

INTRODUCTION TO SPECIAL ISSUE
BEYOND REALISM: AFRICA'S MEDICAL DREAMS

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*The most tragic form of loss isn't the loss of security; it's the loss of the capacity to
imagine that things could be different.*

Ernst Bloch, 1986.

*The world has long since dreamt of something of which it needs only to become
conscious for it to possess it in reality.*

Karl Marx, 1843, Letter to Ruge, cited in Jameson 1994.

Africa has long provided fertile ground for the medical imagination. From the colonial 'civilizing mission' to the ingenuity of post-Ebola 'pandemic bonds', African pathologies and potentials have kindled some of biomedicine's wildest fantasies (while testing the limits of its efficacy, rationality and universality, e.g. Vaughan 1991, Lyons 2002, Hoppe 2003, Lachenal 2017, 2018, Fanon 1959). Dystopian images of Africa – of tropical miasma, preventable deaths, barren women and orphaned children, wildfire epidemics depopulating the continent and spreading beyond – have intersected with visions of discovery, salvation, progress, productivity and mastery, but also with aspirations to equality, welfare, self-determination, authenticity, prosperity and rights.

BIOMEDICAL FANTASY AND SCRIPTED FUTURES

From the outset, the dream of imperial conquest was, in Africa, entangled with that of medical conquest, an entanglement that fostered discovery and innovation (e.g. Headrick 2012, Neill 2012). Although primarily directed toward securing and sanitizing enclaves of colonial military, administrative and economic activity, this newly scientific medicine was, at the same time, deployed to perform the potentially farther-reaching ideological work of Christian and European order and benevolence (e.g. Conklin 1997, Comaroff 2009). From the 1940s, biomedicine, fuelled by accelerating traffic between bodies, experimentation and technology, was hitched to the bigger ambitions of late-colonial, then inter/national, welfare and development (Cooper 2002, Tilley 2011, Lachenal 2017). Expanding the reach of biomedicine – by building clinics and hospitals (Prince, this issue); training and promoting African personnel (Geissler et al., this issue); dispensing new medicines, vaccines and insecticides through mass, mobile action (e.g. Vaughan 1991) or nurturing healthy dispositions as a civic virtue (e.g. Hunt 1999) – materialized new modes of investment not only in Africans’ bodies, but also in their professional mobility, modernity, and prosperity.

The transformative promises of development were, in Africa, initially invoked to define a reformed colonialism, one willing to invest in the continent’s economic and political future at a time of broader post-war moral and political reconstruction (Cooper 2002). At the same time, the focus on a narrow technopolitics of development often served to deflect revolutionary forms of anti-colonial liberation. Development programmes were also pursued to bring about decolonized

international linkages (on either side of, as well as across, the East-West Cold War divide, e.g. Prince, this issue) and national governance, thereby reordering the postcolonial world and Africa's place in it. In the post-independence decades, medicine and health were targets of international programs of cooperation based on technical assistance and technology transfer (Lachenal 2011). Some of these retraced old metropole-colony routes while seeking to infuse interactions with new ethical, material, professional and political possibility. Others opened onto different pathways of exchange and solidarity connecting Africa to new poles of the Cold War world in a context of humanitarian competition. Liberal visions of technological liberation from obstacles to trade and security (and the need for social reform, e.g. Reinhardt 2013, Packard 2016) were complemented and reshaped against the different propositions of 'socialist internationalism' – operating in part through international organisations like the WHO (Antic et al. 2016; Vargha 2018). Medical training and the development of health services were also cornerstones of African state expansion and nation building (e.g. Kusiak 2010).

As the post-war economic boom faltered in the late 1970s, the appropriateness of basing healthcare and development on expensive, imported, technology-based strategies, and of aiming for universal public provision was called into question, notably by the newly emerging academic discipline of 'health economics' (e.g. Forget 2004). In some circles, the rethinking of development inspired new kinds of public health dreams, initially directed at the universal provision of at least basic resources for wellbeing while relying less on aid, technology and expertise (Cueto 2004, Packard 2016). But just as the goal of 'health

for all' through 'primary health care' (PHC) was proclaimed by the World Health Assembly (WHA) in the late 1970s, a resolutely *realist* calculus of smarter investments in health gained traction, dismissing even PHC, at least in its 'comprehensive form', as utopian (e.g. Evans et al. 1981). The promotion, in international health circles, of '*selective* primary health care' guided by cost-efficacy evaluation (Walsh and Warren 1980), and, in international financial institutions (such as the World Bank, which was becoming increasingly active in healthcare lending and reform) of economic liberalization through structural adjustment measures, narrowed the scale and scope of public health provision in Africa (Prince & Marsland 2013). In the 1980s and 1990s, external pressures to reduce the role of the state in Africa combined with deepening economic crisis and an internal 'politics of the belly' (Bayart 1993).

The catalyzed nightmare of the African HIV/AIDS epidemic, which reversed life expectancy gains in many countries, slowly – partly due to Africans' insistent claims to treatment as a *right* (Robins and Von Lieres 2004), but also to the epidemic's construction as a state of exception (and a biosecurity threat) calling for humanitarian intervention (Nguyen 2005) – broadened the resources and ambitions of the new 'global health' around the turn of the millennium. Much criticized for their failure to (re)build national infrastructures of research, prevention and care – as exposed by the recent Ebola crisis in West Africa – and indeed for weakening remainders of existing health system structures by fragmentation and distortion, major global health players such as the Gates Foundation are backing old and new 'technical fixes' for health in Africa – often accompanied by quasi-utopianist

marketing, e.g., regarding the promises of ‘mobile’ and ‘e-health’ (Duclos et al. 2017). By investing in mobile, often minimalist devices and techniques such as point-of-care diagnostics, new vaccines and mobile phone applications, they seek to work ‘off-the-grid’, autonomously from health systems, to extinguish unknown future epidemics, eradicate pathogens and meet mortality-reduction targets (Redfield 2015, David and Le Dévédec 2018, Street 2018). Continuously trailed by critical social scientists, the global health ‘enterprise’ nevertheless often outpaces them with surprising innovations – such as the on-going turn to ‘Universal Health Coverage’, which ambiguously references seemingly anachronistic 1960s visions of health systems, while at the same time ushering in a new kind of marketization of health insurance and care provision (Lagomarsino et al. 2012; Prince 2017).

A generation of critical historians and anthropologists of Africa has held up biomedical *dreams* (those of doctors, bureaucrats, academics and businesses) against the *realities* of ongoing scarcity, inequality and violence. Indeed, as they have shown, the gap has remained wide between promises (those of colonial, inter/national, and global health) and actual resources for Africans’ survival and advancement, which have consistently been thinly and unevenly spread on the ground (e.g. Feierman 1985, Vaughn 1991, Turshen 1999, Foley 2009, Prince & Marsland 2013); as well as persistent social, spatial and racial exclusions in access to capacity and care (as well as to modernity and urbanity, e.g. Swanson 1977, Packard 1989, Hecht 2012); and the sometimes coercive impositions of hygiene, hierarchy and purportedly universal values (e.g. Fanon 1959, Lyons 2002). Indeed, in important ways, the gap has widened – and its geography radically changed - with

the exponential growth of private, high-end health facilities across Africa offering world-class care to the few, while services to the masses continue to decline (e.g. Harris et al. 2011). This scholarship unmasked colonial, international and global health dreams as ideology, or as delusional and fantastic (see also, MacPhail 2015). Yet, while exposing the harsh reality of most Africans' lack of access to health services, or even to the basic conditions for protecting and prolonging life, this critical work – somewhat like the health economists' calculating 'realism' that it politically opposes – left little space for dreaming, even for those dreams that African health workers and professionals, sick people and their relatives, have continued to dream; dreams, for example, of decent working conditions, medicines stocks, affordable care or publishable research.

THE WORK OF DREAMING

Rather than dismiss dreams as disconnected from reality, this special issue instead explores dreaming as 'a practice, a technique' (Gordin et al. 2010) for *working on* and *working out* the present. The papers in this collection were presented at the conference 'Dreaming of Health and Science in Africa. Aesthetics and Affect, Poetics and Politics' (Hinxton Hall, June 2015), which tied together and fanned out ideas, collaborations and sources of inspiration around the 'Anthropologies of African Biosciences' (AAB) collective. Originally based at the London School of Hygiene, this collective (2005-15) studied science and medicine in past and present in Africa, with a particular interest in ideas, visions and imaginaries that pointed beyond the merely medical, towards horizons of political

and social transformation (see earlier edited collections by its members, e.g. Geissler & Molyneux 2011, Kelly & Geissler 2012, Geissler et al. 2013, Geissler 2014, Geissler & Tousignant 2016).

While the special issue coheres around dreaming-in-action, its contributors emphasize different aspects of the concept, marked out by their use of various synonyms. Johanna Crane, for example, alternates between ‘imagination’ and dream. Although she highlights divergences between these and ‘reality,’ she also examines how ‘big’ dreams of equal partnership and heroic global health help to mask and maintain the minutiae of bureaucratic injustice. Noëlle Sullivan instead draws attention, through the term ‘reverie,’ to the generative function of dreaming, which produces something, if not necessary exactly what was dreamt of. ‘Dreaming’ can designate personal aspirations and collective visions, narrow claims and far-fetched imaginaries, concrete aims and marketing spectres. The concept’s common denominator is the gap between the existing and that which could, should or might be – a gap that is open to diverse political and analytic interpretations, and which generates action. Following Ernst Bloch’s concept of ‘concrete utopia’, dreaming is seen across the contributions as creating potential for contact between what is *here now* – imperfect, unfinished, unfair, insufficient – and what is not (yet, or no longer) effectively or materially present (Bloch 1986).

Our collected focus includes but also spans beyond Bloch’s interest in the political, transformative force of dreaming-as-hope, as a way of reaching toward a better future that is immanent or latent, but still unachieved and undecided, in the

present. Some dreams examined in this issue indeed bring dreamers closer to the possibility, even if uncertain or unlikely, of improved health capacity. For example, the aspiration for better-equipped hospitals and laboratories studied by Noelle Sullivan and Iruka Okeke opens up possibilities for infrastructural expansion and improved access to care and capacity, as well as for greater control over and participation in circuits of knowledge and resources that are already being 'performed' through 'dream plans' and improvisation. In other cases, dreams produce collectives, movement and action, which, although not fulfilling the specific fiction that sustain them, do create change – as in the case of Tanzanian scientists described by Wenzel Geissler et al., for whom the failing dream of a crumbling international scientific station has nevertheless created a solid foundation for careers as scientists elsewhere. Some other dreams, however, are forgotten or laughed off; past dreams of collective transformation via cutting-edge Africanized medical science and public healthcare have been closed-off in a future that never happened, which, as Ruth Prince and Geissler et al. point out, has apparently become undreamable. Other dreams yet actively produce failures and contradictions that they are unable to effectively recognize or address, as in the male circumcision campaign described by Nolwazi Makhwanazi, or through administrative systems underpinned by the dream of equal partnership that instead disable fair and constructive working relations, as exposed by Crane. Thus, dreams can pry open or press shut, conceal or expose, leverage or sink into, the distance between the real and what can be envisioned, remembered, hoped for, fantasized or fabulated about (Bloch 1986; Jameson, 2004). But regardless of whether dreams are likely to

generate hoped-for outcomes – whether they are expected to succeed or to fail, whether or not they are, or are recognized as, ‘unrealistic’ – they spur action; they are a form of work through which people make the world they live in and the world they live *for*, through which they constitute themselves and trace possible futures.

Taking dreaming as material for ethnographic study, the contributors to this special issue seek to describe the varied and specific ways in which individuals and collectives – Africans, but also their would-be ‘partners’ and observers, including ethnographers – move and provoke interaction, even define themselves, between material, affective, and imaginative presences. This entails attention to dreams beyond those, often dreamed from outside the continent, that the form of (grand) narratives, such as those laid out as a chronological sequence in the opening paragraphs of this introduction. The dreams of imperial, international and global health have indeed tended to predict or prescribe solutions for a continent diagnosed or coveted – often from elsewhere – as ‘an event that calls for a technical decision’ (Mbembe 2017) and ‘salvaging interventions’ (Goldstone and Obarrio 2017: 6), passing judgment on how Africa is, or how it should (or cannot) become global and modern. This is not to imply cosmopolitan biomedical dreams, for example of global disease eradication, have not *also* been African dreams – shared, reshaped, generated and adopted by African as much as by foreign and expatriate politicians, technocrats, clinicians, scientists and would-be patients. Yet, as ‘scripts’, they do not tell us everything about how the future- (and fiction-) making powers of medical science, technology and care have been defined, invoked, desired, called into question, or reinvented in the working out of lives and livelihoods in Africa,

whether by residents or by visitors to the continent. This also means looking in new ways at blueprints, such as the Alma Ata Declaration or socialist internationalism, seeing them not merely as un/realistic projects – whether failed or successful - but also as potentially generative of durable affective and political positions as well as practices.

This issue opens with an essay accompanying and introducing the ‘Local Intellectuals’ section (with the extended annotated transcript published online: [LINK](#)), the central theme of which is the remembrance of dreams, and, implicitly, their durability over time, providing renewed impetus for claims, contestation and debate in shifting political-economic contexts. The subsequent Part 1 of the issue ask how dreams can thread together or split off past from present visions of the future, being remembered—or not. Past dreams may persist as architectures and place names, coexisting with political amnesia (Prince, this issue), or appear as jokes and awkward moments (Geissler et al., this issue), concerning past futures have become difficult to inhabit or enact *as* dreams in the present. Dreams continue to take effect as movements and gestures that connect dreams of care, community and livelihoods across time and space in Mozambique, as examined by Ramah McKay; or as imaginings of both cure and death from hepatitis B infection in Burkina-Faso, loosely anchored in histories of access to HIV therapy and radically uncertain prognoses, in the contribution by Tamara Giles-Vernick and Fabienne Hejoaka.

Part 2 turns to forms of dreaming that are held up by fictions and fantasies—of a Kenyan nation bound by blood-sharing solidarity, as described by John Harrington,

or, as in Alice Desclaux's contribution, of Senegalese victory over an (imagined?) Ebola epidemic, of victory over HIV via mass circumcision in Swaziland, as described by Nolwazi Mkhwanazi—yet which nevertheless sustain practices and produce effects in the present.

Part 3, finally, turns to dream-plans, for a Tanzanian hospital, as described by Sullivan, or, in Okeke's contribution, for West African genomic laboratories. Yet dreaming, here, is not reducible to planning; in these cases, the future is not foreclosed by a plan, but is instead held open by it, remaining uncertain or even improbable. Along with Crane's analysis of the bureaucratic 'underbelly' of equal-partnership dreams in Uganda, these are also case studies of how 'African' dreaming can bypass, reorient, critique or accelerate external initiatives to 'build capacity' (see also Geissler & Tousignant 2016).

Across diverse cases, this special issue takes up dreaming as a crucial lever for understanding the emerging present of African healthcare and medical science. This is a present littered by the ruins and debris, as well as some standing edifices, of the big mid-twentieth century dreams of fast-forwarded development, expansive welfare provision, medical solidarity and health equity, and cutting edge African(ized) biomedical science. It is a present, also, scarred by several decades of 'practical thinking' (Jameson 2005), when the poverty of budgets (and perhaps also of imagination) was constituted as 'reality', and this status quo was translated by economists into calls to cut back on public spending and heed evidence of cost-efficacy. (Though perhaps in some cases with their own fantasies about market forces as inherently efficient mechanism for generating growth and managing the

'delivery' of 'quality' services, see Harvey 2005). This is a present, finally, into which the newly immoderate and transparently millennial language of global health possibility – of money, technology, predictions and targets – has irrupted, evoking (once again) victory over disease, universal access and humanitarian imperative – albeit with an eerily different ring to it. Even if denouncing this movement as 'nihilist' ignores the dreams of its busy workers (Lachenal 2014), these new utopianisms do call to mind Ernst Bloch's ancient warning against forms of utopian thinking that fail to recognise the real, material situation (with material 'reality' here not referring to available resources, but objective, transformative contradictions in society at a given time (Bloch 1986)).

How are African clinicians, scientists, patients and politicians, but also foreign advisors and partners, moving through and around such remains and reactivations? What distinctly twenty-first century dreams of global expatriate life (Redfield 2012), but also of political activism and change (Wendland 2010) or of routine regulatory protection (Tousignant 2018), do African health professionals weave into successive scripts – of policy, technical and economic experts – for novel global health performances? What other forms of global, national and local health do they envisage, or remember, as they are drawn into accelerating but fragmented streams of knowledge and funds? And how are African patients' dreams of life-saving medicines and of caring, affordable hospitals fuelled by the growing availability (to some) and visibility (to all) of well-advertised cutting-edge private diagnostic and treatment facilities (notably for non-communicable or chronic conditions like cancer)? How, by calling up histories of expanded access to therapy

(Giles Vernick & Hejoaka, this issue) or telling success stories of epidemic containment (Desclaux, this issue), are such dreams disturbing current intersections between persistent scarcity (of funding, equipment, staff) and new hopes (e.g. of universal private insurance coverage), hypes (e.g. of portable technological solutions) and nightmares (e.g. of Ebola)? In other words: What spaces are opened and contested, what is becoming dreamable within, and especially beyond, this new space of anticipation and amnesia (Lachenal, 2013a, 2015; Prince, this issue), but perhaps also of remembrance and nostalgia (Lachenal and Mbodj Pouye 2014, Geissler et al., this issue), of recycled fragments of past modes of anticipation (Buck-Mors 2002) and, surely, of illusion (Desclaux, this issue, Makhwanazi, this issue)?

(ANTI-)UTOPIA AND THE HISTORICITY OF DREAMING

If dreams are meant to transcend the existing, how can they also help us see and grasp the particularities of a located present? Bloch's conception of reality as an unfinished process, and of 'concrete' utopia as operating within the realm of the 'real possible', in terms of the political potentials of societal contradictions, offers one answer. Thus, Bloch's notion of dreaming does not do away with realism, or, importantly, with materialism. Utopianism that lacks grounding in concrete material and political-economic realities, according to Bloch, loses its potential for progressive transformation, leading instead to barbarism or fascism. Concrete utopia is also historically situated: it is *of*, while also reaching *beyond*, its time and place of departure; it is, in Bloch's words: 'transcendent without transcendence', or, in Ruth Levitas's, located 'within but on the edge of the real' (1990). Thus, dreams are 'never arbitrary' (Gordin et al. 2010); they expose historically situated ways of

understanding and inhabiting the present.

Dreams are also historical in their *plausibility*. Even highly improbable dreams – say: a self-regulating market, winning a Nobel prize, gender equality, becoming a revolutionary hero, or halting global warming – change, over time, in how seriously they are taken, and in the extent to which they draw on shared memory, desire, frustration, fear or anticipation. There may be a distinctive postcolonial history of plausible dreaming, arising from both the desire and difficulty of escaping colonial positionings as subject, subordinate, auxiliary, inferior, peripheral and static. It arcs, in a familiar story, from intense optimism for decolonization, development and emergence, through an abrupt reversal that relegated such hopes to the fantastical (e.g. Ferguson 1990, Piot 2010), to an uncertain, emergent present to which the future seems to be returning in a particularly volatile, speculative and exclusionary form (De Boeck 2011; Piot 2017; De Jong and Quinn-Valente 2017; Goldstone and Obarrio 2017), or as mere titillating fiction in the form of ‘Afrofuturism’ and its fantasises of technological-cum-cultural revival, through super-cutting-edge science (Kilgore 2014; Kennedy 2018).

Yet this arc also echoes broader trends that follow from a loss of belief and investment in the state as responsible for ‘maintaining the world openly and robustly’ (Berlant 2011: 168), and perhaps also from a generalization of precarity and deepening social inequalities over the last decades. Many observers have noted the discrediting of the high modern dreams of both liberal and socialist development and welfare *as* utopian, implying that these are instead dystopian and incompatible with freedom and choice (Jameson 2005). The pursuit of the latter

under pure market relations has also been called utopian (e.g. Harvey 2005, though, post-2008, this dream too seems to be losing in plausibility, see: Thompson and Zizek 2013). Still, dreaming big, together, for each other and as 'society', clearly went out of fashion. According to some, hope was privatized: individualized, deregulated, marketed and consumed (Bauman 2003; Thompson and Zizek 2013). For many, the scope of hope also shrank after the demise of Fordism and developmentalism. As even modest 'fantasies of a good life' have grown 'more phantasmatic' (Berlant 2011: 11), optimism has become 'cruel'.

The turn away from collectivized hope and dreaming, and the rise of anti-utopian injunctions to realism, are particularly striking in the debates about healthcare reform in both high and low income settings that emerged in the late 1970s. Alongside the loss of capacity and credibility of states as sources of planning, provision, regulation and redistribution, calls for more rigorous 'evidence-based' judgments of value while giving 'consumers' greater individual freedom and responsibility shifted these debates away from the dream of universal health systems. Across the global North and South, calls arose to contain the spiralling costs of public medical care in the face of constrained fiscal resources. Anti-utopian accusations were levelled not only against social distribution systems, but also against claims of techno-medical progress. The collective health gains from medicine were exposed as a 'mirage' (e.g. McKeown 1976), raising questions about the investment of public authority and resources in experts and technology (Illich 1975), and the restriction of personal choice, responsibility and autonomy (Harrington 2009). Calls for more rigorous proof of *efficacy* were bolstered by a

search for measures on which to base the economic rationalization (and rationing) of medical interventions (Adams 2016). As mentioned above, this critique of high-cost, high-technology, high-expertise health systems briefly inspired new kinds of utopian thinking about health as integral to, and resulting from, a 'good society,' as exemplified by the *Declaration of Alma-Ata* (WHO, 1978). By the 1980s, however, the dominant conversation in international health was about how to *prioritize* the allocation of scarce, and, for the foreseeable future, inelastic public funds by calculating the cost and impact of afflictions and interventions (see, especially, Jamison and Mosley 1991 and World Bank 1993). During the same period, the British National Health Service (NHS), once a herald of Keynesian welfare society, was turned from a utopian project for the protection of societal spaces from market forces, into an aspiration for a dynamic 'process' managed by consumer choice (Harrington 2009). 'Being realistic' about healthcare has, by and large, entailed a search for more and better *evidence* to guide the rationing of public resources and to invigorate private initiative in the 'delivery' and 'consumption' of health services. *Public* decisions about healthcare were increasingly, across the global North and South, justifiable only on the basis of evidence of cost-effectiveness (albeit amid fierce debate about the validity of metrics and the quality of data) and/or as freeing up *private* dreams of responsibility, choice and benefit.

VIOLENCE AND HOPE BEYOND ABSENCE

The disastrous consequences of giving up on the dream of public, accessible and effective healthcare in Africa (and of strong and relevant African public health research, e.g. Geissler & Tousignant 2016, Tousignant 2018) are well documented

(Pfeiffer and Chapman 2010, Prince 2014). A striking example is provided in accounts of the recent Ebola epidemic in West Africa as revelator of the catastrophic neglect of public infrastructures (Fauci 2014, Ferme 2014, Farmer 2014). New kinds of dreams and dreaming seem urgently needed in order to redefine the contours of plausibility – breaking out of the constrictions of realism and realization – of the future for African healthcare and medical science, and to revitalise medicine as tool to ‘dream up’ larger social collectives, in the way in which national health systems and medical science were instrumental for imagining and organising post-war Britain or – involving the same thinkers – post-colonial Tanzania (Titmuss et al. 1964)

Attention to dreams can also reinvigorate debates on two recurring themes in scholarship on medicine in Africa: dearth and violence. Absences – of resources and access to them, of equality, capacity and certainty – cling to the dreams described in this issue; they inspire but also haunt and undermine them. Our attention to dreaming aims to take a step beyond pointing to ‘present absences,’ and toward examining the specific ways in which, whether through hopes, fictions or nightmarish fantasy, the intrusion or enlistment of what is *not* (or only partially) present may *enable* ways (including passive, ineffective ways) of being and doing in African care and medical science. Dreams break into, or out of, the conditions – of suffering and violence, of quests to obtain or provide protection and care – under which medical care and research is engaged with (e.g. Geissler et al. 2013, Hunt 1999, 2015, Wendland 2012, White 1995). What is *missing* (be it medicines or equality of opportunity or accessible services,), or unreachable (cordoned off in

prosperous spaces of private care, global funding, or abroad, e.g. Geissler 2014, Prince & Otieno 2014, Sullivan 2011, Wendland 2012) – may, through dreaming, gain presence in, perturb, give meaning to, or make tolerable, what *is* there.

While dreaming can be hopeful and expectant, mobilize protest and reform, it can also, however, justify or mask oppression and stasis, or become conservative and ‘cruel’ (Berlant 2011) when conditions of possibility and plausibility are altered. The unreachability of the dream, the gulf between what does or can materialize under present historical conditions and the imaginable, also bears the potential for violence (Bloch 1986). The violence of biomedicine in Africa has usually been located in the imposition of its epistemologies and strategies, that is, as inherent to biomedicine’s ideology of superiority, mastery and control (Harding 2011, Fanon 1959), or in the withholding of its benefits, in other words, of unrealized ideals of capacity and care (Feierman 1985, Packard 1989, Turshen 1999,). This edited collection moves beyond the description of suffering engendered by these forms of biomedical domination and exclusion. Its essays illuminate how people work – by dreaming – through, on or up the excesses and insufficiencies of biomedical power and materiality.

Yet they also reveal further forms of violence arising from dreaming itself, or from the ‘loss of the capacity’ to dream of mutual or collective transformation (Prince, this issue, Geissler et al., this issue). The turning of promises, plans and aspirations into (*just*) dreams – when they are continuously postponed (e.g. Hecht 2002; Lachenal 2011), trivialized as pipe-dreams, turned into fantasies, dissolved into futility (Lachenal 2015) or stoked as fictions – can be painful or anesthetizing.

Sharing dreams can be liberating, but dreaming others' dreams can also carry insidious forms of subjection: be it through colonial medical education or global health partnerships, Africans have so often been told what to dream (and what to make do with), thereby offering entry to 'universal' aspiration but also placing limits on full or cutting-edge participation and brushing aside the possibility of more singularly 'African' ways of dreaming. Dreams can also inhibit, defer and dampen demands for transformative action, as when fictions of reciprocity and change – such as those mobilized by postcolonial cooperation or promises of transnational partnership (Crane 2013, and this issue; Moyo Okwaro and Geissler 2016) – permit the persistence of unequal working relationships and projects. Hopeful hype and the rhetoric of goalposts (e.g. MDGs or 3 by 5) mask the circular futility and nihilism of the hunt for solutions (Lachenal 2015) or of endless exercises in capacity strengthening (Geissler and Tousignant 2016)). The dismissal of dreams *qua* dreams can justify the whittling down science and medicine to fit the present tense of urgent priorities and scarce resources.

Still, the dreamt-of, even if impossible (whether acknowledged as such, or not) can be galvanizing. Elusive and utopian goals can mobilize claims, criticism and sometimes, extraordinary attributions of power and resources (e.g. Lachenal, 2010; 2017). The unreachable can give shape to demands, as when ordinary Kenyans imagine the possibility of getting treatments advertised on billboards for private care (Prince, forthcoming) or when racial hierarchies of expertise are set to expire (Iliffe, 1998; Hecht, 2002). Even fictions can bring about opportunity and relationships, as when African scientists pretend to have wonderful conditions for

research in order to attract or secure transnational collaboration (Fullwiley, 2011; Moyi Okwaro & Geissler, 2015). Dreams are often of transformation, critical of the present and articulating alternative and imaginative futures towards which expertise, knowledge and care might lead. They can keep people together, sustain subjectivities and constitute biographies in the face of loss, and give meaning to relations within and between generational and professional groups, whether through sharing of hope and memory, or by way of ironic detachment (Geissler, 2011; Tousignant 2013, 2018; Osseo-Asare 2014; Droney 2014).

An added feature of this special issue is a transcript of two reunions of European and African scientists who worked in Tanzania during ‘Africanization,’ which is included as a ‘Local Intellectuals’ section in association with the article by Geissler et al.’s. This transcript – of which a digest is included as part of the print version of the issue, and a complete version available online – provides an opportunity for readers to explore the complexity and contradictions of African medical dreams, as well as dreamers’ dialogues and conflicts. The intellectuals in question are a group of medical scientists – including technicians and university professors – who worked together in the 1960s and 70s, during an important moment of their career as well as of national history, and the development of science in Africa, in the once famous research station of Amani in north-eastern Tanzania. The “Local Intellectuals” section offers the annotated and illustrated full transcript of two reunions of these science-workers, one held in Britain (2013), the other in Tanzania (2015), during which participants reflected on disappointed and fulfilled dreams, scientific and other, private and public, individual and collective.

Listening to these now elderly people raises many of the issues developed above, and shows how dreams, struggles for their fulfilment, and the memory of dreams and struggles, constitute meaningful lives; and how dreams – shared and bequeathed, appropriated and rejected – constitute collective identity and action.

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