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Medicine and Mobility: Epidemics, Health Systems, and Healing in African History

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Introduction

Medicine and Mobility: Epidemics, Health Systems, and Healing in African History explores how movement—of people, goods, microbes, ideas, and institutions—has shaped health across the continent from deep precolonial times to the twenty-first century. Rather than treating epidemics and health systems as isolated phenomena, the book follows the pathways along which pathogens travel and the circuits through which care is organized. Trade routes, pilgrimage corridors, labor migrations, military campaigns, and new infrastructures of transport and communication have continually reconfigured risk and resilience. Mobility has never meant only exposure; it has also meant connection, creativity, and the circulation of healing knowledge. By foregrounding mobility, we gain a clearer view of how African communities have anticipated, adapted to, and transformed health challenges over time.

Precolonial Africa hosted dense networks of exchange that linked savanna to forest, highlands to coast, and inland markets to the Indian Ocean world. Along these routes, healers cultivated reputations that traveled with them, plants and remedies diffused across ecological zones, and understandings of affliction moved together with travelers' tales. Pastoralists adjusted to seasonal cycles, traders sustained caravan towns, and port cities bridged continents—each setting presenting distinct vulnerabilities and resources for care. The everyday work of households and kin groups—midwifery, herbal pharmacopeias, spirit healing, and ritual protection—formed the backbone of health security. These practices did not disappear with colonization; they continued to shape expectations of care and frameworks of trust that endure to the present.

Colonial expansion reorganized health around the imperatives of rule, extraction, and settlement. Mission stations and government posts built clinics and laboratories that mapped bodies and landscapes through new surveillance practices. Coercive campaigns against sleeping sickness, smallpox, and plague brought laboratory science, quarantine, and vaccination into encounters fraught with unequal power and, at times, violence. Urban sanitation and labor compounds sought to control contagion while securing labor supply, and medical education created new professional hierarchies. Yet colonial systems also depended on African intermediaries—nurses, interpreters, traditional healers—whose labor and knowledge braided together distinct therapeutic worlds.

After independence, many governments sought to extend health as a public good, planning national systems even as fiscal and political constraints mounted. The promise of primary health care and community participation animated reformers, while the Bamako Initiative and later user fees reconfigured access and accountability.

Structural adjustment, humanitarian emergencies, and the proliferation of nongovernmental organizations produced a mixed health economy in which markets, donors, and states intersected. Urbanization, environmental change, and demographic transition reshaped the burdens of disease, from maternal and neonatal mortality to chronic conditions. Throughout, mobility—rural-urban migration, cross-border trade, and the circulation of professionals—continued to challenge the fit between populations and the institutions meant to serve them.

Epidemics have punctuated this history and revealed its underlying dynamics. The 1918–1919 influenza pandemic traversed railways and ports; HIV/AIDS reoriented activism, gender politics, and pharmaceutical access; Ebola outbreaks exposed the centrality of community engagement and trust in public health; and the COVID-19 pandemic reanimated long-standing debates over borders, livelihoods, and the ethics of quarantine. In each case, containment has hinged not only on technologies—tests, drugs, vaccines—but also on the social pathways that connect authorities and communities. Rumors and resistance, far from being peripheral, are part of how people reason about risk in contexts of historical memory and uneven power. Effective responses have emerged where officials and neighbors co-produced strategies that respected local expertise and mobility needs.

A central theme of this book is medical pluralism: the coexistence and interaction of biomedical, herbal, spiritual, and faith-based healing. Traditional healers are not vestiges of a premodern past but active participants in contemporary health landscapes—innovators, entrepreneurs, and custodians of pharmacological knowledge. Collaboration and contestation between healers and biomedical practitioners have shaped referral systems, research agendas, and regulation. By tracing these relationships, we highlight how trust is made and remade, and how legitimacy is negotiated in clinics, marketplaces, churches, shrines, and households. Recognizing pluralism is essential for designing policies that meet people where they seek care.

Methodologically, the volume blends archival research, oral histories, ethnography, epidemiological datasets, and policy analysis. Case studies range from caravan towns on the Saharan fringe to mining compounds in Southern Africa, from lakeshore fishing communities to megacities linked by highways and digital networks. We move across scales—household, neighborhood, district, nation, and region—to show how decisions taken in one arena reverberate through others. Each chapter pairs narrative history with policy-relevant insights, translating past experience into tools for present action. The result is a conversation between historians and public health professionals, grounded in evidence yet attentive to lived realities.

The chapters are organized to follow the long arc from precolonial mobility and community care, through colonial and nationalist state-building, to contemporary systems shaped by markets, aid, and innovation. Readers will encounter epidemics as

windows onto governance and everyday life; infrastructures as both promises and constraints; and healers as central actors in health ecologies. While attentive to diversity across regions and periods, the book insists on a common thread: health is produced in motion. By the end, we aim to equip practitioners and scholars with historically informed perspectives that can guide equitable, resilient responses to today's challenges and those yet to come.

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CHAPTER ONE: Landscapes of Health and Movement in Precolonial Africa

Before microbes had names and routes were drawn on maps, health in Africa moved with the people, animals, and winds that crossed the continent. The story of medicine and mobility begins long before colonial administrations or biomedical laboratories, in a patchwork of ecologies and societies that learned to navigate risk through ingenuity and exchange. From the Sahel's long dry seasons to the Congo Basin's humid forests, from the Great Lakes' fertile shores to the southern savannas, communities adapted their rhythms of movement to the contours of disease and the availability of healing. Health was not a static condition but an everyday negotiation, shaped by travel, trade, climate, and the terrain itself. It was a negotiation conducted at the speed of foot, hoof, and canoe.

Mobility in precolonial Africa was both routine and strategic. Pastoralists followed rainfall and pasture in seasonal circuits that kept herds alive and reduced exposure to vectors clustered around stagnant water. Farmers adjusted planting cycles and market days to minimize time in mosquito-rich marshes. Hunters and foragers read landscapes for medicinal plants and water sources, their knowledge mapping onto songs and stories passed down through generations. Traders moved between market towns, coastal ports, and caravan depots, each leg of the journey introducing new exposures and remedies. Health strategies traveled as companions, tucked into calabashes of herbs, charms tucked in leather pouches, and oral instructions recited under acacia trees.

The geography itself offered both highways and barriers. Rivers—the Niger, the Congo, the Zambezi—were arteries for exchange, but also corridors along which fevers and dysentery spread. The Great Rift's lakes and highlands provided cooler climates where certain vectors struggled, while lowland basins hosted malaria hotspots that seasoned travelers learned to avoid or endure. Mountain passes connected regions but also isolated populations, limiting epidemics while preserving unique healing traditions. Coastlines linked interior markets to the Indian Ocean and Mediterranean worlds, bringing not only goods but also new pathogens and therapeutic ideas. Even deserts, often described as empty, were threaded with paths where knowledge of wells and shade could mean the difference between health and heatstroke.

Different ecological zones produced distinct health profiles. The Sahel's long dry seasons could concentrate populations around scarce water points, increasing the risk of waterborne disease. The rainforests of Central and West Africa harbored diverse insect vectors and zoonotic reservoirs; here, communities developed sophisticated

botanical pharmacopeias and protective rituals. The highlands of Ethiopia and East Africa offered some respite from lowland fevers, but cold nights brought risks of respiratory illness. Coastal mangroves and estuaries were rich in fish and salt but prone to outbreaks of diarrheal disease. Each zone fostered a repertoire of local remedies—barks, leaves, roots, minerals—and social practices designed to mitigate specific risks without the benefit of modern diagnostics.

Caravan routes that crossed the Sahara and penetrated the interior were crucial in shaping regional health ecologies. Towns like Timbuktu, Gao, Kano, and Zanzibar became nodes where travelers, scholars, and healers exchanged more than goods. Pilgrims heading to Mecca carried not only devotion but also stories of epidemics encountered along the way, influencing how communities prepared for newcomers. Merchants moving gold, salt, ivory, and textiles sometimes transported pathogens in their caravans, but they also introduced medicinal herbs and new methods of treatment. These routes were not mere lines on a map; they were circulatory systems through which ideas, pathogens, and cures circulated as surely as any physical commodity.

Port cities along the Indian Ocean and the Red Sea were early sites of medical pluralism. In places like Mogadishu, Mombasa, Kilwa, and Sofala, traders from the Arabian Peninsula, the Persian Gulf, and the Indian subcontinent mingled with local communities. This exchange birthed hybrid healing practices, blending African botanical knowledge with ideas from Unani and Ayurvedic traditions. Herbalists in these cities curated remedies adapted to both local diseases and the ailments of travelers—seasickness, scurvy, and dysentery. Apothecary stalls featured frankincense, myrrh, cloves, and aloe, alongside indigenous plants like neem and moringa. The cosmopolitan character of these ports fostered trust in diverse healers, setting patterns of medical pluralism that would outlast empires.

Inland market towns played a similar role on a smaller scale. Weekly markets drew farmers, herders, potters, and ritual specialists, each bringing not only goods but also health knowledge. Midwives shared techniques for managing childbirth, herbalists swapped seeds and cuttings, and diviners discussed the social causes of illness. A healer's reputation could spread quickly along these networks, and successful treatments traveled with clients who returned home. The marketplace, therefore, was more than an economic hub; it was a clinic, a pharmacy, and a school of medicine, where solutions were tested and refined. Health systems in precolonial Africa were often decentralized and grounded in such social exchange.

Households and kin groups were the foundational units of care. In many communities, health began at the hearth, where elders taught the young how to identify medicinal plants, prepare remedies, and observe symptoms. Women often managed herbal pharmacopeias and midwifery, passing down oral recipes through matrilineal or bilateral lines. Men might specialize in bone-setting, wound care, or the rituals

associated with spirit afflictions. Illness was frequently understood holistically, linking physical symptoms to social relations and spiritual balances. Healing practices were embedded in the rhythms of daily life—planting, harvesting, herding—and organized around kin obligations rather than market exchange.

Ceremonies and ritual specialists played crucial roles in managing collective anxiety and coordinating responses to afflictions. Diviners diagnosed not just the physical symptoms but the social and spiritual causes of disease, revealing disputes, transgressions, or misfortunes that required repair. Ritual cleansing, offerings, and community feasts restored harmony and, in practical terms, mobilized support networks for the sick. This approach had functional benefits: by addressing stigma and social isolation, it improved adherence to treatment and reduced the burden on caregivers. While skeptics might question the efficacy of particular rites, the social medicine they offered was undeniable—health as a communal achievement rather than an individual condition.

Knowledge of medicinal plants was extensive and highly localized. Healers in the Congo Basin identified dozens of antimalarial barks, while Sahelian herbalists cultivated drought-resistant species with anti-inflammatory properties. In the Ethiopian highlands, communities used eucalyptus for respiratory ailments and enset—false banana—for dietary therapies. In southern Africa, plants like pelargonium and aloe were staples for wound care and digestive issues. This pharmacopeia was not static; trial and error, observation, and ecological change continually reshaped it. Knowledge was transmitted through apprenticeships and often guarded within families or guilds, but it also circulated through trade and intermarriage, adapting to new environments and disease pressures.

Pastoral and nomadic groups developed mobile health strategies that matched their lifestyles. The Maasai, Fulani, and Tuareg, among others, organized care around the herd and the season, using mobility to avoid vector breeding sites and reduce exposure to contaminated water. They carried small kits of herbs and relied on specific foods—milk, blood, and fermented products—for nutrition and preventive care. Injuries from animal handling were treated with quick wound-cleaning techniques and topical plants. Their medical knowledge emphasized resilience and flexibility, leveraging movement as a public health tool long before modern epidemiology described the benefits of seasonal migration for disease avoidance.

Fishing communities along lakes and rivers crafted health systems suited to water-based livelihoods. The Luo of Lake Victoria and the Bemba near Lake Tanganyika, for example, dealt with schistosomiasis, fish-borne parasites, and waterborne diarrhea. They developed dietary practices to counteract deficiencies, drying and smoking fish to preserve nutrients and reduce contamination. Canoe travel facilitated contact with neighboring groups, allowing for exchange of herbal remedies and marriage ties that broadened kin-based care networks. Their proximity to water also demanded ritual

practices to placate spirits associated with floods and disease. These communities exemplified how environmental context shaped both vulnerabilities and healing repertoires.

Mountain and highland societies navigated different risks. Cooler climates limited some tropical vectors but exposed people to respiratory infections and cold-related ailments. In Ethiopia's highlands, communities used steam inhalations, honey-based syrups, and specific herbs for chest conditions. Terraced farming required communal labor and created opportunities for collective care during harvest and planting seasons. The relative isolation of highland settlements sometimes slowed epidemic spread, but it also meant that when diseases did arrive, they could be devastating due to limited prior exposure. Healers in these regions often developed deep expertise in local flora, compensating for the narrower range of available species with meticulous preparation and dosing.

Desert and arid zone societies, including those in the Sahara and Kalahari margins, organized health around water discipline and heat management. Caravan leaders enforced strict routines to prevent dehydration and heatstroke, using herbal infusions and salt licks to maintain electrolyte balance. Knowledge of shade, rest cycles, and protective clothing was as vital as any medicine. Skin conditions and eye ailments from dust were treated with plant-based salves and protective goggles fashioned from bone or reed. In these harsh landscapes, healing knowledge often resided with elders who remembered long-ago droughts and the strategies that allowed communities to survive. The mobility of these groups made them adept at sharing and integrating new remedies encountered along the routes.

Warfare and political conflict introduced unique health challenges. Armies and militias on the move spread wounds, infections, and psychological distress. Siege conditions concentrated people in tight spaces, increasing risks of respiratory and waterborne diseases. Nevertheless, military campaigns also catalyzed medical innovation. Skilled bone-setters and surgeons followed armies, developing techniques for treating fractures and arrow wounds. Knowledge of herbal anesthetics and anti-infectives traveled with soldiers and captives. Conflict disrupted everyday care but also prompted the creation of new alliances between healers and commanders, as health became an instrument of morale and capacity. The mobile clinic, in rudimentary form, was born of necessity.

Pilgrimage circuits, such as routes to Mecca or local shrines, created special patterns of health risk and exchange. Long journeys exposed pilgrims to diverse pathogens, but they also built trust networks that facilitated care in distant towns. Stories of epidemics encountered en route informed community preparedness and shaped expectations of quarantine or treatment. Shrines dedicated to healing spirits attracted the sick, blending spiritual solace with practical therapies—herbal baths, dietary regimens, and social support. These circuits became corridors of medical pluralism,

where orthodox religious practices and indigenous spirit healing interacted. For many, the spiritual and the medicinal were not competing frameworks but complementary responses to suffering.

Ritual healing served social and psychological functions that modern public health often overlooks. Divination could identify sources of stigma, resolve disputes, and mobilize caretakers, improving outcomes for chronic conditions and mental health. Festivals marked the end of disease seasons, reinforcing collective resilience and shared responsibility. While these rituals did not target microbes directly, they addressed the social determinants of health: isolation, anxiety, and fractured relationships. In many contexts, a healer's authority derived as much from their ability to mediate conflict and restore trust as from their pharmacological skills. The result was a holistic system where healing encompassed body, mind, and community.

Trade goods included medicines and parapharmaceuticals, shaping health practices across regions. Salt from Saharan mines supported wound care and food preservation; medicinal resins from East Africa entered Indian Ocean pharmacopeias; gold and copper were sometimes used in healing rituals or practical devices like cupping tools. Textiles and ceramics facilitated storage and transport of remedies, while beads and ornaments played roles in ritual healing. Marketplaces displayed a spectrum of healer specialties, from bone-setters to herbalists to spiritual mediums, each with a clientele shaped by reputation and word-of-mouth. The circulation of goods thus carried healing ideas and techniques, embedding medicine in the broader economy of exchange.

Gendered divisions of labor influenced who healed and how. In many communities, women managed household health, midwifery, and much of the herbal pharmacopeia, while men might dominate public rituals and certain forms of surgery or combat medicine. These divisions were not rigid; apprenticeships and marriages often allowed knowledge to cross boundaries. Women's networks—kin groups, market associations—were particularly effective at spreading preventive practices, such as child-feeding strategies or hygiene routines. Recognizing these dynamics clarifies that precolonial health systems were gendered but not necessarily restrictive; expertise flowed through social channels that both constrained and enabled innovation.

Ecological knowledge was integral to preventive health. Communities read the behavior of birds and insects as signals of seasonal change and disease risk. Flowering patterns indicated the arrival of malaria seasons; the calls of certain birds signaled the time to plant or harvest. This observational medicine complemented more formalized healing practices, enabling preemptive action such as moving camps, boiling water, or avoiding specific areas. Such knowledge was often encoded in proverbs and songs, ensuring transmission across generations. Far from passive victims of environment, precolonial societies actively managed risk through mobility and environmental literacy, forming an early public health ecology grounded in place-based expertise.

Diet and nutrition were central to health, with food itself serving as medicine in many contexts. Fermented foods—sorghum beer, millet porridges, milk products—provided probiotics and enhanced nutrient absorption. Leaves like amaranth and baobab added vitamins and minerals crucial for preventing deficiency diseases. In pastoral societies, blood-milk mixtures offered iron and protein during lean seasons. For fishing communities, omega-rich fish supported cardiovascular health and child development. These dietary practices were not merely culinary choices; they were interventions designed to sustain immunity and resilience in the face of variable food availability and endemic infections.

The social organization of care often revolved around age-sets and communal labor. Planting and harvest demanded collective effort, which doubled as opportunities to check on the health of neighbors and redistribute resources. Elders, respected for their memory and experience, mediated disputes that might otherwise cause stress-related illness. Adolescents might be tasked with fetching herbs or water, learning health knowledge in the process. Festivals marked transitions and included cleansing rituals that reduced the risk of disease spread by mobilizing cleaning and waste disposal. These practices created a baseline of communal health maintenance, making crises easier to manage when they arose.

Healing knowledge was preserved and refined through oral traditions, songs, and coded proverbs. Mnemonic devices helped remember complex recipes and treatment sequences. Storytelling encoded warnings about dangerous plants and unsafe routes, serving as a living manual of public health. While some knowledge was secretive, held by guilds or families, much of it circulated through everyday conversation and apprenticeship. Oral archives were dynamic, not static; they evolved as new remedies were tried and old ones were discarded. This fluidity allowed communities to adapt to changing ecological conditions and disease pressures without centralized institutions or written records.

Travelers, including merchants and scholars, served as informal epidemiological observers. They carried news of outbreaks, described symptoms encountered in distant lands, and sometimes introduced new treatments. This role was not without risk—misdiagnosis and rumor could spread panic—but it also fostered a distributed system of health intelligence. Stories of plagues in faraway cities informed local preparations, such as adjusting market schedules or reinforcing ritual protections. Over time, these accounts contributed to a shared understanding of disease patterns across regions, even in the absence of formal surveillance systems. Mobility, therefore, was both a conduit for pathogens and a channel for collective learning.

Water management strategies were essential for preventing disease. Communities developed wells, cisterns, and sand filters, often associating these structures with protective rituals. In flood-prone areas, homes were raised, and drainage channels dug

to reduce mosquito breeding. Along rivers, certain stretches were designated as safer for drinking, while others were reserved for washing or livestock. Knowledge of these distinctions was passed down through practical training and story. Water spirits were often invoked to guard purity, blending spiritual beliefs with material precautions. These practices reveal a pragmatic approach to sanitation that combined environmental engineering with cultural meaning.

Trade in livestock brought both benefits and risks. Cattle, goats, and camels provided food, labor, and status, but also introduced zoonotic diseases such as anthrax and brucellosis. Pastoralists learned to handle animals with care, using protective garments and rituals to manage risk. Veterinary knowledge was integral to human health, as healthy herds meant better nutrition and economic stability. Some communities developed quarantine practices for new animals, isolating them before mixing with existing stock. The line between animal and human medicine was porous; healers often treated both, observing how livestock illnesses preceded or paralleled human outbreaks.

Local governance structures often played a role in health decisions, even before colonial rule. Chiefs and councils could mandate the cleaning of communal spaces, regulate markets to prevent overcrowding, or mobilize labor for well-digging. They might also arbitrate disputes that had health implications, such as access to water or medicinal plants. In some regions, specialized health officers—sometimes hereditary roles—coordinated care during epidemics or famines. These institutions were flexible, varying greatly by region and political system, but they provided a framework for collective action. Their legitimacy rested on trust and perceived effectiveness, qualities that would remain crucial in later health governance.

Adaptation to epidemics, when they occurred, relied on mobility and social learning. Communities might retreat to remote areas, suspend market gatherings, or restrict travel routes. Rituals were intensified to address the perceived spiritual causes of disease, while practical measures like isolating the sick were implemented. The response was often holistic, combining symbolic and material strategies. Observing outcomes informed future actions; surviving elders retained memory of what worked and what didn't. While precolonial societies did not possess modern epidemiological tools, their adaptive capacities were considerable, honed by long experience with environmental variability and interregional contact.

Healers' reputations traveled faster than caravans, sustained by stories of successful treatments and dramatic recoveries. A bone-setter known for mending fractures quickly might be summoned from distant villages, while a herbalist's fame for curing fevers could draw clients from multiple ethnic groups. This reputation economy fostered competition and innovation, as healers refined techniques to maintain credibility. Trust was the currency of medicine; it was earned through results, empathy, and integrity. Precolonial health systems thus relied on informal

accountability mechanisms—social recognition, reciprocity, and the threat of reputational damage—rather than formal regulation.

Public health in precolonial Africa was not a distinct discipline but a woven practice embedded in everyday life. Sanitation, nutrition, and mental well-being were managed through shared norms, environmental knowledge, and social networks. The absence of centralized bureaucracies did not mean absence of organization; rather, it reflected a distributed system where households, kin groups, and local leaders carried primary responsibility. Mobility—seasonal, ritual, economic—was central to this system’s logic, allowing communities to exploit opportunities and avoid hazards. It is a mistake to view precolonial health as static or purely traditional; it was dynamic, empirically informed, and adapted to diverse ecologies.

The foundations laid in precolonial times matter for understanding later history. Colonial systems did not introduce health concerns from scratch; they encountered established expectations, trusted healers, and working strategies for managing disease. Postcolonial health reforms continue to draw on these legacies, even when they fail to acknowledge them explicitly. Modern public health in Africa remains intertwined with mobility—migration, trade, pilgrimage—and with pluralistic healing landscapes shaped long ago. Recognizing these continuities is not about romanticizing the past; it is about appreciating the depth of experience on which contemporary policy can build. The story of health in Africa begins with movement, and that story continues.

This chapter sets the stage for the deeper exploration of trade routes, caravan towns, and the circulation of disease that follows in Chapter Two. It frames the continent’s health histories not as isolated episodes but as a long conversation between people, pathogens, and place. The landscapes of precolonial health were varied and vibrant, defined by practical ingenuity and social solidarity. By understanding these early patterns, we gain perspective on the challenges and opportunities facing health systems today. Mobility has always been central to African life, and medicine has always moved with it.

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