

# GLOBAL SOUTH

SEPHIS e-magazine

Volume 7 No. 2 April 2011



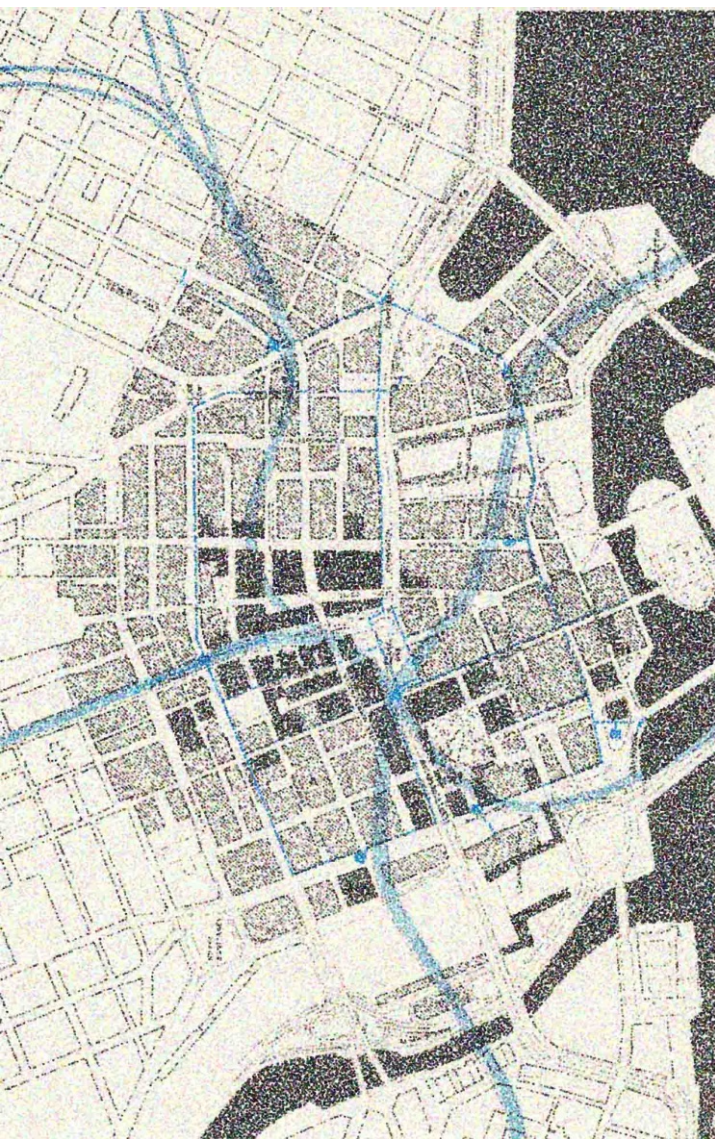
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April 2011

history \* power \* culture

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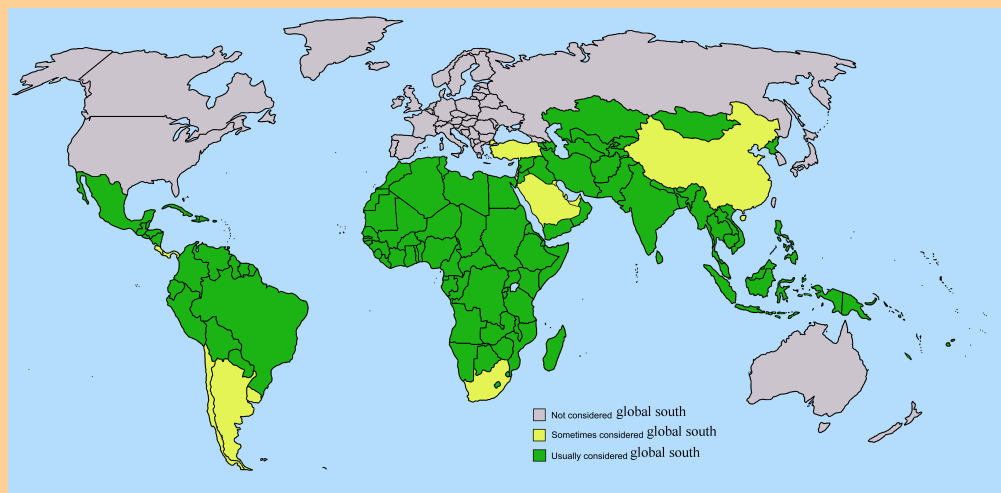
## Our Team

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# ditorial



Volume 7 No.2 April 2011



Recently an interesting study revealed that, going by the Democracy Index, the only country in West Asia which showed any semblance of democracy was Israel, which returned a high Democracy Index score of 7.48. In contrast the Islamic nations of Lebanon and Turkey scored 5.82 and 5.73 respectively, and were categorised as 'hybrid regimes'. The remaining countries of Libya and Saudi Arabia could not even manage to score 2 points, and were labelled as 'authoritarian regimes'. An African country, Egypt, experiencing a change in regimes, fared no better, being labelled as an 'authoritarian regime' with a score of 3.07. This exercise of measuring democracy, bizarre in itself, is rendered more so when we ponder the credibility of a North-generated parameter for measuring democracy in the South. Labels like 'hybrid' and 'authoritarian' have been used, without taking into any consideration the internal dynamics of governance in the South, the complicated legacies of colonialism, the various political and economic realities of specific South regions. So far as countries of West Asia and Africa are concerned, however, it is not only in northern scales that they appear to fall short in the democratic index. Some of these countries are still under hereditary kingships. In spite of being a part of the *global south*, West Asia, having experienced a swift but lopsided development fuelled by its oil economy, has remained largely disconnected from democracy. That we at Sephis, for instance, have failed to connect meaningfully with this region on an 'academic' south agenda,

reflects perhaps this distance.

One glance at the map of West Asia, and one realises the significance of the democracy question. In one corner of the Suez Canal lies the Republic of Mauritania, where General Mohamed Abdel Aziz seized power through a military coup. He conducted elections in 2009 with sweeping success, which ultimately resulted in a dictatorial rule. In spite of having an elected Parliament, King Mohammed VI of Morocco seized power in 1999. In Algeria, the army handpicked President Abdel Aziz to rule over the republic. Colonel Muammar Gaddafi, who is currently facing the ire of the masses, has held on to the reigns of the Great Socialist People's Libyan Arab Jamahiriya since 1969. The Republic of Sudan is ruled over by Omar Al Bashir as the President, and his rule has resulted in nothing other than civil war and a disruption of the socio-political structure. The one-party rule of President Bashar Al Assad over the Syrian Arab Republic disallows any political space and independent voice. In the Republic of Yemen, Ali Abdullah Saleh has been ruling since 1978. Lastly, the Kingdom of Saudi Arabia is ruled by the House of Saud since 1931.

Theories abound regarding the possible causes for such a tendency. Keeping in mind the fact that these are Islamic nations, many argue for the incompatibility of democracy with Islamic culture and values. Others argue that the absence of any clear difference between religion and state restricts the possibility of democracy in the region. But one cannot overlook the fact that a democratic tradition in Islam was not altogether missing. In the early seventh century, Islam – under the prophethood of Muhammad – established a semblance of democracy with the Medinan Constitution. Though not a democratic setup in the modern parlance of the term, it created enough room for the masses to make their voices heard. But with the death of the prophet, and successive reigns of the Islamic Caliphate, monarchy was preferred over democracy to govern a tribal society. Although Islam soon expanded into a world power, the mode of governance remained unchanged. Many blamed the colonial powers for their antipathy towards establishing a democratic regime in the area. Scholars advocating the 'clash of civilisations' thesis sought to situate their argument on the premise that Arab nations are resistant to democracy, and a 'non-rational' Islamic revivalism and Shia fundamentalism further diminishes any chances of democratic development in the region.

Unfortunately, the first casualty of such a structure is the voice of the masses. State security forces killed hundreds of people, and wounded thousands in the name of maintaining law and order. Individual rights and freedom touched such a nadir that people were not ready to lose another life without being heard. The act of self-immolation by a vegetable seller, Muhammad Bouzizi, on the streets of his village in Tunisia, provided the spark to what the western media has named the 'Jasmine Revolution'. Waves of popular protests in Tunisia spilled over into the neighbouring countries, and lashed onto the Egyptian shores. An entire nation rose up against an authoritarian government, in spite of ruthless repression, to a common call made famous by a Western leader, 'Yes, we can!'

The intense discontent brewing deep within the hearts of the masses

of Egypt erupted through eighteen days of concerted protest by the Muslim Brotherhood, Wafd Party, and most importantly by the teeming millions, who gathered at the Tahrir (Liberation) Square to reclaim their lives and rights – right to live as citizens of a nation freed from the shackles of a rapacious and oppressive regime. What we witnessed in Egypt can be characterised as a successful transformation of the grassroots protests into a mass uprising drawing inspiration, not from any elitist intervention, but by another neighbouring unrest. Its success lay not only in the numbers in which the common people thronged the streets, but in their ability to outlast the repressive state apparatus which had for so long silenced their voices.

One noteworthy aspect of this entire upsurge has been the role of the Egyptian army, which, unlike its Libyan counterpart – currently engaged in a bloody civil war in Benghazi – stood firmly by the side of the common masses, enjoying their trust. They were the ones who at one time worked closely with President Hosni Mubarak, in strengthening the imperial control of the North in West Asia. If the army intends to control the scope and pace of change in Egypt, it will, it is to be hoped, at some point, take into consideration the representative civilian forces, and at the same time ensure that decisions are taken through a broad consensus and that transparency is maintained.

At the same time apprehensions lurk around the corner. Such a dynamic upheaval, riding high on the shoulders of a young, Western-educated generation, has all the possibilities of entering into a political vacuum once the common enemy – here President Hosni Mubarak – is removed. And it is here that public vitality and dynamism runs the risk of getting frozen in the absence of a definite structure of governance and a guiding leadership. In the wake of such momentous transformations, the long-term outcome is still shrouded in uncertainty. It needs to be remembered that the masses rose not in favour of a democratic mode of governance, but in opposition to an authoritarian one. And the removal of the latter does not necessarily ensure the birth of the former. The new order has every chance of becoming a reformist rule aiming at curbing the excesses of the neo-liberal world order and the imperial intervention of the North, or may witness the resurgence of another dictatorial regime under the aegis of the army. The future may be decided through a test of strength between the resilience of the *ancient* regime and the perseverance of the rebelling forces together with their leadership. As Alexis de Tocqueville once observed, with the sagacity of a seer, ‘It is not always through matters going from bad to worse that a country falls into a revolution. The most dangerous moment for a government is when it tries to reform itself.’

Given this context, the capture of the world stage by the Egyptian people, it is a remarkable coincidence that the current issue of *Global South* carries three contributions on and from Egypt. The first piece, in the Article section, raises questions regarding the performance of the Egyptian healthcare system, right up to the present day. The paper discusses the Egyptian medical system, which over time has suffered under the British rule. The colonial masters were more interested in using the Egyptian healthcare structure to serve the interests of the Empire rather than those of

the general masses. Consequently, the health sector became a playground of rich men where affluent Egyptians and foreigners took training and offered medical services in return for a neat profit. After decolonisation in 1952, the new government entered into some kind of a compromise where the erstwhile elite were allowed to retain their private practice, while at the same time an attempt at socialisation allowed professionals from less privileged backgrounds to enter the healthcare scenario. The author argues that such a policy created a contradiction in the long run when doctors queued more in favour of private practice at the cost of the public— an ill which even the Mubarak regime failed to address.

The evils of an inefficient medical system are borne, at various levels, even by those indirectly dependent on that structure. In his piece on the East Coast Fever (ECF) in Southern Rhodesia, Wesley Mwatwara traces the conflicts that took place between farmers and veterinary scientists over the origins and possible cure for the disease. The author states that though the origins of the disease remained in dispute, the farmers believed that the government was to blame since it had imported the cattle which subsequently got infected during the transportation process. At the same time veterinary scientists were divided on the nature of the disease— completely new or a newer version of an older disease. The more the veterinary department took time to ascertain the nature of, and possible remedy for, the disease, the more the peasants grew impatient and blamed the government for ruining their investments in cattle farming. The paper, while making a case regarding the incompetence of the veterinary department in controlling and guiding the farmers regarding the spread of ECF, also admits the scientific, physical and financial limitations of the government body in coping with the problem.

The paper on Arts of Healing in Brazil, examines the tradition of indigenous treatment, which, though not always acceptable to western practitioners of medicine, were nonetheless popular forms of treatment among the lower segments of the society— women, slaves and emancipated slaves. Though looked down upon as an inferior form of medical practice, the ‘popular healers’ were respected by doctors, surgeons and apothecaries for their knowledge regarding natural resources. In spite of having a clientele divided along class lines, both the western medical practitioners and popular healers had to take the permission of the Fisicatura mor, responsible for regulating all medical practices. The author argues that although the Fisicatura mor believed in the limited knowledge of popular healers, as compared to the educated medical corps, yet they were in great demand among the population of Brazil, not only because of their knowledge but also due to the scarcity and high service charge of ‘academic doctors’.

The contributions in the Across the South section again deal with various aspects of Egypt. Tarek Selim’s paper deals with the pharmaceutical industry in Egypt. At a time when the country is caught up in crisis and mayhem, Emilio Platti draws our focus into those hidden corners of the Egyptian society, which have been springs of peace— the Sufi shrines. By examining the importance of these religious sites in the socio-political life of Egypt, the author has tried to argue the worth of these spaces, not only as places of worship, but also as sites of social and communitarian bonding,

looking beyond the unhappy experiences of conflict and unrest.

In the Review section, Amusa Saheed reviews a collection of essays on various aspects of medicine and medical practice in countries of Africa. Here the author speaks of useful insights gained from the pages of the book, regarding the resistance offered by traditional forms of medicine, including spiritual healing, in the face of a steady onslaught by western dominated modes of medicine.

## The Development of the Egyptian Medical Institution and Profession: A Brief Overview

The current Egyptian healthcare system has been under scrutiny over the past years, mostly because of the changes that have been proposed for its development but also because of the scandals that have arisen from its malfunction. Many of the stories that relate to the scandals of medicine deal with doctors' mistreatment of patients and their fecklessness towards the patients' health status and sometimes their very lives. Such outrage is directed at both public as well as private health institutions, which have so far existed parallel to each other in Egypt. This paper seeks to give an overview of the development of the medical institution in Egypt and relate it to the changes that are taking place today. It also aims at analysing the impact such developments may have had on the socialisation of doctors and the creation of the profession as it is today.



Salma Shokralla

Salma Shokralla holds an M.A. in Anthropology from the American University in Cairo, Egypt. She obtained a Bachelor of Arts from the University College of Maastricht in the Netherlands in 2006. She is currently working as an Egypt-based journalist at the Ahram Online, an English news website. She also worked as a social researcher in environmental consultancy between 2006 and 2008.  
Email: [salmashuk@gmail.com](mailto:salmashuk@gmail.com)



### Modern Medicine Introduced to Egypt

The origins of the medical institution in Egypt dates back to Mohammed Ali's dynasty (1805-1848). Mohammed Ali's prime concern was to create an independent nation-state that would break away from the Ottoman Empire. To create such an independent entity he embarked on a mission to "Egyptianise" the most important state institution, the military, and to create a health system that would ensure the health of the populace.<sup>1</sup> This strategy dictated much of the development that followed, including the formation of a modern medical institution and profession.

There were two main aspects to Mohammed Ali's modernisation plans. One was its complete break with any past heritage, which has been reflected in how the medical institution and profession has developed. Another was to engage the Egyptian population in every aspect of this development to ensure that independence was accomplished. Although the two seem contradictory, they went hand in hand and this was most prominent in the way modern medicine was established under his rule. Since Mohammed Ali's modern nation-state was following the European model, he greatly depended on European professionals to create the state's institutions. Consequently, most of what was left over from Arab rule or local tradition was either neglected or rejected.

To establish a modern medical institution, Mohammed Ali appointed the French medical doctor Antoine-Barthelemy Clot, known as Clot Bey, to head the first school of medicine in an area called Abu Zaabal.<sup>2</sup> Clot Bey was determined to cut off this new school from all older forms of healing that were present at that time. A book published by Cairo's faculty of medicine in 1935 explains that the healing institutions that were left over from Arab rule, called Marastan, were completely rejected by Clot Bey who believed them to be of very low standards.<sup>3</sup>

Clot Bey stated in his report that '[t]he Marastan School which was originally opened for teaching cadets medicine prior to admission to the school at Abu Zaabal, is now no longer needed. It is not possible to obtain the services of competent teachers from Europe to teach in this school with view of improving its standards, which I consider very low' and added '[a]s to the Marastan School, I propose to close it.'<sup>4</sup> Clot Bey's view is clear: Marastan Schools, which were healing institutions established during Arab rule, were seen as insufficient to meet European standards. Instead, Clot Bey proposed that a group of European-educated Egyptian students needed to be created to teach at the new school of medicine or using Clot Bey's words "mission graduates will be appointed as 'repeaters' and will themselves deliver the lectures in Arabic."<sup>5</sup> In addition, local Berbers who used to practise forms of traditional healing were fiercely fought against, although they were sometimes used as annexes to European-educated doctors, as in the case of vaccinations.<sup>6</sup>

However, creating an Egyptian medical profession also meant that local channels needed to be used by the state to recruit Egyptians. The Kuttabs (mosque schools) were used for this purpose. They acted as channels from which students were recruited for the new medical school. The Kuttabs remained under the supervision of the sheikhs and continued to provide the basic education. A new modern educational system, on the other hand, was gradually being implemented, top down, setting up advanced technical schools first and ending with primary schools, so that the state could later depend solely on it.<sup>7</sup> Involving the Kuttabs at first also meant higher acceptance of the new medical education system since it did not seem to clash with the authority of the Sheikhs within the educational realm.

The school of Hakimat (school for nursing and midwifery), on the other hand, was not accepted as easily. Recruiting women in the profession was met with more hostility and went against the general feeling of society, despite the material temptations that were offered.<sup>8</sup> As a

result, female slaves were first recruited to perform in the school of Hakimat. However, this experiment failed because, according to Shenawy, these female slaves were not trained for this type of work.<sup>9</sup> The school turned to female orphans to take on the job and offered them a relatively attractive monthly stipend in addition to a marriage. Clot Bey ordered the newly graduated medical students to choose for themselves brides from the Hakimat School, and the costs of the meeting and wedding ceremonies were fully covered. By virtue of this, the orphan girls were able to marry, despite the stigma imposed upon them by society that they were bastard children, and Clot Bey was able to create his nursing and midwifery school.<sup>10</sup> How far consent and choice were involved in this process, however, still needs to be examined.

The need for midwives in state hospitals, I argue, could have been generated by the presence of Dayas, traditional midwives. Creating a modern nation-state meant that the new form of governing required higher control over individuals, not via force but via supervision as Foucault's concept of bio-politics explains.<sup>11</sup> The presence of Dayas came in the way of such supervision, since they fell beyond the scope of the state. Therefore, the school of Hakimat was created as an alternative that could be better supervised by the state.

However, most women did not trust hospitals automatically and continued to go to Dayas. Consequently, when the state failed to encourage women to go to the hospitals for delivery, it exerted its influence to try and bring the Dayas under its supervision. Fahmy explains that when the state realised that in a two-year period there were only two deliveries carried out in civil hospitals and that offering women financial incentives to use hospitals had failed, it started encouraging the Dayas to report the difficult cases to the Hakimat and also report the number of births to supply them with statistics.<sup>12</sup>

In short, the state through modern medicine was able to create a modern nation that fell well under state supervision and under the influence of modern European thought. The new professional classes, particularly the class of health professionals, were most effectively indoctrinated by the European model and thus enjoyed a higher status in society. Many of these medical students were sent to Europe by the state on educational missions, which in turn created a professional class influenced by European thinking and culture.<sup>13</sup> The superior position medicine gained through its link to Europe also gave medical professionals a superior position in society, formally and informally. This aspect of social superiority, gained back then, persists even today in Egypt.

What did not remain, on the other hand, was the profit-free medical system and profession which existed back then. Medicine, under Clot Bey's supervision, was still a state-led project and needed to either create incentives for people to seek the modern health service or, at times, even force it, as with vaccinations.<sup>14</sup> It was also competing with the existing traditional healing system which fell beyond the control of the new state. Consequently, profit was not the moving force behind the institution or the profession yet. This is clearly reflected in the code of ethics that guided the medical professionals then. Mahfouz's book includes the 'Oath of the Doctors' of the first medical school which included the following lines: 'I swear by the Name of God the Most High and of His Revered Prophet Mohammed, whose glory may God increase, to be faithful to the codes of honour, honesty and benevolence in the practice of medicine. I will attend the poor gratuitously, and will never exact too high a fee for my work.'<sup>15</sup>

For sometime after Clot Bey had resigned, the school continued to receive hundreds of students. The government covered all their costs including their clothing, food and residence in addition to a monthly salary. When these students graduated, the government also guaranteed them a job and hired them either in the army or in one of the health units. However, as medicine became more established, it started to be desirable for some students to follow the

school even if the government did not support them. Those students who were not covered by government spending and who depended on their families were later allowed to open their private clinics.<sup>16</sup>



Lord Cromer

### The Introduction of the Profit-Making Medical System

When Egypt came under British rule in 1882, reluctance increased towards investments targeting the public health sector. Unlike Mohammed Ali who was concerned with building a healthcare service sector to serve his new nation-state, the British were mainly concerned with serving their empire's interests. When they had to operate the public health-service system, they did not develop it much but actually cut down its spending. According to Chiffoleau, the budget set for education and healthcare together did not exceed 1.15 per cent of the country's total budget and the money spent on public health was less than what was spent on the smallest hospital in London.<sup>17</sup> They also cut down spending on medical education and opened the door for private clinics to operate on profit-making basis.<sup>18</sup>

These changes had several consequences. First, since the British cut down spending on public health, doctors' salaries soared, which made them seek private practice in their free time.<sup>19</sup> Second, the private sector took on the responsibility of healthcare services and, by 1905, out of the twelve existing hospitals only two remained public. All other hospitals were transformed into profit-making institutions and people needed to pay in return for the service. This, in turn, compromised the quality of the public health sector, or what remained of it.

However, the public sector continued to operate when it came to combating epidemics. The British, fearing that epidemics would spread to their army, implemented its compulsory medicalisation. The reluctance of the British to offer healthcare apart from the control of epidemics was expressed clearly by Lord Cromer, the British Controller-General of Egypt who later became a symbol of British colonialism, when he stated that 'the main task of the government is to prevent epidemics not to heal people from regular diseases'.<sup>20</sup> People who were taken in compulsorily were often quarantined and separated from their families. Consequently, public hospitals became suspicious places for most people. They did not provide the healthcare the people needed but only took them in compulsorily in cases of epidemics.<sup>21</sup> Chiffoleau points out that, by 1913, of the 42,794 public hospital cases only 17,652 went to the hospital voluntarily as opposed to 25,142 who were taken there forcefully.

Moreover, the medical school which was established by Clot Bey was not much admired by the British and several changes were made to it. Although Lord Cromer expressed respect for the achievements accomplished by Clot Bey, he did not approve of the members of the medical class that his achievements spawned in Egypt.<sup>22</sup> For example, the reforms implemented under Lord Cromer included hiring British professionals in most of the teaching positions. This view is not at all surprising considering Lord Cromer's view of the Egyptians in general, a view that is known to be highly racist. Under the British, the school witnessed several changes and

among them was the government's withdrawal of the students' financial support. Students who used to receive a monthly salary so long, had to hitherto pay a tuition fee that reached approximately L.E.15 per year.<sup>23</sup>

Consequently, only the rich Egyptians, who could afford paying the school fees and could afford travelling to continue their specialisation abroad, were the ones who became doctors. The door was closed to those from less privileged classes but it was open for either rich Egyptians or foreigners.<sup>24</sup> It has also been argued that it was at this juncture that foreign communities started offering their medical services in return for profit.<sup>25</sup> However, the privileged Egyptians who had the money to go abroad for education broke free of the singular British concern for epidemics. In the process it mounted a challenge to the forced British logic as a whole which gave more importance to epidemics.<sup>26</sup> However, the class of doctors that challenged the British logic was the same class that had been entrenched in European culture and thought and gained privileges from its good relations with the Europeans, especially the British.

In short, the state through modern medicine was able to create a modern nation that fell well under state supervision and under the influence of modern European thought. The new professional classes, particularly the class of health professionals, were most effectively indoctrinated by the European model and thus enjoyed a higher status in society. Many of these medical students were sent to Europe by the state on educational missions, which in turn created a professional class influenced by European thinking and culture.<sup>27</sup> The superior position medicine gained through its link to Europe also gave medical professionals a superior position in society, formally and informally. This aspect of social superiority gained back then, persists even today in Egypt.

This created an elite class of Egyptian doctors, deeply influenced by colonial power and affiliated to it. Nonetheless, it still maintained a slightly different agenda from that of the empire. The conflicting interests that were present within the Egyptian medical elite, between the privileges they got by affiliating themselves to the British and their desire to gain more control and push their agenda within the medical institution, became more clear after the 1919 revolution, which came to challenge the colonial power.<sup>28</sup> From the 1920s up until the 1930s the Egyptian doctors, some of whom gravitated towards the nationalist movement, started to push their demands to gain higher teaching positions. Although they achieved some success, the radical change towards the 'Egyptianisation' of the medical institution was not accomplished until the 1952 revolution. Even then, the British had left behind a class of doctors which mainly comprised the rich elite, who were profit-oriented and highly influenced by European colonial thought and culture.



Antoine-Barthelemy Clot, or Clot Bey

### The Egyptianisation of the Health Institution and the 'Big Compromise'<sup>29</sup>

Shukrallah uses the term the 'big compromise' to explain the development of the medical profession after the revolution. While the new regime opted to implement socialist ideals and to

provide equal public services to all, it still had to face the medical elite that have been formed under the British rule and who were unwilling to give up their privileges. Furthermore, the state's resources were terribly affected by war efforts, especially after the nationalisation of the Suez Canal which eventually led to the tripartite aggression. In the event of these wars, the government invested a lot in the purchase of weapons which affected its investment in public services.

Nevertheless, education and health services witnessed much development under the new regime and the 'Egyptianisation' of both sectors was a big part of this development. The state took the responsibility of education again and it became free of charge. This in turn reopened the door to those from less privileged classes to enter the medical institute. Moreover, it established several rural health units all over the country and nationalised all private civil hospitals to turn them either into Health Insurance Organisation hospitals, free of charge for state workers, or into Curative Care Organisation hospitals, which offered service in return for direct payment or through contracts with state hospitals. It also created several new public hospitals in different Governorates. Still, to avoid a clash with the elite class of doctors that already existed, the government continued to give the private clinics the freedom to operate, as they did before, in return for profit.<sup>30</sup>

The Egyptian medical elite, created under the British rule, backed up the new government in its bid to Egyptianise the medical educational and healthcare institutions but clashed with it in its efforts to socialise them. The compromise reached, or the 'big compromise' as Shukrallah put it, was to create a public healthcare for all but to leave private practice for profit untouched.<sup>31</sup> To do so, the state structured the system in a manner that could absorb both the already-existing elite stratum of doctors with their private clinics and the newly recruited health professionals being drawn from the less privileged backgrounds.

To employ all the newly graduated medical students, who were graduating *en masse* since education had been made free, jobs were created by the expansion of healthcare to the rural areas. The government implemented a system of *takleef*, which meant that those who did not get grades that were high enough to start working at the university were sent to the countryside to work in one of the health units. This was, and still is, done through the Ministry of Health which makes it compulsory for doctors who are not hired at the university to work for at least two years in the countryside. As for those who got the highest grades, they were, and still are, offered a teaching position at the university which enables them to open up private clinics in the capital city, where most money is generated.<sup>32</sup> This ultimately created a hierarchy within the profession which shapes it even today.

Those who were not hired by the university, because of their lower grades, needed to leave Cairo and work as civil servants in the countryside. Consequently, they were unable to open private clinics in the capital city and earned very little money for themselves, depending solely on state allowance. Those who got grades high enough remained in Cairo to teach at the university and opened private clinics to generate more profit. At the outset, to have a job guaranteed either way may have been a good solution for the new graduates. In the long run, however, this proved to be a problem for several reasons.

First, the legacy of the rich doctor, who generated a lot of profit from private practice, never quite died since private practice was never completely terminated. This left those without such a 'privilege' with the feeling that their dreams had collapsed.<sup>33</sup> Consequently, those who worked as civil servants, especially in the countryside, usually considered the compulsory two-year service to be transitory after which they planned to leave their place of work to start private practice. This ultimately affected the quality of their work and led to the exploitation of the

patients.<sup>34</sup> Secondly, since the doctors were allowed to practise privately at the same time as they were required to fulfil their public obligations, the state jobs suffered further, in terms of time and effort and in the countryside as well as in the city, for the doctors focused on the more profitable, private side of their practice.<sup>35</sup> As Shukrallah puts it ‘utilising the public sphere for private patients became the rule rather than the exception.’<sup>36</sup>

A book that carries the title ‘*People and Medicine in the Middle East*’ discussed such a phenomenon and talked about the dreams of doctors and how they perceived their job. It argued that most medical graduates pay attention to their private clinics which they prefer to have in the capital city. When asked why they chose to become doctors, the majority answered ‘to get rich’ while only the minority replied that it was for ‘the desire to serve humanity.’ This latter answer, the book explains, was usually met with sarcasm from the colleagues.<sup>37</sup>

The material desires and ambitions of the doctors as well as the rejection of the position most doctors had as civil servants, especially in the countryside were aggravated when salaries became stagnant and prices rose. Especially after the *infitah* (open-door policies introduced by Sadat), when the state gradually started to decrease its expenditure on public services and focussed more on private investments, the salaries soared even higher. While the contradictions were already present during the Nasserist era, they magnified during Sadat and, later on, the Mubarak era, partially because enough years passed for the contradictions to appear but also due to policy changes.

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### **The *Infitah* and Healthcare**

The ‘open-door policy’ implemented in the late seventies started encouraging foreign investments in Egypt. The door was also opened to private investment in hospitals. The argument given then was that such hospitals would attract patients from abroad, especially the Gulf, and would encourage health tourism which would generate money for the economy.<sup>39</sup> This ultimately established the view of the medical profession as a profit-making machine.

The switch of alliance from the Soviet Union to the United States no doubt played a role in policy switch too. Correspondingly, with the signing of the peace treaty with Israel, the USAID invested a bulk of its funding in Egypt and about \$87 million were invested between 1977 and 1983 to be allocated to the population programme.<sup>40</sup> As Ali explains, the population programme was part of a much bigger agenda pushed through by the USAID as well as the World Bank, which encouraged the government to decrease its spending on public services and encourage private investments instead.

The population control plan was part of the argument that, if it was not for overpopulation, Egypt would not have poverty problems and logically everyone would afford private healthcare. It also went well with decreasing government spending since it argued that the smaller the family is, the better they can manage their budget without state help.<sup>41</sup> Introducing the population plan meant that the state was gradually shifting its responsibility on

to the individual. The programme, as Ali argues, was creating ‘new selves’ and ‘new bodies’. This state strategy continues up till today and has expanded more with the newly proposed health reform plan which proposes to switch all responsibility over to the private sector and the individual.

### Conclusion

There is an obvious link between the changing state policies and healthcare services. The healthcare sector, I would argue, is where the impact of the state’s system and policies becomes most clear and magnified. This is partially because it is a sector that cannot be neglected, since it deals directly with people’s lives and well-being and can work as a reflection of how well or not the system is functioning. Health services can also be a tool used by the state, in its different stages, to implement its control over the population, whether through compulsory services, as under the Mohammed Ali dynasty, or through people’s ‘free consent’ to its programmes, as under Sadat’s liberalised economy. Most importantly, the medical profession and the socialisation of the medical professionals largely depended on the state’s orientation.

This paper endeavoured to show how under Mohammed Ali the medical profession was shaped by French educational and medical culture. Under the British, the medical profession was largely socialised to become profit-oriented. Although the Nasser regime supposedly had a plan to ‘socialise’ medical healthcare and change healthcare from a commodity into a right, as stated in the 1962 constitution, it failed because it never challenged the profit-led orientation of the medical profession. Consequently, when Sadat, with the help of the World Bank and USAID, encouraged profit-making investments, he only furthered the profit-making orientation that already existed within the medical institution. His plan to cut down expenditure in the public health sector dealt a body blow to the concept of healthcare as a right as opposed to it being a commodity. Today, healthcare is primarily viewed as a commodity and the medical profession is mainly guided by profit-seeking. Plans for health reform are only a continuation, albeit an influential step, towards the enhancement of such a view. Consequently, as Farmer and Rylko-Bauer argue, when health is viewed as a commodity it is essentially compromised.<sup>42</sup> Therefore, stories of maltreatment of patients and their negligence become the norm rather than the exception.

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- 13 Shukrallah, *Politics and Health*.
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- 15 Mahfouz, *The History of Medical Education*, p. 38.
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- 18 Ibid., pp. 67-75.
- 19 Ibid., p. 68.
- 20 Ibid., p. 69.
- 21 Ibid., pp. 69-70.
- 22 Ibid., p. 77.
- 23 Ibid., pp. 77-78.
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- 25 Shukrallah, *Politics and Health*.
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- 28 Ibid., pp. 93-96.
- 29 Shukrallah, *Politics and Health*.
- 30 Ibid.
- 31 Shukrallah, *Politics and Health*; Chiffolleau, *Medecines et Medecins*.
- 32 Shukrallah, *Politics and Health*.
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Picture Source: All sites accessed on 7 March 2011.

1. <http://www.the-american-interest.com/images/issues/v2/n5/Sicherman3Big.jpg&imgrefurl>
2. [http://www.museum-grenoble.fr/collections/personnes/Antoine\\_Barthelemy\\_Clot.html](http://www.museum-grenoble.fr/collections/personnes/Antoine_Barthelemy_Clot.html)



## An Assessment of the Conflicting Positions of the Settler Farmers and the Veterinary Department in Southern Rhodesia Over East Coast Fever (1901-1920)

This study unpacks and assesses the conflicting positions of the settler farmers and the Veterinary Department in Southern Rhodesia over East Coast Fever. It does not seek to give an exposition on the aetiology and epidemiology of the disease but discusses its different conceptualisations by the parties to the conflict. The study demonstrates the general ignorance that pervaded the territory, both among the farmers and veterinary officials and how this created a fertile environment for conflict. It argues that these conflicts had a paradoxical effect, on the one hand, they acted as obstacles to the eradication of the disease but, on the other, they spurred further research on the aetiology of the disease and how it could be checked.



Wesley Mwatwara

Wesley Mwatwara is a full-time lecturer in the History Department at the University of Zimbabwe and has a special interest in the impact of colonial science on African healing methods. Email: [wesley@classicmail.co.za](mailto:wesley@classicmail.co.za)

## Introduction

The appearance of a new disease is a rare event as is the identification of a previously unrecognised disease. A serious new disease whether it affects human beings or animals of economic importance presents challenges to the public, to its government and scientists.<sup>1</sup>

This observation by P.F. Cranefield is a succinct description of what happens whenever a new disease breaks out. East Coast Fever (ECF) is one disease that accounted for very large numbers of cattle casualties in Southern Rhodesia<sup>2</sup> from 1901. While it presented economic challenges to the farmers, it offered a different challenge to the Veterinary Department. Veterinary scientists (vets) had to delve into more research in an attempt to understand its aetiology and epidemiology. Despite sharing a common goal of eradicating ECF, the settler (white) farmers and veterinarians differed on how that could be done; hence the conflicts. It is the purpose of this study to examine these conflicts and to argue that the bickering between the two parties largely account for the continued existence of the disease.

What gave birth to the conflicts were the cattle restocking efforts by the BSAC (British South Africa Company) following the Rinderpest epidemic of 1896.<sup>3</sup> After the Rinderpest disaster, the state imported 1000 cattle from Australia in 1900 through the port of Beira in Portuguese East Africa. However, due to transport problems, they could not be immediately ferried to Southern Rhodesia. While at Beira, many of them died of what later turned out to be ECF. The few that remained were transported to several farms in Umtali and Marandellas and, from these areas, the disease spread quickly throughout the colony. In October 1901, 48 cases were reported in Umtali and 112 cases in Melsetter.<sup>4</sup> By January and April 1902, it had reached Salisbury and Bulawayo respectively. Since the disease had been brought by cattle imported by the government, the farmers always blamed it for having brought the disease into the country.



A Casualty of East Coast Fever

## 'Ill-informed' Farmers Versus the 'Inefficient' Veterinary Department

Identifying a new disease, accepting that it is indeed new and, worse still, finding a remedy have always been difficult stages in the history of diseases. During the first ECF outbreak, the fact that the disease was tick-borne was not a contested issue. Instead, debates centred on whether this was a new disease or not. The settler farmers were quick to point out that this was a new disease whereas the veterinarians maintained that it was not but was just a virulent form of red water.<sup>5</sup> Interestingly, when the disease first broke out in 1902 in the Transvaal, the vets argued that this was a new disease while some farmers argued to the contrary.<sup>6</sup> That the disease got contrasting interpretations in two neighbouring territories calls for an explanation.

The reason is that in Southern Rhodesia, the disease came disguised as red water and even showed all the signs of red water under the microscope. Thus, the veterinary scientists concluded that it was red water. As for the view of some farmers, one can say that they must

have realised that though the new disease had all the characteristics of red water, unlike red water cases no animal survived the new disease. It is not surprising that in the Transvaal veterinary scientists were arguing that the disease was new because most of them, such as W. Robertson and A. Theiler, had studied the 1901 Rhodesian outbreak in detail. In fact, it was Robertson that the Rhodesian government first called for scientific advice. Between 1903 and 1904, A. Theiler worked with R. Koch at Bulawayo in Southern Rhodesia.

These differences delayed the implementation of 'curative' and preventive measures. Before the Veterinary Department could accept that this was a new disease, the disease thoroughly entrenched itself in several districts. By 1904, the disease had already decimated 20,000 European cattle and this meant that as long as the disease remained uncontrolled, efforts at restocking cattle in the country were impractical.<sup>7</sup> The period after 1910 was not any better as ECF outbreaks became more frequent. There were 111 new cases of ECF between 1911 and 1917 as compared to forty between 1906 and 1910.<sup>8</sup> Even though there was this escalation in the incidence of the disease, in relative terms, Southern Rhodesia was better off than the Union of South Africa which in 1913 alone recorded 329 new outbreaks.<sup>9</sup>

In cases where the disease was discovered after cattle had died or large herds had been infected, farmers castigated the veterinary officials for their 'failure' to diagnose it. On the other hand, the vets felt that their efforts were not to be criticised because the farmers were not custodians of 'scientific' knowledge on bovine diseases. This mentality can be discerned in the 1910 report of the Director of Agriculture in Southern Rhodesia,

During the year, much public attention was centred upon the Veterinary service of the country and as usual, in such cases, much criticism has been offered by well intentioned but ill-informed public and private bodies. ... quite impracticable measures were strongly advocated by irresponsible men.<sup>10</sup>

While the farmers' arguments were sometimes wrong, the director's sentiments as reflected above smacked of hypocrisy because at that time the veterinary officials too were ill informed on the aetiology and epidemiology of ECF.

The settler farmers emphasised their 'right' to criticise the Veterinary Department. However, at a purely scientific level, this was largely unfair. Scientific solutions are not the same as instant coffee and are, therefore, bound to take time to be of any effect. The vets deserved time to study the disease before they could produce any remedy. Nevertheless, at an economic level, one may forgive the farmers for their impatience. Many of them had invested all their financial resources in the cattle industry and they, therefore, stood to lose if a remedy was not found immediately. Resultantly, the need to use whatever methods were available to control this disease, whose aetiology or epidemiology was not fully understood, led to an unsatisfactory situation that success or failure was, in reality, due to factors whose existence was not fully appreciated. What can be said with certainty is that this situation, where ignorance reigned supreme on both sides, offered a very fertile environment for bitter conflicts. Valuable time was lost as the two parties struggled to find common ground. Whenever they agreed on a particular issue, other conflicts would emerge. This meant that the disease always had a head start.

Some of the farmers' criticisms threatened the dignity of the whole veterinary profession. For instance, they severely castigated the government's appointment in 1909 of a veterinary surgeon who, despite having carried out several tests on the cattle for two months, had 'failed' to diagnose the disease at Springvale farm in Marandellas.<sup>11</sup> For those two months, the Springvale farm-owner argued that the disease was not red water but ECF while the

veterinary surgeon argued in the contrary. The basis of the farmer's argument was that where red water broke out some cattle recovered, yet on his farm none had. While this might have been mere coincidence that the farmer had 'diagnosed' the disease when the vet had thought otherwise, this had serious repercussions on the farmers' attitude towards the Veterinary Department and, in turn, created new conflicts.

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In view of the Springvale case, one might, at face value, conclude that the vet was indeed guilty of having 'failed' to deal with the disease and in preventing further outbreaks. However, it would be doing injustice to the issues at stake if the case is not examined keeping in mind the veterinary situation prevalent not only in Southern Rhodesia but also in the whole world during that time. The ECF outbreaks received significant attention of the veterinary scientists from all over the world especially from the major cattle importing and exporting areas such as Australia, Argentina, France, Britain, Germany, United States of America and the Cape. Thus, throughout the world vets were closely following the progress of the disease but none of them was able to unlock the real mystery surrounding the disease. Of course, in Southern Rhodesia the settler farmers were also in the dark and no meaningful scientific suggestions came from them.

The above discussion proves that East Coast Fever was far more sophisticated than the veterinary practice of the time. What R. Koch and A. Theiler (veterinary scientists) had proven was that the disease was tick-borne but that was hardly enough. There was need to unravel the link between ECF and red water but this never happened during the period under study. The puzzle not known then was that red water and ECF parasites are both seen in red blood cells, sometimes in the same red blood cell, each capable of destroying the cell.<sup>12</sup> Thus, here were, 'two distinct parasites, transmitted by the same tick, two diseases caused by the bite of the single tick, one disease arising in a few days and the other only after some weeks.'<sup>13</sup> Therefore, it will be unfair to apportion blame on the Veterinary Department for having failed to do something which was not scientifically possible under the prevailing situation.

Regardless of the general acceptance that the brown tick was the medium of transmission of the ECF disease, conflicts existed on why the infected ticks had become so widespread in the country. Several theories were advanced by the farmers for this. They suggested the conveyance of infected ticks on the bodies of other animals, birds and on the clothing of human beings. All these were not accepted by the vets because scientific knowledge of the day taught that once an infected tick fed on a mule or any other domestic animal besides cattle it lost its infection.<sup>14</sup> The possibility of infected ticks having been spread by birds or human beings was very slim and this fails to adequately explain why the disease after having occurred at Umtali in 1908 broke out at Marandellas, many miles away. The possibility of a tick sticking onto a dog, mule or even a bird without feeding on it over such a long distance was highly questionable. The increased number of ECF outbreaks after 1910 made the transmission of infected ticks a heavily contested issue. Notwithstanding a barrage of criticism, the Veterinary Department remained adamant that though the farmers' views were theoretically possible, they were practically impossible. What one can say is that the bickering by the

farmers over the conveyance of the infected ticks reflects one thing about human nature, that is, when offered a fact that goes against their instincts they will refuse it even in the face of overwhelming evidence. The demands demonstrate the disillusionment among the farmers, which was rooted in what they considered to be the undermining of their ideas by an administration that appeared not to care about their concerns and troubles.

Despite noting that the vets were unfairly accused it should be stated that they were not always innocent victims of the farmers' accusations. Sometimes their ineptitude proved costly to the farming community. For instance, in 1920 they did not respond quickly to deal with ECF outbreaks at Matopos, Clearwater, Melsetter, Mazoe and Penhalonga. What makes this charge credible is that at Clearwater cattle had started to die of ECF in December 1918 but there never was any cattle inspection at the farm by the vets despite having been notified.<sup>15</sup> When they finally arrived they could not find any evidence that there was ECF and even permitted the movement of sixty cattle to one Newitt's farm in Mazoe. When the disease finally manifested itself, a large number of cattle had already been contaminated. Therefore, had there been effective cattle inspection at Clearwater, the infected cattle would not have been moved to Mazoe.

When the disease first broke out in 1901, cattle movements were not strictly monitored in southern Rhodesia just as in the Transvaal. This was partly because cattle movements were not yet recognised as a way through which the disease was spreading. However, when this was discovered, cattle movements began to be monitored through the permit system. Several forms of cattle movements were considered and these were: Movement of cattle by cattle dealers, ox transport by the farmers and miners, and the transport riders. All parties agreed that the unrestricted movement of cattle was partly responsible for the escalation of the ECF outbreaks in the colony. However, in a country where cattle offered the most common form of transport for private and business purposes, restrictions caused conflicts.

Differences centred on what could have been done/ could be done to monitor cattle movements. The farmers laid the blame on the Veterinary Department for its 'failure' to manage cattle movements in the country. The permit system, with its inherent weaknesses, bore the brunt of the farmers' vitriol. Then, when one needed to move cattle from one district to another, a cattle permit had to be issued. However, the settler farmers showed considerable contempt towards the permit system. For instance, J. Meikle argued,

Suppose one man had two wagons, he might get a permit for a span of white animals and might come in tomorrow with a span of black ones... even if a man had a permit and a policeman asked for it he could not tell anything from it, for it simply states that a permit was given to so and so for fourteen oxen. They maybe white today and black tomorrow.<sup>16</sup>

It is apparent from the above statement that the permit card was poorly structured. It was going to be more workable if the Veterinary Department had introduced a permit card with conclusive details of the cattle such as, number, colour, breed, size and a district brand. As it was, it was only workable in theory. In practice, especially in areas which were relatively free from the disease, it usually degenerated into mere formality. Permits were issued without cattle inspection hence cattle dealers and ox transport riders capitalised on these weaknesses thereby worsening the situation.

Having fully appreciated the dangers posed by random cattle movements, the Veterinary Department imposed restrictions in several districts and periodically threatened to call for a general stoppage of all cattle movements throughout the country in clean and unclean areas

alike. For instance, in 1910 there was outright stoppage of cattle movements in Goromonzi, Mazoe, Marandellas, Insiza, Mzingwane, Gwanda and Tuli.<sup>17</sup> These restrictions and calls for the stoppage of all cattle movements, even in clean areas, did not endear the Department to the farmers. Restrictions caused great worry among the settlers than the actual deaths. This was a contradiction in settler thinking because, on the one hand, they advocated the eradication of ECF and, on the other, they hated measures taken to eradicate it, especially where they threatened their interests.

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The Veterinary Department regarded the complete replacement of ox transport by mules and donkeys as the best way to curb the spread of ECF. The idea was first brought out at an inter-colonial Veterinary Conference in 1904 where the use of camels and donkeys was raised but was rejected on financial grounds.<sup>18</sup> Mules and donkeys, which the Veterinary Department was advocating, are immune to ECF which affects bovines only. While the idea was scientifically sensible, it was unpopular among the farmers. Citing high mortality rates, farmers emphasised the unsuitability of mules and donkeys for Southern Rhodesia's climatic conditions. Worse still, this provision was called for when there existed no bacteriological station for the provision of inoculants. Furthermore, many farmers had invested heavily in ox transport. Hence the shift to mules and donkeys would have affected their productive activities. Evidence by R.G. Snodgrass of Umtali clearly shows how the shift had affected his farming and ruined his mining operations. He lamented that,

It affected me to the tune of £1,500 when I was changing from ox to mule transport. I could not get timber and I lost several of my principal adits for want of timber and besides I had 1,200 boys hung up because I had no work for them to do.<sup>19</sup>

Mules had to be imported and needed time to acclimatise upon their arrival in the country before being put into use. They were also susceptible to horse sickness. Donkeys were unpopular because of their unsuitability for heavy work.

Though the ECF situation was serious enough to merit strict measures, on this issue the Veterinary Department's position was unrealistic. Considering the importance of ox transport to the Rhodesian economy, its outright curtailment and subsequent replacement by mules and donkeys would have been heroic but in all aspects suicidal. That ox transport was indispensable is highlighted by the fact that as late as 1926 the Roads Department, for instance, had 326 scotch carts, 2262 oxen, 126 mules and only six motor lorries.<sup>20</sup> Probably what the Veterinary Department needed to emphasise was the strict control of ox transport and opening the main transport routes under strict measures for mining, agriculture and trading activities. Of course, this would only work with the maximum co-operation of the farmers themselves.

For lack of, and inability to appoint suitable men, the colonial government, to the chagrin of the farmers, used Native Commissioners (NCs) as acting cattle inspectors. The farmers wanted the appointment of competent cattle inspectors who were entirely under the Veterinary Department. Despite their problems, the administration was inimical to any

criticism. The senior veterinary officials rarely acknowledged the staffing problems facing their department. Amidst strong denial, Sinclair unwittingly revealed that the cattle inspectors were overwhelmed by the tasks they had to undertake,

Our staff is large enough to deal with the disease in the country but the greater part of our work is on the issue of cattle permits ... many of our cattle inspectors consequently hardly leave their stations because if they are away for a week they would have twenty farmers in for permits and no one to issue them there.<sup>21</sup>

There was a critical shortage of cattle inspectors and veterinary surgeons in many parts of Matopos, Bubi and Nyamandlovu.

Their lack of veterinary expertise notwithstanding, NCs had a myriad of tasks. Hence they did not have adequate time to work on ECF cases. As such, some veterinary duties, even those which required little or no expertise were not performed satisfactorily. One farmer, E.J. Berry, brought this out more clearly,

There are a number of Greek traders going out into the district and they come to the NCs and say I have traded in your district give me a permit. The NC has no time to go and see for himself where the cattle came from.<sup>22</sup>

This inadequacy had serious repercussions on the farmers' attitude towards cattle inspectors. Partly blinded by their arrogance and partly from the "atrocities" committed by the cattle inspectors, many farmers considered themselves as more knowledgeable than the veterinary officials. The mistakes made by the NCs cum cattle inspectors were considered to be representative of the general 'ignorance' that was said to pervade the Veterinary Department. Shortages of vets meant that those few who were available operated in enormous areas. In many cases, areas allocated to cattle inspectors were so large that they could not get around them easily. In turn this meant that vast areas were left without the supervision of a veterinary official for very long periods. Complaints, such as the one by R. Black who lamented that 'the cattle inspector was here only once in nine months', were, therefore, rampant.<sup>23</sup> Thus during those nine months, some parts of the district were largely unsupervised. Letters sent by cattle inspectors to their superiors are revealing on this aspect. One A.J. Nicholson explained;

In Mazoe I had a fairly large area and to go around it would take me three months and then there were one or two places I could not get to. I had about 96 dipping tanks in the area and if you went to one of these tanks everyday it would take you three months.<sup>24</sup>

This clearly demonstrates that cattle inspectors were overworked. The denials that characterised the upper echelons of the administration are highlighted by the Chief Veterinary Surgeon (CVS) who said, 'I do not think that the areas are too big, we have increased the numbers of cattle inspectors this year. It is not the duty of the government to go around looking for the diseases; it is the duty of the owner to report it.'<sup>25</sup> The CVS was not being truthful because even in cases where farmers wanted to make a report, there were times when there was no one to report to. Given this, it is justifiable to blame the absence of cattle inspectors for certain ECF outbreaks. In fact, the Committee of Enquiry (1920) revealed that at Matopos and Clearwater, the disease could have been discovered early had there been effective inspection.<sup>26</sup> The cattle losses of 1920 could thus have been lower because with ECF, when discovered early, the infection can easily be checked and mortality would be low.<sup>27</sup> What was required, considering the inadequacies of

the time, was adequate extension work by the Veterinary Department to enable farmers to spot diseases.



Considering that most of the men appointed as cattle inspectors had no prior veterinary knowledge it was necessary they were supervised closely for some time. This was rarely the case. Judging from the conduct of some cattle inspectors, farmers believed that they were not given instructions on their duties and that there was no supervision whatsoever to ascertain whether they were carrying them out effectively. In 1920, farmers demanded that cattle inspectors should move around with a patrol sheet signed at all farms they passed and then to make a report to the veterinary surgeon.<sup>28</sup> This provision was called for so as to make sure that the cattle inspectors did their duties properly. Contrary to this, the Gwelo District Veterinary Surgeon M.H. Kingcombe reflected popular thinking within the establishment when he said ‘if my cattle inspector comes back and says he has seen the cattle then I am satisfied that is genuine.’<sup>29</sup> Such a comment was unfortunate because these men lacked prior veterinary experience. In the absence of any facilities for training veterinary officials the Veterinary Department was forced to recruit laymen. However unleashing them to deal with a dangerous disease without even some basic on-the-job training was the greatest abomination. Attaching the new recruits to work under a veterinary surgeon or an experienced cattle inspector for sometime would have given them a good orientation. Unsurprisingly, the farmers were bitter about the arrangement as they felt that it was some kind of mutual trust that had caused massive negligence of duties by junior veterinary officials. Expressing his disappointment, one Glendale farmer lamented that,

I do not think that any written instructions are given to these cattle inspectors who are sent out. He maybe a new man who has never seen ECF ... I think that too far many instructions are given at the side of a motor car and there is no record.<sup>30</sup>

Farmers, thus, wanted cattle inspectors to have definite instructions on what to do when they suspected an outbreak.

Destruction of infected cattle was an issue of considerable debate. The Veterinary Department killed all infected cattle while the farmers felt that this could not be done without receiving compensation from the government. Whenever an outbreak was reported, the suspected herd was placed in a temperature camp where their temperatures were kept under surveillance by a cattle inspector. Animals that showed temperature rises were killed. Farmers did not trust the temperature system and alleged that there were other causes for temperature increases as well, such as injuries. However, it is unlikely that everywhere when temperatures were taken the cattle had injuries. This did not save their herds but prolonged the existence of the disease.



### Conclusion

Evident in this discussion are the conflicting positions of an over-expectant farming community and a financially incapacitated Veterinary Department over the ECF disease. Their conflicting visions over the future of the cattle industry in the wake of the East Coast Fever found expression in several debates which occurred during this period. The fact that debates were constantly shifting does not mean that the settler concerns were solved but that public opinion changed over time. Paradoxically, conflicts acted as brakes on the speed at which the Department could spearhead the eradication of the disease, but, at the same time spurred further research on the aetiology of the disease and how it could be checked. This study has also shown that in some cases the farmers expected the Veterinary Department to implement certain things, which were not scientifically, physically and financially possible at the time.

- 1 P.F. Cranefield, *Science and Empire: Coast Fever in Rhodesia and the Transvaal*, Cambridge University Press, Cambridge, 1991, p. IX.
- 2 This was the colonial name for present day Zimbabwe.
- 3 H.S. de Brujn, a Rhodesian farmer cited by S. Mandimika, “The Impact of East Coast Fever, or African Coast Fever on Colonial Zimbabwe Cattle Industry and State Response: 1901-1927”, B.A. Hons. Dissertation, Department of History, University of Zimbabwe, 1983, p. 2.
- 4 Cranefield, *Science and Empire*, p. 3.
- 5 *Ibid.*, p. 142.
- 6 *Ibid.*
- 7 V.E.M. Machingaidze, “The Development of Settler Capitalist Agriculture in Southern Rhodesia with Particular Reference to the Role of the State: 1908-1939”, Unpublished Ph.D. Thesis, University of London, 1980, p. 312.
- 8 Report of the Committee of Enquiry on ECF, 1917.
- 9 Cranefield, *Science and Empire*, p. 218.
- 10 NAZ RG4, Report of the Director of Agriculture, 1910, p. 7.
- 11 NAZ V1/2/6/2, Letter from the C.V.S to the Director of Agriculture on the discussion on Coast Fever at Mashonaland Farmers Association, 15 January 1910.
- 12 Cranefield, *Science and Empire*, pp. 279 – 280.
- 13 *Ibid.*
- 14 NAZ RG4, Report of the Committee of Inquiry in respect of African Coast Fever, 1920, p. 4.
- 15 *Ibid.*
- 16 NAZ ZAB 2/1/1, African Coast Fever: Oral evidence by J. Meikle, Umtali, 14 July 1910.
- 17 NAZ ZAB 2/2/1, written evidence by E. Nobbs to the ECF Committee 1910.
- 18 Cranefield, *Science and Empire*, p. 183.
- 19 NAZ ZAB 2/1/1, Oral evidence by R.G. Snodgrass (cattle owner and miner), Umtali, 14 July 1910.
- 20 A.S. Mlambo, “From Dirt Tracks and Modern Railways: Towards a History of Roads and Roads Transportation in Colonial Zimbabwe 1890 to World War Two”, *Zambezia*, 21, 2, 1994, p. 158.
- 21 NAZ ZAB 2/1/1, Oral evidence by J.M. Sinclair, 4 July 1910.
- 22 NAZ ZAB 2/1/1, Oral evidence by E.J. Berry (Mazoe Farmer), 7 July 1910.
- 23 NAZ ZAF 2/1/1, Oral evidence by R. Black (Gwelo farmer), 27 April 1920.
- 24 NAZ ZAF 2/1/1, Oral evidence by A.J. Nicholson (Glendale cattle inspector), 10 May 1920.
- 25 NAZ ZAF 2/1/1, Oral evidence by J.M. Sinclair, 10 May 1920.

**26** NAZ RG4, Report of the committee (1920), p. 4.

**27** J.P. Hamilton, "African Coast Fever: Who is to Blame?" *Rhodesia Agricultural Journal*, 26, 1929, p. 828.

**28** NAZ ZAF 2/1/1, Oral evidence by H.P. Finn (Bulawayo farmer), 21 April 1920.

**29** NAZ ZAF 2/1/1, Oral evidence by M.H. Kingcombe, 27 April 1920.

**30** NAZ ZAF 2/1/1, Oral evidence by R.S.P. Newitt (Glendale farmer), 10 May 1920.

Picture Source: All sites accessed on 7 March 2011.

1. <http://www.flickr.com/photos/ilri/3950197516/sizes/o/in/photostream/>

2. [http://nv.wikipedia.org/wiki/E%CA%BCelyaa%C3%ADg%C3%AD%C3%AD:Tick\\_jena.jpg](http://nv.wikipedia.org/wiki/E%CA%BCelyaa%C3%ADg%C3%AD%C3%AD:Tick_jena.jpg)

## Arts of Healing in Brazil in the First Half of the Nineteenth Century

This paper intends to analyse the relationship between healers and medical institutions focusing on the blood-letter's practice during the first half of the nineteenth century. The curing practices employed by these blood-letters and folk healers ranked low on the hierarchy of medical practices acceptable by the Fiscatura-mor. Quantitative data analysis demonstrates a link between these practices and underprivileged social positions.



Tânia Salgado Pimenta

Tania Salgado Pimenta is a researcher and professor of Casa de Oswaldo Cruz, Fundação Oswaldo Cruz, Brazil. Her M.A. and Ph.D. in History focus on public health and relationship among popular therapeutics and official doctors in nineteenth century Brazil. She is a professor at the Instituto de Saúde Coletiva of Universidade Federal da Bahia and member of the Board of Health, Science, and Society, a section of Latin American Studies Association. Presently she is involved in the project Health and Development in Africa and the African Diaspora: Benin, Brazil and the British Caribbean during the second half of the nineteenth century, sponsored by SEPHIS. Email: [taniaspimenta@fiocruz.br](mailto:taniaspimenta@fiocruz.br)

### The Era of the Fiscatura

In 1808 the Court of D. João VI went to Brazil because of Napoleon's invasion of Portugal. Therefore, many institutions had their headquarters transferred to Rio de Janeiro. Among them was the 'Fiscatura-mor', a bureau responsible for regulating all medical practices and giving permission to anyone who wanted to practise the healing arts.

The Regiment of Chief Physicians was created in order to supervise its representatives in the exercise of their functions in 1810. There was a division of responsibilities separating medical practices related to the prescription and fabrication of remedies, which fell under the jurisdiction of the Chief Physicians, and medical practices related to surgical interventions, which fell under the jurisdiction of the Chief Surgeons.

These practices were quite varied: In addition to letters for doctors, surgeons, apothecaries, dentists, blood-letters, midwives and folk healers, there were also licences for the treatment of specific illnesses such as alcoholism and leprosy. However, a licence to cure alcoholism did not carry the same prestige as that of possessing a "doctor's letter", for example. There was, in fact, a hierarchy of healing practices implemented by the institution— and the blood-letters, tooth pullers, folk healers, midwives and healers of specific illnesses were considered, according to the Fiscatura, as practitioners of less prestigious occupations than those of doctors, surgeons, and apothecaries.



Barber Shop

People of the subaltern social positions— women, slaves, and emancipated slaves— occupied these less prestigious categories. Therefore, the distribution of authorisation letters would occur in accordance with the social and economic differences within society. Granting titles, in turn, reaffirmed the greater or lesser prestige of the people who received them.

The doctors, surgeons and apothecaries considered their professions superior to that of popular healers but did not totally disqualify the latter, since their knowledge of the region's natural resources was well recognised. The officialisation of the folk healing practices meant the acknowledgement that this kind of knowledge was legitimate; it would permit the inclusion of popular healers among those people authorised to exercise some form of healing practice. Thus, in the context of a society in which social relations functioned through complex ties of dependence on people to grant favours, loyalties, obedience and protection,<sup>1</sup> such favours often materialised in the form of nominations to public offices, privileges afforded to a person in the bureaucratic process. This system of dependencies encompassed everyone from the highest rung of the social hierarchy— the King or Emperor— to that of the most inferior, such as those among the officials of the Fiscatura, who could facilitate obtaining a licence for a healer whom he knew personally.

This paper intends to analyse the relationship between healers and medical institutions focusing on the blood-letter's practice during the first half of the nineteenth century. The primary sources are official correspondences, legislation and documents related to the process of officialisation of medical activities. There are not many studies in the history of medicine in this period. Indeed, most of them, focusing on the medicalisation of the Brazilian society, give

to academic doctors a power that they in fact did not wield.

### Popular Healing Practices

During the twenty years of the Fiscatura's functioning (1808-1828), around 1,300 requests for healing licences originated in Brazil, a figure that represents seventy per cent of the total. The breakdown of this data shows the following: The profession that sought most officialisation in Brazil was that of the surgeons (thirty per cent), followed by apothecaries (29 per cent), blood-letters (sixteen per cent), those licensed to heal using practical medicine (surgeons who had authorisation to prescribe medicines) (fifteen per cent), midwives (five per cent), doctors (three per cent) and healers (two per cent— included in this category are those licensed to heal specific ailments). These numbers diverge radically from those evidenced through other sources, such as travellers' records, the newspapers and the correspondences between authorities, which refer to the presence of these healers disseminated throughout Brazil.

As this institution understood it, popular healing practices that could be legalised were those that could be made to fit into already established categories, in which activities were clearly delimited. Popular healing practices were much more diverse than the Fiscatura's classification categories. Thus, the midwife must only assist in childbirth, while the folk healer must restrict himself to healing the most common illnesses with native medicinal plants. However in reality midwives prescribed medicines and the folk healers, many times, would attend patients whom the doctors were unable to cure.

It can be seen in this way that blood-letters did not restrict themselves to bleeding, they could also act as healers, diagnosing, prescribing and even preparing medicine. Moreover, blood-letters carried out a widely diffused activity that could move between and bring together concepts from academic and popular medicine. Bleeding, so often practised by individuals from disadvantaged social groups, could have for these individuals a much different significance than it had for doctors. To a certain extent the blood-letter illustrates the permeability between the two poles of medicine— academic and popular.

Popular medicine as discussed here differed from academic medicine principally in the social class that practised and utilised it. Popular cures were practised by slaves, manumitted slaves and the free poor, while those who practised academic medicine were, in general, men of economic privilege. Whatever their form, official therapeutic practices inherited from their European forbearers conceptions of illness and healing which were classified according to the type of ailment and specific methods of therapy. They also had in their favour the fact that they were exercised by men of higher social standing who had the power to prohibit practices that differed greatly from their own preconceptions. But the relationship between the two was not as simple as that of domination by one side and resistance by the other. Some medications held in high esteem by academic doctors could have been used by the practitioners of popular medicine and certainly the opposite happened as well. Beyond this, patients of the dominant class had recourse to the remedies of popular medicine, prescribed by practitioners from the popular classes not only because of the scarcity of academic doctors but also because of the recognised efficacy of these remedies, although we cannot speak of a state of reciprocity since the population in general did not have much access to official medicine.

The official apparatus put in place never had enough resources either to officially recognise all those whose work was in compliance with legal definitions of legitimate practices or to curb those activities considered illegal. This is a conclusion that has been drawn in different studies of healing practices in different contexts, especially in the eighteenth and early nineteenth centuries.<sup>2</sup>

Therefore, we assert that healers, blood-letters and midwives did not concern themselves much with authorisation of their activities. Probably many of them were not even aware that they were working illegally. And those who knew of the existence of the Fiscatura did not see any advantage in procuring a licence or letter that conceded the “right” to put into practice their knowledge.

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Medical Practitioner

### Blood-Letters

Petitions to exercise the art of bleeding were simple affairs, but it is possible to identify certain interesting characteristics. Possession of an official letter granting licence to practise bleeding was a prerequisite for those who wished to take the exam in the art of surgery.<sup>3</sup> Of all petitions for bleeding, 79 per cent came from Brazil,<sup>4</sup> where the profession was largely practised by slaves (manumitted or not) in 84 per cent of all cases (which corresponds to 101 slaves and 63 manumitted slaves in 193 petitions). Moreover, slaves and freed blacks were almost always blood-letters, since they could not aspire to the higher healing professions within the principles established by the Fiscatura.

The art of bleeding— a healing practice that was a small component within the larger arts of surgery— involved incision, the application of leeches and other instruments such as cupping glass or horn to facilitate bleeding. Since the documentation produced by the Fiscatura does not include explanations of the therapeutic practices employed, we must rely on those of contemporaneous observers, such as the Reverend Walsh, who noted the prominence of blacks in this occupation:

For rheumatic pains, they use the singular method of leeches, which are generally applied by a black. One day, while passing in the street behind the Palace, I saw a black doctor applying this treatment to some patients seated in the steps of the church. He bound the arm and shoulder of a woman who appeared to be in terrible pain, and, making small incisions in various places with the point of a razor blade, he began to lightly tap in these places with the flat part of the blade until the blood began to flow. He then placed small cupping made of horns on the wounds and, placing his mouth on an opening in the end of the horn, deftly extracted the air from its interior and closed the opening with clay, leaving them firmly pressed to the skin. When they were removed, the arm was covered in blood and the woman said that she felt great relief.<sup>5</sup>

Bloodletting was much used in Europe, and in Brazil it had been practised since the sixteenth century in an equally indiscriminate manner, being recommended for almost all illnesses. Moreover, some indigenous communities routinely practised scarification and bloodletting, usually of the front or thigh veins, and more rarely on those of the elbow. The instruments used to cut were animal teeth, birds' beaks, bamboo slivers, rock crystals and knives (after the onset of commerce with the Europeans).<sup>6</sup>

The majority of people who worked as blood-letters were Africans (64 per cent), while 21 per cent had been born in Portugal and thirteen per cent, in Brazil. Among the Brazilian-born, the largest part were slaves and freed blacks, being descendents of Africans. Thus, we may guess that more highly socially placed Brazilians and Portuguese first obtained a licence in bloodletting in order to later take the exam in surgery.

An official letter from the Chief Surgeon José Correia Picanço, dated September 1820, and addressed to the councillors of the Senate Chambers of Court (Senado da Camara da Corte) may help us better define the social group that practised this medical specialty. Justifying the reasons why slaves should be allowed to practise the art of bloodletting and pulling teeth, Picanço explained that more highly positioned members of society ought to relegate the profession of blood-letter to slaves.<sup>7</sup>

Blood-letters who worked in the streets and squares charged less for their services of bloodletting and barbering than those who attended clients in shops, and they perhaps constituted the majority of those who practised the art of bleeding.<sup>8</sup> They did not officialise themselves for the most part because their clients did not demand it, and their methods of working facilitated the avoidance of those who would check. For this reason, perhaps the majority of blood-letters who applied to the Fisicatura for licences worked in shops, typically belonging to blacks or mulattos. According to Debret<sup>9</sup> many times freed blacks employed slaves themselves, whom they taught as apprentices,<sup>10</sup> a fact that is confirmed by the analysis of the documentation.

It was not difficult for freed slaves to purchase and maintain their own slaves while the continuing Atlantic trade kept their purchase price relatively low, a fact that changed after 1850, when prices for slaves soared. In the urban centres as well as in rural areas, the free poor and freed slaves tended to invest in goods, cows, jewellery and money and, principally in cities, in *negros de ganho*. As a result, freed slaves who had been *negros de ganho*, as was the case for barbers and artisans, bought and trained other slaves to assist them in their work.<sup>11</sup> Although the practice of the art of bleeding was concentrated in the lowest social levels, there were no such class restrictions on the people who sought their services. In many of the letters of support accompanying the petitions for licensure as a blood-letter, we find surgeons affirming that the supplicant had bled many of their own patients. However, principally in places remote from urban centres and among the poorest sectors of the population, the petitions alluded to the fact that often, in the exercise of his profession, the blood-letter surpassed the limits imposed by his licence, serving as a healer.

### Return to Africa

Apart from earning a livelihood in the plazas and streets or in a shop, a blood-letter may also have tried to make extra money by exercising his services on ships, especially slave ships. In general, blood-letters who worked on ships were not required to take an exam, and they did not receive an official letter permitting them to practise. Instead, they requested a provisional licence which permitted them to exercise their profession during the period of the voyage they intended to take.

The owners of slaves who knew how to bleed made arrangements with owners of ships embarking to the East Coast of Africa in order that their slaves should be permitted to care for the newly-captured Africans who would be brought back. At times, the owner of the slave and that of the ship was the same person. These black blood-letters constituted the only medical assistance that the Africans would receive both during the voyage to Brazil and once they had disembarked there.<sup>12</sup>

The slowness of the process of officialisation as opposed to the regularity with which new ships sailed for Africa was also cited along with the impossibility of taking an exam. However, often, the licences were granted in rapid succession to the same blood-letter, suggesting that these were merely excuses, duly accepted by the Fiscatura in order to conserve finances by foregoing officialisation<sup>13</sup> or by performing fewer bureaucratic procedures to save time. It also happened that a blood-letter would be assigned many voyages, of which I could find no trace in the register of their licences, as happened with the majority of those who alleged that they had had this experience, suggesting that this was later required when the bureaucratisation became more rigorous, as seems to have happened in 1828.

Among the petitions for blood-letters working on ships, 75 were related to voyages to Africa, constituting 29 per cent of the total registered by the Fiscatura. The majority of those who travelled officially were slaves, among whom some had originally been brought from the East Coast. But there were also freed slaves who were employed in this work— including freed Africans. Africans were probably sought after for this work, since there was a strong possibility that they could more easily communicate with the recently-acquired slaves.<sup>14</sup> And, on their part, as freed slaves, they may have considered this work to be a form of recompense.

But communication between Africans was not limited solely to the level of linguistics. Particularly as regards the centre-south of Brazil, where African slaves came mostly from the centre-west of Africa, we can say that the Brazilian and African slaves shared elements of the same cultural complex, having similar notions of ancestry and cosmology. Among these was the idea that imbalances, misfortune and illness were caused by the malevolent actions of spirits or of persons, frequently through the action of witchcraft or spells.<sup>15</sup> And this suggests an important source of support that these blood-letters could have provided for the newly-enslaved Africans on the slave ships.

Many of the slaves who worked on the slave ships had been brought from Africa in the same way as the Africans they now had to treat. But, what we do see in the documentation are successive petitions for licences to travel to the East Coast of Africa made by the same blood-letter, whose history, although limited to the data recorded by the Fiscatura, can be traced out in brief as being an African who arrived in Brazil via a slave ship, who probably learnt his craft in Brazil, and who returned to Africa as a blood-letter in order to treat newly-captured slaves, and later returned to Brazil.

We find this general scenario to be true in the case Vicente José Coelho, an African blood-letter who thought it indecorous to continue his work with a letter stating that he was a slave when he had already been freed.<sup>16</sup> He began to teach others this profession and in 1827 he provided a signed testimony for his disciple, the freed slave Manoel, an African of the Cabinda nation, to receive a licence for one year of travel to the East Coast of Africa, promising to complete the exam upon his return with the money he would make.<sup>17</sup> In 1828, he testified for another African petitioner, Afonse of the Congo nation, to achieve a licence for travel to the East Coast of Africa.<sup>18</sup>

One of the overlaps in the documentation of the Fiscatura presents us with some information on the relationships constituted by or reinforced through the apprenticeship of a



blood-letter, which may have contributed to the decision of an African to remain in Brazil. Joaquim da Silva Senna, a mulatto, took the bloodletting exam in December 1811, and was approved, but with the delay in receiving his official letter, he petitioned for a licence that would allow him to journey to Africa while the official letter was being issued.<sup>19</sup> Ten years later, the name of Joaquim appears in the documentation again, this time attesting that Luís João Caldas, a freed Creole from the city of Luanda, had practised with him the art of bleeding for two years, ‘performing those types of bloodletting services that we offer, applying cupping glass and leeches and all the procedures that compose the aforementioned art, showing himself to be very cautious in performing his obligations ....’ Luís was approved, but did not claim his letter because he was leaving briefly on the brigand *Ligeiro* for Cabinda with a stop in Benguela, having received a licence for this trip. In 1826, Luís still did not have his official title in hand, ‘for lack of means’, and petitioned for another licence, which was granted on the condition that his official letter was no longer valid.<sup>20</sup>

At this juncture, Joaquim already owned a shop in the Court and there he continued to teach other disciples such as: João Ribeiro da Silva (who was licensed in May 1827), a freed black of the Mina nation; the African Gaspar (licensed in December 1827), slave of de Antônio José de Castro; and Januário, a black of the Angola nation (licensed in January 1828), slave of Francisco José dos Santos.<sup>21</sup> All of them presented an affidavit signed only by Joaquim (since none of them knew how to read or write) as a guarantee that they were capable of exercising the profession of a blood-letter— a specialty of the art of curing that, on land as well as on slave ships, was seen by many slaves and freed blacks as a viable option in the quotidian struggle to survive and to better their lives.

Among the petitions for blood-letters working on ships, 75 were related to voyages to Africa, constituting 29 per cent of the total registered by the *Fiscatura*. The majority of those who travelled officially were slaves, among whom some had originally been brought from the East Coast. But there were also freed slaves who were employed in this work— including freed Africans. Africans were probably sought after for this work, since there was a strong possibility that they could more easily communicate with the recently-acquired slaves. And, on their part, as freed slaves, they may have considered this work to be a form of recompense.

Although it was based on the well-respected, European theories of Hippocrates and Galen, the mechanical nature of the profession of bloodletting and its limitation to minor surgical procedures helps to explain, on the one hand, why the higher social classes held the profession in disdain. And, on the other hand, the predominance in this profession of slaves and freed blacks, among these many Africans, may be explained by the fact that this group saw in the profession, at least in the urban centres, an opportunity for accumulating wages— that is, a way to increase the possibilities of buying their freedom and bettering their lives. The knowledge of bloodletting was transmitted among those of the lower social classes and was thus reinterpreted according to their conceptions of illness and healing. The extant bibliography on the topic presents data that may be extrapolated into the hypothesis that the people who exercised these practices extracted from a European tradition and reinterpreted them according to their folk conceptions of illness and healing. Ewbank, for example, describes the practice of bloodletting as practised by Africans as an attempt to release malignant spirits, instead of the excess humours of the official medical view. On the other hand, some may have brought from Africa the techniques of bloodletting with cupping horns, as the practice was known among the Bakongo of West Africa, according to Karasch.<sup>22</sup>

### **The End of the Fiscatura**

Despite the small number of authorisation, the blood-letters, folk healers and midwives who wanted to, or felt pressurised by the officials of the Fiscatura to, legitimise their activities could do it. After 1828, this was no longer the case. In this year, the Fiscatura was eliminated and the activities relating to the authorisation and monitoring of the practice of healing remained without substitutes.

The end of the Fiscatura-mor heralded in a period of new relationships between the government, qualified physicians and popular therapists. One might argue that when popular therapists ceased to be recognised officially, this marked the decline of the official space given to folk healers and other popular therapists and the recognition their practices received. Yet, in any study of nineteenth century healthcare, one cannot ignore the fact that qualified medical practice was just one of a whole host of treatments to which the public, or part of it, had access. And it was not even the most popular, as many recent studies have shown.<sup>23</sup> It had neither the legal power nor the muscle to restrict other practitioners nor monopolise the healing arts.

Its elimination occurred within the context of the growing anti-Portuguese sentiment then in vogue, in which the Fiscatura came to be identified with Portuguese interests.<sup>24</sup> The government's response to the problem of authorisation and regulating healing practices was delayed. Only in 1830 did the question resurface. The Rio de Janeiro's Municipal Council determined that all physicians, apothecaries, midwives and blood-letters must have their letters (titles) registered in the Council.

Thus, the category of folk healers was not even considered. Knowledge about native plants no longer guaranteed the legitimacy of their practices. However, being ignored by the law did not necessarily weaken the healers, given that when there was a licence available for their work, they rarely bothered to get one.

In 1832, the blood-letters also had their practice affected by a law that transformed the medical-surgical academies into medical schools. These schools began conferring degrees of doctor of medicine, of apothecary and of midwife. From then on the title of blood-letter would no longer be conferred and the Council would no longer register the letters dispatched by the Fiscatura.<sup>25</sup>

These transformations occurred in an unstable political climate resulting from the process of independence from Portugal (obtained in 1822) and the provincial conflicts. At least until the end of the 1840s, no other laws were passed that specifically focused on the practice of bloodletting and healing. Independently of the legislation in force, their activities continued. Advertisements for their services did not cease to be published in newspapers and this indicates that the sale and rent of blood-letter slaves were not suppressed.

### **Conclusion**

The work of the Fiscatura did not have the same results in all categories of healers. The people who were specialised in medicine, surgery and pharmaceuticals submitted themselves to officialisation with a far greater frequency than blood-letters, midwives and folk healers.

However the analysis of the relationship between the institution and popular healers highlights an aspect of the Fiscatura's nature, its recognition of popular conceptions of illness and healing, derived from the recognition that popular healers possessed a legitimate knowledge. Folk healers were incorporated into the official system during the period of the Fiscatura rather than being simply tolerated. Even though the outward difference between popular and academic medicine was not very marked, especially in terms of the forms of treatment, such as the utilisation of medicinal plants and the practice of bleeding, the internal significance that these procedures held for each set of practitioners was probably quite different.

According to the discourse of the Fiscatura, popular healers were less knowledgeable and less competent. So, their activities were to be limited and regulated. But the general population believed in these healers. In addition, academic doctors were in small supply and charged highly for their services.<sup>26</sup> Popular healers, on the other hand, held more similar conceptions of illness and healing as those of their patients, and were also attuned to the spiritual dimensions attributed to infirmities.

The reason given by the Fiscatura for the granting of licences to popular healers was the lack of more qualified personnel—doctors and surgeons—available to treat the population. While popular healers were often said to exist in excess, doctors and surgeons available were very few. Thus, instead of imagining that there were many popular healers working only because there were few doctors, we can also consider that the existence of an adequate number of popular healers, to serve the population, restricted the activities of doctors in Brazil.

- 1 The Fiscatura, like others institutions of Brazilian society in that period emphasised the social hierarchy, insisted that each person had a particular place. Cf. Tânia S. Pimenta, “Barbeiros-sangradores e curandeiros no Brasil (1808-28)”, *História, Ciências, Saúde-Manguinhos*, 5, 2, pp. 349-374, 1998. See Richard Graham, *Clientelismo e política no Brasil no século XIX*, Ed. UFRJ, Rio de Janeiro, 1997, pp. 23-24.
- 2 Jorge Creso, *A história do corpo*, Difel: Lisboa, 1990. John Tate Lanning, *The Royal Protomedicato— the regulation of the medical professions in the Spanish Empire*, Duke University Press, Durham, 1985. Jacques Léonard, *La médecine entre les pouvoirs et les saviors*, Aubier, Montaigne, 1981. Luz Sáenz, *Learning to heal— the medical profession in Colonial Mexico 1767-1831*, Peter Lang, Nova Iorque, 1997.
- 3 But the number of blood-letters does not include those who were authorised to exercise the art of surgery.
- 4 The requests also came from Portugal and its others colonies between 1808 and 1822 because Rio de Janeiro became the headquarters of the Empire of Portugal during this period.
- 5 Robert Walsh, *Notícias do Brasil (1828-1829)*, Editora Itatiaia/Edusp: Belo Horizonte/São Paulo, 1985, pp. 177-8.
- 6 Lycurgo Santos Filho, *História geral da medicina brasileira*, Hucitec/Edusp: São Paulo, 1991.
- 7 Arquivo Geral da Cidade do Rio de Janeiro, codex 6-1-23.
- 8 Mary Karasch, *Slave life in Rio de Janeiro, 1808-1850*, Princeton University Press, Princeton, 1987, p. 203.
- 9 Jean-Baptiste Debret, *Viagem pitoresca e histórica ao Brasil*, Livraria Martins Fontes, São Paulo, 1940, p. 151. See images in the article.
- 10 Manuela Cunha, *Negros, estrangeiros— os escravos libertos e sua volta à África*, Brasiliense, São Paulo, 1985, p. 32.
- 11 See, Karasch, *Slave life*, p. 211; Cunha, *Negros, estrangeiros*, p. 24.
- 12 Karasch, *Slave life*, pp. 40, 194, 203.
- 13 A licence cost less than the exam and the official letter. Despite the fact that a licence was temporary, there was always opportunity for bleeders to embark without a licence or letter, as the majority appear to have done.
- 14 Specifically in the Centre-South of Brazil, slavery was characterised as African and Bantu. Even after 1810, when there was a greater variation of regions from where Bantu-speaking slaves came, linguistic similarities still permitted the use of a common lingua franca, as

demonstrated by Robert Slenes, “Malungu, ngoma vem: África coberta e descoberta no Brasil”, *Revista USP*, 12, 1991-92, pp. 48-67.

- 15 *Ibid.*, p. 58; Robert Thompson, *Flash of the spirit*, First Vintage, New York, 1984, p. 104.
- 16 Arquivo Nacional, Fiscatura-mor, Box 1212.
- 17 Arquivo Nacional, Fiscatura-mor, Box 1193.
- 18 Arquivo Nacional, Fiscatura-mor, Box 1198
- 19 Arquivo Nacional, Fiscatura-mor, Box 1209
- 20 Arquivo Nacional, Fiscatura-mor, Box 1191
- 21 Arquivo Nacional, Fiscatura-mor, Boxes 1210, 1198, 1199.
- 22 Thomas Ewbank, *A vida no Brasil ou diário de uma visita ao país do cacau e das palmeiras*, Conquista, Rio de Janeiro, 1973. Karasch, *Slave life*, pp. 264-5. See also Sidney Chalhoub, *Cidade febril – cortiços e epidemias na corte imperial*, Companhia das Letras, São Paulo, 1996, on different interpretations of questions related to health (specifically about smallpox and its vaccine) among diverse social groups in the nineteenth century.
- 23 Betânia Gonçalves Figueiredo, *A arte de cura – cirurgiões, médicos, boticários e curandeiros no século XIX em Minas Gerais*, Vício de Leitura: Rio de Janeiro, 2002. Gabriela Sampaio, *Nas trincheiras da cura: as diferentes medicinas no Rio de Janeiro imperial*, Editora da Unicamp, Campinas, 2002. Márcio Soares, “A doença e a cura– saberes médicos e cultura popular na corte imperial”, *Unpublished Masters Dissertation*, UFF, Niterói, 1999.
- 24 See Sérgio Buarque de Holanda, “A herança colonial– sua desagregação”, *HGCB*, II, 1, Difel, São Paulo, 1982. Regarding the identification of the Fiscatura with Portuguese politics, see Machado *et al.*, *Danação da norma– medicina social e constituição da psiquiatria no Brasil*, Graal: Rio de Janeiro, 1978, p. 157; Guilherme das Neves, *E receberá mercê– a Mesa de Consciência e Ordens e o clero secular no Brasil (1808-1828)*, Arquivo Nacional, Rio de Janeiro, 1997, p. 131.
- 25 Lei de 03/10/1832, *Coleção de Leis do Brasil*.
- 26 According to Goubert, in France at the end of the eighteenth century, doctors and surgeons with diplomas also confronted this situation. Jean-Pierre Goubert, “L’art de guérir. Médecine savante et médecine populaire dans la France de 1790”, *Annales– économies, sociétés, civilisations*, sept/oct, Paris 1977, pp. 908-926.

Picture Source: Author

# Exogenous Evolution in the Egyptian Pharmaceuticals Industry within a Global Landscape



Tarek H. Selim

Tarek H. Selim is Associate Professor of Economics at the American University in Cairo, Egypt. He received his School's Research Excellence Award (2006) and has been faculty affiliate to Harvard University's Microeconomics of Competitiveness (MOC) Network since 2008. He holds an MBA from Johns Hopkins University and Ph.D. in Economics (USAID Fellow) from George Washington University. He has completed professional programs from leading universities, such as MIT, Harvard, Georgetown, Imperial College, and Oxford. He has been consultant to numerous local, regional, and international organizations in the areas of market behavior, industry performance, competitiveness and strategy. Email [tselim@aucegypt.edu](mailto:tselim@aucegypt.edu)

The Egyptian pharmaceutical industry has gone through multiple stages. Each stage has certain historical characteristics and policy directions pertaining to industry development. Historically, one may say there has been a five-phase development of the industry: The start-up phase (1933-1961), nationalisation phase (1962-1975), an open-door phase (1976-1983), the phase of expansion (1983-1992), and the phase of privatisation (1992-till date). In the ongoing phase, marked by privatisation and the power of the multinational companies, public policy has been overwhelmed with increasing external pressures. Some experts claim that external pressures from multinational lobbying have hindered local progress and endogenous research and development (R&D). At the outset, multinational agencies had put political pressure on Egypt to privatise its pharmaceutical industry. This, in addition to Egypt becoming a new member of the World Trade Organisation (WTO), has forced patent policy to comply with the new rules of the WTO, including those related to the *Trade Related Aspects of Intellectual Property Rights* or TRIPS<sup>1</sup>, where a minimum of twenty years protection have to be applied from the day of filing for the patent application.

Moreover, passing of the privatisation law (No. 203 of 1991) involved a gradual privatisation of state-owned enterprises (SOEs), including all pharmaceutical firms. In addition, a new investment law (No. 8 of 1997) has

permitted the legislation for 100 per cent foreign participation in all types of business in the country and the gradual elimination of price controls and profit margin limitations. These combined laws and legislations have been seen by some experts as actual stimulants for Egypt's pharmaceutical industry, where Egypt now has approximately one-quarter of the world's one hundred largest multinational enterprises (MNEs) operating within its borders, including Bayer, Glaxo Wellcome, and Novartis. It is anticipated that more fierce competition, positive spill-over effects in innovation, supply chain externalities and cluster effects will produce a new pharmaceutical industry for the nation.

### **Competitive Landscape of the Egyptian Pharmaceutical Industry within a Global Perspective**

The general characteristics of the Egyptian pharmaceutical industry can be summarised as having the following attributes<sup>2</sup>:

- a size of US\$ 2 billion
- growth rate of ten per cent annually
- largest producer and consumer of pharmaceutical products in the Middle East and North Africa (MENA) region
- local production covers more than eighty per cent of the industry, with 85 per cent of the raw materials and ingredients imported
- 74 pharmaceutical factories producing over 7,600 different types of drugs
- Multinational companies supply 65 per cent of the market, of which thirty per cent is through direct production, while sub-licensing to local companies account for the remaining 35 per cent

There is a lot of scope for improvement in patent law in Egypt, with data protection and enforcement being major concerns. In January 2005, the TRIPS agreement came into effective force in the Egyptian pharmaceutical sector. However, there has been controversy over the implementation of the new intellectual property regime. It became obvious that full employment of TRIPS would raise the prices of the patent-protected drug by prohibiting or delaying their imitation, thereby forcing the government to either import or accept foreign firms as the sole source of domestic supply. In response, the Egyptian minister of health began to expedite the registration of drugs patented outside Egypt, for which an application had not been made in Egypt. In so doing, the ministry of health was clearly and strongly encouraging the registration of new generic drugs during the transition period. This policy brought the government under intense pressure from the Pharmaceutical Research and Manufacturers of America, and from US diplomatic personnel, to restore the earlier system of *de facto* patent protection—prevalent during the open-door phase of pharmaceutical development (1976-1983) and afterwards—by delaying approvals for new generic drugs while expediting the approval of brand-name products.

### **Concluding Remarks and Future Outlook**

Three most critical global factors in pharmaceutical production are: (1) R&D is essential for survival; (2) demand is a stable ship; (3) patents vs. generic imitations constitute the largest risk factor to businesses. It is within this context that the Egyptian pharmaceutical industry has grown over time. There is potential for growth in the Egyptian pharmaceutical industry due to increase in health awareness and early detection of diseases within the largest demand population of the MENA region. Fierce competition between multinationals and generics, in terms of price and quality, must be contained for the benefit of patients in order to escape the

chance of a low cost-low quality industry development trap. Although MNEs locally have the potential for economies of scale with country export benefits due to low comparative labour costs in Egypt, behavioural demand in population and local technological diffusion in production will ultimately shape the industry's future advancement. The main risk, however, is the possibility of over-dominance of generic drugs driving out original MNEs and their associated technologies, with international supply-chain linkages persistently broken. A vision for sustainable development of the Egyptian pharmaceutical industry within the global landscape is possible and viable given its historical roots and socio-economic contexts. To achieve this vision, Egypt must enhance its R&D efforts locally with endogenous technological innovation. Simultaneously global MNE supply chain linkages have to be effectively captured. If such a vision is fulfilled, the Egyptian pharmaceutical industry will shift from local to global, and the evolution of the industry will cease to be exogenous.

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This article is co-authored by May Moustafa, Perihan Atia, and Rasha Hammam; for their initial research work on the *Competitiveness of the Egyptian Chemotherapy Industry*; as part of MBA group research at the American University in Cairo; under the research supervision of Tarek H. Selim.

- 1 Trips is an international agreement administered by the WTO that sets down minimum standards for many forms of intellectual property regulation. It was negotiated at the end of the Uruguay Round of the General Agreement on Tariffs and Trade in 1994.
- 2 Basma Abdelgafar, "The Illusive Trade-off: Intellectual Property Rights, Innovation Systems, and Egypt's Pharmaceutical Industry", *Studies in Comparative Political Economy and Public Policy Series*, University of Toronto Press, 2006. In addition, Cipla's Official website <[www.cipla.com](http://www.cipla.com)> and Roche's Official website <[www.roche.com](http://www.roche.com)> were used for reference purposes.

## Sufism and Devotional Islam in Egypt



Emilio Giuseppe Platti

Emilio Platti is Professor Emeritus of Islamic Studies at the Katholieke Universiteit Leuven, Belgium. He is a member of the Dominican Institute in Cairo, and the Research Center for Dialogue with Muslims and Study of the Islamic Literary Heritage.

Emilio is also the editor of the journal *Mélanges de l'Institut Dominicain d'études orientales*. Email [Emilio.Platti@theo.kuleuven.be](mailto:Emilio.Platti@theo.kuleuven.be)

Egyptian Islam is often identified with the traditional Sunni institution of Al-Azhar, the famous University, on the one hand, and the militant organisation of the Muslim Brothers on the other hand. There are, however, many other aspects of Egyptian Islam, which though very popular, are left to the reluctance of the political authorities who refuse to support the activities linked to it.<sup>1</sup> Of these the most important is the form of devotional Islam associated with the tombs of saints spread all over Egypt.

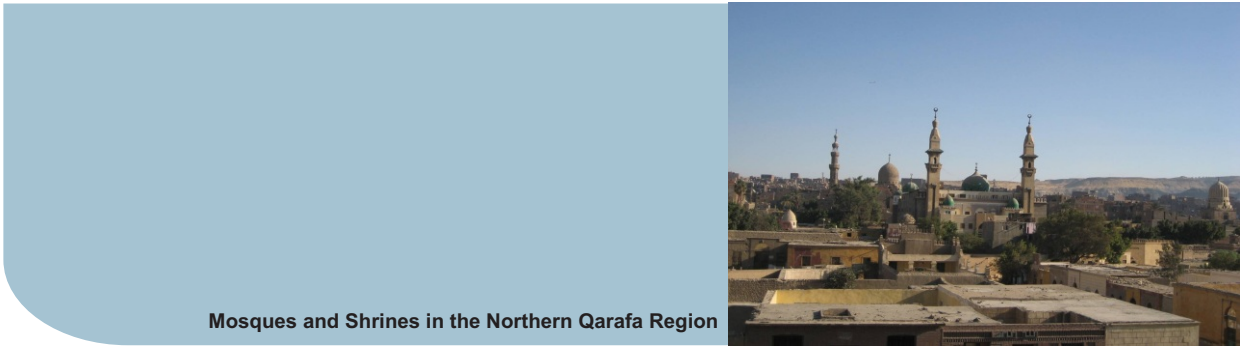


Interior of a Mosque in Cairo

They are situated in the northern delta or Alexandria and also in the land south of Cairo called 'al-Sa'id.' In the words of Tetsuya Ohtoshi these tombs have acted 'as a magnet for *tasawwuf* (mysticism)'.<sup>2</sup> Tombs of saints, mausoleums, *zawiyas* and *khanqas* (hospice), buildings and institutions for gatherings of Sufi brotherhoods and places for spiritual retreat, attract pious visitors. Modern



research has shown how much the *ziyara*, or the visit of these places of devotion, was, and is still, practised by many Egyptian Muslims. Some of these places are still very much active as centres of contemporary devotion.



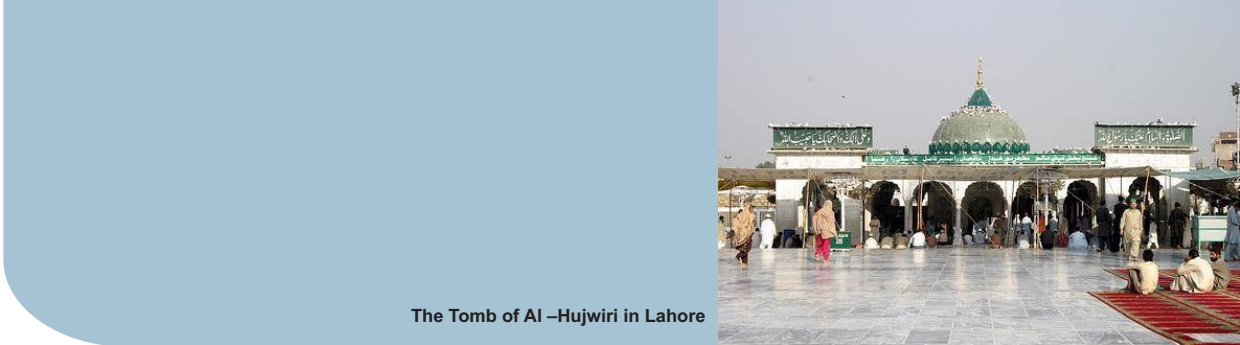
Mosques and Shrines in the Northern Qarafa Region

Recently, my attention was drawn to the Shadhiliyya brotherhood, who have their headquarters in the Northern Qarâfa region. This region houses the tomb of Ibn ‘Ata’ Allah al-Iskandari (or Sikandari, d. 1309), the second successor and biographer of Abu al-Hasan al-Shadhili. Abu al-Hasan, born in Morocco, was the founder of the Shadhiliyya brotherhood, and died in 1258 in Humaythara, in the Eastern desert of Egypt, while he was on his pilgrimage to Mecca. The Shadhiliyya being one of the most popular *tariqas* (plur. *turuq*) or brotherhoods in Egypt, the shrine of Abu al-Hasan is highly venerated. The importance of the shrine of Ibn ‘Ata’ Allah too cannot be underestimated. He was directly involved in the attacks against Ibn Taymiyya (d. 1328), the Hanbali jurisconsult who condemned directly certain doctrines held by the Sufis and in particular Ibn ‘Ata’ Allah himself.



Tomb of Ibn ‘Ata’ Allah al-Sikandari

Condemnation of the form of devotion linked to the shrines of Muslim saints has been repeatedly expressed in modern times, sometimes with explicit references to Ibn Taymiyya. The roots can also be traced to the doctrines of Muhammad Ibn ‘Abd al-Wahhab (d. 1792) and the resultant Wahhabi tradition that has a considerable influence on militant Islam as we see it today. In this regard it should be kept in mind that the suicide attack in Lahore on 1 July 2010, at the shrine of Abul -Hasan al-Ghaznawi al-Hujwiri (d. 1074), was carried out by the followers of militant anti-Sufi movements such as Wahhabism or Salafism. Al- Hujwiri authored one of the famous and earliest books on Sufism in Persian, the *Kashf al-Mahjub* (Unveiling of the Veiled).<sup>3</sup>



The Tomb of Al-Hujwiri in Lahore

While visiting the tombs of saints, mostly in the Qarâfa area in Cairo, one realises that there are several ‘types’ of saints in Egypt. In the first place, there are the famous medieval Muslim scholars, such as Al-Imam Layth (d. 791) and, the more famous, Al-Imam al-Shafi‘i (d. 820), founder of the renowned Sunni school of law. Whenever one visits his mausoleum, one finds devotees praying, reading the Qur’ân, or writing a prayer-intention which is left on the carpet inside the wooden enclosure, called *Al-Maqsurâ*. It is obvious that Al-Imam al-Shafi‘i as well as Al-Imam Layth are considered as saints. This is however not the case for the contemporary scholars, who are also very famous. They include ‘Abd al-Rahman Ibn al-Qasim (d. 806) and Al-Imam Ashhab (d. 819). They belonged to the Maliki school of law and were buried in a small, and now desolate mosque, together with several other renowned medieval scholars.



Tombs of Scholars Belonging to the Maliki School of Law

I attended the prayers of a Sufi brotherhood at the Sayyidna al-Husayn square, on the night of the *Mawlid al-Nabi*, or the birthday of Prophet Muhammad, with sermons, *dhikr* and recitations until dawn. It was only much later that I realised how two very different devotional traditions are intertwined, to such an extent that devotional Islam in Egypt showed a very specific character, as compared to other Islamic countries. Prayers were held not only in tents at the Al-Husayn square, but also inside the Al-Husayn mosque, in the Sayyida Zaynab mosque and the Zayn al-‘Abidin mosque. These saints are all members of the so-called *Ahl al-Bayt*, or members of the family of Prophet Muhammad. This devotional tradition was established in Egypt by the Fatimids (969-1171), an Isma‘ili dynasty, a branch of the Shi‘a traditions. The three mosques mentioned above are the most popular shrines and centres of daily devotion towards the members of Prophet Muhammad’s family— his grandson Al-Husayn, the son of his cousin ‘Ali and daughter Fâtima; his granddaughter Al-Sayyida Zaynab and his great grandson ‘Ali Zayn al-‘Abidin, the son of Al-Husayn.



Al-Husayn Mosque in Cairo

When the Fatimids came to power in Egypt, from North-West Africa, they founded their own new city in 970, called *Misr al-Qâhira*, ‘Egypt, the Victorious.’ Very soon they brought to the city the relics of several members of Prophet Muhammad’s family, and in particular the relic of Al-Husayn, and built several mausoleums.



Tomb of Al-Sayyida Zaynab, the Granddaughter of Prophet Muhammad

In Taha ‘Abd al-Ra’uf Sa’d’s collection, thirteen saints of Prophet Muhammad’s family are presented, whose shrines are still very much visited by pilgrims. But I discovered others, sometimes ignored even by the most detailed inventory of holy shrines in Egypt<sup>4</sup>, such as the small tomb of Sayyida Fatima, Umm al-Ghulam – daughter of Al-Hasan, the brother of Al-Husayn, in the very neighbourhood of Al-Husayn square and Umm al-Ghulam street. A clear and mysterious reference to the Shi’a Imams is found on the sheet covering the tomb, with the name of Musa al-Kazim, the seventh Shi’a Imam and father of Sayyida Ruqayya, whose tomb in Cairo is almost as old as Cairo itself. Another shrine is situated in the southern city of Beni Sueif, that of Zaynab al-Sughra, the little Zaynab, another daughter of Al-Husayn.



Inside the Shrine of Ali Zayn al-Abidin, the Great Grandson of Prophet Muhammad

While mentioning the *Ahl al-Bayt* saints in the context of Islamic mysticism it is important to take note of the fact that these shrines could not have survived but for a very strong support from Sufi brotherhoods in Cairo. Brotherhoods, *turuq sufiyya* – have their rituals in these mosques, their procession on the *Mawlid al-Nabi* brings all the devotees to the Al-Husayn mosque. They bring together Sufism and the *Ahl al-Bayt* in one tradition of *ziyara*, or

the ritual of visiting the shrines. The detailed inventory of holy shrines in Egypt is written by the secretary of the general office of Sufi brotherhoods in Egypt, and he brings together saints from both traditions – *Ahl al-Bayt* and Sufism. If the *Ahl al-Bayt* shrines are still the most important category of shrines in Egypt, many other revered saints belong to the Sufi movement and Sufi brotherhoods. But in this case also, the link to Prophet Muhammad is essential. The link to Muhammad is very explicit in the genealogy (the *nasab*) going back to him. I came across at least three complete genealogies of a Sufi master, whose ancestors go back to the Prophet. The genealogy on the epitaph of Abul -Hasan al-Shadhili's tomb traces him back to Al-Hasan, the son of 'Ali.



Imam Salih al –Jafari, a Shaykh of the Jafariyyah order

In another instance the complete genealogy at the shrine of Imam Salih al-Ja'fari, a shaykh of the *Ja'fariyya tariqa*, or the Ja'fariyya brotherhood goes back to the Messenger himself, Prophet Muhammad, through his great grandson 'Ali Zayn al-'Abidin, grandson Al-Husayn, and finally 'Ali and Fatima.



A Sufi Genealogy Going Back to Prophet Muhammad

Saints of the Wafa'iyya order are buried all together in different tombs in the mosque called *Masjid al-Sadat al-Wafa'iyya*. This brotherhood originated from Al-Maghrib, and in particular from the Tunisian city of Sfax. The first to come to Egypt was Muhammad al-Nijm. He met the Sufi saint Ibrahim al-Dusuqi and lived in Alexandria. His grandson, Sidi Muhammad Wafa became the pole of his time. He was the son of Muhammad al-Awsat Ibn Muhammad al-Nijm, and was born in Alexandria in 702 A.H., where he met the Shadhili Sufi master Yaqut al-'Arshi from Alexandria. He died in Cairo in 765 A.H., and is buried in the mosque belonging to the brotherhood, not far from the tomb of Ibn 'Ata' Allah al-Iskandari, near the Muqattam hill. Over time, many other members, more than twenty, of the *Sadat al-tariqa al-Wafa'iyya*, are buried inside this mosque, making it a very exceptional concentration of tombs.

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- 1 Catherine Mayeur-Jaouen, “Pèlerinages et Politique en Islam Egyptien”, *MIDEO*, 28, 2010, pp. 101-125.
  - 2 Tetsuya Ohtoshi, “Tasawwuf as Reflected in Ziyâra Books and the Cairo Cemeteries”, in Richard Mc Gregor & Adam Sabra (ed.), *Le développement du soufisme en Égypte à l’époque mamelouke – The Development of Sufism in Mamluk Egypt*, IFAO, Le Caire, 2006, 299-330.
  - 3 Reynold A. Nicholson (ed.), *The Kashf al-Mahjub. The oldest Persian treatise on Sufism by ‘Alî b. ‘Uthmân al-Jullâbî al-Hujwîrî*, (new ed.), Darul-Ishaat, Karachi, 1990.
  - 4 Sa‘d Abû al-As‘ad, *Nayl al-Khayrât al-malmûsa bi-ziyârat Ahl al-Bayt wa l-Sâlihîn bi-Misr al-mahrûsa*, Sharikat al-Fath, Cairo, 2004.

## African Medicine between Tradition and Modernity: A Review

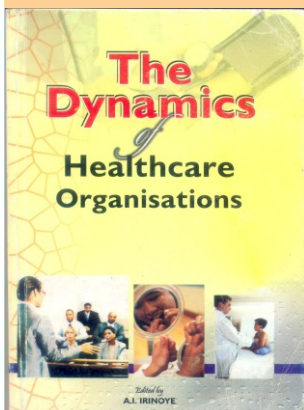
book review



### Amusa Saheed Balogun

Amusa Saheed Balogun teaches in the Department of History at Obafemi Awolowo University, Ile-Ife, Nigeria where he is also a Ph.D. student. His special research interests concern contemporary social and political history of Nigeria, such as religious issues, health and medical discourse, education development and modern governance. He has published articles in learned journals both within and outside Nigeria. E-Mail.: [sbbamusa@oauife.edu.ng](mailto:sbbamusa@oauife.edu.ng); [saheedamusa43@gmail.com](mailto:saheedamusa43@gmail.com)

**A.I. Irinoye (ed.), *The Dynamics of Healthcare Organisations*, College Press Ibadan, Nigeria, 2008, pp. XI + 273.**



Book Cover

This collection of academically brilliant essays on some aspects of medicine and medical practice in contemporary Africa by a galaxy of scholars from Nigeria is indeed a great contribution to the history of medicine in Africa. Although the editor and the contributors are not historians (most of them are medical and health

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practitioners), their analyses give some useful insights into the history of medicine in Africa particularly. The book discusses the continued relevance and resilience of African traditional medicine in the face of the domination of and preference for modern medicine. The twelve-chapter book covers a wide range of medical topics from African traditional medical system, religious and spiritual medicine to topical issues in modern medical practices.

The first three chapters discuss the nature of the African traditional medicine and spiritual healing. While the fourth chapter deals with the school health programme, the fifth focuses on the medical management of anxiety disorder and late-life depression. The next three chapters deal with the political economy of modern healthcare system by analysing the impact of acute poverty in Africa on access to health care delivery and the need to improve facilities and remunerations of health workers for better health care delivery. The last four chapters discuss the imperative of cooperation, team work and all-round efforts in the health sector of African states to offer quality health care services to the African people.

Historically, the history of medicine in Africa has passed through several phases. In the pre-colonial period, Africans had their traditional ways of responding to diseases and epidemics through both prevention and cure/healing. Some of these methods survive to the present day. There are three categories of professional practitioners of African traditional medicine: Medicine-men or herbalists, diviners and performers. African traditional medical practitioners use various methods of healing, which include those of herbalism, hydro-therapy, cupping or blood letting, surgery and heat-therapy. Furthermore, in treating diseases through the aforementioned methods, traditional African medical practitioners make use of a diverse range of ingredients, mainly leaves of various kinds, barks of trees, roots, mineral matters and parts of animal bodies.

It must be emphasised that apart from the medicines that are used for curing diseases and illnesses, African traditional medicine also involves the use of charms, the practice of witchcraft, sorcery, magic and other related practices. A major criticism of African traditional medicine is the secrecy associated with it, which is considered to hinder its scientific recognition and possible integration into the modern therapeutic process. The coming of the Europeans and the subsequent introduction of modern medicine greatly affected the status and practice of African traditional medicine. At present, in spite of the dominant status of modern medicine in Africa, traditional medicine is still patronised by a lot of people.

The emergence of spiritual healing associated with Islam and Christianity is another important aspect of African medical history described in this book. Both these religions brought into Africa their own traditions of spiritual healing. Both hold that man is made up of spirit, soul and body and that both health and sickness come from God who created man. A major point of difference between the Christian and Islamic views of sickness is that while the former holds that sickness is as a result of man's sins, the latter considers it to be a test of faith from Allah. However, both religions agree that if a man is sick, health can be restored by praying to God who caused the sickness and who alone has the power to remove it. The scriptures of both religions support such claims. For instance, the Bible says: "And the prayer of faith will save the sick, and the Lord will raise him up..." (James 5:15-16 NKJV). In the same instance, the Qur'an says: "We send down in the Qur'an what is healing and a mercy to those who believe..." (Qur'an 17:82). This is why it is a common practice in Africa for people to throng to Churches and Islamic healing centres for healing and cure of diseases, including terminal ones like AIDS. Today, the spiritual healings of both Islam and Christianity have been coloured by several African values and methods, as a result of which distinct traditions of religious healings have emerged among African Christians and Muslims.

Significantly, a major legacy of colonial rule in Africa since early nineteenth century was the introduction of a modern healthcare system. The colonial masters not only imposed modern medicine on the colonised people but also officially outlawed traditional medical practice. This relegation of African traditional medicine to the margin began in the colonial period and continues even today, many decades after the attainment of independence. In the contemporary period, the official government response to African traditional medicine in most African states is that of non-recognition, disdain and condemnation. The promotion of modern medicine appears as a lip service in most of present day Africa because the healthcare provision in most of its states is minimal. To this end, several essays in this book devote themselves to the examination of some aspects of modern medical practices in African settings. These include tips on healthful living, motivating healthcare practitioners for excellence, the essence of team approach in public health practice, school health programme, conflict management in health organisation.

It is rightly pointed out in the book that, in spite of the popularity of modern medicine and the relegation of traditional medicine to the background, many Africans do not have access to quality healthcare. As an alternative, traditional medicine is still embraced by many Africans. The high level of poverty and a low standard of living among Africans have been identified as major factors preventing African masses from having access to modern healthcare in African countries. The poor healthcare delivery system as well as the expensive nature of modern medical treatment also discourage people from accessing modern healthcare delivery. Those who can afford go abroad for modern medical treatment or resort to traditional medicine or spiritual healing, particularly when they have no means to travel abroad.

This book would have benefitted enormously from a historical contextualisation of the issues discussed in it. Thus it falls short of situating its arguments against an appropriate historical background. A possible further addition to the book could have been some investigation in the nature of the interrelationship of the practice of African traditional and modern medicine in contemporary Africa.

Nevertheless, *The Dynamics of Healthcare Organisation* remains a major scholarly contribution to the pool of existing literature on medicine and medical practices in contemporary Africa.



our team@sephis e-magazine



Editor: Professor Samita Sen.  
[sensamita@yahoo.co.uk](mailto:sensamita@yahoo.co.uk)



Editor: Professor Shamil Jeppie.  
[shamil.jeppie@gmail.com](mailto:shamil.jeppie@gmail.com)



Editorial Assistant : Pratyay Nath.  
[pratyay.history@gmail.com](mailto:pratyay.history@gmail.com)



Editorial Assistant : Kashshaf Ghani.  
[kashshaf@hotmail.com](mailto:kashshaf@hotmail.com)



Design Assistance : Hardik Brata Biswas.  
[hardikbb@gmail.com](mailto:hardikbb@gmail.com)



Administrative Assistant : Joyanti Sen.  
[sachetana@vsnl.net](mailto:sachetana@vsnl.net)



On-Line Assistance : Sadik Bhimani.  
[sadikbhimani@gmail.com](mailto:sadikbhimani@gmail.com)



DTP Assistance : Pradipta Saha.  
[pradiptasaha78@gmail.com](mailto:pradiptasaha78@gmail.com)

GLOBAL SOUTH  
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Volume 7 No. 1 JANUARY 2011