AFRICAN HISTORIES AND MODERNITIES

HISTORICAL PERSPECTIVES ON THE STATE OF HEALTH AND HEALTH SYSTEMS IN AFRICA, VOLUME I

The Pre-Colonial and Colonial Eras

Mario J. Azevedo

African Histories and Modernities

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The Pre-Colonial and Colonial Eras

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Preface

Contribution to the Literature on History and Health in Africa

This volume titled *Historical Perspectives on the State of Health and Health Systems in Africa: Struggle for Survival*, which places more emphasis on Sub-Saharan Africa, does not purport to be the definitive history and analysis of public health on the continent from its earliest times to the present. Based on a variety of sources, primary, secondary, and special reports from the World Health Organization (WHO) and other agencies of the United Nations, data from international organizations working in Africa accumulated over many years of experience, and archival sources consulted in N'Djamena, Paris, Lisbon, Maputo, Fort Portal (Uganda), Nairobi, New York, and Washington, the author sees his work as providing some of the most basic health information on Africa from pre-historic and colonial times to the most recent period. In this context, this volume is intended to serve as a comprehensive compendium of what is known only by experts about health in Africa in terms of the challenges, achievements, shortcomings, and failures, and the reasons why. Written for lay people, historians, and public health professionals, practitioners, academicians, Africanists, and novices on the African scene, *Historical Perspectives on the State of Health and Health Systems in Africa: Struggle for Survival* does not waste time with unproven theories or non-evidence-based interventionist speculations but relies on solid or plausible information and on scientific and sociobehavioral findings, theories, and themes in the field of public health.

In the process of writing this book, the author has tried to give fair treatment to both Western medicine or biomedicine and traditional medical practices and therapies that have served Africa for at least five thousand years beginning with Egypt around 3000 B.C.E. The major themes and assumptions underlying this study, which appears to be the very first in scope, methodological themes, and use of interdisciplinary approaches on Africa, are listed below, namely, that:

- Traditional or ethno-medical work and practices have saved lives on the continent for centuries prior to colonialism
- Poverty and health go hand-in-hand
- Health is a people's right
- Prevention and health promotion are preferred as health strategies over treatment, a principle adopted at the 1978 Alma-Atta global conference, which emphasized primary health
- Colonial medicine focused primarily on Europeans rather than Africans, and only to the extent that the latter would be beneficial to the colonial economic project if healthy, focusing, in the name of combating diseases more effectively, on health opportunities in the segregated urban areas to the neglect of the countryside
- The crisis that Africa seems to experience at present is mostly a result of uncontrolled or non-contained infectious diseases, which have almost disappeared from the developed industrialized world, but also of the rapid spread of the neglected non-communicable diseases, otherwise also known as the second disease burden or the silent killers of Africa
- Lack of accelerated progress in health cannot be blamed primarily on the lack of financial or natural resources but on the absence of vision, transparency, and commitment on the part of the leadership, which lets health facilities crumble and, at times, cling to a non-functioning health system, exacerbated by overall illiteracy and ignorance, geographic but surmountable obstacles, corruption, and bribery
- The workforce in Africa remains demoralized, barely properly equipped, and congregated in urban areas, refusing to go back to the villages, and benefits the areas whence much of it came, either preferring to work abroad or engage in private practice at the expensive of the public health system that trained and hired them in the first place and pays their salary
- Over the past decades, improving sanitation and hygiene has been proven to reduce infectious diseases by over half percent and is therefore unforgiveable that things have not changed much on the continent

- Africa seems to be totally unable to stem the unacceptable maternal and child morbidity and mortality rates, when other continents have been able to reduce by more than two-thirds or even by half over the past two decades
- The current poor treatment of women as second class citizens who are, in fact, deprived of the rights to health, education, and equal opportunity is a major setback of the continent's effort to stem the rise of the disease burden
- Overreliance on international assistance to run and maintain the health care system has endangered the continent's ability to impact the disease environment meaningfully, as external funding is selective on impact and never guarantees sustainability for the long-term
- The paucity of needed health research funds, which would help strengthen the experience of scholars, practitioners, academicians, and community activists, provides little accurate health data on the continent of Africa, and prevents policy-makers and health systems managers from making wiser and more effective decisions and policies, thus explaining the deplorable state of health affairs at hospitals, health clinics, health centers, and medical schools
- A focus on the purchase of sophisticated technology to solve even the simplest health problems and the inability to sustain or upgrade medically related equipment when it breaks down results from a major displacement of health priorities
- Neglect of the second disease burden, that is, non-communicable diseases, which receives an average of 4% of the health budget, with the rest being used for salaries and infectious diseases, is a problem Africa needs to tackle immediately
- Neglect of the poor and blindness to the huge inequalities both in access to and quality of health care continue to increase the nefarious impact of socioeconomic disparities
- The high priority given to the education of the children of the elite, civil servants, influential politicians, the wealthy, and the powerful barons has created insurmountable inequalities and inequities that make the poor poorer and the rich richer and
- Africans' lack of robust investment of financial and other resources to meaningfully protect the health of the present generation and the generations to come makes the health system short-sided and often irrelevant for the majority of the African people.

To the best of his recollection, this author believes there is no comprehensive book on health in Africa and the continent's health care systems that, using the most available current and accurate data for the time being, looks critically and historically at the interplay between culture and geographic or regional disease prevention measures and between simple awareness and emphasis on preventive rather than on treatment or cure. Written, hopefully, by a well trained and experienced Africanist historian and a public health expert, this volume will serve the public well—lay persons, policy-makers, academicians, and health care practitioners in Africa as well as any individuals or organizations interested in the global issues that affect health. Furthermore, most of the writing on health in Africa has tended to focus on factual information rather than on understanding and challenging the traditional or conventional approaches adopted by the leaders of the continent and their supporters abroad. In sum, writings on health and health care in Africa have usually taken the easy route, namely: Simply blaming the failures or shortcomings on corrupt leadership rather than on lack of understanding of health issues; pointing to adverse geographic conditions as the root causes rather than on incompetence and lack of vision and investment in the future of Africa on the part of the elite; emphasizing the scarcity of natural resources rather than the understanding of how the existing resources, such as timber, rubber, oil, and gas, might be used more effectively, even if scarce in many parts of the continent; and minimizing the nefarious cultural and colonial traditions that cannot withstand the test of time but continue to be major obstacles to the enactment of robust health care systems that focus primarily on disease prevention.

Ultimately, the author will consider his work successful if it can "shake things up" in Africa, intrigue scholars and health practitioners, and cause them to debate the issues rationally and realistically, motivate the leaders and the people to think critically about their health care approaches, and understand why these should focus on all factors associated with the unfair, unjustified, and glaring health disparities that divide the poor and the wealthy. If there are two overriding themes in this work, they are: (1) disease prevention and health promotion; and (2) elimination of health disparities, a task that is not impossible, but is designed to protect the health of all citizens and not just that of a few before disease strikes, always guided by the UN principle—accepted by all African leaders—that "health is a right of all people" regardless of wealth and occupation or socio-economic status.

This book focuses on the historic and current state of health and the health of the African people, including Arab North Africa, as determined by such factors as historic regional and individual differences and future trends; competing ethno-medical systems; the colonial past and its specific legacies; Africa's past and current policies on health and health care; the contested requirements for individual and public health consumption; geographic and economic resources as determinants of the health of a nation; international trends, such as globalization, the media, medical tourism, and technology, and their impact on people's health and the overall health care system; and the prevalent gross health disparities or inequities in Africa viewed from both historic and contemporary perspectives. In contrast to others that focus on Africa's health, this work is intended to be comprehensive, historical and contemporary, and interdisciplinary, providing clues to the future of the health of Africans collectively, while pointing to the shortcomings of the present public health efforts as a goal at medical schools, colleges, universities, and Africa's Ministries of Health. Thus, interestingly but sarcastically, because they are viewed by many experts as betraying their primary mission of preventing disease and protecting the health of all citizens (and not simply that of the aspiring "middle class" and the privileged government officials), Ministries of Health in Africa have been called *Ministries of Disease*. The author tends to subscribe to this designation.

Overall, the proposed volume argues that, contrary to popular opinion, Africa has the resources to improve the health of its people exponentially and to address and reduce the existing glaring health disparities. The author plans to show that disparities are often factors of failed leadership and lack of vision and commitment to the welfare of the people. He also believes that, if the goal of "health for all" announced and subscribed to by African leaders at Alma-Ata in 1978 is still taken seriously, Africa's priorities must be re-examined and perhaps reversed. In this context, primary health care, though viewed by some as an irrelevant *cliché of the past*, can play a most important role in redirecting priorities and the thinking of those in positions of authority. If well understood and properly implemented, primary health care should begin at home through the adoption of simple concepts of hygiene, sanitation, and health awareness, which then must perforce span the entire educational system—the universities, medical schools, the media, and all technological advances. Indeed, health must occupy center-stage in all policies and goals conceived and enacted by leaders and imposed on the citizens, because, in

the absence of health as defined by the UN, no economic, social, or educational advancement is possible. A sick workforce results in a sick and deceiving mirage of progress.

The main goals of the manuscript are described below. Defining health, public health, health disparities, and the factors that make Africa's health improvement challenging, to say the least, and historically exposing in lay terms the various geographic and cultural constraints Africa encounters daily, which, from a superficial point of view, seem to prevent the continent from charting an optimal future of health for its inhabitants. Simultaneously, the book argues that, at present, the major obstacle to good health and the causes of health disparities have not been primarily the tropical geographic constraints but man-made problems, worsened by lack of vision on the part of the leadership, as just noted, people's reluctance to accept and embrace new medical practices, and misdirection and misappropriation of domestic and international financial, human, and physical resources. In sum, deducing from empirical data, leadership constitutes a major theme permeating the following health project in Africa.

The role of education and hygiene and the redirecting of the goals of Western medical education that drive all of Africa's health models and health priorities are another important component of the analysis of the problems of the health situation in Africa today, as the two aforementioned prerequisites, education and hygiene, must go hand-in-hand. Evidently, no treatise on medical and public health conditions can be understood without looking at undying ethno-curative practices that permeate all social systems, as is, for example, the resilience of Africa's practices related to circumcision, sexual behavior and taboo, male social and political dominance in the family setting, and some unhygienic practices that begin at childhood. Unhygienic habits are more often than not hard to alter or eliminate, because they are a part of the social milieu and are constantly reinforced by learned behaviors. Anthropologists tell us that all medical systems, no matter how advanced, are culturally-based. In this book, the continent's ethno-curative and cultural outlook is sharply contrasted to the Western medical system, which has often been blindly copied and embraced by Africans. Conversely, the author plans to try to debunk the health models brought about by colonialism, biomedicine, and the contrasting legacies reflected in the various colonial policies called *indirect rule* and *association* or *assimilation*, and *paternalism,* which were nothing more than camouflaged racial manifestations. At closer look, intrinsically these policies and their health systems have always been based

on a sense of racial superiority, which African leaders, the educated elite, and the most dominant ethnic groups seem to have embraced without questioning their roots. Recently, the skewed health care system has often being reinforced by such factors as globalization, the structural adjustment programs imposed by major international institutions, including the World Bank, the International Monetary Fund (IMF), the Paris Club, the church, and the ubiquitous Western media.

It is the author's belief that a re-examination of the concept of disease and health in Africa is paramount in the effort to sharpen and re-direct the continent's priorities and search for solutions that can withstand the test of time, which, unfortunately, are often not popular. Many of these require a shift in lifestyles both on the individual and the population level, to prevent disease and allow one to stay alive. Does it make sense, for example, for people to refuse to shift their livelihood from agriculture to pastoralism or vice-versa, when climatic conditions are altered beyond repair, as happens in times of famine and hunger in the Sahel? Lifestyle changes require, among other factors, persuasion, vision, and understanding, and avoidance of the disease environment if at all possible. Consequently, as noted earlier, the primary focus of a health system should be prevention rather than secondary and tertiary treatment requiring the use of devices whose premises and effectiveness are often doubtful or ineffective. In fact, a state must strike a balance and make a choice between opposing tendencies, including: Financial remuneration versus the responsibilities of private and public medical practice; attendance to the needs of the rural versus the urban populations in African cities; and the nefarious impact of the stagnant slums and the reasons why they exist versus the creation of incentives for people not to flock to the cities, which, ultimately, overwhelms and clogs the health care system for all.

Finally, it is the goal of the author to weigh the health balance sheet, which, in most of Africa, leans toward an increase in the double burden of disease. The resulting imbalance has compelled many analysts to characterize Africa's health system as one that is experiencing a serious crisis, overwhelmed by high rates of infant and maternal mortality, two of the most significant determinants of the poor indices of the population health in Africa. Let it also be noted that the following work devotes heightened attention to the need to educate the African woman and mother. Studies have shown that improving the health and education of women can eliminate most of the infant and maternal morbidity and mortality, which, if taken seriously, could revolutionize the dynamics of the health system on the entire continent of Africa.

In sum, this book attempts to strike a balance between theory and practice and between social justice and privilege, and essentially answer the following questions: What is health? What is public health? What have been the suggested best practices that might be used to improve the health of Africans? How can resources be used more effectively and efficiently to improve the health of all citizens? How can Africa prevent a repetition of the medical pitfalls of the West? How countries as poor as Cuba are able to provide some of the best health care services to their people? Are there alternatives to the health models embraced so far by Africans? Is the pyramidal health system and its structure properly serving the needs of the rural as well as the urban populations in Africa? Are our physicians specifically trained to meet the specific health needs and the justified demands of the African people? What is the impact of the migration of Africans to the Western world and elsewhere, such as the US, Canada, the UK, and even South Africa? Is Africa in a health crisis, as some critics say, resulting from the so-called “double burden of disease” caused by endemic and epidemic infectious diseases and the rapidly emerging silent chronic illnesses in the form of stroke, obesity and diabetes, hypertension, and the types of cancers prevalent or common in the West? Is there anything individuals and civil society can do to strengthen their own health care system? Are the present estimates of disease in Africa accurate, “scientific,” and unbiased? How do Africans communicate the message of good health and convince the population to forego or abandon outright cultural practices that clearly go counter to the concept and goal of good health such as what is called “female genital mutilation”? This first volume is organized into eight chapters and is published in two volumes.

Chapter 1 introduces the reader to the field of public health as relates to the African context and emphasizes the importance of epidemiology on the premise that one needs to know the enemy first to fight him successfully. Epidemiology is the study of the determinants of disease and its distribution (i.e., incidence and prevalence) in a given population during a specific period of time. The chapter discusses the other disciplines of public health and how they too impact the health of Africa. On the critical question as to whether Africa has public health, the author posits that the core, the guiding principles, and the goals found in public health as we know them today, comprising such disciplines as nutrition, maternal and child health, behavioral health education and promotion, global health, health policy and management, and environmental health are there but perhaps in their infancy or in a veiled form.

Chapter 2 looks at how Africans were able to combat disease and pestilence thousands of years before they faced big waves of strangers on the continent through intercommunication, war and conquest, religious conversion, and cultural diffusion. The premise in the chapter is that, prior to the great demographic movements of the fifteenth through the nineteenth and twentieth centuries, the relation between man and his ecosystem in Africa was relatively in a state of equilibrium or balance, allowing Africans to combat disease and natural disasters and to successfully survive and thrive in their immediate environment. A major health and continental ecological disturbance was caused by the advent of colonialism, whose legacy Africans are still grappling with today. This chapter stresses the view that the disease environment continued to worsen in Africa until the 1930s and began to improve only after the two World Wars—1914–1918 and 1939–1945, respectively—and that, even today, it has not advanced enough.

Chapter 3 examines the pre-colonial health practices in Africa, which had empowered people to live a normal life, as well as the perennial positive (and sometimes negative) impact of traditional medicine, and the influence exerted by culture. In this chapter, the author tackles the issues of efficacy of African therapeutic "systems" and focuses his attention on the association between the individual patient and the community and his culture, the importance of determining the state and degree of the social and psychological balance when diagnosing and treating a patient, as well as the vast knowledge of the traditional physicians, whose popularity still lingers today even among the Western-trained physicians themselves, other educated Africans, and those who call themselves Christians or Muslims. Current experience clearly shows that, contrary to their public pronouncements and public behavior, the latter still accept the way their ancestors practiced medicine, and continue to view the cosmos and the role of spiritual values in people's lives traditionally. Traditional medicine, the author argues, enriches Africa by presenting pragmatic and real personal options to the Africans in the face of the intrusion of biomedicine. Indeed, biomedicine has claimed to be infallible, and has therefore fought with tooth and nail, but unsuccessfully, the persistence of traditional medical or curative practices, the concomitant therapeutic knowledge, and the worth of the authentic African "physicians."

This discussion is followed by Chap. 4, whose objective is to explore how the scramble for Africa and the continent's subjugation by Europe impacted the health of the people. The nineteenth and the early twentieth centuries were a critical period for Africa, as living conditions changed

radically and rapidly, forcing the African to switch his centuries-old outlook and resigning himself to adapting to the dictates and the goals of a foreign colonizer, whose primary health concern was focused on the European settler, the army personnel, and the expatriate, a system imposed through forced labor and a cash crop economy tied to taxation and exports. This violent period and its colonial system began to improve markedly but gradually only during the 1930s, 1940s, and 1950s, after Africa had gone through a period when even the Europeans themselves feared that the demographic growth of the continent was in peril due constant famines, uncontrollable epidemics, and the steady depopulation of certain crucial areas of the colonial empire. Chapter 5 takes a look at the British colonial empire and the health conditions it created, often through segregated living and racist policies and behavior, and what measures the British took to improve the health conditions. The point made in the chapter is that, if the British had not used a racist policy, camouflaged in the theory of indirect rule, focusing primarily on the health of the European administrators and the army, they would have done better than the French and the other colonizers in Africa.

Chapter 6 goes on to discuss French presence in Africa and highlights its assimilationist policies and their impact on health. Here, it appears that only a few assimilated Africans reaped the health benefits of the policy, while most Africans, subjected to the bulk of European racism and discrimination, saw, until the late 1950s, their health conditions deteriorate. Chapter 7 examines the health conditions controlled by the lesser colonial powers in Africa, such as the Portuguese in Mozambique, the Italians in Somaliland, the Belgians in the Belgian Congo Free State, the Spanish in Equatorial Guinea, and the Germans in Tanganyika, South-West Africa, and Cameroon. In most instances, in the territories, the policies tended to be brutal, including in the Portuguese territories, where, as was the case in the French possessions, assimilation was the official policy. All of these colonial powers' health systems in Africa could accurately be characterized as racist, segregationist, European-oriented, and ineffective, whose legacy the Africans in these former colonies inherited and have been unsuccessful in shaking up their continued grip, making the health systems in the new independent states, exacerbated by civil unrest and war, precarious and, at times, backward.

Chapter 8 takes a glimpse at the work of the missionaries, who, invariably were entrusted with the day-to-day health and education of the Africans virtually all over the continent, including North Africa.

The verdict of their work still remains murky and ambiguous as the primary intention of many among them was to use medicine and therapy to convert the Africans and not as a sacred tool designed to improve the lives of the Africans. As a result, quite often, missionaries faced the ire and resistance of the Africans against even associating themselves with their medical practices as they often saw the new-comers, one hand with a cross and the other with a bible, as the handmaiden of colonialism. However, this impression began to wane a bit at the dawn of the independence movement in most of Africa, particularly in the positive reaction to the missionaries' involvement in the education of the Africans and their effort to train African physicians.

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CHAPTER 1

Public Health in Africa: Theoretical Framework

This introductory chapter sets the parameters for the study and tries to define clearly the major concepts and terms contained in the volume, such as the distinction between medical practice and public health; causes and impact of health disparities; and the reason why Africa functions under several health care systems which seem to be dysfunctional. Also covered in this chapter are such topics as available resources; the degree of national integration and nationhood that impacts health; people's educational level; cultural practices that may be obstacles to healthy behavior; Africa's specific geographic location and its eco-system; the state of the infrastructure; and constructive or hostile international relations. The point made in this chapter is that health can only be understood and properly managed if all variables are considered individually and collectively, given that synergetic phenomena can make or break a system, and overwhelm or prevent people's ability to manage their health and access to quality health care wherever they might be. Therefore, the concepts that inform the whole discussion include:

1. Health, health care, and public health, global health
2. Tropical medicine
3. Health systems and culture
4. Climates and climate changes and their impact on diseases

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5. Infectious, communicable, or transmissible diseases versus chronic or non-communicable diseases
6. Disease burden and health disparities in Africa
7. Globalization
8. International Health Organizations

These are examined as parts of the health or medical systems from an historical perspective that enables the reader to link the present to the past and vice-versa.

Assessing the changes that have occurred since independence in most of the African continent, which it achieved during the 1960s–1970s, and the impact of privatization and reliance on voluntary NGOs (forced on the Africans by the neo-liberal theories imposed by international financial organizations to advance the health and health care of Africans), is a difficult task. In fact, Prince and Marsland doubt whether the continent has "public health" as we understand it, given that the recent global health focus is unable to reach all citizens of the struggling countries in Africa. It appears that Africa, as a result of the hard economic decades of the 1980s and thereafter, has hardly pursued a serious and successful path toward the improvement of the health of its people, which is embedded in the modern, scientific medical principles that hold the premise that health strategies must be linked to prevention (and treatment), with policies based on real local conditions, adequate infrastructure, clean water, proper sanitation, and the eradication of environmental pollution, among other health-related factors. Indeed, the neo-liberal health policies of the 1980s compelled post-independence African states and governments to forget Alma-Atta's emphasis on primary health care, even after the 1987 Bamako Declaration. Primary health care was designed to focus on prevention of disease rather than treatment and not leaving the individual to fend for himself, while neglecting to "tackle the broader socioeconomic and political conditions underlying ill health," out of which "health services [in Africa] have become more containment of disease," often defined simply as "health emergencies" (Prince and Marsland 2014: 1–5).

Tropical Medicine

It might be enlightening to the reader if we discuss briefly the concept of tropical medicine as used by the pioneers of public health a few centuries ago. Tropical medicine has caused unnecessary debate among African

health experts and the former colonizers, or others, who have used the two words loosely. It is important that this distraction from the real health issues be dealt with here before it causes further confusion when addressing the most important concepts of public health, medicine, and global health. This much we know on the controversy. It is agreed that the concept of tropical medicine started during the nineteenth century in British, French, and German laboratories and schools of medicine whose primary motive was to care for the health of the army and the European administration living in tropical climates, as is the case of 80% of the African continent. However, in trying to solve the problem of ill health, the pioneers of the tropical effort focused on disease without seriously thinking about the socioeconomic factors responsible for certain disease clusters and the various pathogenic agents.

In many cases, diseases were considered to be tropical even if they did not originate within the tropics or occurred only occasionally in places such as Africa. It is widely accepted today, for example, that in Africa, many of the contagious diseases, such as syphilis and smallpox, spread to the interior from the coast—the preferred place for Europeans—which allowed the newcomers to control the shipping industry, the welcoming and enhancement of the arrival of more colonizers, and the discharging of laborers from one area of the continent to another. The reasons and impact of the stigma associated with several diseases, such as leprosy and mental illness, and how to combat them received little attention then. Sadly, this neglect continued even with the emergence African universities and medical schools at the end of the colonial period. In fact, the spread of such diseases as influenza is related to population density and people's relation to disease vectors such as mosquitoes, flies, helminthes, and lice, resource allocation, social interaction, and relationships of power that influence social organization and space, and not simply to geographic characteristics, climate, and tropical location (Niang 2008: 29).

Many public health experts make a sharp distinction between the concepts and goals of public health and global health, between international health and tropical medicine, between health itself and its disciplines, and between population and individual health. For one, some maintain that "tropical medicine has connection with [an] international [domain]," which is somewhat inaccurate, because one can focus on tropical medicine [or public health] and not necessarily transcend a country's or colonial national boundaries. Due to its connection with the early years of colonialism, as noted above, tropical medicine originated among interested colonial

doctors and scientists in England who described the state of Africa's health negatively while portraying themselves as the saviors of the continent. Eddleston notes in this context that, when the organization of European Schools of Tropical Medicine (TropMed Europe) met in Addis Ababa in 1997, "we were persuaded by our African colleagues that the term 'tropical medicine' still had patronizing colonial overtones and should be replaced by 'international medicine' although this decision was never implemented" (Eddleston 2011: vi). Prominent historian Roy Porter (1997: 462) objected to the use of the concept as it created the wrong impression of "Intrepid doctors going off to the steaming jungles and overcoming some of the most lethal diseases besetting mankind," as the greatest benefactors to mankind (Eddleston et al. 2011: v). To be sure, tropical medicine was defined by Manson in 1898 as the branch of medicine that focuses on the diseases "occurring only, or which from one circumstance or another are specially prevalent, in warm climates," requiring "the necessary skills and experience needed to meet its special challenges: the zoology of vectors and reservoirs, hygiene, anthropology, economics, epidemiology and demographics as the mainstream medical sciences."

No wonder the replacement of the concept of tropical medicine with that of "international medicine" was never adopted. Indeed, talking about international medicine makes little sense because, as the preceding authors noted, tropical medicine asks several questions whose answers are extremely relevant to such continents as Africa, including those that are not in the tropics: issues of medicine chain; impact of the heat on medication; drying a blood film or staining a malaria film; stabilizing airways obstruction by using a "a bloody tracheotomy"; weighing patients quickly in a humid temperature; operating a hospital without electricity and clean water; sanitizing and sterilizing hospital needles and similar equipment; applying the technique of weighing patients and monitoring their fluid balance "at the most peripheral levels of the health service"; avoiding contamination in situations where water is scarce; and improving the methods that might offset the impact of mosquitoes, flies, rodents, germs, and parasites that thrive in humid climates and wet areas. These and myriad other health-related issues are important or less critical where geography presents advantages or disadvantages for managing health care more efficiently and more effectively. Thus, even though tropical medicine has local, international, and even global implications, it need not be international: it may be simply national or regional depending on its specific focus. This means that in dealing with diseases health experts must go

beyond the concept because it is narrow in approach and confuses those who see health as determined by more factors than climate. In short, one must be careful when using the concept of tropical disease or diseases, which should mean that certain diseases are common in certain geographical locations and not that all found in such locations are tropical, as is the case with HIV/AIDS and SARS. Additionally, diseases appearing in cooler climates are not necessarily non-tropical, as many can adapt to any climate. As the world continues to shrink, the distinction between tropical and non-tropical becomes less accurate. Finally, one must consider genetic predisposition of an individual born in a tropical or cooler climate when trying to classify the disease.

Defining Public Health and Its Disciplines in Africa

The terms "public health" involve a set of critical concepts, a number of important actors, the various disciplines it evolved from and into, the constant changing or expanding foci it takes, and the misgivings that cynics have spread among the consumers of health care when presumably scientific studies continue to contradict one another, thus creating confusion and doubts about its significance for both populations and individuals. In the US, the resistance to imposing or promoting certain behaviors that public health professionals, practitioners, and advocates request is heightened when politicians and policy-makers claim that the field should be the domain of states rather than the federal government. This ideology has, for a long time, hurt the government's ability to act as the most important agent for the protection of people's health. In the US, such type of thinking is clearly underscored by the continued controversy over President Barack Obama's Affordable Care Act passed by Congress in March 2010 and declared constitutional by the Supreme Court in 2012.

The attempt by the opponents to repeal this law without suggesting any alternative comes from nothing else but an ideological framework that is based on the premise that health and access to (quality) care is not a right of all people, and that the poor and the unhealthy must be held responsible for their condition, for which they are to blame in a social environment that asks each citizen to fend for himself—an echo of sociologist Herbert' and anthropologist Darwin's theory of the "survival of the fittest." If this is the basis of social behavior and assessment of how

suffering fellow global citizens should be handled, the federal government has no legitimate authority over legislation on health. However, if one were to follow this logic to the extreme, as is the case among certain US politicians and pharmaceutical conglomerates, then one could simply posit that no state, federal, locality, or community has the right to regulate people's lives in so far as health is concerned and that only the individual can determine by himself his own conduct, even if this may result in an epidemic or a pandemic outbreak that affects everyone else. Such thinking demonstrates how absurd or unwise it is to reject the tenets and the sociopolitical requisites of public health. It is fortunate, at least for now, that this debate has not permeated discussions over the power of the African governments to legislate, survey, monitor, evaluate, fund, and advocate for certain types of policies designed to protect the health of the community and, consequently, that of the individual. This non-combative attitude in Africa has its roots in the colonial authoritarian regimes Africans inherited, the family and community-based traditions prevalent on the continent prior to the imposition of a system that focused on individualist capitalism interested only in the accumulation of material goods regardless of the methods used, one that sought instant or visible gratification brought about by the public health system. In the long run, however, a population-based approach is less expensive than a focus on individual disease cases and individual well-being.

Even though the definition of health was suggested as early as 1948 by the World Health Organization (WHO), few experts ever took it seriously until two decades ago. Yet, even today, some still consider it to be too utopian and, therefore, unattainable. The WHO defines health as "a state of complete physical, mental and social well-being and not merely the absence of diseases." In the context of such a definition, health is a positive concept that makes its opposite, ill health, undesirable, even if the ill person does not suffer from a disease. A person with a broken arm or a slight injury from a car crash does not have a disease but he is not healthy either. In the same vein, an individual who has an infection that does not develop into a disease is not in "health;" he or she is, instead, unhealthy.

The WHO's definition seems utopian but it is accurate as long as it stands as a long-range goal, an ideal that humanity should always strive for. One reason why this definition was introduced by the experts was to make the point that mental disorders are also diseases that should merit as much attention as physical illnesses. For a long time, in fact, mental disease remained neglected by the medical profession and even public health

practitioners and scholars, and policy-makers globally, including the West. As a positive concept, the United Nations (UN) definition emphasizes the point that "social and personal resources as well as physical capabilities" are all important elements for the health of the community (Lloyd and Morrow 2010). Public health is precisely what the two words mean, that is, "the state of complete physical, mental, and social well-being" of the public "and not merely the absence of disease" in its midst. This can be expressed in so many ways making the debate among experts unnecessary.

Novick and Brown defined public health as "organized efforts to improve the health of communities rather than individuals," combining science and social approaches, with the central goal of "reducing disease" and improving the health of the community (Lloyd and Brown 2010). However, it is agreed that definitions must be concise, precise, and relatively brief, while containing the essential elements that make something what it is, presenting a form of existence and operation that are unique to the subject been defined. In this light, Novick and Brown's definition seems to be too general to the extent that it needs some elaboration. Some definitions note, for example, that public health relies on a combination of science and art. Suppose there is no science, does one still have public health? What is science and who defines it? Can a community have public health without the element of art? What is art and who defines art? Aristotle gave us a simple principle for defining something: showing the specific genus and its unique species. By defining public health the way we have done over the past three decades or so, Africa and the less developed world may not have public health, which is only acceptable as long as we maintain the Eurocentric definition of science and art.

The Institute of Medicine, in its *The Future of Public Health* (1988), defined the concept(s) as "an organized community effort to address the public interest in health by applying scientific and technical knowledge to prevent disease and promote health." Though this definition has received much praise and acceptance from researchers and health practitioners, it must still answer this question: What is scientific and what is technology, so that it may be applicable to all health systems of the world no matter how underdeveloped? Indeed, did Hippocrates, the so-called father of modern (Western) medicine, or Thucydides, who wrote about epidemics in his part of the world of the time, have the scientific and technical knowledge expected to prevent disease and promote health? In a word, did the Greek and other ancient civilizations have public health?

C.E.A. Winslow, one of the best known promoters of public health since he began his work during the 1920s until his death in 1958, tried to define public health as:

> The science and art of preventing disease, prolonging life, and promoting physical health and mental health and efficiency through organized community efforts toward a sanitary environment; the control of community infections; the education of the individual in principles of personal hygiene; the organization of medical and nursing services for the early diagnosis and treatment of disease; and the development of social machinery to ensure every individual in the community a standard of living adequate for the maintenance of health. (Winslow 1920)

Winslow caused more confusion than was needed when presenting a definition that seems to cause more problems than it clarifies the essence of the field of public health with its many functions, means, strategies, goals, disciplines, and desired outcomes, interjecting the word individual, which takes the essence of public health away, namely, from its primary focus on the community and populations, or the public. Winslow's definition has received such negative criticism that renowned sociologist Paul Starr called it a downright subversive "—a conception [that is, if taken seriously, is an invitation to conflict." Starr continues his criticism: "Public health cannot make all these activities its own, without, someone, sooner or later, violating private beliefs or private property or the prerogative of other institutions…Much of the history of public health is a record of struggles over the limits of its mandate" (Starr 1982: 180). Starr further adds that, in the past, religious organizations opposed public health because it was perceived as officially introducing its own concepts of health and hygiene, while businessmen and merchants did not welcome the emerging field as they perceived it as encroaching upon their domain. At the end of the nineteenth century, physicians also vehemently objected to the impression that public health was infringing on the core of their medical profession.

This writer found an interesting definition that seems to present fewer problems and little confusion. Samantha Battams defined the "new" public health as "the sum of activities undertaken by societies, occurring both within in and beyond the health system and health sector, to promote health and prevent disease" (Battams 2014). Thus defined, public health may be applicable to even ancient societies, including those found in Africa, because it does not make essential the subjective Western understanding