

# Putting Anthropology into Global Health

## A Century of Anti-Human African Trypanosomiasis Campaigns in Angola

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**ABSTRACT:** This analysis of over a century of public health campaigns against human African trypanosomiasis (sleeping sickness) in Angola aims to unravel the role of (utopian) dreams in global health. Attention to the emergence and use of concepts such as neglected tropical diseases (NTDs) and ideas about elimination or eradication highlights how these concepts and utopian dreams are instrumental for the advancement of particular agendas in an ever-shifting field of global health. The article shows how specific representations of the elimination and eradication of diseases, framed over a century ago, continue to push Western views and politics of care onto others. This analysis generates insight into how global health and its politics of power functioned in Angola during colonialism and post-independence.

**KEYWORDS:** Angola, elimination, eradication, global health, human African trypanosomiasis, neglected tropical disease

Our revels now are ended. These our actors,  
As I foretold you, were all spirits and  
Are melted into air, into thin air:  
And, like the baseless fabric of this vision,  
The cloud-capp'd towers, the gorgeous palaces,  
The solemn temples, the great globe itself,  
Ye all which it inherit, shall dissolve  
And, like this insubstantial pageant faded,  
Leave not a rack behind. We are such stuff  
As dreams are made on, and our little life  
Is rounded with a sleep.

— William Shakespeare, *The Tempest*  
Act 4, Scene 1, 148–158

Three is the magic number for human African trypanosomiasis (HAT), or sleeping sickness, in Angola. Sleeping sickness occurs when trypanosomes, flies and humans all coincide. Three also refers to the number of new HAT cases that health workers recorded immediately prior to Angolan independence (1975). The small number of new cases made the 'dream' of

HAT's apparent elimination seem real and permanent at the time. But it was not. Based on several years' archival research and ethnographic fieldwork, this article explains why the goals of Angola's anti-HAT elimination and eradication campaigns can be considered 'utopian dreams'. It also explores how such health programmes are linked to the emergence of the idiosyncratic concept of neglected tropical diseases (NTDs). We show how specific representations have framed more than a century of public health interventions in Angola, and argue that these have aggressively pushed Western views and politics of care onto others. This analysis generates insight into how the politics of power functioned in Angola through health programmes during colonialism and post-independence.

HAT is a vector-borne disease. The HAT parasite, *trypanosome gambiense*, is spread via the bite of infected tsetse flies. It can take up to four months for the first signs of infection to surface. The parasite's



progression through the human body, from blood to brain (the haemo-lymphatic phase to the neurological phase), produces neurological signs and symptoms that reveal the disease's advancement. If not successfully treated, the disease results in a comatose state and death within four years. Western scientific knowledge of HAT aetiology, its vector and the drugs used for treatment only appeared in the early twentieth century, after European colonial expansion into the heart of Africa, which significantly also created the conditions for several large-scale HAT epidemics.<sup>1</sup>

While HAT's impact in Central Africa at the turn of the twentieth century attracted attention from historians, scant corresponding research exists from the period by anthropologists or other social scientists.<sup>2</sup> Today, by giving attention to HAT and its ecosystem, global health researchers can perceive how 'trypanosomal dreams' are born, constituted and re-energised. This term, trypanosomal dreams, is ours. It refers to promises of a sleeping-sickness-free future that would give rise to economic prosperity (as emphasised in the London Declaration 2020).<sup>3</sup> In as much as global health has inherited this idea from rhetorics that have historically accompanied health projects in Angola (and other African states), we make reference to global health's trypanosomal dreams. Besides highlighting the historical socio-cultural construction of sleeping sickness in Angola, HAT also offers the perfect case for exploring an important aspect of how anthropology and global health interrelate.

## Anthropology, Global Health and Indicators

Anthropology's relationship with global public health dates from the period of the Second World War. Since then, it has accompanied many Western countries' health and development programmes. Anthropology, in this context, testified to Western ideas of triumph and disenchantment. Though the discipline would eventually adopt a critical view of the values and practices that supported health and development ideologies (Parker and Harper 2006), this relationship is tainted by *aporia*.

The respective ethos of anthropology and of global health push the two disciplines apart. Anthropology, with its qualitative methodologies and holistic outlook, favours broader conceptualisations of (ill) health where culture, local and individual experiences, social determinants, and structural issues are

present alongside critical analyses of (health) policies and representations (Reynolds and Lange, this issue). Contemporary global health, on the other hand, is driven by metrics and its professionals may often prefer biomedical views of ailments that aim to apply solutions that will (potentially) work irrespective of the context or timescale.

Biomedicine informs most scientific thinking about HAT. Within the majority of published HAT studies, attention usually focuses on the disease's clinical, neurological and entomological characteristics. This is in addition to newer global public health initiatives that concentrate on elimination and eradication. Elimination refers to a very low number of cases in a certain area as a consequence of deliberate efforts and requires continued intervention to prevent the disease's re-establishment; eradication denotes the complete and permanent worldwide reduction to zero cases via deliberate efforts with no further control measures required for a sustainable period of time (Dowdle 1999). Meeting elimination goals would require close attention to structural elements and cannot simply rely on medicine availability. Since animals may provide disease reservoirs, eradication is also very hard to achieve. The quasi-messianic goals of eradication and elimination and their role in guiding global health infectious disease initiatives should not be understated.

Numbers, grouped into meaningful statistical entities, carry global health's ideas. With over 3,500 health indicators feeding today's global health practice, the number is king (Erikson 2012). Numbers guide research and development (R&D) initiatives, funders' priorities as well as public health campaigns. More importantly for this article, numbers elicit and shape (possible) futures. However, these metrics obscure the complex power systems underlying their production (Adams 2016). Each number hides as much as it reveals. To grasp the political economy of data production is to untangle the different layers of complexity inherent in a numerical representation. Nothing in this is novel. Statistics (metrics), after all, were one of the key elements of the 'colonial playbook' and also factor significantly in anthropology's entanglement with global health.

The metrics that describe new cases of HAT are only one representation of a reality within which parasites (trypanosomes), vectors (tsetse flies) and hosts (humans) interact in a particular environment. That is, HAT metrics ultimately refer to an intersection in time and space between nature and humans, an entanglement of local and natural milieus with socio-cultural, economic and political factors within a spe-

cific historical context. Travelling to and being in HAT endemic and epidemic territories for anthropological fieldwork brought into immediate focus the relevance of history as lived with respect to the complex interweaving of the factors described above.

## The Angolan Context

Angola is located in south-western Africa between Namibia (to the south), the Democratic Republic of the Congo (to the north and west) and Zambia and the Atlantic Ocean (to the west). Its enclave province of Cabinda borders the Republic of the Congo and the Democratic Republic of the Congo. However, the focus of this article is on public health policies that were applied in Angola's mainland territory.

After a protracted war for liberation that started in 1961, Angola achieved independence from Portugal in 1975. However, civil war ensued and continued until 2002, when peace was finally established. During this period, funding for public healthcare came second to the war and the economy. Between 2009 and 2014, Angola spent only 4.5 per cent of the national budget on average on health-related expenses. Angola is dependent on oil revenues, which leaves the country vulnerable to slumps in oil prices (such as the ones during 2014–2016). Low oil prices profoundly and detrimentally affect livelihoods as well as the national budget and health expenditure. Today, more than a decade after the end of civil strife, Angolans still face a variety of problems. These include high levels of poverty, maternal and child mortality, as well as illiteracy and limited access to basic public services like biomedical care, education and energy. As one might expect, rural areas are worse off than urban ones (WHO 2016).

## A Short History of HAT in Angola

Public health's roots in Angola penetrate into its past, a period when delivering biomedical care justified imperial projects and interventions. Unsurprisingly, some colonial era public health projects offer fertile ground to contemporary global health initiatives. In the case of HAT, key ideas have been harvested and re-interpreted through dreams of progress and the promise of Western science and technology (Varanda 2015). Elimination and/or eradication initiatives, saving the underprivileged, securing geographic areas from epidemic threats and, ultimately, the regulation and sanitisation of the world, factor in amongst the

most important of these. Though the recurrence of epidemics has warned of the risks arising from the embrace of progress premised on such a foundation, the utopian dreams that it brought into existence have nevertheless always found new ways to resurface – often more perniciously. The history of anti-HAT public health campaigns in Angola (1880s–2010s) is exemplary in this regard.

The Berlin Conference (1884–1885) pushed imperial European nations to occupy and explore the African continent and to subjugate African people. As various colonial projects extended into the hinterlands and away from capital cities through the construction of roads or railroads, Africans working as porters, as rubber collectors or as indentured labourers in coffee, cotton or mining came into contact with the infected HAT vector. The scale of European exploration profoundly altered the existing ecological equilibrium and led to an explosion in the number of sleeping sickness cases reported throughout central Africa (De Raadt 2005; Dias 1981; Ford 1971).

In Angola, the first cases of sleeping sickness appeared in 1871 in Massangano, which was near Dondo, which was then a key commercial hub (Dias 1981). At the time, there was little or no medical knowledge about HAT's aetiology. As a result, imperial powers initiated scientific sleeping sickness research. Besides medical knowledge, these kinds of studies also sought legitimisation for colonial political projects. Portugal, for instance, launched a research mission in 1901 (Bettencourt et al. 1903), while Belgium's Leopold II contracted scientists from the Liverpool School of Tropical Medicine to conduct research in the Congo Free State (now part of the Democratic Republic of the Congo) around the same period (Lyons 1991). This was the perfect example for biomedicine to show its might, and, in doing so, imperial powers reaffirmed their (very selective) care for others.

The epidemic nature of HAT and the disproportionate attention that the colonial public health apparatus gave to it throughout central African region led many to consider it a colonial disease. The imperialists' civilising mission extended to health programmes, and anti-HAT public health campaigns provided a perfect instrument for imposing the colonialists' sense of order and allowed them to have control over a restless public (Last 2014; Marsland 2014; Varanda 2007). The results of these initiatives, however, were not always as predicted (Lachenal 2010; Lyons 1991). Angola was no exception.

By the mid-1940s, the government had created an anti-trypanosomiasis service – the MCT (Missões Contra Tripanossomíase [Missions against Trypano-

somiasis]) – which mimicked the famous anti-HAT campaigns designed by Eugène Jamot in French West Africa.<sup>4</sup> These campaigns relied on mobility, active case detection and treatment in the bush by specially trained personnel (locals included), and they featured administrative and budget autonomy (De Raadt 2005). The MCT worked in tandem with the local colonial administration and African police force. Dozens of health staff made up MCT teams, which included a handful of European physicians and nurses as well as a large contingent of local auxiliary nurses and support staff. These teams toured and mapped the endemic districts for several months a year. They contacted the local administration, which ordered its local African police, *cipaios*, to command the local chief to call their populace to present themselves on a specific date for HAT-screening. Attendance was mandatory. Absence meant physical punishment for the local chief and/or for the absentees.

By the 1950s, the usual examination process consisted in the capturing of personal and physical data, and the provision of a physical exam that started with a neck palpation. For those suspected of being infected, these examinations entailed a blood exam and/or a referral for a spinal tap, and involved a week-long period of hospitalisation. The general population received pentamidine prophylactic vaccinations. Those infected and experiencing the second stage of the disease, in which the central nervous system is involved, received from 1949 onwards intravenous treatment with an arsenic drug known as melarsoprol (trade name arsobal). The colonial state imposed ‘care’ not only on the HAT-infected, who suffered forced admission to hospital treatment centres, but also on those who were deemed healthy, that is, the non-infected. (Bell 1999; Varanda 2007, 2010). The activities and interventions of the mobile campaigns were important tools of the colonial government. After an epidemic outbreak in the 1920s, the number of cases rose and reached their peak in 1940 with roughly 9,000 identified cases. This number fell to 4,318 in 1949, and infections continued to decrease over the next few decades until only residual infections remained, which was, in part, because of the involvement of private enterprise.<sup>5</sup>

Early in the twentieth century, Lisbon decreed that large private enterprises must provide biomedical care. The diamond company of Angola, Diamang (1917–1975), embraced this new responsibility contractually and wholeheartedly from 1921 onwards. This meant that the company cared for a territory almost double the size of Guinea-Bissau, Portugal’s West African colony (Varanda 2007, 2010, 2014). By

the 1960s, Diamang reported only residual numbers of HAT cases, with no cases identified by the 1970s. However, HAT’s elimination was not permanent.

In the late 1970s, since HAT was no longer a pressing problem, it plummeted on the priority list for the National Health Service’s meagre budget. After independence, the MCT was replaced by the Programa Nacional de Luta Contra a Tripanossomiase (National Programme to Combat Trypanosomiasis), which was funded through international aid from the World Health Organization (WHO) and the Swedish Agency for International Development. Over the next 20 years, the number of Angolan HAT cases grew exponentially. In 1985, the number of cases increased to 1,000. By 1997, identified infections peaked with 8,275 cases (Stanghellini and Josenando 2001). In this environment, characterised by general inattention and increased political and military turmoil, HAT made an impressive return in Angola (Simarro et al. 2008).

The new millennium brought a new dawn for the fight against sleeping sickness. The increase in global attention that HAT had attracted coincided with the end of the civil war (1975–2002). The new national sleeping sickness project, which is ran out of the Instituto de Combate e Controlo das Tripanossomíases (ICCT – Institute for Combat and Control of Trypanosomiasis), found its inspiration in the *modus operandi* of the MCT (Abel et al. 2004). At its peak, in 2005, the ICCT had 42 treatment centres, 23 mobile teams, seven anti-vector units and a total staff of 500 full-time workers. Their focus, as well as national and international funding, contributed to a steady decline in the number of HAT cases in Angola. These dropped to 1,727 by 2005 and decreased further to 218 in 2010; in 2013, there were only 69 reported cases (ICCT 2013; Varanda 2015).

## HAT Research and Representations

Ethnographic fieldwork and archival research of more than a century of anti-sleeping sickness campaigns and interventions in Angola comprise the data that this article analyses and interprets. Initially, the research focused on archives and publications scattered throughout Portugal and Angola. Following on from that stage, the first author (JV) conducted months of fieldwork in different Angolan HAT treatment centres and had discussions with staff at the WHO and staff at non-governmental organisations (NGOs) in Angola and Switzerland whose work relates to HAT. The bulk of the research was carried out

between 2009 and 2013, and JV travelled to Angola (more specifically, the provinces of Uíge, Bengo, Luanda, Kwanza-Sul and Kwanza-Norte) several times for fieldwork during this period, eventually spending more than one year collecting ethnographic and qualitative data.

JV interviewed African Angolan health professionals (nurses, laboratory technicians, drivers) who had worked under the colonial health service in addition to Angolans who had endured the famous MCT mobile colonial campaigns.<sup>6</sup> These interviews allowed JV to gain insight into the daily work of the missions and into the sometimes 'draconian' and negotiated nature of biomedical care that developed alongside racial and gender views shaped by Portuguese colonial ideology. Some of the health professionals who JV interviewed continued to work with sleeping sickness and/or in biomedical care provision after independence. Their perceptions and experiences helped us bridge different historical periods'

treatment and care processes and give this article its particular understanding of biomedical care in Angola that is both colonial and global in character.

Research in contemporary treatment centres permitted interaction with HAT patients, their relatives and local health staff. There, JV witnessed first-hand the fear experienced by people who had undergone HAT diagnosis via spinal tap or who had been subjected to harsh intravenous treatments that – because of the drugs involved, the length of treatment and the subsequent effects on the body – had to be withstood.<sup>7</sup> Critical for the argument advanced here was JV's joining in on national health teams' treks into the bush on their annual HAT find-and-referral campaigns (Figure 2). Accompanying these teams meant making first-hand contact with the geographies of HAT in places where there are no tarmac roads, or brick-and-mortar houses, let alone fresh water or electricity. JV saw that find-and-referral teams arriving in areas labelled 'high risk' by global maps found



Figure 1: Photo of the sleeping sickness centre at N'dalatando. Photo by Jorge Seixas (2010)

little public interest in their presence or in sleeping sickness. He observed that working-age adults did not modify their daily activities to attend HAT screenings. By witnessing the plight of Angolans living in deprived rural and remote regions with little or no access to state services, JV saw the experiences of those whose relatives or who themselves were infected with HAT make the trypanosomiasis metrics of global health come alive. But public health interventions did not change their lives or context in substantial ways.

Undertaking these excursions into the field underscored the geographic and historical extension of global health in action. This was tangible in the trail of global health projects' bio-technological detritus that extended far beyond the capital. This left-behind material consisted of laboratory instruments, garments, medical vehicles, t-shirts, stickers and even statues of tsetse flies. These 'breadcrumbs' are left-over artefacts from the humanitarian response to the 1990s HAT epidemic, while abandoned R&D facilities highlight the global attention given to sleeping sickness in the 2000s. Paradoxically, such debris also attests to the resilient and complex nature of the disease. As seen in Figure 1, the statue of the tsetse fly and the left-behind vehicles attest to the scale of the humanitarian intervention that sought to address the 1990s epidemic.

## Contemporary Concerns

In 2010, accompanying a local ICCT find-and-referral team proved enlightening. The team was sponsored by a European R&D project and followed a regular route through a number of Angola's HAT-endemic provinces. Auxiliary nurses, laboratory technicians and a driver comprised the nine-member team. Despite the difficult operating conditions, the seven men and two women carried out the month-long tours largely because of the extra money that these trips earned them.

Despite taking place only during the dry season, the erecting of impromptu labs in villages located in remote locations along with setting up food and washing and sleeping arrangements faced a lot of logistical hurdles. Upon arrival, the team contacted the local government authorities, which in tandem with the traditional leaders, or *sobas*, called the local residents for examination and possible referral. The lack of knowledge of local administrators about the number of inhabitants within their area of responsibility pushed the team to act beyond its biomedical purview and carry out its own census. In post-independence Angola, attendance is no longer mandatory and no one is punished for being absent, so it was not unusual that in village after village the



**Figure 2:** ICCT find-and-referral campaigns in the village of Kimunualassa in the Gombe municipality (Bengo Province). Photo by Jorge Varanda (2009).

vast majority of those coming forward were mothers with children and the elderly (Figure 2). Both groups usually sought medical attention for concerns other than HAT, and the mobile team was not trained or medically equipped to treat other diseases or illnesses. The HAT screening procedure, however, still found inspiration in the pioneering methods of the colonial-era MCT teams described above, despite their still being important differences between the two kinds of teams. One of these differences was the inclusion of women as technicians and auxiliary nurses, which helped the present-day teams establish a more inclusive rapport with local women.

Getting back to the team JV accompanied, it filled out and distributed HAT cards. The examination started with ganglion palpitation, followed by new technological examinations that replaced the 'traditional' blood exam. This was the CATT exam (card agglutination test for trypanosomiasis), and, if it was positive, then the mini-spinal column examination followed suit. New up-to-date treatments were also offered at the ICCT treatment centres. While pentamidine was still the drug of choice for the first stage of the disease, for second-stage trypanosomiasis NECT therapy (nifurtimox-eflornithine combination therapy) was now used in lieu of the troublesome arsenic drug melasoprol.

As the epidemic faded and its prevalence became residual, locals treated sleeping sickness with neglect. HAT no longer posed a threat in their minds, so their focus and energy was on everyday livelihood issues such as food production, home-building and commercial trade. The degree of isolation from wider Angola that characterises these remote settlements often emerged in their interactions with the health outreach teams. Local residents would seek to trade with health workers for goods from the capital, and local children, who had little experience with white Portuguese often thought that the expat researcher was Chinese or related to the local Italian missionary, the only other 'white' people who they had ever encountered.

### Could Negligence Have Been Bliss? The Rise of Neglected Tropical Diseases

The AIDS pandemic would eventually lead to the emergence of Global Health. But what about HAT? On the ground, social, economic and political elements were again slowly but steadily producing an epidemic. No red flags were raised at the global level. As the attention to sleeping sickness waned from

most Western scientific researchers and pharmaceutical companies, it silently fell into 'oblivion', only later to be rescued from 'neglect' by the same science that had almost eliminated it. This disappearance from and resurfacing within the global agenda is as novel as it is unexpected.

Central to the 'recollection' of HAT was a new concept, that of the neglected tropical disease (NTD). This political-nosological classification is an umbrella category that integrates different ailments with the goal of obtaining attention and funding to produce new drugs. The NTD is a peculiar concept, as NTDs share little in terms of biological or epidemiological characteristics. However, the NTD concept channels attention to these diseases and consequently enables funding for novel scientific research and needed public health campaigns.

If the 2000s was the decade in which the NTD concept took off, the pivotal year for HAT was 2001. Several agreements between the WHO and pharmaceutical companies (Sanofi-Aventis and Bayer AG) made the continued production of existing (older and toxic) HAT treatments possible (Jannin et al. 2003). By 2003, the Drugs for Neglected Diseases initiative (DNDi) emerged with the goal of contributing to the development of new treatments for neglected diseases, and HAT featured prominently in it. In 2012, these efforts by pharmaceutical companies, donors, NGOs and countries like Angola culminated in the London Declaration on Neglected Tropical Diseases. The purpose of the declaration was to control, eliminate or eradicate 10 diseases by 2020 and by doing so benefit individuals and countries economically. As mentioned above, HAT was one of these diseases (Lenk et al. 2018).<sup>8</sup>

The NTD concept was central to advances made in providing diagnosis and treatment triggered by the 1990s HAT epidemic in Angola. It 'brought' less-invasive tests and ground-breaking new drugs. For HAT, the international global consortium produced speedy results. R&D initiatives currently generate innovative oral pharmaceutical treatments (fexinidazole winthrop and SCYX-7158) as well as new non-invasive diagnostic kits (FIND [Foundation for Innovative New Diagnostics] rapid diagnostic tests [RDTs]). However, reducing HAT's impact, though undeniably beneficial, does nothing to change the effects of poverty in HAT-endemic areas, nor people's vulnerability to HAT infection. Disease control, eradication and elimination programmes promise improved health as well as reduced poverty, which is a promise that generally goes unrealised. HAT can be seen as an NTD success story, but there is still no

'cure' for vulnerability to poverty or the negative consequences of future environmental changes.<sup>9</sup>

## Conclusion: Daydreaming of Utopias

In the case of HAT in Angola, three is the most important number. It proves that elimination is possible and opens the door to eradication. But this proof is not value-free. It represents a particular vision (health-civilisation-development) that has been endorsed by colonial, private and public health interventions within a framework of hierarchical and racialised power relationships. The relevance of colonial representations, their tool box of statistics, vertical programmes, photos, maps and neo-Foucauldian medical dreams of sanitised and ordered Africa cannot be overstated. Unfortunately, global health metrics still hide the context or the complexity of factors which lead to the unfortunate entanglement of people, flies and parasites. But, like numbers, dreams also withhold *their* contexts – even more so if these are biomedical or public health in nature. Dreams simplify the broad ecological system that 'produces' humans infected with HAT. Dreaming these trypanosomal dreams is indicative of Western ideas of causality and the strength of modernist ideas of progress. Locally, in Angola, these dreams find little resonance amongst those enduring the disease, their relatives or many of the health staff. Usually, such people worry less about the disease's elimination/eradication and more about daily affairs, be it food sovereignty, steady income, local politics, religious matters or just plain daily issues linked to their nuclear or extended families. For them, divisions between biomedical global health and local views might be as incommensurable as they are irreconcilable.

Broad global issues and strategies related to a future possibly safe from epidemics or related to accessing adequate health services, eliminating poverty and/or effecting ecological transformation cannot be guaranteed priority, and locals know it. Unfortunately, NTDs, HAT elimination and eradication, the pharmaceuticalisation of ailments (Biehl 2007; Parker and Allen 2013; Redfield 2012) and the financialisation of risk via pandemic bonds will not lift people out of the poverty trap or 'underdevelopment'. Thinking so is the stuff of dreams. Such ideas are utopias, key elements for global health. And just as in the colonial period, scientists and physicians were and are an integral part of the mythopoesis.<sup>10</sup> The ideology of progress marches on with novel algorithms, eradication courses, and new global funds promising,

with persuasive jargon, disease-free, poverty-free futures, as development and production increase. This mythopoesis grants elimination/eradication its oneiric nature.

The proof of the pudding is in its eating. To properly judge the 'pudding', it is important to critically note the skewing effects of (a) the single example of eradication (smallpox); (b) the importance of the magic-bullet 'ideology'; and (c) the human 'need' for utopian dreams. The rebound effect of the only successful disease eradication, that of smallpox, in today's mantras is considerable. However, the smallpox success had 200 years of variolisation or inoculation and vaccination combined with viral characteristics that permitted such a positive ending. Alongside this, it is also worth highlighting the surprising resilience and strength of the idea of the magic bullet, be it under the guise of chemical products (DDT in the 1950s), genetically modified organisms (sterile male mosquitoes/flies in the 1990s), or new chemical drugs (fexinidazole winthrop or SCYX-7158 in 2018).<sup>11</sup> Such persuasion and resilience is only matched by its failure to deliver (so far).<sup>12</sup> Still, dreams matter: the trypanosomal dreams are important persuasive fictions that have enabled and proven that the elimination of HAT is doable in the short term if funds keep flowing, if drugs in the pipeline continue to be developed, and particularly if the bar by which we identify success exists at 'fewer than 2,000 reported cases per year'" (Franco et al. 2017).

## Coda: Anthropology and Global Health

Anthropologists are usually suspicious of global health's representation of ready-made disease-free futures being just around the corner. Anthropology's disciplinary knowledge is unique, as is true of other disciplines as well. Still it contributes to global health through a holistic approach that perceives how different scales (local, regional and global) and time-lines (past and present while eliciting futures) weave into ethnography, where individuals and global institutions are made to dialogue in ways that are seldom found elsewhere. Anthropology also scrutinises the politics of health as well as health politics, R&D agendas, public health approaches and local responses, while power relations and representations are brought forward for consideration alongside the historical treatment of concepts.

If anthropological knowledge is so rich, where is anthropology in global health? Certainly, it is not on the agenda; it is not present in global health's most

relevant forums; it is not found in elimination roadmaps or in global health's membership-restricted evaluation committees. At best, it might be in the corridors, where informal conversations about fieldwork in the bush take place. It might be found living in risk areas, or in local responses to the first waves of climate change, which impact disease vectors. Presently, anthropology faces plenty of challenges, one of which might be to critically assess whether its relationship with global health might be better described as a Sisyphean task or a Herculean challenge.

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## Notes

1. See, for instance, John Ford (1971); Jill Dias (1981); and De Raadt (2005).
2. For some relevant examples, see Ford 1971; John McKelvey Jr. (1973); Martin Shapiro (1983); Maryinez Lyons (1991); Heather Bell (1999); Hoppe 1997; and Daniel Headrick (2014).
3. [http://www.who.int/neglected\\_diseases/London\\_Declaration\\_NTDs.pdf](http://www.who.int/neglected_diseases/London_Declaration_NTDs.pdf) and <https://www.gatesfoundation.org/media-center/press-releases/2012/01/private-and-public-partners-unite-to-combat-10-neglected-tropical-diseases-by-2020> (accessed 20 April 2018).
4. For more details, see Jean-Paul Bado (2011).
5. For detailed information on HAT mobile teams on the ground led by Diamang between the 1920s and the 1970s, see Jorge Varanda (2007). For a metropolitan view on putative nationalist blueprints, see Samuël Coghe (2017).
6. 'African Angolans' and 'Angolans' were and still are legal and racial designations printed in Angolan state-issued ID cards.
7. The lumbar puncture (LP) is a medical procedure in which a needle is inserted into the spinal canal to collect cerebrospinal fluid (CSF) for diagnostic testing for the presence of trypanosomes. This will entail different stages of the disease and thus different therapeutics.
8. [http://www.who.int/neglected\\_diseases/London\\_Declaration\\_NTDs.pdf](http://www.who.int/neglected_diseases/London_Declaration_NTDs.pdf) (accessed 20 April 2018).
9. Studies on climate change and HAT vectors are scant; those that do so focus narrowly on the vector and often produce non-conclusive and contradictory results. See, for example, Sean Moore and colleagues (2011); and Jennifer Lord and colleagues (2018).
10. For more analysis on utopia, see Ruth Levitas (1990).
11. Several historical works have also traced this duality of approach for malaria: see Socrates Litsios (1996); Randall Packard (2007); Marcos Cueto (2013); James Webb (2014).
12. It is worth studying the day-to-day reality of past elimination/eradication experiences such as the hookworm eradication campaign (1910s–1930s), the

malaria eradication program (1950–1960s) and the contemporary, but still belated, polio eradication campaign.

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