

Introduction

AROUND 1900, many people living on the northern shores of the great Nyanza (Lake Victoria) began to die after wasting into thinness and falling into a nodding, impenetrable sleep. Their strength had been diminished and their ability to care for themselves was gone. Similarly, around the vast and deep Lake Tanganyika, wasting sickness and a deadly sleepiness began to affect people on the lake's western shore, driving their flight from villages and migration to areas not yet touched by illness. The first people afflicted were primarily those who traveled to trade and work around the region's growing commercial hubs on the lakes, those who farmed on the fertile edges of the Lake Victoria basin and the Lake Tanganyika valley, and those whose lives took them to the shores of the lake to fish, to draw water, or to row across the vast inland seas. In these areas, they were bitten by various insects as they went about their daily routines. They were already contending with the irregular rains and droughts that in recent years had brought widespread hunger and insecurity and coping with outbreaks of illnesses that struck people down swiftly and without respite.¹ They had survived the disruption and violence of European colonial incursions that had divided the region into Belgian, British, and German spheres of influence after 1880. But this wasting sleepiness that led to the deaths of increasing numbers of people on the lakes' shores was something different.

In the first years of the twentieth century, the process of making sense of this illness had just begun for people living on the Ssesse Islands of Lake Victoria, in the kingdoms of the Haya people on the lake's western shores, and in the coastal lowlands of Lake Tanganyika. Around Lake Victoria, people named this new form of illness and death *kaumpuli*, *botongo*, *isimagira*, *mongota*, *tulo*, or *ugonjwa wa malale*; on the shores of Lake

Tanganyika, people called the sickness *malali*, *ugonjwa wa usingizi*, or *ugonjwa wa malale*. European observers in the region identified a disease, naming it *maladie du sommeil*, *Schlafkrankheit*, or *sleeping sickness*. These diverse names reflect differing experiences rather than a unified and uniform understanding. As illness increased, African elites, affected individuals and their communities, colonial officials, missionaries, researchers, and a few scattered ethnographers began to document the arrival of this sleeping sickness, which seemed to be new to the area and unprecedented in its scale and severity.²

While evidence exists that sleepy, wasting illnesses were known and recognized as serious by some populations around Africa's Great Lakes (the interlacustrine region), their greater extent in the early twentieth century was novel and alarming. Tens of thousands of people died around Lake Victoria alone in the first few years of the 1900s; other epidemics peppered the continent simultaneously. As historical phenomena, these epidemics of sleeping sickness loom large in studies of African life. Scholars have argued that the expansion of sleeping sickness and its staggering mortality rates related to colonial incursion and subsequent colonial economic imperatives.³ Equally compelling are studies that demonstrate how colonial disease prevention efforts attempted to completely reconfigure African lives and livelihoods.⁴ But such emphasis on the causes of these epidemics and on extensive prevention efforts that followed has effectively concentrated our attention on the actions of European colonial regimes at the expense of understanding African intellectual worlds and existing systems of managing illness and disaster. Scholars have paid scant attention to how people responded to widespread illness at the time—what intellectual resources they drew upon, how they acted in response.⁵ In the interlacustrine region, many populations linked new illnesses directly to past experiences of sickness and death. Their strategic responses drew on the intimate histories, experiences, and memories that loomed large as family members or neighbors began to sicken and die in new ways. Affected people also engaged with European colonial officials and European missionaries, relatively recent arrivals in the region. While German, British, and Belgian empires were expanding in the Great Lakes region, the area's social, political, economic, and ecological dynamics also shifted. Between 1902 and 1914, the overlap between the habitat of a particular biting fly and the spaces and lands used daily by people in the region would ultimately catalyze some of the most ambitious, extensive, and disruptive colonial public health campaigns of the twentieth century.

This book is a history of public health and politics in Africa's Great Lakes region in the early twentieth century. It focuses on epidemic sleeping sickness and colonial and African efforts to prevent it, drawing on case studies from colonial Uganda, Tanzania, and Burundi. It fits sleeping sickness into local people's pasts and presents in order to highlight the experiences and intellectual worlds of the vast majority of the people who sickened and died at the time. It argues that African systems of managing land, labor, politics, and healing were central in shaping the trajectory, strategies, and tactics of colonial public health campaigns around Lake Victoria and Lake Tanganyika. African engagement with, evasion of, or negotiation within anti-sleeping sickness measures shaped the very nature of the campaigns, as people sought to make colonial interventions work within their own frameworks and colonial officials were forced to respond to (if not accommodate) this engagement in order to maintain their programs. Possibilities for negotiation opened up through the mutability and uncertainty of biomedical knowledge and practice as well as through the evolving nature of new political and economic relationships. In these changing circumstances, multiple players—such as the German scientists, British officials, Ziba royalty, Rundi or Bwari commoners, Belgian doctors, or Ssesse islanders in my case studies—interacted to shape anti-sleeping sickness measures.

Following Frederick Cooper's conceptualization of colonial power as "arterial . . . concentrated spatially and socially . . . and in need of a pump to push it from moment to moment and place to place," I argue that sleeping sickness provided just such a "pump" for the movement of new energy and resources into rural communities in the Great Lakes region, but that unpredictable points of friction and openness within African life shaped its ultimate direction and impacts.⁶ The individual and communal goals and ethics of diverse stakeholders sometimes aligned to produce the programs that European policymakers envisioned, but sometimes tilted so drastically in another direction as to require a fundamental reconceptualization of colonial public health practice. In this early era of colonial civilian administration, amid processes of engagement, negotiation, contestation, and accommodation, populations living around Lake Victoria and Lake Tanganyika asserted their own moral politics and therapeutic judgements to shape sleeping sickness control. The situated, spatial dynamics of interlacustrine intellectual worlds—their place-centered politics, therapies, mobilities, and social relations—fundamentally defined the field within which colonial interventions took place.⁷

At the center of this study is sleeping sickness. From a biomedical standpoint, sleeping sickness, known today as human African trypanosomiasis, is

an infection caused by two different trypanosome parasites (*Trypanosoma brucei rhodesiense* and *T. b. gambiense*). It is transmitted exclusively by several species of a biting fly (*Glossina spp.*) known widely as *tsetse*. Human African trypanosomiasis caused by either subspecies of parasite is generally fatal when untreated. It is, importantly, a disease of two stages; a person may not know that they have been infected for weeks, if not months, after being bitten by a fly. The first stage of illness, following transmission of the parasite by an infected fly, involves fever, malaise, local swelling of the eyelids and face, headache, and gland inflammation as the parasite becomes established in the blood, lymph, and other tissues. Inflammation of the cervical lymph glands on the back of the neck, known as Winterbottom's sign, has been considered a telltale sign of the disease for centuries. As the parasite moves into the central nervous system and causes inflammation, "progressive neurological disturbances" appear, manifesting in changes in behavior and mood, tremors in the fingers and tongue, difficulty walking, wasting and weakness, and deeply disrupted sleep patterns. Disrupted nighttime sleep and excessive daytime sleepiness, culminating in a coma-like inability to be awakened, characterize late stages of infection and give the disease its colloquial name.⁸ The parasites causing human disease, *T. b. gambiense* and *T. b. rhodesiense*, cannot be differentiated by appearance during microscopic examination, but cause radically different clinical manifestations of disease.⁹ Clinicians distinguish them by the speed of their progress to second-stage illness and death. *T. b. rhodesiense* causes the acute form of disease, moving swiftly, with outward signs of advanced disease appearing as early as two months after infection, and an average duration absent treatment of around six months until death. *T. b. gambiense* presents, by contrast, as a chronic illness, with a slow progress and an average of around two years absent treatment before coma and death.¹⁰ The two parasites have different and distinctive geographic distribution on the African continent. Historically limited in their spread to the north by the Sahara Desert, *T. b. rhodesiense* has predominated across southern and eastern Africa, while *T. b. gambiense* has predominated in western and central Africa, with possible convergence points at Lake Victoria. Species of flies that transmit the disease prefer two common ecologies in eastern Africa—either the damp environments and thick vegetation found near many bodies of water or in forests (riverine tsetse or forest-dwelling tsetse) or the dense grasses and brush of open grasslands (savannah tsetse). Cattle and wild ruminants are important reservoirs for *T. b. rhodesiense* and implicated in outbreaks of human illness, but no nonhuman reservoir exists for *T. b. gambiense*.¹¹

This consensus about the etiology and transmission of sleeping sickness has evolved over the course of the twentieth century. During the period discussed in this book, however, neither Africans nor Europeans understood the illness consistently on these biomedical terms.

RECONSIDERING SLEEPING SICKNESS CONTROL AND COLONIAL PUBLIC HEALTH

We now understand that epidemic sleeping sickness exploded in communities around Lake Victoria and Lake Tanganyika at the turn of the twentieth century, concomitant with apparently unprecedented mortality—an estimated 250,000 people purportedly died around Lake Victoria alone—before 1920. Parallel epidemics in the Congo River basin killed hundreds of thousands of people.¹² The epidemic followed several difficult decades for the region's populations, during which internal political conflict, drought, famine, cattle disease, sand fleas (*Tunga penetrans*) and other epidemics struck in succession, preceding and alongside European colonial incursion.¹³ The wide extent of sleeping sickness across regions of eastern and central Africa in the late 1890s connected to new, extractive colonial economies and the widespread disruption of ecological and agricultural circumstances brought by the imposition of European colonial rule. Across a wide territory, African political authorities acted to cope with this seemingly new form of misfortune and severe illness. In 1902, British scientists at work in Uganda identified the causative parasite and fly carrier. Thereafter, with rising fears of the impact of sleeping sickness on colonial economies, European colonial administrations kicked prevention and control campaigns into high gear.

Between 1902 and 1914, German, British, and Belgian colonial authorities in the Great Lakes region imposed myriad measures to try to control the disease's spread. Anti-sleeping sickness measures were European authorities' first attempts to focus specifically on African health as part of wider colonial health concerns, in contrast to attending primarily to European survival in the tropics in the prior decades.¹⁴ These measures ranged widely, from the forced depopulation of the lakeshores to the local eradication of crocodiles to experimental chemotherapies to the deforestation of fly habitats to the internment of the sick in isolation camps. Colonial authorities sought to alter how African communities fished, farmed, hunted, traveled, and sought healing, often under coercion and sometimes by force. Anti-sleeping sickness measures took place concurrently with increasingly strong assertions of colonial influence in royal politics, pressure to cultivate cash crops, and efforts to enumerate and locate populations to facilitate taxation and control mobility. Likewise, they occurred amid

increasingly frequent efforts on the part of targeted populations to evade the brunt of such political and economic impositions. Sleeping sickness prevention and control measures differed across colonial regimes, but all involved strategies aimed at breaking the cycle of transmission by limiting contact between humans and flies.¹⁵ Prior to World War I, there was no durable pharmaceutical cure for sleeping sickness and the drugs being tested had serious and sometimes deadly side effects. Drug treatments that were later developed were often toxic and difficult for patients to endure.¹⁶ The majority of people infected with trypanosome parasites ultimately died. After the 1920s, mortality rates seemed to drop off precipitously across Africa for several decades, before the disease roared back to life among the rural African poor in the 1970s and 1980s.¹⁷

Epidemic sleeping sickness is often understood as a great rupture in turn-of-the-century Africa. Both the disease and colonial responses to it had significant and enduring impacts on African lives and livelihoods. While I, too, share an interest in understanding the nature and extent of the disruption that the epidemics in the Great Lakes region caused, diverse evidence indicates that these epidemics also had strong continuities with past experiences and illnesses. Widespread illness and death in new forms may have shaken communities deeply, but people did not meet either at a standstill. In this book, I seek to disrupt and expand our histories of sleeping sickness by orienting around affected communities and how they responded to and made sense of illness amid colonial control measures. I center key local contexts of colonial public health—place, politics, and mobility—in examining how sleeping sickness prevention measures functioned. Each requires attention to a deeper past. People living on the shorelines of the Great Lakes drew on intellectual and practical resources based on past experiences and utilized established strategies to address widespread illness. Interlacustrine societies' ideas, practices, and strategies, in turn, shaped the horizons of possibility for a particular colonial intervention that is a core concern of this book: the sleeping sickness isolation camp. In the camps established by German authorities at Lake Victoria and Lake Tanganyika, colonial medical officers concentrated on identifying and diagnosing cases, isolating the sick, and experimentally treating people with a variety of drugs; camps also served as a base for work to destroy fly vector habitats, all within a wide catchment area.¹⁸ But these sleeping sickness camps had contingent, unpredictable stories, rife with negotiation, conflict, hope, misunderstanding, and shrewd calculation. Their history offers new insight on the continued importance of African intellectual worlds and of established systems of healing in how new colonial public health programs functioned.

This book argues that reorienting explorations of sleeping sickness around interlacustrine African concerns can generate productive new insights for an admittedly well-studied phenomenon in African history. Such a reorientation requires viewing sleeping sickness prevention and control from a different perspective, subordinating biomedical priorities and scientific detail to focus instead on the social, environmental, and political contexts of public health. To illustrate this shift and its consequences, consider two German colonial maps (figures I.1 and I.2) produced during the sleeping sickness epidemic. Figure I.1 is a 1907 map depicting Lake Victoria and its immediate environs and figure I.2 is a map of the northeastern littoral of Lake Tanganyika and its environs, circa 1913. Each map resulted from the combined efforts of colonial cartographers, medical researchers, and countless auxiliaries and assistants in the early twentieth century.¹⁹ The Lake Victoria map emphasizes three spaces, each roughly equidistant on the three sides of the lake in German colonial territory, and highlights known outbreaks of human illness around the northern arc of the lakeshore. Colonial borders are important on the Lake Victoria map, which draws the eye to where British Uganda and German East Africa meet as bright red hotspots, concentrations of human cases in German territory; important, too, are sketches of green along the lakeshore, depicting the range of the tsetse fly vector and suggesting the epidemic's potential spread. A map-reader anticipates a problem—what would happen if the green and red zones should overlap?—and thus also considers the potential location of some checkpoint or intervention in those areas of impending overlap of fly vectors and human disease, to keep the disease from spreading. The Lake Tanganyika map shows a series of stations, evenly spaced along the lake, where eight sleeping sickness camps (*Lager*) in colonial Burundi were located. Shaded areas along the lakeshore and adjacent rivers indicate that colonial geographies prioritized particular ecologies, denoting areas where fly habitats had been “*saniert*”—cleared away.

These two maps encourage an aerial imagining of a colonial public health problem and the campaign that solved it: tactically precise, strategically balanced, rationally comprehensive, and covering all bases. The mapped campaign seems proportional: sensible for the management of both manpower and resources and fitting with contemporary epidemiological practice. These maps and their makers' perspectives capture colonial public health as it emerged in the early twentieth century to begin considering epidemic diseases among colonized populations: a top-down, hierarchical apparatus of the state, targeting specific problems in geographically focused campaigns, and prioritizing the implications of illness for the imperial economic bottom line.²⁰