to those centered on biomedical interventions, particularly after the advent of PEPFAR. By historicizing RHSP's circumcision demand generation program, the paper aims to inform some of the debates about male circumcision for HIV prevention such as the fear that it will lead to risk compensation or disinhibition, the potential for stigmatization of uncircumcised men, and consent for infant and childhood circumcision.

Seeking engagement

Tracey Chantler - Becoming part and parcel of KEMRI-CDC': Hopes and expectations undergirding stakeholder engagement in health research

This paper will relate a story of hopes and aspirations which have material implications. It will focus in on civic and administrative gatekeepers' interactions with the KEMRI/CDC health research programme in western Kenya. These gatekeepers provide a critical commentary on the complexity of applying a modern well-resourced project in an environment characterised by economic constraints. They challenged the research organisation to complement their research agenda with a mandate which pays increased attention to solidarity. They were concerned about the equitable distribution of research benefits and the widespread association of trial participation with poverty. Essentially they argue that partnership and collaboration between researchers and the local community must account for moral concerns, foster a sense of mutuality and result in concrete material contributions. Senior gatekeepers and local chiefs were ready and willing to contribute to this partnership on this basis.

Birgitte Bruun - Daily trials: Lay engagement in transnational medical research projects in Lusaka, Zambia

Over the past two decades there has been a steep rise in transnational medical research conducted by resourceful organisations in less privileged settings. Debates about this rise are often framed either in terms of research ethics or the political economy of transnational medical research. Based on 12 months of ethnographic fieldwork in Lusaka, Zambia, this paper takes an ethnographic starting point in following lay people's trajectories of engagement in transnational medical research projects as they emerged over time in a widerlandscape of health and social development projects. The paper explores what was at stake for people engaging in the

projects not only in the context of their daily concerns, hopes and obligations as partners, neighbours, friends, colleagues and employees, but also in the context of their considerations about being exploited. Tracing lay people's engagement in medical research projects and their moving on among hopes and fears with regard to the projects the paper offers an alternative frame for debate that highlights similarities and differences between development and medical research projects and volunteering as a pragmatic practice.

Crystal Biruk - Blueprints and minor dreams: The polyrhythms of survey research projects in Malawi

Every year, American-led AIDS survey research projects collect household-level information and HIV-tests from thousands of rural Malawians during seasonal fieldwork. Their task is grounded in a particular kind of modernist dream: careful planning, meticulous survey design, and intensive training of "unskilled" fieldworkers will conjure solid evidence to be enlisted into future AIDS policy and interventions. Yet, even as researchers invest time and resources to implement this blueprint, I have shown elsewhere that the data they collect are imperfect and provisional, dogged by the messiness of fieldwork. The dominant anthropological narrative of global health in Africa emphasizes the unexpected ways in which people "make do" and navigate "failed" projects, and draws attention to exclusions and inequalities along the way. Yet, amid disciplinary interest in exposing and complicating global health's shortcomings and stakes, few have closely tracked how the contingent and fleeting "present-tense" of health projects in Africa can become a resource for minor, intermediary actors who temporarily occupy project infrastructures. The rhetoric of dreams and nightmares as it plays out around colonial and contemporary health projects in Africa tends to eclipse the dreams of interstitial actors in its primary interest in powerful scientists and disenfranchised target populations. Drawing on 18 months of ethnographic research with survey projects in Malawi, this paper excavates an archive of minor dreams that take root in the spaces opened by the grand designs and spatial ordering employed by transnational projects. I foreground the stories, aspirations, and mobilities of a cohort of young Malawian fieldworkers employed by survey projects to show how the linear and urgent tempos of such projects enable and constrain parallel rhythms of surviving and thriving from "project to project." Projectification of the Malawian landscape simultaneously sustains and threatens fieldworkers' ability to achieve a "good life," in the process producing new kinds of subjects and social boundaries. An archaeology of survey projects in 2007-08 Malawi not only recovers the "in-between" dreams and aspirations of often invisibilized fieldworkers, but also draws attention to the boundary work and forms of labor that sustain them.

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